Title: Exploring and enhancing autonomy for older people in residential care

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Publication Date: 2012-10-25

Item record: http://hdl.handle.net/10379/3043
Exploring and Enhancing Autonomy for Older People in Residential Care

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July 2012
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This thesis is the work of Claire Welford, and its contents have not been previously submitted in pursuit of a degree at National University of Ireland, Galway or any other University.
Acknowledgements

First and foremost I would like to thank the Health Research Board (HRB) for their vision and commitment to nurse PhD education and also for their support of this research for the benefit of older people in residential care.

I would like to thank my grandparents; I miss Jack, Margaret, Tom and Dorothy every day.

For the residents and staff of the case study site, you always made me feel welcome and I really wish to thank you for your desire to work on this research project. Special thanks to the Clinical Nurse Manager (II) who was extremely passionate about trying to make things better. This genuinely couldn’t have been completed without all of you.

Next I would like to thank my supervisor, Professor Kathy Murphy, for her time and direction. Also my co-supervisors Dympna and Meredith for their advice.

Pauline and Sinead, thanks for all the support, you were always there for me and you listened.

Ben Meehan, thank you for unravelling the mystery of NVivo. Maura thank you for the guidance with the concept analysis. To my twin sister and her imaginative brain.

To my family, who eventually stopped asking if I was nearly finished!

Finally to Dave, you bring me sunshine in the happy house.
Abstract

The purpose of this study was to explore autonomy for older people in residential care. A single exploratory embedded case study design was used.

The case study was adopted for the purpose of gaining a better understanding of resident autonomy from multiple perspectives and multiple data sources. Prior to commencing the data collection phase of the research, a concept analysis of autonomy for older people in residential care was undertaken. This analysis was used to inform the development of the data collection tools. This first phase of the research included interviews, observations, documentary analysis and a staff attitude survey. Analysis of the findings from phase one revealed that there were problems with resident autonomy in the case study site. Two main themes emerged from the findings: The Personal and Being Personal.

Findings from phase one resulted in a second phase of the research whereby staff participants enhanced one aspect of resident autonomy. Phase two was guided by action research principles in order to introduce a change in practice. Care plans with a focus on autonomy were designed and implemented in order to enhance the residents autonomy.

Discussion of the findings from both phases of the research was summarised into promoting and prohibiting factors for resident autonomy.

Recommendations are made in relation to the knowledge, skills and attitudes that health care professionals working with older people in residential care need to possess. Recommendations are also made for encouraging negotiation, biographical care planning and facilitation of resident decision making in residential care. Additional recommendations are made for further research which will extend the operationalisation of the concept of resident autonomy.
Publications

During the course of this PhD, a number of publications have been produced that were based on the work presented in this thesis. These are listed here for reference.

Journal Publications


Conference Presentations


Chapter 1: Introduction and Background

1. Introduction and Background

This chapter introduces the background to this study. It describes the current context of the global ageing population. It then describes how the context of residential care for older people has evolved and changed in response to the ageing population. Finally, it reflects on the future context of residential care for older people. It highlights throughout that resident autonomy is an issue that needs to be explored if older people are to experience a satisfactory quality of life in residential care. The conceptual framework that guided this study is then outlined. This chapter concludes with the research aims and objectives, and outlines the following thesis.

This thesis uses the term “residential care”, which is defined as a long-stay healthcare nursing home for older people. The older person will not be discharged from this home and will have replaced living in their own home with living in this home. An older person is defined as a person who is aged 65 years or over.

1.1 The Current Context

Global statistics reveal a steady increase in the age of the world’s population. In the USA it is estimated that by the year 2020, 35million people will be over 65years of age and 7million people will be over 85years of age. Thus between 1990 and 2020 the population in the USA aged between 65 and 74years is projected to grow by 74%. In Australia, 13% of the population were aged 65years and over in 2004. Those over 85 years of age represented 1.5% of the Australian population and this is estimated to increase to 2-3% by 2021. The Swedish population of over 65s in 2000 was 23% and this is also expected to increase, to 31% by 2050. In the UK, 20 million people were over 50years of age in 2003 and this is projected to increase to 27.2million by 2031. In Ireland, the ageing population is also growing (Table 1.1 shows the growth from 2007-2009). In 2009, 13.14% of its population was over 65 years of age (495,000 people). This is estimated to increase to 22.4% by 2041.
Further analysis of national statistics reveals that while the overall population is ageing, the number of the oldest old is growing even more quickly. There is a notable increase in those aged 85 years and over, with this population growing from 50,300 in 2007 to 55,400 in 2009 (Table 1.1). The Central Statistics Office (CSO) predicts that this trend will continue, and foresees the numbers of people over the age of 85 years to more than quadruple from approximately 60,400 in 2011 to 255,100 in 2041 (Figure 1.1). According to the CSO, one of the reasons for this predicted increase is the relatively high birth rate (compared with other countries) up to the early 1980s.
Figure 1.1: Projected Numbers of Older People in Ireland by Gender and Age Group, 2011 to 2041

In the context of this study, the projected growth in the numbers of older people reaching advanced old age is particularly significant as the majority of people in this age group reside in residential care (Department of Health and Children, 2006). Recent statistics for older people who were in residential care in Ireland on 31st December 2011 reveal that the greatest population of older people in residential care are also the oldest, with 47.2% over the age of 85 years. This is an increase from 38.8% in 2001 (Department of Health and Children, 2012).

“The Years Ahead” report (Working Party on Services for the Elderly, 1988) was adopted as official government policy in 1993 and re-published in 1998 as “Adding Years to Life and Life to Years” (National Council on Ageing and Older People, 1998). The policy is to maintain older people in good health in their own homes for as long as possible and to provide high quality hospital or residential care when the older person is no longer able to manage at home. Older people enter residential care for a variety of reasons. Figure 1.2 from the CSO illustrates a broad summary of the reasons for admission to residential care, categorised into physical disorders, mental disorders and social reasons. Physical disorders represent the largest reason for admission to residential care facilities.
Figure 1.2: Residential Units by Regional Health Office: Percentage Distribution of Patients Resident at 31 December 2008 by Bed Type and Medico-Social Status (CSO, 2008)

It is of paramount importance that older people who are no longer able to continue living in their own homes can experience a satisfactory quality of life in residential care. Researchers who have specifically focused on quality of life in residential care have found that autonomy, choice and control are central to quality of life (Murphy et al., 2007; Tester et al., 2004; Edwards et al., 2003; Ball et al., 2000; Kane and Kane, 2000; National Council on Ageing and Older People, 2000). Further evidence suggests that older people themselves feel that autonomy is important for good quality of life (Barkay and Tabak, 2002; Edwards and Staniszewska, 2000; Edwards, Staniszewska and Crichton, 2004; Murphy, 2007). The United Nations (UN) Madrid International Plan of Action on Ageing (MIPAA, 2002 and 2008) recognised that there is global acknowledgement of the need to include older adults in autonomous decision-making processes. The Irish courts have stated that the constitutional rights of every person include the right to autonomy and self-determination (National Council on Ageing and Older People, 2008). The National Council on Ageing and Older People (NCAOP) was established in 1997 with the aim of improving the lives and autonomy of older people who are affected by illness and impairment. However,
research has found that the older person’s level of autonomy is often eroded in residential care (McWilliam and Ward-Griffin, 2006; Randers and Mattiasson, 2004; Barkay and Tabak, 2002; Lothian and Philip, 2001; McCormack, 2001; Brown, Davies, Ellis and Laker, 2000). It is important, therefore, to examine the residential care service in order to try and understand why this may be so.

1.2 The Changing Context of Residential Care

As the number of older people continues to increase, the demand for residential care rises and this also leads to changes in the way this care is provided.

Different terminology is used in different countries to describe the various housing and health care service options for older people. Various housing and health care service options also exist in Ireland and these are discussed in the subsequent sections. Recently, Howe, Jones and Tilse (2012) reported that “nursing home” is the most common and least ambiguous term used which has common meaning across five countries (the United Kingdom, the United States of America, Canada, Australia and New Zealand). The review by Howe, Jones and Tilse (2012) revealed that “nursing home” always related to facilities in which skilled nursing care is available on a 24/7 basis and whereby nursing care is received by a high proportion of residents. In Ireland, “residential care” is the current term used by government, policy makers and healthcare providers to describe similar care. However, Howe, Jones and Tilse (2012) also discovered that nursing homes are not the only settings in which high levels of nursing care are delivered to highly dependent older adults. It was found that in the UK and Australia there are “residential care homes” and in New Zealand there are “continuing care hospitals”. Howe, Jones and Tilse (2012) found seventy two terms in the literature which pertained to nursing home care. Variations occurred according to how the home was funded, what its regulatory arrangements were and which professions were involved. Therefore, Howe, Jones and Tilse (2012) suggest that a consistent term should be used for future research and policy documents relating to nursing home care for older adults. It is suggested that the use of a consistent term with international meaning would enable comparative research and international transfer of knowledge.
Public health provision of residential care in Ireland dates from the early nineteenth century. Many changes to how this care was funded and provided have taken place. Analysis of the type of facilities provided reveals a shift from an “institutional” type facility for long-stay or residential care to a more home-like facility. Analysis of the funding provided also reveals a shift in the level of contributions an individual makes to their care provision. Originally, residential care was provided in “county homes”. These county homes were previously used as “workhouses” and aimed to provide accommodation for people who were financially poor or had nowhere to live. At the same time the only other community residential services available to older people were provided by the voluntary sector. Disease and infection soon began to spread in the county homes and “The Care of the Aged” report (Department of Health, 1968) subsequently recommended that older people should be enabled to remain in their own homes for as long as possible, and that this should be supported by the government’s policies, initiatives and funding.

The “Care of the Aged” report led to the development of “geriatric hospitals” and “welfare homes”. Welfare homes were built all over Ireland and were all built to the same architectural design. They were built for older people without means or who could no longer financially support themselves in their own homes. They were also built to cater for older people who were socially isolated or without family to care for them. They were not originally designed to cater for medical or nursing needs, and the older person was expected to be able to walk through the doors of the welfare home fully mobile and without physical dependence. As a result of this the welfare homes were usually predominantly staffed with care assistants and small numbers of nursing personnel. Conversely, the geriatric hospitals were designed to cater for the physically or medically dependent older person. Both welfare homes and geriatric hospitals were institutional in design and contained large wards (Florence Nightingale-style). Problems began to arise as the residents in the welfare homes grew older and began to experience the health problems associated with increasing age. By 1988 the Department of Health recognised that the welfare homes now had a completely different type of resident from those originally admitted, and that the geriatric hospitals were institutionalised in their approach to care (National Council on Ageing and Older People, 2000).
Thus, “The Years Ahead” policy (Working Party on Services for the Elderly, 1988) proposed a re-organisation of welfare homes to become “community hospitals”, staffed by a Director of Nursing and a team of nurses, allied health professionals and multi-task assistants. These new community hospitals were to be more active in providing assessment and rehabilitation for patients. The Health (Nursing Homes) Act (1990) was subsequently introduced and presented a plan that would enable the integration of public and private residential care provision. This led to a means-tested “subvention” system whereby older people could choose private residential care or public care. The state would contribute towards some of the costs of the care and the older person or their family would pay the rest. The Health (Nursing Homes) Act (1990) also introduced a system of compulsory registration of nursing homes, clearer standards for design, staffing and management, and a code of practice aimed at fostering good quality care and high ethical standards among providers. In 1991, O’Shea et al. warned that regardless of the type of care provision (public or private):

“...the role of institutions, ranging from high technology acute hospital to relatively low-tech nursing home or welfare unit, must be defined more rigorously so that all can contribute to the maintenance of the dignity, quality of life and autonomy of the individual for as long as possible.”

(O’Shea et al., 1991, pp.8)

However, O’Neill and O’Keefe (2003) and Ruddle, Donoghue and Mulvihill (1997) found that many recommendations from “The Years Ahead” report remained unfulfilled and noted that almost no extra government spending had been directed to older people. Ruddle et al. (1997) also reported that the quality of the care received was not rated highly.

Hence in 2009 the Health (Nursing Homes) Act (1990) was revised and “A Fair Deal” (2009) was launched (Nursing homes support scheme, Department of Health and Children, 2009). The “subvention” scheme was abolished. Older people can still choose to receive residential care in a public facility or in a private nursing home but the finance arrangements have changed. Some older people may also be cared for in “extended care units” while awaiting a residential bed vacancy or if they still require some level of specialist medical care, e.g. stroke rehabilitation. “A Fair Deal” is a scheme of financial support for older people who need long-stay residential nursing
home care. Under this scheme, the older person makes a contribution towards the cost of their care and the state pays the balance. This applies whether the nursing home is public or private. In summary, the older person will contribute 80% of assessable income (their assets, e.g. pensions and property) and 5% of the value of any assets in excess of the asset disregard per annum in care. The asset disregard is the amount of assets that is totally excluded from the means assessment. The asset disregard is €36,000 for an individual or €72,000 for a couple. The older person can avail of a deferred contribution that will apply only to each year of care and will be charged on a pro rata basis for any period of care of less than one year. The principal residence will only be included in the financial assessment for the first three years of the time in care. This is known as the 15% or three-year cap, and means that after three years of care the older person will not be liable for any further deferred contribution based on the principal residence. In the case of a couple, this means that the deferred contribution based on the principal residence will be capped at 7.5% where one partner remains in the home while the other enters long-stay residential care. If there is a partner or certain dependants living in the residence, the charge may be further deferred for their lifetime.

While choice of residence is now possible, many researchers have found that the quality of life experienced in these residential care homes is not satisfactory. One of the issues identified that impacts upon residents’ quality of life is the lack of resident autonomy (Cook, 2010; Murphy, 2007; Murphy et al., 2007; Brown, McWilliam and Ward-Giffin, 2006; Edwards, Staniszewska and Crichton, 2004; Randers and Mattiasson, 2004; Tester et al., 2004; Edwards et al., 2003; Barkay and Tabak, 2002; Lothian and Philip, 2001; McCormack, 2001; Ball et al., 2000; Davies, Ellis and Laker, 2000; Edwards and Staniszewska, 2000; Kane and Kane, 2000). Rodgers and Neville (2007) argue that a major problem in enabling personal autonomy in residential care facilities is that of communal interests, whereby organisational needs are privileged over the rights of individuals. They add that while institutional routines maximise efficient use of staff time and provide care efficiently and economically, they are highly likely to interfere with the autonomy of those cared for. Cook (2010) adds that these routines affect residents’ identity and autonomy. To date no research has been undertaken in Ireland that specifically explores the phenomenon of resident autonomy. Further research is now required, which will
explore the factors that affect residents’ autonomy in residential care. Davies, Ellis and Laker (2000) recommend that further work needs to be carried out that will operationalise “resident autonomy”. This is important for an acceptable quality of life for residents.

1.3 The Future Context of Residential Care

Older people living in residential care represent a unique group of people, largely because care is provided in their place of residence.

The Health and Wellbeing for Older People, Western area (2001-2006), recommended that individual residential care units should search for ways residents could exercise more choice over their day and be actively involved in daily decision-making. It further stated that making choices, no matter how small, contributes significantly to the quality of life experienced by the older person.

Similarly, the HSE Corporate Plan 2005-2008 stated that in order to provide client-centred care it is committed to delivering timely and responsive care in appropriate settings. The plan stated that in order to achieve this it would be:

“Committed to listening to and learning from the experience of our service users, partner service providers, staff and other stakeholders. We will actively consult around planning, delivery and evaluation of our services.”

(HSE, 2005, pp.18)

Including older adults in policy-making not only ensures that they voice how services and public policies might best serve their needs, but also enables service providers and policy makers to draw on older adults’ considerable experience and expertise in order to effect change. The most recent national development to address this has been the establishment of an independent inspectorate for residential care, managed by the Health Information and Quality Authority (HIQA). HIQA is an independent authority that was established to drive continuous improvements in Ireland’s health and social care services. The authority is responsible for setting standards in collaboration with older people and healthcare providers for health and social care services, and ensuring that these standards are met. Appendix 1
summarises the 32 national standards that must now be met by all residential care facilities for older people in Ireland. Other national developments include the establishment of a new Office for Older People on 30th January 2008, and proposals to develop a “National Strategy on Positive Ageing”, which will focus on setting the strategic direction for future policies, programmes and services for older people. Reiterating the United Nations (UN) Madrid International Plan of Action on Ageing (MIPAA, 2002 and 2008), which recognises that there is global acknowledgement of the need to include older adults in autonomous decision-making processes, these developments may be viewed positively as a means to actively engage with older people so that future healthcare policies can to be meaningful for older people.

However, while research has suggested that autonomy is important for older people in residential care, and while policies state that autonomy should be promoted, there is no consensus in the literature about what autonomy for older people in residential care actually means. Hewitt-Taylor (2003) states that autonomy is high on the current healthcare agenda but that a universally accepted definition has yet to be adopted or tested in practice. Rodgers and Neville (2007) state that autonomy has significance for everyone and that formulating a precise definition is problematic due to the wide ranging meanings attached to autonomy. This indicates that research needs to be conducted that will firstly analyse the meaning of the concept of autonomy for older people in residential care, and secondly explore the concept of autonomy in the real world of practice.

The growing ageing population will demand not only sufficient healthcare services but high quality healthcare services, and trends show that there will be an increase in the demand for residential care facilities that facilitate an acceptable quality of life. The importance of autonomy for quality of life has been recognised, and therefore autonomy for older people in residential care should not be underestimated. Autonomy is an important concept because it brings dignity to people’s lives, regardless of physical circumstances. However, many older people living in residential care find that their autonomy is curtailed. This is largely because autonomy for older people is poorly understood and hence nurses working with older people need to become clear about what autonomy is and how it can be facilitated.
1.4 The Guiding Conceptual Framework for the Study

Due to the lack of consensus in the literature about what autonomy for older people in residential care actually means, a concept analysis of resident autonomy was undertaken at the outset and this was then used to guide this research (Welford et al., 2010). The next chapter, the literature review, details this process.

The following attributes of resident autonomy were delineated from the concept analysis:

- Residents delegate care needs based on the right to self-determination and the rights of older people.
- Residents’ capacity is encouraged and maintained.
- Negotiated care plans through open and respectful communication. Family or significant others included when the resident is cognitively impaired.
- Residential unit has culture and atmosphere of flexibility within an ethos of maintaining resident dignity.
- Residents involved in decision-making.

Antecedents for resident autonomy were also identified:

- Staff attitudes are positive in relation to ageing and older people.
- Values and beliefs of staff are person-centred and non-paternalistic.
- Staff communicate effectively with each other, with residents and with visitors.
- Resident assessment is robust and involves gathering life histories.
- An atmosphere of openness, motivation and flexibility.
- Respect for dignity and for fellow human beings evident between staff, and between staff and residents.
The following consequences for a residential care unit facilitating resident autonomy were identified:

- Respect for dignity and for fellow human beings evident between staff, and between staff and residents.
- Staff retention.
- Homely atmosphere.
- Evidence of negotiated care plans, which include a focus on the residents’ social and recreational needs.
- Life histories of the residents—knowing the person.
- Observation of effective communication between staff, residents and visitors.

The data collection tools for this study were designed from the concept analysis of autonomy for older people in residential care. The antecedents, attributes and consequences of autonomy were used to inform the development of the interview schedules, the observation guide and the documentary analysis audit tool.

1.5 Rationale for the Research

The purpose of this case study is to explore autonomy for older people in residential care in one residential care unit in Ireland.

The study is divided into two phases, with specific rationales and aims for each phase.

1.5.1 Rationale for Phase One

The meaning and experience of autonomy for older people in residential care in Ireland has not yet been explored. Interest in the current study stemmed from the researcher’s own clinical experiences in gerontological nursing, and specifically in residential care. Lack of resident autonomy was often observed. Barkay and Tabak (2002) state that increased levels of autonomy lead to increased levels of resident satisfaction, and decreased levels of routinised practice, thereby contributing overall to the residents’ quality of life. It is evident from the relevant policy documents that
autonomy has been considered key to enhancing residents’ quality of life. It is of concern, however, that no evaluations have been undertaken in order to assess the level of autonomy actually experienced by older people in residential care. It is essential, considering the rapidly changing demographics within our society, to develop a residential care service that is acceptable to older people.

The literature recognises that there are a number of global challenges arising in gerontological nursing: a growing older population, the need for different ways of working, changing core skills and competencies, mixed cultures, and a focus on choice. Respecting patient autonomy and seeing patients as partners in healthcare decision-making are high on the current healthcare agenda. It is argued that adopting a specific research focus on resident autonomy is key to the success of these challenges.

A Health Research Board (HRB) fellowship was sought and granted for this research.

1.5.2 Aim for Phase One
In phase one the aim is to explore autonomy for older people in residential care. The specific objectives for phase one are to:

- Define resident autonomy.
- Explore resident autonomy in one residential care setting in Ireland, from multiple perspectives and from multiple data sources.

1.5.3 Rationale for Phase Two
Phase two of the study evolved from the findings of phase one, which revealed a lack of resident autonomy in the case study site.

According to Meyer and Sturdy (2004), if research is to be meaningful to both older people and those caring for them, there is an urgent need for gerontological nursing research to become much more practice/action orientated. Only then will we derive outcomes that are valid for older people.
1.5.4 Aim for Phase Two
In phase two the aim was to enhance one aspect of resident autonomy. The specific objectives for phase two were to:

- Agree with staff on a change in practice focused on enhancing resident autonomy, based on the findings from phase one.
- Involve staff and residents in designing, planning, implementing and evaluating a change in practice that would enhance resident autonomy.
- Adopt an action research approach to diagnose, action plan, action take, evaluate and specify the learning.

1.6 Thesis Outline
The thesis is organised as follows:

- Chapter One presents the introduction and background.
- Chapter Two reviews the literature and performs a concept analysis.
- Chapter Three describes the methodological approaches used.
- Chapter Four describes the method.
- Chapter Five presents the findings from phase one.
- Chapter Six presents the findings from phase two.
- Chapter Seven presents a discussion of the research findings. Recommendations and conclusions are made.

1.7 Chapter Summary
This chapter presented the background to this study. It described the growing ageing population. It revealed that the oldest old population is also increasing and that the majority of people in this population require residential care. It was reported, however, that quality of life for older people in residential care is not satisfactory. The literature identified resident autonomy as one of the factors affecting residents’ quality of life and it was further reported that older people in residential care frequently lack autonomy in this care environment. However, the lack of consensus about the meaning of resident autonomy makes the issue even more problematic. The need to undertake research to explore the concept of autonomy for older people
in residential care was therefore highlighted. The results of a concept analysis of resident autonomy undertaken by the author were subsequently outlined and these will be used to inform this study. This chapter concluded with an outline of the research aims and objectives and the underlying motivation for the study.
2. Literature Review

In this chapter the literature about autonomy is reviewed. Analysis of the literature identified three key areas: 1) Definitions and determinants of autonomy, 2) Residential care research and 3) Autonomy for older people research. The review of the literature also led to a subsequent analysis of the concept of autonomy for older people in residential care. Prior to the literature review a brief overview of the search strategy is given.

2.1 Literature Search Strategy

This section outlines the literature search strategy and review process adopted for this study. The purpose of the review was two-fold. Firstly, to establish what is known about the concept of autonomy. Secondly, to identify any research studies that had been undertaken that would inform the phenomenon of autonomy for older people in residential care.

Six main steps were undertaken. The first step of the review process involved searching two health-related bibliographic databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medline. The initial database results for the broad search term of “autonomy” yielded papers which had broad associations with autonomy including nurse autonomy, autonomy and assisted living, autonomy and restraint and ethical autonomy. Many of the same papers appeared in both CINAHL and Medline. At this point 3 criteria were established to focus the search: 1) primary research studies that were peer-reviewed (years 1990 to present day), 2) theoretical work that focused on defining autonomy would be included and 3) studies focused specifically on autonomy and older people or autonomy and residential care would be reviewed. Hence the search terms were narrowed (using the Boolean operators) in order to adhere to this criteria. Various key word combinations using Boolean operators were searched and these included: 1) Autonomy for older people, 2) Autonomy for older people in residential care, 3) Autonomy for older people and patient autonomy and 4) Resident autonomy.
The second step in the search process involved combining references from the databases. The third step involved a careful review of authors and titles and the deletion of non-English language titles. In the fourth step, the abstracts from the resulting references and selected articles were analysed for their relevance to autonomy for older people in residential care. This step also involved identifying further references within appropriate papers, sourcing them, and adding them to the results for analysis. The fifth step involved conducting hand searches of gerontology-focused journals and relevant reports (e.g. from the National Council for Ageing and Older People and government policies). A systematic approach for identifying the key features from each study was used. This approach required that all research studies were reviewed and categorised according to theme, the date, methodology and quality of the study. This information was then entered into a comparison table that enabled the similarities and differences of the studies to be detailed.

A further check on the comprehensiveness of the search was undertaken; the subject librarian carried out an independent search and confirmed that there were no new papers to add to the search. An iterative analysis process was used to compare and contrast key findings and draw out a number of themes and generalisations. Studies were compared to identify similarities and differences, and the literature was divided into key areas.

Throughout the course of the research, journals were reviewed regularly to identify any new material that was pertinent to the study. Conference proceedings were also monitored for relevant information. Dictionary definitions of “autonomy” and internet search engines were also reviewed.

### 2.2 Defining Autonomy

This section looks at how autonomy is defined. The first known use of the word *autonomy* was documented in 1623. It was derived from the Greek word “autonomia” or the freedom to live by one’s own laws – “autos” meaning “self” and “nomos” meaning “rule”, translating literally into the term “self-rule”. However, the literature review revealed that despite its historical use in ancient Greece there is no clear consensus on the meaning of autonomy in the context of health care today.
Hofland (1994) states that the issue of personal autonomy has dominated healthcare ethics debates for decades. Many philosophers have debated the true meaning of autonomy and most agree that it is difficult to define or fully explain (Atkins, 2006; Doyal and Gough, 1991; Feinberg, 1989; Gillon, 1995; Kant, 1989; Meyers, 1989; Mill, 1975). Attempts to explain autonomy have focused on relating it to other concepts or identifying its related terms.

The literature review also revealed that the defining terms for autonomy varied. The terms used by dictionaries to explain autonomy include, “freedom”, “independence”, “self-determination” and “self-government”. The Collins English Dictionary defines freedom as “Freedom to determine one’s own actions and behaviour” (2010, pp.103), but Gillon (1995) states 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. Similarly, the Oxford English Dictionary explains that the “freedom” in autonomy is that which is independent of external control or influence from others and that the “independence” (in Kantian moral philosophy) is the capacity of an agent to act in accordance with objective morality rather than under the influence of others’ desires. Thus an understanding of autonomy focused on freedom of the will alone is inadequate (Atkins, 2006). Blackwell’s Dictionary of Nursing (2010: 73) also uses the term “independence” to define autonomy, but refers to functional independence and states that autonomy is about “having the ability to function independently”. The realisation that autonomy could be explained as independent of external control or influence from others (social power, organisational power and individual power) has led authors to suggest that the autonomous individual is free from power and that 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 (Atkins, 2006; Manley and McCormack, 2003; Burkhardt and Nathaniel, 2002; McCormack, 2001; Quill and Brody, 1996; Beauchamp and Childress, 1994; Gillon, 1995; Mill, 1975). Furthermore, Mill (1975) had previously stated that being autonomous is about being able to enjoy productive and enabling relations with others rather than being subjected to the deleterious effects of power.
Hence power is perhaps a related term, but also integral to autonomy. Power has been discussed for many years and many theories of power have been presented. Dahl (1961) presented his theory of “community power”, which he explained as power being exercised in a community by a particular concrete individual, while other individuals are prevented from doing what they prefer to do. Power is exercised in order to cause those who are subject to it to follow the private preferences of those who possess the power. Power is the production of obedience. Gaventa (1980) examined power in the decision-making process. Gaventa’s (1980) model of power suggested that if there is a shift in the power relations then a challenge occurs: there must be a loss of power by A or a gain of power by B for a change to occur, and B must take some steps to overcome his powerlessness. A can interfere with B’s plans, can interfere with B obtaining resources and developing abilities, and can incite against the opening up of issues. Foucault (1980) assumed that a power/knowledge connection cannot be separated. Foucault (1980) described disciplinary power, which he stated affects most social institutions and leads to a psychic punishment of the soul. He stated that power relations are dependent on culture, place and time.

Giddens (1984) constructed the inclusive social theory called “structuration” or “duality of structure”. He stated that power is exercised by human agents and is also created by them, influences them and limits them. Giddens (1984) stated that absolute lack of power means ceasing to be a human agent and therefore it is always part of relations. Giddens (1984) stated that power can be described on a continuum of autonomy and dependence. Unequal access to resources for realising goals and unequal opportunities to influence the course of the interaction ensure mutual relations, because each side is to a certain extent dependent on the other, and also autonomous to a certain extent in its action. The investigation of power involves exposing the dialectics of dependence and autonomy in specific situations.
Horanson Hawks (1991) also concluded from a concept analysis of power that it is integral to relationships:

“The actual or potential ability or capacity to achieve objectives through an interpersonal process in which the goals and means to achieve the goals are mutually established and worked through”

(Horanson Hawks, 1991, pp.754)

Horanson Hawks (1991) presented four defining attributes of power: 1) the actual or potential ability or capacity to achieve objectives or attain goals, 2) an interpersonal process, 3) mutual establishment of goals and the means to achieve the goals and 4) mutually working toward the goals. Antecedents were identified as: 1) the presence of two or more people, 2) the acquisition of power skills such as trust, communication skills, knowledge, concern, caring, respect and courtesy, 3) possession of at least one of the four power sources – informational, referent, expert or legitimate, 4) an orientation of power as good, and 5) self-confidence.

Further defining terms are also identified. Webster’s online dictionary states that self-government is a defining term for autonomy: “The quality or state of being self-governing; the right of self-government, self-directing freedom and moral independence”. Similarly, Mill (1975), Horowitz, Silverstone and Reinhardt(1991), and Agich (2004) suggest that autonomy is the right to self-determine or self-govern for oneself, one’s interests, goals and values, and one’s own conception of a good life free from unwarranted interference, thus concurring with the original Greek definition of “self-rule”. Agich (2004, pp.6) identified freedom, independence and self-determination as defining terms for autonomy in his definition but also added that autonomy is “equivalent to dignity, integrity, individuality, responsibility and self-knowledge, whilst containing the qualities of self-assertion, critical reflection and knowledge of one’s own interest”.

The complexity of the concept of autonomy was recognised by Feinberg (1989) who claimed that there are at least four different meanings of autonomy in moral and political philosophy. Further to using commonly understood terms like freedom and independence to attempt to define autonomy, some authors tried to explain its meaning by differentiating it according to “types” of autonomy and explaining its
“opposite” meanings (Beauchamp and Childress, 1994; Collopy, 1988; Feinberg, 1989; Kant, 1989). The direct opposite of autonomy is “paternalism”, which Beauchamp and Childress (1994) defined as:

“The intentional overriding of one person’s known preference or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose will is overridden.”

(Beauchamp and Childress, 1994, pp.274)

Kant (1989) distinguished two main “types” of autonomy: “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 (authentic means the “person”- their likes, dislikes, hobbies, interests, etc.) 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. This subjective element of autonomy (authentic) was also recognised by Feinberg (1989) who suggested that it was about personal ideas and expressions. Meyers (1989) wrote about the distinction between choices that express the internalisation of oppressive social forces (objective autonomy) and those that express one’s genuinely reflective considerations (authentic subjective autonomy). In the early 1990s explanations of autonomy continued to include subjective elements.

Beauchamp and Childress (1994) defined autonomy using words like “meaningful” (to the individual) choice:

“A personal rule of self that is free from both controlling interference by others and from personal limitations that prevent meaningful choice”.

(Beauchamp and Childress, 1994, pp.121)

Beauchamp and Childress (1994) explained that autonomy is about what makes life one’s own and how personal preferences and choices shape it. Gillon (1995) further added that explanations of autonomy that see only “desires” as the focal point are too narrow, as people can exhibit autonomy relative to a wide variety of personal
characteristics, such as values, physical traits and relations to others. Atkins (2006) subsequently analysed the contrasting elements of subjective autonomy and objective autonomy. Atkins (2006) did not agree that one type of autonomy (subjective) should be in opposition to another (objective), and also commended 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. Atkins (2006) stated that 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) had previously argued that this is a basic requirement for comprehending and negotiating one’s needs, wants, and responsibilities (self-government) in the many different circumstances one faces in life.

Thus there is no clear, succinct definition of autonomy, but related terms include freedom, independence, power, self-government and self-determination. Several authors have tried to explain autonomy by defining its opposite concept – paternalism – and by illustrating and describing different “types” of autonomy, which include “basic and ideal, subjective and objective”. Agich (1990) stated that while action, speech and thought are important elements of autonomy, it must be remembered that these associations with autonomy date back to seventeenth-century political and legal debates, and hence the understanding of the concept of autonomy needs newer associations. He further stated that definitions of autonomy that focus only on action and choice are idealistic, and that a concrete definition of autonomy should include a daily living account of the person who engages with meaningful options (meaningful to the older person). Agich (1990) rationalised that autonomy is socially conditioned and contextually situated and thus expressions of autonomy are unique to each individual.

2.2.1 Determinants of Autonomy
Further to definitions of autonomy, the literature revealed many determinants of autonomy that are useful in defining and understanding the term. Many authors describe “capacity” as an integral ingredient/element of one’s autonomy and they use descriptions of capacity to explain the essence or meaning of autonomy (Boyle, 2008; Harnett and Greaney, 2008; Gillon, 1995; Beauchamp and Childress, 1994;
Hofland, 1994; Doyal and Gough, 1991; Feinberg, 1989; Collopy, 1988; Mill, 1975). Mill (1975) explained that capacity is an integral ingredient in one’s autonomy and that sometimes one’s lack of capacity reduces one’s ability to self-govern/self-determine. Self-determination was identified by many authors as a defining term for autonomy (Agich, 2004; Horowitz, Silverstone and Reinhardt, 1991; Mill, 1975).

Feinberg (1989) also linked one’s autonomy with one’s capacity to govern oneself and with one’s personal ideal and set of rights expressive of one’s sovereignty over oneself. Abramson (1985) claimed that autonomy is a form of personal liberty that recognises capacity. Beauchamp and Childress (1994) explained that an individual’s autonomy is determined by their capacity to engage in rational decision-making and to disregard or choose options whilst remaining free from coercive elements.

Recognising the defining terms of freedom and independence, Gillon (1995) stated that autonomy is the capacity to think, to decide and to act freely and independently and without hindrance. Gillon (1995) linked these terms to one’s capacity; hence one’s autonomy may become dependent on one’s capacity, and autonomy can be explained by citing examples of how capacity affects one’s realisation of autonomy.

Doyal and Gough (1991) suggested that there are four main determinants of one’s level of autonomy and that capacity is central to these: the individual’s level of understanding, the expectations of one’s culture, the psychological capacity (or mental health) of the person to formulate opinions, and the objective opportunities available for exercising autonomy. Boyle (2008) explained that while some older people may not have the “capacity” to exercise autonomy, it does not mean that they no longer have the “need” to exercise autonomy; therefore assistance from others may be required to facilitate the older person’s autonomy. It should not be assumed that the absence of physical health, functional capacity or cognitive capacity in older people is a barrier to them being, at least, somewhat autonomous. Boyle (2008) further states that while mental health may be a prerequisite of autonomy, impaired autonomy can in turn lead to mental ill-health for the older person. In other words, mental health or capacity enables the person to exercise freedom, independence and self-government (autonomy), but being prevented from doing this may contribute to depression or apathy in the older person. Similarly, Harnett and Greaney (2008) state that current explanations of autonomy do not encompass the complexities involved in respecting autonomy when caring for patients with diminished capacity (e.g.
Alzheimer’s or dementia in old age). Hofland (1994) had previously recognised that the capacity to make decisions is integral to autonomy and stated that autonomy is still relevant for older people with diminished cognitive capacity. Hofland (1994) explained that making decisions is key to realising one’s autonomy and that the capacity to do so varies along a continuum of cognitive ability as one ages. Personalising daily routines by choosing what clothes to wear or expressing food preferences are examples of simple decisions that most older people have the capacity to make. Cook (2010) classifies residents’ decisions as micro or macro. Micro refers to decisions about clothes and food, etc. Macro refers to decisions about operations and medical interventions, etc.

“Decisional incapacity on some dimensions does not mean decisional incapacity on all dimensions. The capacity to make a decision is decision-specific.”

Hofland (1994, pp.31)

Hofland (1994: 31) explained that patients’ autonomy is threatened by professional paternalism and “institutional self-interest”. Hofland (1994) suggested that when a resident’s cognitive ability fades, as in the case of dementia, the caregiver must reconfigure the balance between paternalism and autonomy, subsequently providing beneficent care that is guided by respect for autonomy, dignity and personhood. Mill (1975) explained that autonomy is about persons who are radically individualistic and who determine their 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. Historically, health care was provided in a paternalistic manner (Department of Health, 1968; O’Shea et al., 1991). However, the changes that 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 (Health (Nursing Homes) Act, 1990; McCormack, 2001; Ruddle et al., 1997). The meaning of autonomy becomes essential when one considers the changes that are taking place in healthcare provision. Murphy et al.’s, (2007) analysis described three phases in the approaches to residential care for the older person in Ireland. Up to the late 1950s there was custodial care, which was care dominated by routine and focused on the needs of the organisation rather than on the
needs of the person. Up to the late 1980s there was a focus on more personalised care, a more humane and individualised approach, while present-day care strives to be more patient-centred, holistic, based on autonomy, respect, choice and promotion of independence.

The reality is that many older people do have diminished cognitive or physical capacity and many authors recognise that this makes it difficult to facilitate older people’s autonomy (Boyle, 2008; Harnett and Greaney, 2008; Doyal and Gough, 1991; Hofland, 1994). However, the theologian Collopy (1988) stated that older people should not be labelled as “incapacitated” and suggested that there are ways in which the older person can maintain their autonomy despite reduced capacity. Collopy (1988) suggested that autonomy can be best explained by giving contextual examples of it, and suggested that it consists of six polarities (opposites): competence, decisional ability, authenticity, directness, immediateness and negativity (Table 2.1). These polarities may be present or absent in an individual and it is the absence of any one of these that impacts upon their autonomy. The challenge for healthcare professionals is to ensure the balance is found between the polarities for their clients/patients/residents. For example, Collopy (1988) explained that “decisional autonomy” and its polar opposite “autonomy of execution” is about making decisions and having personal choices and values, irrespective of one’s ability to carry out decisions independently. In other words, older people’s autonomy must be recognised even if a certain degree of it needs to be transferred or delegated to the healthcare professional. Hence the importance of “authentic” autonomy or knowing the older person’s past and present life, which may shape their wishes. Collopy (1988) also explained that autonomy may be “immediate” or “long range”. “Immediate” autonomy is time-specific and decision-specific and often maximised during moments of a cognitively impaired older person’s lucidity, while “long range” autonomy focuses on realising long-term goals. Collopy (1988) warns that only choosing to meet long range goals may reduce the healthcare professional’s opportunity to avail of the immediate moments of the older person’s decision-making ability. Furthermore, Collopy (1988) explains that when the older person has reduced capacity the healthcare professional can act as their advocate (positive) and also ensure that they remain safe and free from making harmful decisions (negative) without being over-protective.
Table 2.1: Collopy’s (1988) six polarities of autonomy

<table>
<thead>
<tr>
<th>Type of Autonomy</th>
<th>Meaning</th>
<th>Type of Autonomy</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent</td>
<td>Refers to a person’s capacity/ability to perform an activity</td>
<td>Incompetent/Incapacitated</td>
<td>Refers to a person’s lack of capacity/inability to perform an activity</td>
</tr>
<tr>
<td>Decisional</td>
<td>Refers to a person making decisions</td>
<td>Autonomy of Execution</td>
<td>Refers to a person being prevented from implementing their decisions</td>
</tr>
<tr>
<td>Authentic</td>
<td>Refers to a person’s past and present values – their life history – needs, values and goals</td>
<td>Inauthentic</td>
<td>Refers to not recognising the person’s past and present values – their life history – needs, values and goals</td>
</tr>
<tr>
<td>Direct</td>
<td>Refers to a person’s capacity to exercise their own decisions</td>
<td>Delegated</td>
<td>Refers to a person who does not possess the capacity to exercise an autonomous decision</td>
</tr>
<tr>
<td>Positive</td>
<td>Refers to the process of advocating for a patient based on their expressed needs</td>
<td>Negative</td>
<td>Refers to the prevention of a person expressing their needs</td>
</tr>
<tr>
<td>Immediate</td>
<td>Refers to a person’s autonomy at the present moment in time</td>
<td>Long-range</td>
<td>Refers to a person’s autonomy in the future</td>
</tr>
</tbody>
</table>

Collopy’s (1988) explanation of autonomy using 12 polarities (six pairs) reveals the complexity of the concept of autonomy. However, it also helps to advance the understanding of autonomy by placing it in context and making it applicable to residential care by using terminology that is more universally understood, which helps one to better understand the nature of autonomy.

2.2.2 Section Summary
In summary, many of the explanations and definitions of autonomy found in the literature do not relate directly to autonomy for older people in residential care, as it is only in recent times that publications have focused on this aspect of autonomy. While a clear consensus on an explanation or definition of autonomy was not apparent in the literature, attempts had been made to outline its key defining terms. Several authors agreed that freedom, independence, self-determination and self-government are key defining elements of autonomy (Agich, 2004; Horowitz, Silverstone and Reinhardt, 1991; Mill, 1975). Others chose to explain the concept of autonomy by demonstrating how capacity, decision-making, power and polar
opposites of its elements are integral ingredients in its realisation and how the absence or presence of these can affect one’s autonomy (Boyle, 2008; Gillon, 1995; Beauchamp and Childress, 1994; Feinberg, 1989; Abramson, 1985; Mill, 1975).

Several authors acknowledged the importance of one’s capacity in order to exercise one’s autonomy (Boyle, 2008; Beauchamp and Childress, 1994; Hofland, 1994; Agich, 1990; Gillon, 1990; Feinberg, 1989; Collopy, 1988; Abramson, 1985; Mill, 1975). Gillon (1995) explained that this capacity is about being able to think, to decide and to act freely and independently and without hindrance. Feinberg (1989) advised that capacity must be encouraged and maintained. Cognitive impairment should not be assumed to reduce one’s capacity (Boyle, 2008; Harnett and Greaney, 2008; Hofland, 1994; Doyal and Gough, 1991). Many explained that in addition to capacity older people have fundamental rights, which include self-determination, and that they delegate care needs based on these rights (Agich, 2004; Hofland, 1994; Horowitz, Silverstone and Reinhardt, 1991; Kant, 1989; Collopy, 1988; Mill, 1975). There was a lot of discussion in the literature about the importance of recognising the subjective element of autonomy that recognises older people’s needs, values, goals and personal preferences. When the subjective element of autonomy is recognised, the healthcare professional and the resident together can negotiate care (Meyers, 1989). However, open and respectful communication must also be maintained in this process (Atkins, 2006; Beauchamp and Childress, 1994; Gillon, 1990; Feinberg, 1989; Kant, 1989; Meyers, 1989; Collopy, 1988) and imbalanced power relationships can affect this. Residents must be involved in decision-making (McCormack et al., 2008; Faulkner and Davies, 2006; Hofland, 1994; Agich, 1990; Collopy, 1988) and dignity should be maintained as it was suggested to be integral to autonomy (Agich, 2004).

The following section will review the remaining literature and this will further clarify the concept of autonomy in order to delineate its attributes, antecedents and consequences for residential care.
2.3 Residential Care

This section is about residential care. The focus of this research is autonomy for older people in residential care; it is therefore important to review the literature about residential care. The literature revealed that many studies have been conducted in residential care units for older people. Some of these studies examined the organisations’ approach to care including the institutional philosophy, the leadership and the impact of task-based approaches to care (Walsh and Waldman, 2008; Forbes-Thompson and Gessert, 2005; Swagerty, Lee and Smith, 2005). Some explored perceptions of residential care including staff perceptions (Murphy, 2007; Redfern et al., 2002; Ryan and Scullion, 2000), resident perceptions (Cooney, Murphy and O’Shea, 2009; Boyle, 2004; Higgs et al., 1998) and families’ perceptions (Ryan and Scullion, 2000). One study examined the role of nurse specialism in gerontological/residential care (Hunter and Levett-Jones, 2010) and several researchers connected healthcare professionals’ level of knowledge about ageing to their attitudes towards older people (Mandy, Lucas and Hodgson, 2007; Wells et al., 2004; Wade, 1999). A number of studies investigated quality of life and quality of care in residential care for older people (Dwyer, Nordenfeldt and Ternestedt, 2008; Murphy, 2006; Pearson et al., 1993). Resident autonomy was identified as being an integral ingredient in person-centred care and ultimately in achieving quality of life. Several papers discussed the benefits of delivering person-centred care in residential care for older people (Manley and McCormack, 2008; McCormack, 2004, 2001) and provided frameworks for operationalising it (Manley and McCormack, 2008; McCormack and McCance, 2006; Nolan et al., 2004; McCormack, 2001; Ford and McCormack, 2000; Titchen, 2000). However, Hunter and Levett-Jones (2010) suggested that delivering person-centred care remains a challenge for nurses working in residential care. Many researchers suggested that life plans are essential for knowing the person in person-centred care-provision, and for the realisation of autonomy for older people in residential care (Tutton, 2005; Lidz, Fischer and Arnold, 1992; Agich, 1990; Meyers, 1989).

2.3.1 Organisational Approach to Residential Care

The organisation’s approach to residential care for older people has been discussed in the literature for many years and some of the first discussions appeared in the
Chapter 2: Literature Review

early 1990s (Brody, 1996; Hofland, 1994; Erlander, Drehler and Wallin Pearson, 1993; Quill and Smith, 1992). Many researchers found that leadership permeates all aspects of care (Forbes-Thompson and Gessert, 2005; Swagerty, Lee and Smith, 2005) and that lack of leadership results in fragmented, task-based approaches to care (Swagerty, Lee and Smith, 2005). Ford and McCormack (2000) stated that registered nurses possessing expertise in their individual practice are not enough to sustain effectiveness in gerontological care, and that nurses require expertise in leadership to create an organisation that values an approach to care that sustains expert practice.

One study explored nurses’ experiences one year after an organisation’s commitment to providing a client-centred and client-empowering approach to care (Brown, McWilliam and Ward-Griffin, 2006). Using an interpretive phenomenological design, the researchers purposively selected eight Canadian nurses and conducted in-depth interviews (averaging 55 minutes in length). Their aim was to understand the lived experience of registered nurses practicing in home care who had implemented a philosophy of flexible client-driven care. Hermeneutic analysis was used to elicit themes and patterns from the data. The researchers found that barriers to introducing the new approach to care were encountered at system, organisation and personal levels. They suggested that nursing leaders need to promote professional knowledge and practice regarding relationship building, client-centredness and autonomy if nurses and clients are to be empowered. The study identified potential pitfalls in implementing a change in approach to care-giving, and further identified the potential ways for nurses in other care settings to address the leadership challenges in dealing with these pitfalls. The decision to adopt a phenomenological approach was appropriate to meet the aim of this research, which was to understand the lived experience of the nurses. The main concern with this piece of research is that the case manager selected the participant population from which the researchers were to recruit their sample. The data analysis was described in detail, but the design of the open-ended interview guide was not detailed.

In another study, Forbes-Thompson and Gessert (2005) found that leadership permeates all aspects of care in residential homes for older people. They discussed the impact of structures, processes and outcomes in an organisation’s approach to
care for older people. Using a qualitative case study design this study was conducted across two American residential units (NH1=125-bed unit and NH2=120-bed unit). It used multiple data collection methods including formal and informal interviews, participant observation and document review. The aim of the research was to explore in depth the experience of dying in two nursing homes from the perspectives of residents, staff and family members. Observations were recorded in multiple locations around the residential unit and formal interviews were semi-structured. Observations were carried out by three graduate students who spent a total of 40 hours each week, including different shifts and days of the week, for nine months in NH1 and for eight months in NH2. The participant observations included observations of care processes and everyday life in the homes. Interviews, both formal and informal, were conducted with residents, staff and family members. The resident sample included those with cognitive impairment (total sample n=56). Thirty-one residents participated in NH1 while 25 participated in NH2. Qualitative content analysis was used to code and categorise the textual information. Each residential unit was described in its appearance and atmosphere.

The researchers found that NH1 and NH2 adopted different approaches to care. NH1 operated on a philosophy of only providing physical care and paying higher wages to a core group of staff rather than lower wages and employing more staff, whilst NH2 operated on a philosophy of providing the best possible nursing home services to residents who had limited assets. Resident admissions to NH2 were in line with staffing levels and were reduced during times of staff shortages. NH1 was described as noisy, lacking privacy and with unpleasant odours while NH2 was described as bright with a home-like feeling, pets and gardens adding to the initial impression. NH1 focused on task orientation while NH2 facilitated residents’ requests to stay in bed and eat outside meal times, and demonstrated affectionate relationships with the residents. The researchers discussed the powerful connections between structure, process and outcomes in an organisation’s approach to care. At the structural level the two homes had contrasting institutional philosophies, which were reflected in staffing and the environment. The two homes contrasted in their processes of care by having different patterns of planning, communicating and making decisions. Thus the outcomes were substantively different and the relationship between the organisation’s approach to care and positive resident outcomes, particularly in
relation to autonomy, was highlighted. Routine and task-based care was revealed to impact negatively on resident autonomy. The case study design enabled a holistic exploration of the phenomenon.

Similar issues in relation to routine and task-based care have also been reported from a European perspective. McCormack et al. (2008) stated that many older people felt disempowered by a system of care delivery or an approach to care that did not include them in decision-making about their own care and treatment and did not enable them to be autonomous. McCormack et al. (2008) suggested that residents can identify with staff who listen to them and plan care around their individual needs, thus enabling them to participate in their own care as opposed to an approach to care where older people feel that care is “done to” them. Thus resident perceptions of care may differ from staff perceptions of the approach to care.

2.3.2 Perceptions of Care

Perceptions of care for older people in residential care from older people themselves, from staff, from students and from family members have been researched. Many researchers have explored older people’s perspectives of care (Cooney, Murphy and O’Shea, 2009; Boyle, 2004; Higgs et al., 1998). One study examined students’ perceptions (Alabaster, 2006), while three studies examined staff perceptions (Murphy, 2007; Redfern et al., 2002; Ryan and Scullion, 2000) and one study examined families’ perceptions (Ryan and Scullion, 2000). Conflicting perceptions were found across all of these studies. Family members perceived themselves to have a greater role in caring for their older relatives than that perceived by staff (Hertzberg and Ekman, 2000; Ryan and Scullion, 2000). There were also conflicting perceptions about the ward atmosphere, with residents rating it lower than staff did (Redfern et al., 2002) and student ideals for providing person-centred individualised care were eroded by staff perceptions that talking to older patients was not a legitimate nursing activity (Alabaster, 2006).

Ryan and Scullion (2000) used a quantitative questionnaire and qualitative semi-structured interviews to investigate staff and family perceptions of their roles in the approach to care giving. Their aims were threefold: firstly, to investigate family and nursing home staff perceptions of the role of families in nursing homes; secondly, to
identify the factors that influence family involvement in nursing home care; and thirdly, to seek the opinions of families and nursing home staff on changes they would like to see in the role of family carers. Sixty nursing homes in Northern Ireland were selected randomly and invited to participate in the study. Fifteen homes agreed to participate. A member of staff from each nursing home then distributed a questionnaire to all family members. The questionnaire was developed from a task inventory designed by Shuttlesworth et al. (1990), which identified a range of tasks that nursing home administrators, relatives and friends of residents deemed essential in nursing home care. The questionnaire was also distributed to all staff in the participating homes. Of the 225 questionnaires distributed to family members, 44 were completed (19.5%) and of the 225 questionnaires distributed to staff, 78 were completed (34.6%). For the interviews, a convenience sample from the completed questionnaires resulted in interviews with 10 family members and 10 staff members. The interviews were semi-structured and focused on thoughts, feelings and issues not explored in the questionnaire (the interview guide was tested in a pilot with three nurses and three family members).

Overall, the study found that family carers perceived themselves to have a greater role in caring for relatives than that perceived by staff. The researchers suggested that either families over-estimated their involvement, or staff under-estimated families’ involvement. The families perceived nurses as providers of technical care and they perceived themselves as having an important role to play in providing social care (e.g. personalising the resident’s room, keeping them company, taking them out and providing a link with the resident’s past) and in care planning (providing information about the resident’s likes, dislikes, hobbies and biographical details). Families wished to see more individualised care and more activities. The researchers suggested that families are perhaps under-valued as a resource in residential care. The researchers concluded that family members have biographical preservative expertise, which should be utilised to enhance resident autonomy and that family members should be involved in the assessment, planning, implementation and evaluation of care. It is acknowledged that the questionnaires yielded low response rates (19.5% and 34.6%). However, the researchers supplemented the questionnaire data collection method with qualitative interviews of sufficient numbers. Ryan and Scullion (2000) stated that Shuttlesworth et al.’s (1990) inventory had been used in
many previous studies and that it was a reliable and valid instrument, but it is worth noting that it was 10 years old at the time the research was conducted.

Similarly, Hertzberg and Ekman (2000) conducted an observational study that aimed to establish promoting factors for well-functioning staff-relative relationships. Data were collected from 27 hours of non-participant observations of group discussions about relatives and staff communication, interactions and experiences. The groups had eight members including one professional group leader (a psychiatrist with experience of working in geriatrics, in supervising staff and in providing support for relatives), a representative from the Dementia Association, staff members, and relatives. The groups met six times over a three-month period. They found that the experiences relatives and staff had of each other were determined by their level of influence, level of participation, level of trust and the measures taken to avoid conflict. Hertzberg and Ekman (2000) also reported that staff and relatives’ accounts of their experiences were sometimes contradictory and the researchers suggested that the relatives’ role is not fully utilised. Relatives did not always know how to communicate their wishes. Relatives felt that staff did not always communicate with each other and that some staff placed more value over establishing relationships with the resident and the resident’s family than others did. Relatives expressed feelings of exhaustion when staff turnover was high and they had to start all over again with building new relationships with new staff members. It is worth noting that family participants took their own initiative to join the discussion groups and therefore those who chose to participate may have been fuelled by a desire to voice concerns. Both of these studies (Hertzberg and Ekman, 2000; Ryan and Scullion, 2000) confirm that staff and family members often have different perceptions of the approach to care for older people.

Staff and residents’ perspectives of the approach to care can also vary between care homes. Murphy et al. (2007) adopted a mixed-method design to examine quality of life for older people in residential care settings. The aim of the research was to explore the quality of life of older people living in residential care in Ireland from the perspectives of the residents and staff. Three data collection methods were employed: focus groups with managers (n=7), a quantitative survey of 526 long-stay facilities in Ireland (public, private and voluntary) with a response rate of 62%, and
interviews with residents (n=101) and staff (n=48). The researchers found that the approach to care varied across care sites. It suggested that the staff perspectives or ethos of care was a factor in the quality of life for the residents and that this was often dependent upon differences in staffing provision and skill mix. The skill mix of staff has been discussed by numerous researchers in the literature, and in particular the contribution that the skilled nurse can make to creating positive residential care experiences.

2.3.3 The Nursing Role

Researchers suggest that working with older people is a specialty in nursing that requires specific competencies (Hunter and Levett-Jones, 2010; Reed et al., 2007; Ford and McCormack, 2000; Hope, 1994). McCormack (2001) describes these competencies as listening, negotiating, enabling opportunities and choice, and enabling decision-making. The Australian Nursing Board (1997) produced “Competency Standards for the Advanced Gerontological Nurse” and these were reflective of the complex and diverse role of nurses working in residential care.

The nurse working in residential care must be knowledgeable and professionally up to date so that he/she can play an essential role in contributing to positive experiences of the approach to care. In addition to those nurses working in residential care, Hope (1994) suggests that all nurses would benefit from gerontological education as older people are patients in all specialities. The American Nurses’ Association of Gerontological Nurses also identified that the most critical professional nursing issue was continuing education and ongoing development, and furthermore that residential care facilities should identify baseline knowledge of staff and implement educational programmes in order to enhance that baseline (Huber, Reno and McKenney, 1992).

Ford and McCormack (2000) explained that the gerontological nurse needs experience of caring for and working with older individuals, an understanding of the socio-political context of ageing, an understanding of biological and psychological developments through the lifespan, and an understanding of the needs of the population. The Royal College of Nursing (RCN) (1997) advised that gerontological
practitioners need to reflect upon their values and beliefs, review their knowledge base, and review their practice.

Hunter and Levett-Jones (2010) examined the role of the nurse in residential care. Adopting a mixed-method research design, questionnaires, document analysis and semi-structured interviews were used to elicit the role of the gerontological nurse from nurses (n=48) and nurse managers (n=16). Their aim was to provide a contemporary description of the practice of nurses caring for older people in residential care. Six residential care facilities were purposively selected and all had government accreditation. Two rural, two regional and two metropolitan facilities were included in the sample, some of which were for-profit and some which were not. Eighty-six questionnaires were distributed to nurses and 21 to nurse managers, and the response rates were 56% and 76% respectively. Twenty-one nurses and 11 nurse managers consented to being interviewed post-analysis of the questionnaires. The findings confirmed that the role of the nurse in residential care has expanded and the practices of the nurses in this study were consistent with current descriptions of gerontological nursing skills, which include listening, negotiating, enabling opportunities and choice, and enabling decision-making (McCormack, 2001; Ford and McCormack, 2000; Australian Nursing Board, 1997; RCN, 1997). While this study was only conducted in one state in Australia, it is a recent study and its methodological design enabled a detailed description of practice.

Further to the individual nurse’s role in residential care, the quality of care and quality of life for residents has also been researched and discussed.

2.3.4 Quality of Care and Quality of Life

Many studies have sought to evaluate quality of care and quality of life in residential care for older people (Cooney, 2010; Dwyer, Nordenfeldt and Ternestedt, 2008; Murphy, 2007; Murphy et al., 2007; Pearson et al., 1993). These studies have identified various approaches to residential care that impact upon quality. These include the skill mix provided, the creation of an atmosphere with a sense of belonging, enabling older people to retain their social connections and relationships, providing activities, involving the family and creating a homely physical environment.
Murphy (2007) specifically examined quality of care in residential care services in Ireland (public, private and voluntary). Adopting a mixed-method approach, one part of this study used a self-response questionnaire and elicited a 68% response rate from a sample of 498 nurses. The aim was to identify the underlying dimensions of quality care and the key factors that have an impact on quality care. Organisational approaches to care, such as resistance to change and being bound by routine, were found to be factors that hinder overall quality of care.

Two projects in the UK have attempted to introduce different approaches to care and subsequently examine the difference it makes to older people: the CARE profiles (Faulkner and Davies, 2006) and the My Home Life project (Help the Aged, 2006). These projects focused on the need to actively encourage older people to participate in their care and thus enhance their autonomy and quality of life. The findings support a link between an organisation’s approach to care, and autonomy and quality of life. Faulkner and Davies (2006) outline the CARE profile (Combined Assessment of Residential Environments), which was developed in Canada and tested in the UK. This project represents a more flexible and client-driven approach to care. It aims to potentially optimise the potential of clients, improve their quality of life and create a more empowered workplace. The resident should be supported and enabled to lead his/her own care to the greatest extent possible. The client and the caregiver should actively engage in a partnership that builds on each other’s strengths, resources and expertise to make care decisions. The project involves gathering information from residents, residents’ families and from staff in order to celebrate what works well in the home and to identify areas that need attention. The aim of the project was to identify day-to-day events that could be made more positive in relation to residents’ autonomy and quality of life. It has involved 28 residents, 25 staff and 38 relatives in seven care homes in South Yorkshire, UK. It has found so far that poor staffing levels and workload constraints feature prominently, and consequently affect several aspects of social care such as communal activities and one-to-one staff/resident interactions. Simply “getting the work done” contributes to staff feeling dissatisfied with their work and being socially detached from the residents. Ultimately this affects the opportunities available for residents to express their autonomy and to express a satisfactory quality of life.
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The “My Home Life” project (Help the Aged, 2006), also in the UK, was developed from a partnership between Help the Aged, the National Care Forum and the National Care Homes Research and Development Forum, in collaboration with older people and representatives from the care home sector. Amongst its main aims is to promote “shared decision-making”, which should be realised by helping staff to encourage residents to be active participants in their care. It was stated that an approach to care which recognises the importance of decision-making is key to partnership, sharing power and ultimately experiencing autonomy and quality of life. It recognises that the wish to be involved in decision-making is likely to vary from one individual to another and that severe cognitive impairment does not mean that those residents’ views should not be sought, even if it is more difficult to do so. It suggests that creative methods be employed in order to involve residents with cognitive impairment in decision-making and thus in realising their autonomy and quality of life. While both the “CARE” and the “My Home Life” projects highlight how different approaches to care can impact upon older people’s autonomy and quality of life in residential care by moving from task-based routine care to partnership, participation and involvement in decision-making, they are ongoing projects and therefore no final conclusions about their effectiveness have been reported.

2.3.5 Person-Centred Care

The theory of person-centred care evolved from a desire to create an approach to care that is non-paternalistic and non-task orientated and promotes autonomy. There has been an extensive amount of debate and discussion in the literature advocating for organisations to adopt a person-centred approach to care in residential homes for older people (Manley and McCormack, 2008; McCormack, 2004, 2001). Most importantly, policy documents (Department of Health, 2008; HSE Corporate Plan 2005-2008, The Health and Wellbeing for Older People, Western area, 2001-2006 have recognised that autonomy is a central ingredient in realising person-centred care and subsequently quality of life for older people in residential care. Therefore without the core ingredient “autonomy” there is a lack of person-centred care and ultimately a good quality of life.
Patient- or person-centred care (PCC) may be explained as care that is respectful of and responsive to individual patients’ preferences, needs and values whilst ensuring that patient values guide all clinical decisions (Institute of Medicine, 2001). Manley and McCormack (2008) explained that PCC is a term used to describe the therapeutic relationships between care providers and service users, and between care providers themselves.

The majority of papers published about person-centred care have focused on providing frameworks for clinical practice (McCormack, 2008; McCormack and McCance; 2006; Manley and McCormack, 2001; Nolan et al., 2001; Ford and McCormack, 2000; Titchen, 2000). Many of these frameworks share similar recommendations for effective staff/resident communication, staff expertise in working with older people, a sense of humanity in the care environment, and the establishment and maintenance of successful staff/resident relationships. The “positive-person framework” was developed by Kitwood (1990) and has its roots in social psychology. Kitwood (1990) stated that the approach to communication influences the type of caregiving and the culture of care. Titchen (2000) then devised the “skilled companionship” theory, which stated that the nurse must possess a high level of expertise in knowing the older person in order to deliver PCC. Similarly, the Burford Nursing Development Unit in Oxfordshire developed a humanistic framework that facilitated nurses and residents to consider the lived experience. Furthermore, Nolan et al. (2001) devised the “senses framework”, which focused on residents’ need for security, belonging, continuity, purpose, achievement and significance. Nolan et al. (2001) concluded that the senses framework for PCC is actually dependent upon relationships.

McCormack (2001) then aimed to further develop the PCC theory and stated that there are four concepts underpinning person-centred nursing: being in relation, being in a social world, being in place and being with self. Being in relation is about the relationship between the nurse and the patient. Being in a social world relates to knowing the person’s social interests and devising life-plans for them. Being in place relates to the working environment and its systems, which may promote or hinder person-centred practice, and being with self relates to knowing the patient and their values. What all of these frameworks have in common is the recognition of the
patient as central to the care relationship and the patient has a personality shaped by their life experiences. However, Dewing (2004) argued that these frameworks need further development in order to make them meaningful for older people and for the nurses working with them.

In order to advance the use of these frameworks in practice, various prerequisites to PCC have more recently been presented in the literature. McCormack (2001) stated that getting close to the patient and building a relationship with them is the vital step required for achievement of PCC. McCormack and McCance (2006) added that a PCC approach to care delivery requires prerequisites 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.

There are currently no published research reports that examine whether or not these prerequisites do in fact lead to PCC. In one mixed-method study Hunter and Levett-Jones (2010) found that delivering person-centred care remains a challenge for nurses working in residential care in Australia. Operationalising and understanding one of its key ingredients, i.e. autonomy, may help to eradicate part of the challenge. Their aim was to provide a contemporary description of the practice of nurses caring for older people in residential care. Data were collected via purposive questionnaires, document analysis and semi-structured interviews from 48 clinical registered nurses and 16 nurses managers across six long-stay care facilities for older people. There was a balanced mix of two rural, two metropolitan and two regional facilities in the study sample and these included both profit and not-for-profit facilities. The questionnaires yielded a low response rate of 56% from the nursing sample (86 were distributed and 48 returned) while a high 76% response rate was achieved with the nurse manager sample (21 distributed and 16 returned). Hunter and Levett-Jones (2010) found that while nurses have moved to a more person-centred approach to care they are not using any person-centred frameworks. The researchers state that observations would have further enhanced the research findings.
In summary, the literature relating to person-centred care identified knowing the person as key to the success of this approach to care.

### 2.3.6 Life Plans

Many researchers state that life plans are essential for knowing the person and subsequent realisation of autonomy for older people in residential care (Tutton, 2005; Lidz, Fischer and Arnold, 1992; Agich, 1990; Meyers, 1989). Meyers (1989) stated 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 that life plan. Agich (1990) also recognised the importance of life plans if older people with reduced capacity wish to remain autonomous.

Focusing his work on older people in residential care he called for a refurbished, concrete concept of autonomy that systematically attends to the history and development of persons and takes account of experiences of daily living. He also recognised that the “individual” is always in a state of change and development across the life cycle.

> “Thus, to speak of individuals as autonomous requires that we pay attention to the kinds of things with which they properly identify in their lives….we need to learn how to acknowledge their habits and identifications”

(Agich, 1990, pp.12)

Agich (1990) added that to be dependent on something is not a loss of autonomy if one truly identifies with what one is dependent on. He reflected on the concept of autonomy as it relates to residential care and questioned if the choices actually afforded to residents were indeed meaningful or worth making, and stated that being able to identify with one’s own choices is a prerequisite for true autonomy. In other words, whether or not a resident has a shower at 06.00am or 12noon may be irrelevant to them, but what they may wish to be autonomous about is their love for documentaries about animals and being enabled to watch them on TV. Knowing the resident through gathering life plans enables staff to provide meaningful choices.

Similarly, Lidz, Fischer and Arnold (1992) explained that autonomous acts are accomplished by individuals with a past, present and future. Autonomy is consistent with an individual’s life history and subsequent life plans. Therefore, assessing
whether or not an act is autonomous requires the act to be assessed within the context of the person’s life. It is suggested that when a person has dementia then their life history can be used to assist caregivers with offering them options for everyday decisions that are consistent with their life history.

Tutton (2005) and Cook (2010) stated that understanding patients’ personal histories and biographies creates opportunities for knowing what is important to them. It also provides an insight into how they are experiencing their present situations. Tutton (2005) reported that knowing the (authentic) person and how they would like to live their daily life provides the basis for participation in daily care. Thus compilation of life plans may impact upon whether or not an older person in residential care experiences autonomy. Furthermore, the importance or value that staff place on getting to know the resident in order to compile these life plans may be determined by their own attitudes about older people.

2.3.7 Staff Attitudes

Randers and Mattiasson (2004) state that research has shown healthcare professionals’ values, beliefs and attitudes towards older patients affect how they view and approach the patients in their care, and this ultimately affects the level of autonomy and quality of care they experience. Rodgers and Neville (2007) supported this by stating that negative or ageist attitudes towards older people are a direct threat to their autonomy. Katz (1960) defined an attitude as an individual predisposition to evaluate a symbol, object or aspect of the individual’s world as positive or negative. Wesley (2005) stated that attitudes shape individuals’ ability to understand, organise and clarify the world around them and influence the individual’s behaviour and knowledge acquisition. More recently, Mandy, Lucas and Hodgson (2007) explained that attitudes may be considered to be a combination of positive and negative evaluations by which we interpret events, situations and relationships. They are based on our own experience of what others have told us, or what others have patterned for us. Several researchers have connected healthcare professionals’ level of knowledge about ageing with positive attitudes (Mandy, Lucas and Hodgson, 2007; Wells et al., 2004; Wade, 1999), while others have suggested that negative attitudes arise out of the type of work often associated with caring for older people (Wells et al., 2004; Pursey and Luker, 1995; Hope, 1994). In contrast, Salmon
(1993) found virtually no relationship between nurses’ attitudes and their behaviour with patients.

Public awareness or representation of ageing issues may also impact upon society’s level of understanding of older people’s abilities to be autonomous. Mandy, Lucas and Hodgson (2007) stated that the way older people are perceived publicly needs to be addressed. Murphy (2004) conducted a documentary analysis of older people and ageing issues in Irish newspapers and found that less than 10% of news items about older people addressed ageing issues. Murphy (2004) also found that the national newspapers give much less coverage of older people than the local weekly newspapers (on average 3.3 per national edition versus 11.0 per local edition) and that national newspapers used significantly fewer photographs of older people than local newspapers. This report revealed that tabloid newspapers tend to use words like “granny” in sensational headlines while the word “elderly” is still used extensively. Only one advertisement included a picture of older people. All of this does little to promote positive attitudes about ageing and older people.

Wade (1999: 342) stated that historically, the images portrayed for caring for older people have done little to create positive attitudes. Furthermore, nurses themselves working in this specialty have an “inferiority complex” and feel “isolated, undervalued and less glamorous” than their colleagues in other specialties. Wade (1999) concluded that staff need to be empowered, encouraged and educated to meet the care needs of older people in residential care and this will in turn create a shift in attitudes. This shift is necessary if there is indeed a link between staff attitudes to ageing and residents’ experiences of autonomy (Rodgers and Neville, 2007; Randers and Mattiasson, 2004).

A number of scales to quantify/score healthcare staff’s attitudes towards older people have been developed (Palmore, 1977; Rosencranz and McNeving, 1969; Kogan, 1961). In 1961 Kogan developed a Likert scale to facilitate the study of attitudes toward older people with respect to both norms and individual differences. It has been used many times since it was published and has been translated into many languages. It has been shown to have good psychometric properties. The scale contains one set of 17 items expressing negative sentiments about older people and a
second set of 17 items expressing the reverse positive statements. The positive and negative paired items are separated and distributed at random points in the scale. Positive items are scored from left to right with “strongly disagree” being one point and “strongly agree” being six points. Negative items are scored from right to left with “strongly disagree” being six points and “strongly agree” being one point. The higher the total score for the scale, the more positive a person is in their attitude to older people. The instrument’s reliability has been found to be alpha 0.79 (Lambrinou et al., 2005). Holroyd et al. (2009) state that Kogan’s scale is valuable in nursing research due to its caring dimension.

In 1969 Rosencranz and McNeving developed the “Aging Semantic Differential” (ASD). The 32-item ASD is used to measure attitudes, and quantify bias and negative stereotypes toward older people. To date there are no reports on the validity or reliability of this scale.

The “Facts on Aging Quiz” (FAQ) was devised by Palmore in 1977. According to Lusk, Williams and Hsuing (1995) the FAQ I and II (Palmore, 1977, 1981) were designed to assess knowledge and to measure misconceptions regarding older people. This study compared results on the FAQ I and II administered to freshmen nursing students. In contrast with Palmore’s (1981) findings, the FAQ I and II were not related (r=0.04) and alpha coefficients were low (0.45 and 0.32 respectively). However, use of theta coefficients (which make fewer stringent assumptions about items being parallel) resulted in values of 0.60 and 0.64 respectively. The factors emerging in this study differed from Palmore’s (1977, 1981, 1988) conceptual structure and explained only 45% of the variance. Results from this study suggest that while the FAQ I and II may be useful as a stimulus for discussion, revisions and testing need to be done if they are to be used for research purposes. Palmore (2005) himself reflected upon his work and highlighted that he started doing his research on ageist stereotypes at around the same time that Butler (1969) coined the term “ageism”. Palmore (2005) explained that the FAQ was developed in order to provide an alternative form of a quiz that would facilitate before and after tests of the effects of courses and workshops, and by 1997 there were more than 150 known reports of studies using the quizzes. Palmore (2005) stated that the Facts on Aging
Quizzes remain the only published, documented, and tested measures of knowledge about ageing.

The “Reactions to Ageing Questionnaire” (RAQ) was developed by Gething in 1994 and aims to measure attitudes toward personal ageing and thus assess how individuals anticipate their own personal ageing. It is designed to measure negative and positive reactions and thus conform to the widely accepted definition of an attitude as involving positive or negative evaluation. It is a 27-item questionnaire requiring respondents to rate statements regarding their own ageing on a six-point Likert scale with 1 being “agree very much” to 6 being “disagree very much”.

Gething et al. (2004) applied the RAQ to Sweden and the UK and concluded that it was applicable to countries outside of Australia where it was designed. Gething et al. (2004) also concluded that the RAQ provides a complementary instrument to attitudinal instruments that focus on the societal level of measurement, and its inclusion in data collection enables a more comprehensive study of attitudes by providing access to information gathered at the personal level. It requires further application by other researchers.

Several researchers have used these scales to investigate attitudes to ageing (Gething et al., 2004; Wells et al., 2004; Hope, 1994; Huber, Reno and McKenney, 1992). In one study Gething et al. (2004) used the RAQ across several countries. Their aim was to establish if the psychometric characteristics and norms of the RAQ identified by Australian nurses also apply to nurses in Sweden and the UK. The RAQ was completed by 147 nurses in Australia, 218 nurses in the UK and 102 nurses in Sweden. The average response rate was 78%. Demographic details were also obtained. The researchers found that the Swedish sample had more positive attitudes than in the UK or Australia and that there was no significant difference between the UK and Australia. They concluded that attitudes of nurses towards older people can impact upon healthcare service provision for this client group and that the RAQ is applicable in countries other than Australia where it was developed. This was a significant study as it further validated the RAQ. Hope (1994) found that attitudes not only vary across countries but also across care sectors. Hope (1994) administered a postal questionnaire containing demographic information, the FAQ and Kogan’s Attitudes towards Old People scale (KAOP). One hundred and forty-nine distributed
questionnaires (to nurses working in acute care for older people and acute medical care) yielded 86 valid and completed questionnaires (57.7% response rate). The main finding was that nurses working in acute care for older people had significantly higher or more positive attitude scores than those working in acute medical care. Hope (1994) suggested that this may be because nurses with a positive attitude toward older people find themselves working with older people. Hope (1994) also found that socialising forces within nursing may actually reinforce ageist attitudes and that patient dependency may influence staff attitudes. However, this study is over 10 years old and the sample size is small at n=86.

In addition to attitudes varying across countries and across care sectors, several researchers have found that there are links between level of education of healthcare staff and level of positive attitudes about older people (Doherty, Mitchell and O’Neill, 2011; Mandy, Lucas and Hodgson, 2007; Wells et al., 2004; Huber, Reno and McKenney, 1992). Wells et al. (2004) explored the prevalence of negative attitudes regarding ageing amongst nurses working with older adults, and examined factors such as education and work environment that may influence such attitudes. Their aim was to document ageist attitudes and practices among aged care and health services providers in Victoria, Australia. A questionnaire was developed for the study through consultation with the project reference group and was pilot tested with a small number of volunteers. The final questionnaire contained four sections: demographic and personal data, the Facts on Aging Quiz, the Reactions to Aging Questionnaire and the Practice Costs and Rewards Questionnaire (PCRQ: a 12-item scale adapted for the study with statements that reflect practice rewards and other statements that reflect practice costs). Two hundred and five nurses participated. They found that nurses were more likely to hold positive attitudes if they worked for a service provider rather than an employment agency, had gerontology education, and/or worked outside the residential care sector, and that nurses had less accurate knowledge of ageing than other healthcare professionals. They also found that nurses expressed a higher anxiety about ageing and were more likely to believe that working with older adults was associated with low esteem in the profession. The researchers did not reveal how many questionnaires were originally distributed and consequently we are unaware of the response rate.
Previously, Huber, Reno and McKenney (1992) investigated if there was a change in attitudes of residential care employees (all personnel including domestic and administrative) and a change in knowledge level after educational sessions. The Facts on Aging quiz was used. Each participant attended three one-hour classes that consisted of simulation of handicaps, normal age-related changes and myths and realities of ageing. Class materials included hand-outs, audio-visuals and discussions. Overall they found a significant increase in knowledge from the pre-test to the post-test (nurses did not show a significant increase but all other personnel did) and thus concluded that continuing education is an effective means of influencing the knowledge and attitudes of most personnel in residential care facilities. However, they recommended that this study be replicated in another facility and include the addition of a job-satisfaction tool.

Pursey and Luker (1995) challenged the assumption that an identified lack of desire in nurses to work with older people is due solely to negative attitudes that nurses hold towards older people. They used a two-phase multi-method approach to research four educational institutions in the north-west of England. Their aim was to examine the retrospective experiences that nurses have had in working with older people, in an attempt to draw out the differences between nurses’ attitudes towards work with older people. The convenience sample included 25 experienced health visitors, 62 student health visitors and 40 practice nurses. Phase one administered a questionnaire that contained forced-choice and open-ended questions and sought demographic information. Respondents’ current work involvement with people over 65 years of age was also sought. In addition, respondents were asked to write about incidents from hospital or community settings where they had been involved with older people and felt they had been “effective” or “ineffective”. Phase two involved in-depth conversation-style interviews with a sub-sample of the questionnaire respondents. A total of eight practice nurses, eight student health visitors and six experienced health visitors participated in the interviews. The researchers found that high dependency levels of older people and the structure of nursing work with older people in hospitals means that fewer nurses make this area a positive career choice. Pursey and Luker (1995) state that one would have expected this to have changed with the development of individual patient-centred care and public awareness around this new approach to care, but that this was not the case. Pursey and Luker (1995)
concluded that there may be a difference between nurses’ negative feelings about the structural context of work and their more positive feelings about individual older people with whom they work. It may be argued that retrospective opinions or perspectives may not accurately report the present reality of a phenomenon.

More recently, Doherty, Mitchell and O’Neill (2011) measured the attitudes of healthcare workers towards older people in a rural Irish population. Their aim was to explore the attitudes held by nurses, healthcare assistants, ward managers, student nurses and public health nurses who were on duty in a 24-hour designated data collection period. Three hundred and three questionnaires requiring demographic information and completion of the Kogan Attitudes towards Old People scale (KOP) were administered and 190 were returned, yielding a response rate of 62.2%. The researchers found that there was no significant difference in attitude scores measured across gender, job title, length of service in current role, or workplace setting. However, they did detect differences in scores for university graduates when compared with those who had not attained a university qualification. Those with university education held more positive attitudes. They found no difference in attitudes between those working in different care environments. Public health nurses had the most positive attitudes. The researchers acknowledged the public criticism of the KOP scale (its age and its lack of focus on context) but argued that it is still used extensively and has high reliability ratings.

2.3.8 Section Summary
This section has discussed the issues in residential care for older people as reported in the literature. It revealed that an organisation’s approach to care is central to positive resident experiences of care. It also revealed that staff, residents and residents’ families often have contradictory perceptions of care and that gerontological nurse expertise is key to enhancing residents’ autonomy and quality of life. The studies presented in this section suggest that nursing leaders need to promote professional knowledge and practice regarding relationship building, client-centredness and autonomy if nurses and clients are to be empowered. It is also suggested that there are powerful connections between structure, process and outcomes in an organisation’s approach to care and that these ultimately affect a resident’s autonomy. Family members were recognised as having important
information about the biography or life story of the resident, which should be utilised to enhance resident autonomy. It was reported that routine and task-based care impact negatively on residents’ autonomy. An approach to care that recognises the importance of decision-making was suggested to be key to partnership, sharing power and ultimately enhancing residents’ autonomy and quality of life. Autonomy was recognised as an integral ingredient in providing person-centred care, and person-centred care is viewed as essential to achievement of quality of life. Knowing the person is key to person-centred care and this involves knowing the older person’s needs, wants, values and history thus leading to the development of a negotiated life plan. Positive staff attitudes were associated with the type of care experienced. It was suggested that staff attitudes may be positively influenced by education. There was no consensus on whether or not the work environment influences attitudes. The next section of this literature review will analyse the research studies that have specifically examined autonomy for older people.

2.4 Autonomy for Older People

Very little research has been undertaken that has specifically examined and explored autonomy for older people. Some studies have examined the issues that impact upon the operationalisation of autonomy (Persson and Wasterfors, 2008; Solum, Slettebo and Hauge, 2008; Scott et al., 2003; Proot et al., 2002; Davies, Ellis and Laker, 2000; Davies et al., 1999) while one study investigated how autonomy and participation in residential care can lead to an enhanced quality of life (Barkay and Tabak, 2002). It is suggested that knowledge of the issues that impact upon the operationalisation of autonomy contributes to our understanding of what autonomy actually is.

2.4.1 The Operationalisation of Autonomy

Some researchers suggest that nurses adopt “strategies” or practices that may positively or negatively impact upon an older person’s autonomy (Slettebo and Haugen-Bunch, 2004; Davies, Ellis and Laker, 2000) and often find themselves ethically challenged between enabling autonomy and giving what they believe is “the best type of care” (Scott et al., 2003; Solum, Slettebo and Hauge, 2008). It has also been suggested that there is a link between the educational preparation of nurses and
the level of autonomy that older people experience (Davies, Ellis and Laker, 2000; Davies et al., 1999), and that the healthcare physical environment may constrain autonomy (Proot et al., 2002).

One study observed the practice of nurses who had at least six months’ experience of working with older people (Davies, Ellis and Laker, 2000). Adopting a qualitative design, the researchers purposively recruited 30 nurses whom they observed in practice. Their aim was to evaluate the outcomes of educational programmes for the nursing care of older people and to contribute to a greater understanding of resident autonomy. The complete data set analysed included field notes from 87 observational periods (more than 270 hours) and from more than 1,000 separate care events. The analysis involved simple thematic content analysis. The researchers found from this robust study that there was a wide variation in the extent to which individual nurses implement strategies for promoting autonomy and independence for older people. Several strategies were revealed, including negotiating care, informing older people, encouraging physical independence, recognising individuality and personhood, avoiding controlling language, being alert to cues, and promoting individualised care. The researchers provided examples of how these strategies were observed positively and negatively in practice. They recommended that nurse educators should consider practical examples of ways in which the broad aims of promoting autonomy and independence for older people could be realised in practice, which would in turn reduce the strategies or practices that contribute negatively to older people’s realisation of their autonomy. The researchers also recommended that further research needs to be undertaken that would yield a more precise definition of autonomy and independence for older people.

Similarly, Slettebo and Haugen-Bunch (2004) suggested that nurses use several strategies to solve ethically difficult care situations, and in particular those related to autonomy. Using a qualitative comparative design and a grounded theory approach the researchers conducted interviews and observations. The aim was to investigate how nurses apply strategies to resolve ethical dilemmas such as preserving autonomy, integrity and self-respect. Fourteen semi-structured interviews were conducted with nurses. Two (three-hour) observations over an eight-week period were also conducted on four wards. Data analysis was guided by Glaser and Strauss
(1967). The researchers found that nurses use three distinct strategies for solving ethically difficult care situations: negotiation, explanation and restraint. The nurses related the strategy of negotiation with autonomy and stated that this was their preferred strategy for respecting patient autonomy. It is recognised that this research was only undertaken in care homes that fulfilled the Norwegian quality regulations. However, both of these studies (Davies, Ellis and Laker, 2000; Slettebo and Bunch, 2004) identify negotiation strategies as integral to operationalising autonomy. Slettebo and Bunch (2004) state that patients in nursing homes sometimes give accounts of episodes in which they feel their autonomy and/or self-respect is violated as a result of the care they receive from nursing staff. They suggest that further research needs to be undertaken that explores the meaning of autonomy for older people in residential care and the ways it can be truly operationalised.

Proot et al. (2002) stated that the majority of studies regarding patient autonomy are based upon theoretical reflections and not on empirical evidence. Proot et al. (2002) explored autonomy in stroke rehabilitation. Their aim was to pinpoint which dimensions of autonomy are identified by care providers and to determine which factors, in their opinion, influence patient autonomy during the stroke rehabilitation process in nursing homes. A qualitative research method was adopted and grounded theory was used to explore the care providers’ views. Twenty-seven members of multi-disciplinary teams from three nursing homes in The Netherlands were interviewed. The interview guide was designed from a previous study and from a literature review. It was piloted prior to use. Detailed description of the analysis was provided. It was found that autonomy exists in dimensions and that it can be constrained or facilitated by patient factors and environmental factors. The dimensions of autonomy include self-determination, independence and self-care, and these change during stroke rehabilitation. Patient factors were also revealed to influence autonomy before a stroke (life history, activity rate, character and multi-morbidity) and after a stroke (disabilities, multi-morbidity, emotional state and expectations of the nursing home and of the future). The environmental factors that affect patients’ autonomy include the approach and strategies of care providers and families, and the nursing home. Proot et al. (2002) explain that the dimensions of autonomy, the patient factors and the environmental factors are related to each other. Strategies that Proot et al. (2002) identified for facilitating autonomy included
teamwork, attentiveness/respect, giving information, assessment/training, enhancing patient choice, co-operation with family/patient, and risk-taking. They also identified one constraining factor, which is “institutionalisation” created by care providers. They conclude that autonomy is not static and changes over time, thus reiterating the work of Agich (1993).

In summary, while not all of these studies were conducted in residential care units, there are some identified factors that impact upon the operationalisation of older people’s autonomy in healthcare environments. These include factors related to the physical environment, factors related to the patient’s pre- and post-illness personality and lifestyle, and factors related to the strategies nurses use in their practice.

2.4.2 Autonomy and Quality of Life
One small Israeli study by Barkay and Tabak (2002) specifically investigated the importance of the concept of autonomy among older people in residential care. The aim of the research was to describe and evaluate the degree of autonomy, participation and well-being of frail old residents. For the purpose of this study, autonomy was defined as “a set of values, related to a person’s natural right to autonomously choose among several possibilities; that is, a right within their independent personality, motivated by ambition and choice” (Barkay and Tabak, 2002: 199). The study was conducted in two wards. Thirty-nine residents completed a questionnaire that was designed for the study. The questionnaire contained eight items that examined the residents’ degree of autonomy and was completed by the researchers in collaboration with the residents. The analysis focused on clarifying a correlation between autonomy and well-being. The study revealed that autonomy has a positive influence on residents’ social functioning and that a high level of autonomy has a positive influence on satisfaction and quality of life. There was a significant correlation between autonomy and participation and encouragement to participate. There was also a significant correlation between autonomy and friends’ visits. The researchers concluded that the degree of autonomy a resident is given is pertinent to their quality of their life. The small sample size in one healthcare setting is a limitation of this study. The questionnaire takes three hours to complete and this would be of concern if the study was to be replicated on a larger scale, as this is both time consuming for the researchers and may also be tiring for the participants.
2.4.3 Section Summary
This section revealed that there has been very little research undertaken that has specifically explored and examined autonomy for older people in residential care. The few studies that were conducted were small in scale and recommended further research. There were, however, suggestions that nurses are a central and important element in the realisation of resident autonomy and that they sometimes use strategies that ultimately overrule the older person’s autonomy. Further research is required that will gather perspectives of autonomy from residents, healthcare staff and family members in order to contribute further to our understanding of what resident autonomy is or is not, and whether or not we can operationalise it in residential care.

2.5 Summary of the Literature Review
This literature review revealed three main areas related to autonomy for older people in residential care: definitions and determinants of autonomy, residential care research literature, and autonomy for older people research literature.

The first part of the review revealed that the lack of a clear, concise definition of autonomy for older people in residential care has been a major contributing factor to the lack of operationalisation of the concept and the lack of studies relating to it. Operationalising a concept means developing the concept from the abstract to the concrete and practical, thus enabling practitioners to realise it in the clinical setting. Several researchers have agreed that this “operationalisation” of resident autonomy (a working definition) has yet to be developed and tested in practice (Rodgers and Neville, 2007; Randers and Mattiasson, 2004; Hewitt-Taylor, 2003; Lothian and Philip, 2001; Aveyard, 2000; Davies, Ellis and Laker, 2000). As early as 1994, Hofland suggested that “much work needs to be done – and must be done” on enhancing residents’ experiences of autonomy in residential care. More recently, Boyle (2008) agrees that personal autonomy for older people in residential care still needs to be fully considered for future research.

The second part of the review revealed that there are numerous factors that impact upon older people’s autonomy in residential care. One main factor identified in the
literature was the organisation’s approach to residential care. It was suggested that if residential care moves from task-based care to person-centred care then older people’s autonomy will be enhanced. Policy documents recognise that autonomy is an integral ingredient in person-centred care and subsequent quality of life. The role of the nurse within the care environment was also reported to be important for residents’ experiences of autonomy, and it was suggested that educational programmes need to be delivered in a way that can equip nurses with the knowledge and skills to promote resident autonomy. The role of the family was suggested to be significant in terms of staff getting to know the resident and planning with them how they would like to spend their day. This section also highlighted the importance of negotiated care planning for the realisation of a resident’s autonomy. Finally, the literature revealed that negative staff attitudes in relation to ageing may impact upon the level of autonomy experienced by residents.

The literature review revealed that of the few studies undertaken, the majority had adopted qualitative approaches. The most common data collection methods included interviews and observations. The most informative study adopted a case study approach (Forbes-Thompson and Gessert, 2005). It yielded succinct and richly descriptive findings, suggesting that examination of this research phenomenon lends itself well to a case study approach. The lack of operationalisation of the phenomenon suggests that action- or practice-based research approaches are also required in order to advance our understanding of autonomy for older people in residential care.

To summarise it can be established at this point what is known and unknown about resident autonomy:

What is known about resident autonomy:

- It is known that autonomy is integral to person centred care and subsequent quality of life for older people in residential care.
- It is known that policy makers and older people themselves believe that person centred care is related to quality of life in residential care. It is also
known that autonomy is an integral ingredient in person centred care and hence quality of life.

- It is known that further research needs to be done that will operationalise the concept of autonomy for older people in residential care.
- It is suggested that there are numerous factors that impact upon older people’s autonomy in residential care which include the organisations approach to care, the nurses role, the family’s role and staff attitudes.

What is not known about resident autonomy:

- It is not known how the concept of autonomy can be operationalised in practice.
- The definition of autonomy for older people in residential care remains unclear.
- It is not known what residents’ experiences of autonomy are.
- It is not know which factors are most important in residents experiencing autonomy or indeed what facilitates or hinders these factors.

The most profound finding from the literature review was the lack of consensus in about the meaning of resident autonomy. Therefore a concept analysis of autonomy for older people in residential care was subsequently undertaken. The same literature from the literature review was used for the concept analysis. A systematic approach for identifying the key features from each study was used. This involved establishing what was similar and what was different in each paper. An iterative analysis process was used to compare and contrast key findings and draw out their common core elements. Using Rogers’ (1989) framework, the attributes, antecedents and consequences of resident autonomy were subsequently delineated. This also facilitated the compilation of a succinct definition and model case for autonomy (Appendices 2 and 3).
2.6. Concept Analysis of Resident Autonomy

A concept analysis (CA) has many purposes, including refining ambiguous concepts in a theory and clarifying over-used, vague concepts. Concept analysis is important for three main reasons. Firstly, in theory development whereby theories are developed by clarified concepts (Chinn and Kramer, 1991). Secondly, in operationalising a concept, enabling research and perhaps the development of measuring instruments (Browne, 1993), and thirdly, to improve practice by offering nurses a clearer understanding of what certain terms mean (Mairs, 1994). For the purpose of this research the concept analysis will initially clarify the concept of autonomy for older people in residential care and compile its attributes. Norris (1982) stated that abstract concepts need to be clarified so that the operational definition can be used as a foundation for research. Baldwin (2008) suggested that concept analysis is the essential first step in research and that it can provide a knowledge base for practice by offering clarity and enabling understanding rather than mere knowing. He concludes that it is a pragmatic and rigorous approach to defining concepts that can make a significant contribution to knowledge and, by implication, to nursing practice.

No previous concept analysis of resident autonomy has been undertaken and in light of the lack of consensus on what resident autonomy actually is or is not it was necessary at this point to conduct a concept analysis. The literature from the literature review was further analysed in order to delineate the attributes, antecedents and consequences of resident autonomy. Rodgers’ (1989) framework was used to guide the concept analysis. The literature used for the concept analysis included all literature from the review. Therefore theoretical texts and research reports were analysed for their content. The literature which informed the attributes is detailed in table 2.2, the literature which informed the antecedents is detailed in table 2.3 and the literature which detailed the consequences is detailed in table 2.4.

The first step in Rodgers’ (1989) approach to concept analysis involves identifying and naming the concept of interest. A gap in research was identified in relation to autonomy for older people in residential care; hence the concept of interest was identified. Step two involves identifying surrogate terms and relevant uses of the
concept. The surrogate terms were identified in the literature as freedom and participation. The literature also revealed the uses of autonomy as explained by philosophers, social workers and other healthcare professionals. Step three requires one to identify and select an appropriate realm for data collection. It was stated at the outset that this research is focused on older people in residential care. Step four requires one to identify the attributes for the concept. 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 (Rodgers, 1989). The attributes should be present in all examples of the concept.

The attributes were delineated from the literature review (Table 2.2). Six key attributes were deemed essential for autonomy for older people in residential care. 1) Residents’ capacity encouraged and maintained. 2) Residents involved in decision-making. 3) Residents’ delegate care needs based on the right to self-determination and the rights of older people. 4) Negotiated care plans encouraged through open and respectful communication. 5) Residential unit has a culture and atmosphere of flexibility within an ethos of maintaining resident dignity. 6) Family or significant others included when resident is cognitively impaired.
### Table 2.2: List of attributes of autonomy for older people in residential care

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Refrences</th>
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<tbody>
<tr>
<td>Residential unit has a culture and atmosphere of flexibility within an ethos of maintaining resident dignity.</td>
<td>McCormack et al., 2008; Faulkner and Davies, 2006; Agich, 1990; Collopy, 1988.</td>
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<tr>
<td>Family or significant others included when resident is cognitively impaired.</td>
<td>Boyle, 2008; Harnett and Greaney, 2008; Hertzberg and Ekman, 2000; Ryan and Scullion, 2000; Beauchamp and Childress, 1994; Duncan and Morgan, 1994; Hofland, 1994; Robinson, 1994; Doyal and Gough, 1991; Ekman and Norberg, 1988.</td>
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Several authors acknowledged the importance of one’s capacity in order to exercise ones autonomy (Mill, 1975; Abramson, 1985; Collopy, 1988; Feinberg, 1989; Agich, 1990; Gillon, 1990; Beauchamp and Childress, 1994; Hofland, 1994; Boyle, 2008). Gillon (1995) explained that this capacity is about being able to think, to decide and to act freely and independently and without hindrance. Feinberg (1989) advised that capacity must be encouraged and maintained. Cognitive impairment should not be assumed to reduce ones capacity (Doyal and Gough, 1991; Hofland, 1994; Boyle, 2008; Harnett and Greaney, 2008). Many explained that in addition to capacity, older people have fundamental rights which include self-determination and that they delegate care needs based on these rights (Mill, 1975; Collopy, 1988; Kant, 1989; Horowitz, Silverstone and Reinhard, 1991; Hofland, 1994; Agich, 2004). There was a lot of discussion in the literature about the importance of recognising the subjective element of autonomy which recognises older peoples’ needs, values, goals...
and personal preferences. When the subjective element of autonomy is recognised, the health care professional and the resident together can negotiate care (Meyer, 1989). However open and respectful communication must also be maintained in this process (Collopy, 1988; Kant, 1989; Meyers, 1989; Feinberg, 1989; Gillon, 1990; Beauchamp and Childress, 1994; Atkins, 2006). Residents must be involved in decision making (Collopy, 1988; Agich, 1990; Hofland, 1994; Faulkner and Davies, 2006; McCormack et al., 2008) and dignity should be maintained as it was suggested to be integral to autonomy (Agich, 2004).

### 2.6.1 Identifying antecedents and consequences

Step five of Rodgers’ (1989) approach to concept analysis requires one to identify antecedents and consequences (Appendix 2) of the concept. This can further help in explaining how the concept is used in the social context. The antecedents (Table 2.3) answer the question “what happens before?” the concept, and the consequences answer the question “what happens after?” the occurrence of the concept (Rodgers, 1989).

Several papers suggested that the organisation’s approach to care is an essential antecedent to resident autonomy. The approach to care should be person-centred, non-paternalistic, should recognise individuals’ needs, values and histories, should be flexible in order to accommodate these needs, and there should be a move away from task-based routine care (Manley and McCormack, 2008; Faulkner and Davies, 2006; Forbes-Thompson and Gessert, 2005; Swaggerty, Lee and Smith, 2005; Tutton, 2005; McCormack, 2004, 2001; Beauchamp and Childress, 1994).

Furthermore, staff should perform robust assessments and work with residents and their families in gathering life histories and compiling life plans (McCormack et al., 2008; Atkins, 2006; Forbes-Thompson and Gessert, 2005; Swaggerty, Lee and Smith, 2005; Tutton, 2005; Burkhardt and Nathaniel, 2002; Davies, Ellis and Laker, 2000; McCormack 2001; Beauchamp and Childress, 1994; Lidz, Fischer and Arnold, 1992; Agich, 1990; Meyers, 1989). The approach to care should recognise the importance of maintaining resident dignity (evident between staff, and between staff and residents) (Randers and Mattiasson, 2004; Beauchamp and Childress, 1994). The approach to care should create an atmosphere that enables staff to communicate effectively with each other, with residents and with visitors (Redfern et al., 2002;
Ryan and Scullion, 2000). The literature also identified positive staff attitudes towards older people as being an essential factor in enhancing residents’ experiences of autonomy (Rodgers and Neville, 2007; Randers and Mattiasson, 2004).

There were also consequences identified in the literature for residential units, that aimed to enhance residents’ autonomy (Table 2.4). It was suggested that staff would be more likely to stay working in an environment that approached care in a non-paternalistic manner (staff retention) (Faulkner and Davies, 2006; McCormack and McCance, 2006; Forbes-Thompson and Gessert, 2005; Wade, 1999; Pursey and Luker, 1995). It was also suggested that the environment would be more homely if it was client-driven and flexible (Cooney, 2010; Forbes-Thompson and Gessert, 2005; Cohen and Weisman, 1990). If the residential unit was striving towards enhancing residents’ autonomy then staff would negotiate with residents around their care needs and their interests in life and would complete care plans that recognise the resident’s life history (McCormack et al., 2008; Atkins, 2006; Forbes-Thompson and Gessert, 2005; Swaggerty, Lee and Smith, 2005; Tutton, 2005; Burkhardt and Nathaniel, 2002; McCormack 2001; Davies, Ellis and Laker, 2000; Quill and Brody, 1996; Beauchamp and Childress, 1994; Lidz, Fischer and Arnold, 1992; Agich, 1990; Meyers, 1989). One would observe effective communication between staff, residents and visitors (Burkhardt and Nathaniel, 2002; Faulkner and Davies, 2006; McCormack and McCance, 2006; Tutton, 2005) and residents would experience an enhanced quality of life and increased satisfaction in daily routine, and participate in social activity (Faulkner and Davies, 2006; McCormack and McCance, 2006; Murphy, 2006; Barkay and Tabak, 2002; Agich, 1990). The role of the resident’s family or significant other was deemed integral to the realisation of residents’ autonomy, particularly if the resident is cognitively impaired (Boyle, 2008; Harnett and Greaney, 2008; Hertzberg and Ekman, 2000; Ryan and Scullion, 2000; Beauchamp and Childress, 1994; Duncan and Morgan, 1994; Hofland, 1994; Robinson, 1994; Doyal and Gough, 1991; Ekman and Norberg, 1988).
Table 2.3: Antecedents of autonomy for older people in residential care as delineated from the literature

<table>
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<th>Antecedents</th>
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<td>Staff’s attitudes are positive in relation to ageing and older people. Values and beliefs of staff are person-centred and non-paternalistic. (Rodgers and Neville, 2007; Tutton, 2005; McCormack and McCance, 2006; Randers and Mattiasson, 2004; Burkhardt and Nathaniel, 2002; RCN, 1997; Quill and Brody, 1996).</td>
<td></td>
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<tr>
<td>Staff communicate effectively with each other, with residents and with visitors. Resident assessment is robust and involves gathering life histories. (McCormack et al., 2008; Atkins, 2006; Swaggerty, Lee and Smith, 2005; Forbes-Thompson and Gessert, 2005; Tutton, 2005; Burkhardt and Nathaniel, 2002; McCormack 2001; Davies, Ellis and Laker, 2000; Beauchamp and Childress, 1994; Lidz, Fischer and Arnold, 1992; Agich, 1990; Meyers, 1989).</td>
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<tr>
<td>An atmosphere of openness, motivation and flexibility. (Faulkner and Davies, 2006; Forbes-Thompson and Gessert, 2005; Swaggerty, Lee and Smith, 2005; Tutton, 2005; Redfern et al., 2002; Ryan and Scullion, 2000; Beauchamp and Childress, 1994).</td>
<td></td>
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<tr>
<td>Respect for dignity and for fellow human beings evident between staff, and between staff and residents. (Randers and Mattiasson, 2004; Beauchamp and Childress, 1994).</td>
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Table 2.4: Consequences of autonomy for older people in residential care as delineated from the literature

<table>
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<th>Consequences</th>
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<td>Residents who feel autonomous express an enhanced quality of life and increased satisfaction in daily routine, and participate in social activity. (Faulkner and Davies, 2006; McCormack and McCance, 2006; Murphy, 2006; Barkay and Tabak, 2002; Agich, 1990).</td>
<td></td>
</tr>
<tr>
<td>Staff retention. (McCormack and McCance, 2007; Faulkner and Davies, 2006; Forbes-Thompson and Gessert, 2005; Wade, 1999; Pursey and Luker, 1995).</td>
<td></td>
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<tr>
<td>Evidence of negotiated care plans that include a focus on the resident’s social and recreational needs. Life histories of the resident – knowing the person. (McCormack et al., 2008; Atkins, 2006; Forbes-Thompson and Gessert, 2005; Swaggerty, Lee and Smith, 2005; Tutton, 2005; Burkhardt and Nathaniel, 2002; Davies, Ellis and Laker, 2000; McCormack 2001; Quill and Brody, 1996; Beauchamp and Childress, 1994; Lidz, Fischer and Arnold, 1992; Agich, 1990; Meyers, 1989).</td>
<td></td>
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<tr>
<td>Observation of effective communication between staff, residents and visitors. (Faulkner and Davies, 2006; McCormack and McCance, 2006; Tutton, 2005; Burkhardt and Nathaniel, 2002).</td>
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Following the identification of the attributes, antecedents, consequences and empirical referents (Appendix 2), step six requires the researcher to identify concepts that are related to the concept of interest. This literature review identified these as; freedom, independence, power, self-government and self-determination. Step 7 requires the model case for the concept to be identified.

The identification of the model case (Appendix 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 (Rodgers, 1989).

Having worked through this concept analysis framework utilising the available literature, the following definition for autonomy for older people in residential care settings was produced:

An older person living in residential care chooses and negotiates how they would like to spend their day. Their capacity and dignity is encouraged and maintained. Staff recognise that the past and present lives of all residents, particularly those with cognitive impairment, may shape their desires and decisions. The resident feels a sense of belonging in the homely, open and flexible unit. Family feel included and useful.

The concept analysis from the literature review enabled clarification of the concept of resident autonomy, which was initially vague and inadequately defined (Atkins, 2006; 1975; Doyal and Gough, 1991; Feinberg, 1989; Kant, 1989; Meyers, 1989; Mill, 1975).

The next chapter will discuss the research framework, which includes the methodological approach and the data collection method adopted for this research study.
3. Research Framework

3.1 Introduction

This chapter will discuss the various research paradigms and research methodologies/strategies used in healthcare research. Subsequently the rationales for choosing a pragmatic paradigm and a phase one case study and phase two action research approach will be presented. This chapter will then explore the data collection methods and data analysis options available to the researcher. Issues around maintaining research rigour will then be addressed. The chapter will conclude with a discussion of the ethical responsibilities inherent in conducting research.

3.2 Research Paradigms

Paradigms are sets of practices and beliefs. They categorise inquiry within disciplines. They are characterised by ontological, epistemological and methodological differences in their approach to research and contribution to knowledge. According to Denzin and Lincoln (1994), “ontology” describes what is the real world and what can be known about it, “epistemology” describes what is the relationship between the knower and what can be known, and “methodology” describes how the inquirer can go about finding out whatever he or she believes can be known. Thus the researcher’s ontology directs the epistemology and subsequently the methodology. Therefore the paradigm provides a framework or a lens in order to accomplish an investigation. A paradigm may also be referred to as a “disciplinary matrix”, “research tradition” or “worldview” (Allen et al., 1986).

Weaver and Olson (2006) suggested that there is no one paradigm superior to another. Rather, different paradigms can inform different aspects vital to nursing practice and that the choice of the research paradigm is often guided by the current state of knowledge about a particular area of nursing. The literature revealed that there are many paradigms recognised for nursing research but no apparent consensus on these (Creswell, 2009; Weaver and Olson, 2006; Denzin and Lincoln, 1994). Denzin and Lincoln (1994) outlined six main paradigms: constructionism, interpretivism, feminism, positivism, post-positivism and critical theory. Creswell (2009) outlined four main paradigms: post-positivism, participatory/advocacy, social

The paradigms most commonly used in nursing research will now be described according to their ontology, epistemology, methodology and method.

3.2.1 Positivism
This term was first coined by Auguste Comte (1798-1857). The ontology of positivism assumes a “real” ordered and regular world (Young, 2008). An apprehendable reality is assumed to exist, driven by immutable natural laws and mechanisms and an absolute truth (Denzin and Lincoln, 1994).

Hesse (1980) stated that the positivist paradigm is reductionist and deterministic. The researcher using this paradigm strives for objectivity and uses measurement to test hypotheses (Young, 2008). Maintaining tight control over the context of the problem allows the researcher to make generalisations about the specific concepts studied (Young, 2008). Positivism is referred to as a received view, which uses a scientific method of inquiry to describe and predict patterns in the physical world (Suppe and Jacox, 1985). Theory is established deductively through formal statistical testing of hypotheses (Lincoln and Guba, 1985). The goal of positivist research is control and prediction (Weaver and Olson, 2006).

According to Reason and Bradbury (2008), positivists are traditionally committed to a view of scientific neutrality; in other words, the researcher separates the facts from their values. Epistemologically, positivists are wedded to an individual vision of the world and this determines behaviour (Reason and Bradbury, 2008). Positivists are objective in their inquiry and believe that distance should be maintained between those who study reality and those who experience it (dualism). Gaventa and Cornwall (2008) stated that this epistemological view can in fact distort the “real” world view that positivists hold. However, Guba and Lincoln (1994) state that it is this objectivity that enhances its credibility (because scientific neutrality requires the researcher to separate the facts from their values (Reason and Bradbury, 2008). Methodological approaches require scientific methods including questionnaires and
experiments. It may be argued that this approach makes participants the objects of another’s inquiry rather than subjects of their own (Gaventa and Cornwall, 2008).

3.2.2 Post-Positivism

Post-positivism was developed as a result of concerns about the positivists’ rigid ontology. Post-positivism challenges the notion of absolute truth of knowledge (Phillips and Burbules, 2000). Ontologically, the post-positivist paradigm believes that reality can never be completely known. The epistemology of post-positivism is objective and knowledge is sought through replication (Weaver and Olson, 2006). The goal of post-positivist research is also control and prediction, and theory is established deductively.

In contrast to positivism, post-positivist research focuses on falsifying hypotheses (Lincoln and Guba, 1985). Campbell and Russo (1999) stated that post-positivism, unlike positivism, recognises that discretionary judgement is unavoidable in science, that proving causality with certainty in explaining social phenomena is problematic, and that knowledge is relative rather than absolute. Denzin and Lincoln (1994) stated that post-positivist research attempts to respond in a limited way to the criticisms of positivist research. Patton (2002) described the post-positive approach as that which uses empirical evidence to distinguish between more and less plausible claims, to test and choose between rival hypotheses. Methodologically, post-positivists do not place as much emphasis as positivists on early design of strategies and methods but rather allow the research to shape its own journey (Denzin and Lincoln, 1994). Similar to positivism, post-positivism also uses controlled research methods, precise instrumentation and empirical testing (Guba and Lincoln, 1994). Methods include multiple observations in order to observe the world numerically (Creswell, 2003). Weaver and Olson (2006) stated that post-positivist research is appropriate for nursing research that seeks to systematically gather and analyse data from representative samples. Pearson (1990) argued that post-positive research neglects the “whole” person by studying the parts, while in contrast Schumaker and Gortner (1992) argued that post-positive research in fact attempts to address holism.
3.2.3 **Interpretivism**

Denzin and Lincoln (1994) explained that interpretivism is rooted in the tradition of hermeneutics and the Verstehen tradition of sociology. Its emphasis is on understanding the meaning individuals place on their actions (Weaver and Olson, 2006). Mutual recognition between the researcher and the participant is fostered and valued (Horsfall, 1995). Phenomena are studied through the eyes of the people in their lived situations, and it assumes multiple situated realities in which context gives meaning to phenomenon (Weaver and Olson, 2006).

Ontologically, interpretivism believes that truth can be viewed from multiple perspectives and multiple realities that are holistic, local and specific (Forde-Gilboe, Campbell and Berman, 1995). Epistemologically, Denzin and Lincoln (1994) stated that this creates a paradox of how to develop an objective science from subjective human experience. Rabinow and Sullivan (1987) argued that this can be overcome by accepting the hermeneutical character of existence and thus denying the opposition of objectivity and subjectivity. In other words, objectivity and subjectivity do not need to be separated, but rather can exist together.

Weaver and Olson (2006) stated that the goal of interpretive research is understanding and finding meaning in experience from multiple perspectives. Theory emerges inductively. Methodologically it has many choices such as case study, phenomenology and grounded theory. It can employ methods that can reveal these multiple perspectives (observations, interviews) and may combine qualitative with quantitative approaches.

According to Morse and Field (1996), interpretive research may use hermeneutic analysis to identify common patterns. It recognises that the participant is the expert and that there is no one ultimate or correct interpretation. Hypotheses may be formulated and tested to generate theory, and sometimes established theory is used to explain the data.

3.2.4 **Pragmatism**

Derived from the Greek word for action, pragmatism is about determining the value of an idea by its outcome in practice and conduct. It calls for a theory to be designed
and tested in practice (Weaver and Olson, 2006). Pragmatism is believed to have originated in the work of the American philosopher Pierce (1839-1914). According to Creswell (2003), there are many forms of pragmatism but the main aim is for knowledge claims to arise out of actions, situations and consequences. Ontologically, pragmatism recognises the existence and importance of the natural or physical world and places a high regard for the reality of, and influence of, the inner world of human experience in action (Johnson and Onwuegbuzie, 2004). Murphy (1990) explained that in pragmatism the truth value of an expression is determined by the experiences or practical consequences of belief in or use of the expression in the world. In other words, there may be academic definitions or explanations of a concept but how it is understood or applied in everyday practice situations is what pragmatism is about. Johnson and Onwuegbuzie (2004) stated that pragmatists consider empirical and practical consequences in judging ideas and take an explicitly value-oriented approach to research. Johnson and Onwuegbuzie (2004) also stated that epistemologically, pragmatism rejects traditional dualism (objectivity versus subjectivity: in the philosophy of science, dualism often refers to the dichotomy between the "subject" (the observer) and the "object" (the observed)) and generally prefers more moderate and commonsense versions of philosophical dualisms based on how they work in solving problems (interactions between the subject and the object). Creswell (2003) stated that pragmatists are interested in “what works”.

Patton (2002) stated that pragmatism allows the researcher freedom with methodological choices, and that methodological decisions are made based on appropriateness to answer the research question. Patton (2002) stated that multiple methods may subsequently be used to gather data. Pragmatism is not committed to any one system of philosophy or reality and applies mixed methods of qualitative and quantitative forms of inquiry (Creswell, 2003). Weaver and Olson (2006) supported this and stated that a pragmatic approach can move nursing beyond the boundaries and restrictions of a single paradigm towards theory construction tailored to fit particular situations.

Mertens (2003) argued that pragmatism may fail to answer the question “for whom is a pragmatic solution useful?” However, Johnson and Onwuegbuzie (2004) stated that pragmatists view theories instrumentally – in other words, they become true and
they are true to different degrees (and to different people) based on how well they currently work; workability is judged on the criteria of predictability and applicability.

3.2.5 Constructionism

Social constructionism is principally concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live (Gergen, 1985). Furthermore, Gergen (1985) stated that these forms of understanding are of critical significance in social life, as they are integrally connected with many other activities in which people engage. Constructionists believe that human beings have evolved the capacity to construct and interpret reality (Patton, 2002).

Ontologically, constructionists believe that reality is ongoing, dynamic and reproduced by people acting on their interpretations and their knowledge of it. Epistemologically, constructionists are subjective. This becomes important in social and nursing research when the researcher wishes to gain an understanding of how a phenomenon is interpreted and implemented in practice. Crotty (1998) asserted that the focus of constructionism includes the collective generation and transmission of meaning. It is concerned with the study of social institutions, issues of power and alienation and envisioning new opportunities (Gillis and Jackson, 2002). The researcher works within a group or community, respects the expertise of the participants and collaborates with them to bring about change. It is emancipatory but the focus is on the process not the product (Thorne, 1999). The research becomes a means for taking action and a theory for explaining how things could be. Combining action and reflection, this paradigm enables research to effect transformation (Mill et al., 2001). Theory and knowledge are illuminated through shared meanings of social interactions. Thus a major focus of social constructionism is to uncover the ways individuals and groups participate in the creation of their perceived social reality. Methodologically, it generally uses action research methods and will triangulate between qualitative and quantitative approaches. Specifically, it enables the researcher to look at the ways social phenomena are created, institutionalised and made into tradition by humans.
3.3 Rationale for Choice of Research Paradigm

Weaver and Olson (2006) stated that the practice of situating research within paradigms, as well as the knowledge resulting from research processes, must be considered in the light of their ability to advance the social mission of nursing and to enhance health and well-being.

In the author’s opinion, paradigms may be visualised on a continuum with positivism on the far right and constructionism on the far left. The continuum moves from an objective positive epistemology towards a subjective one, and somewhere in the middle of this continuum lie the practical and dualist views. Similarly, the continuum moves on the right from an ontological view of a real, ordered and structured world to a world of multiple realities constructed by humans on the left. Somewhere in the middle is the ontology that the world is practical and situationally responsive. This imagery of a continuum is useful for the researcher when attempting to frame research within a paradigm or understand which paradigm shapes the research. If the researcher wishes to test hypotheses, conduct surveys, make correlations or conduct experiments then the paradigm will be positivism, which believes in a real, ordered and regular world. If the researcher wishes to understand the lived experience of a phenomenon, then interpretive or pragmatic paradigms will underpin the research. If the researcher wishes to understand how participants construct their reality, attach meaning to their world and subsequently introduce ways that may improve this experience, then constructionist or pragmatic paradigms will underpin the research.

The aim of this research is to explore autonomy for older people in residential care. Consideration has been given to the different paradigms in relation to their ontologies, epistemologies and methodologies, and pragmatism is deemed most suitable to the proposed study. Pierce (1838-1914) proposed the theory of meaning, explaining that a word is rather like a tool. You grasp its meaning when you know how to use it. He gives the example of how to define “hardness” and explains that you may not know how to define it but you may know in practice what difference it makes for a substance to be hard, i.e. you know what hardness means. This he defined as pragmatism. Similarly, for this study the researcher wishes to understand
resident autonomy. It must therefore be ascertained what it means to be autonomous – how is it experienced in practice and how do people explain it. Doane and Varcoe (2005) explained that pragmatism is a process that offers a fundamental change in the approach to theory development and to nursing practice whereby the theory moves beyond an abstraction that is developed in isolation from everyday practice and becomes a practical activity that is central to every nursing moment.

In other paradigms the researcher is very much like a scientist who emerges from research with new knowledge, but the participants remain in relative ignorance (Weaver and Olson, 2006). Positivism and post-positivism were not deemed appropriate as the context-stripping process required limits their application to such a practical-focused research question (Schumaker and Gortner, 1992). The positivist’s focus on rigid scientific investigation through control groups, experiments, etc. would not enable a thorough or contextual understanding of resident autonomy to be reached. It is believed that post-positivism neglects the “whole” person by studying parts and it does not make explicit how the views of the stakeholders are drawn into the research process (Pearson, 1990). According to Rodriguez and Kotarba (2009), positivists claim that truth can be ascertained by maintaining researcher objectivity and by controlling confounding variables. However, this approach can devalue the exploratory and discovery phases required to answer some research questions. Interpretivism, while capable of articulating, appreciating and making visible the voices, concerns and practices of research participants, does not take the findings a step further by adding the objective view (which pragmatists believe is important) (Gortner, 1993).

Crotty’s (1998) framework suggests that once the theoretical perspective or paradigm has been established the researcher can then choose the methodology that best meets its epistemological and ontological beliefs (the researcher has summarised these approaches in a table format in Appendix 4).

The main research methodologies will now be discussed. Some researchers (e.g. Creswell, 2003) refer to these as strategies.
3.4 Research Methodologies/Strategies

This section will look at the various research methodologies/strategies available to the researcher. It will begin with an overview of qualitative research and then outline some of the key approaches used within this domain. It will then give an overview of quantitative research and some of the key approaches used within that domain.

Very broadly speaking the main research methodologies/strategies can be classified as either qualitative or quantitative approaches. Morse and Field (1996) stated that qualitative research constructs theory and quantitative research tests theory. Denzin and Lincoln (1994) stated that qualitative researchers stress the socially constructed nature of reality, the relationship between the researcher and what is being studied and the situational constraints that shape inquiry. In contrast, Denzin and Lincoln (1994) stated that quantitative research emphasises the measurement and analysis of causal relationships between variables, not processes.

3.4.1 Qualitative Research

The goal of qualitative research is to yield rich, in-depth descriptions of phenomena. Qualitative inquiry is a process of documentation, description, identification of patterns and concepts, identification of the relationship between concepts, and creation of theoretical explanations that explain reality (Morse and Field, 1996). Qualitative research is inductive. Inductive theory is directed towards bringing knowledge into view. It is generally descriptive, naming phenomena and positing relationships. It is frequently conducted in the naturalistic setting and considers context as part of the phenomenon. The goal of the researcher is to identify patterns or commonalities by inference from examination of specific instances or events (Morse and Field, 1996).

According to Polit, Beck and Hungler (2001), qualitative research is flexible. It sometimes involves a merging together of various data collection strategies or methods. It tends to be holistic, and requires the researcher to become intensely involved and remain in the research field for long periods of time. Burns and Grove (2001) stated that qualitative researchers believe there is no single reality, that reality changes over time and that meaning is contextual and situational.
Qualitative research involves several stages, which include orientation and overview of the phenomenon of interest, a focused exploration of the phenomenon and confirmation that the findings are trustworthy (Polit, Beck and Hungler, 2001).

Ethnography, phenomenology, grounded theory, mixed methods, action research and case study methodologies have been described by Denzin and Lincoln (1994), Patton (2002), Creswell (2003), Reason and Bradbury (2008) and Yin (2009) as qualitative methodologies. These will now be discussed.

3.4.1.1 Ethnography
Ethnography is the study of people or cultures. Commonly used by social anthropologists, it requires the researcher to spend considerable time in the research field and relies heavily on the analysis of field notes and participant observation (Patton, 2002).

Denzin and Lincoln (1994) stated that ethnographic approaches have been adopted in numerous disciplines and applied fields such as social and cultural anthropology, sociology, human geography, organisation studies, educational research and cultural studies. According to Patton (2002), ethnographic inquiry takes as its central and guiding assumption that any human group of people interacting together for a period of time will evolve a culture. Creswell (2003) supported this by offering that ethnography directs the researcher to study an intact cultural group in a natural setting over a prolonged period of time by collecting primarily observational data, but also using field notes and interviews. It aims to understand from the point of view of those involved (the emic perspective) rather than explaining from the outsider’s point of view (the etic perspective) (Denscombe, 2007).

The researcher must acknowledge the role of the “self” in the research and must present an account of one’s own beliefs, interests and experiences in relation to the topic being researched. It relies mostly on participant observation, has a strong emphasis on exploring social phenomena, tends to work with unstructured data, investigates small numbers of cases or one case in detail, and analysis involves interpretation of meaning (Denzin and Lincoln, 1994).
According to Barton (2008), ethnographers should be familiar with its three general features: it is naturalistic and studies people in their natural setting; it is holistic and accepts the complexity of social organisations and order; and it recognises culture, which enables understanding of group identity and group regulation.

### 3.4.1.2 Phenomenology

Phenomenology is a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants. It aims to understand the lived experience (Moustakas, 1994). It does not use scientific measurements but uses subjective, descriptive approaches instead. Rather than provide an understanding of the cause of something it tries to provide a description of how things are experienced first hand. Two main approaches to phenomenology exist: the Heideggerian approach and the Husserl approach. Husserl (1913) developed a phenomenology whereby researchers bring their own understanding and experiences to the research process and advocated for the use of “bracketing” of the researcher’s experiences (keeping the researcher’s own understanding and experiences separate). Heidegger (1962) stated that phenomenology aims to understand the “lived experience”. Mapp (2008) explained that Heidegger developed the phenomenological approach known as “hermeneutics”, meaning interpretation. According to Patton (2002), phenomenology can be a philosophy, an inquiry paradigm, an interpretive theory, a social science analytical perspective or orientation, a major qualitative tradition, or a research methods framework. Patton (2002) added that what these varying approaches share in common is a focus on exploring how human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning.

Creswell (2003) stated that phenomenology requires the researcher to identify the “essence” of human experiences concerning a phenomenon. This “essence” is described by the participants. Creswell (2003) added that this understanding of the “essence” of this “lived experience” means that phenomenology is not just a strategy but also a philosophy.

Data collection methods for this strategy usually include in-depth interviews with people who have directly experienced the phenomenon of interest. In other words,
they have the “lived experience” (Patton, 2002). It aims to gain a deeper understanding of the nature or meaning of everyday experiences (Van Manen, 1990).

### 3.4.1.3 Grounded Theory

Grounded theory is qualitative, exploratory and humanistic research. It is a strategy of inquiry in which the researcher derives a general, abstract theory of a process, action or interaction grounded in the views of the participant (Glaser and Strauss, 1967; Strauss and Corbin, 1998). It expects the researcher to start the research without any fixed ideas about the nature of the thing that is about to be investigated or how it operates. Some approaches to grounded theory negate against conducting a literature review prior to commencement of the research (Charmaz, 2000).

Strauss and Corbin (1998) also stated that grounded theory is a general methodology for developing theory that is grounded in data systematically gathered and analysed. This theory evolves during the research. Researchers may also use theory from previous research in order to elaborate the theory (Strauss and Corbin, 1998).

Grounded theory emphasises steps and procedures for connecting induction and deduction through the constant comparative method, comparing research sites, doing theoretical sampling and testing emerging concepts with additional fieldwork (Patton, 2002). Creswell (2003) added that grounded theory requires the researcher to attempt to derive a general, abstract theory of a process, action or interaction grounded in the participants’ views.

Data collection methods are usually less structured. For example, many grounded theory studies use open questioning in their interviewing (Strauss and Corbin, 1998).

### 3.4.1.4 Mixed Methods

A “new movement”, mixed-methods research combines alternative approaches within a single research project (Denscombe, 2007). It is considered by Johnson and Onwuegbuzie (2004) as the third wave or third research movement. According to Creswell (2003), this approach may have originated in 1959. It recognises that all methods have limitations and that by mixing methods, the various limitations could be counterbalanced (Creswell, 2003). It has been defined by Johnson and
Onwuegbuzie (2004) as the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study. Johnson and Onwuegbuzie (2004) explained that the mixed methods logic of inquiry includes the use of induction, deduction and abduction. It focuses on the practical outcomes and “what works”. The key issues in mixed-methods research include the order (in what order do the methods get used?), timing (at what point are the methods changed or combined?), proportion and priority (which methods are seen as dominant?), comparison and contrast (are the methods similar or different?) and use and benefit (for what purpose are the alternative approaches combined?) (Creswell, 2003). Mixed methods can produce comprehensive research findings and require the researcher to have a broad range of skills and knowledge for data collection and analysis that will use both qualitative and quantitative approaches.

Johnson and Onwuegbuzie (2004) stated that the goal of mixed-methods research is not to replace either qualitative or quantitative approaches but rather to draw on the strengths and minimise the weaknesses of both.

3.4.1.5 Action Research

According to Greenwood and Levin (1998), there are many different types of action research. Generally speaking, action research (AR) is social research carried out by a team encompassing an action researcher and members of an organisation or community (stakeholders) seeking to improve their situation. It promotes broad participation in the research process and supports action for problem solving. Together the researcher and the stakeholders define the problems to be examined, cogenerate relevant knowledge about them, learn and execute social research techniques, take actions and interpret the results of actions based on what they have learned.
Reason and Bradbury (2008) define action research as a:

“Participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities”.  
(Reason and Bradbury, 2008, pp.8)

This definition reveals that AR is multi-faceted and collaborative as it brings people together in order to reflect and act. Action researchers believe that people accumulate, organise and use complex knowledge and experience constantly in everyday life. AR is thus a process that engages with problems and learning in order to create a change (Greenwood and Levin, 1998). Action research is a form of enquiry that enables practitioners everywhere to investigate and evaluate their work. They ask, “What am I doing? What do I need to improve? How do I improve it?” It is coming to be seen as methodology for real-world social change (Greenwood and Levin, 1998).

3.4.1.6 Case Study

According to Yin (2009), case studies provide a systematic way of looking at events, collecting data, analysing information and reporting the results. As a result the researcher may gain a sharpened understanding of why the instance happened as it did and what might become important to look at more extensively in future research.

The essence of case study is that it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented and with what result (Schramm, 1971). Firstly, the case study can explain the presumed causal links in real-life interventions that are too complex for other research methods. Secondly, it can describe an intervention and the real-life context in which it occurred. Thirdly, it can illustrate certain topics within an evaluation, and finally it can enlighten a situation in which an intervention is being evaluated (Schramm, 1971).

Zucker (2001) identified case study research for nurses as a method that centralises the patient in the process. Gangeness and Yurkovich (2006) stated that case study
research supports community engagement, empowers minorities and utilises multiple data sources, thus increasing comprehensiveness and rigour. Yin (2009) also explains that case study research can either examine or explore a single case or multiple cases.

Gerring (2007) defined case study research by explaining that a case connotes a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. A case may be created out of any phenomenon so long as it has identifiable boundaries and comprises the primary object of an inference.

Yin (2009) also explained that multiple data collection methods may be used (e.g. interviews, observations, documentary analysis, etc.) and that method and analysis may occur simultaneously in case study research. Specifically, data collection and analysis occur as an iterative process, wherein the researcher moves between the literature and field data and back to the literature again. Stake (1995) highlighted the importance of the description of contexts in case studies. Schatzman and Strauss (1973) suggest that keeping journals or logs helps to track methodological, observational and theoretical field notes during data collection in case studies.

### 3.4.2 Quantitative Research

According to Polit, Beck and Hungler (2001), quantitative research is divided into five dimensions: decisions around control over independent variables, type of group comparisons, number of data collection points, occurrence of independent and dependent variables, and the research setting. Burns and Grove (2001) described four types of quantitative research (descriptive, correlational, quasi-experimental and experimental), while Polit, Beck and Hungler (2001) described three categories of quantitative research (experimental, time specific and types). They further explain that quantitative approaches include experiments, quasi-experiments, cross-sectional studies, longitudinal studies, surveys, evaluations and outcomes measures.

Johnson and Onwuegbuzie (2004) explained that quantitative researchers advocate objectiveness, time- and context-free generalisations, eliminating biases, remaining emotionally detached and uninvolved with the objects of study, and testing or empirically justifying the stated hypotheses. Rodriguez and Kotarba (2009) defined
quantitative research as that which uses measurements as data and produces computations as outcomes. Furthermore, Rodriguez and Kotarba (2009) explained that quantitative research differs from qualitative research in its philosophical underpinnings and consequently the methods used produce different knowledge. This is done by posing different questions and then making different epistemological and ontological assumptions.

Burns and Grove (2001: 39) stated that control of possible research variables is central to quantitative research:

“Through control, the researcher can reduce the influence or confounding effect of extraneous variables on the research variables”.

(Burns and Grove, 2001, pp.39)

In other words, quantitative researchers have a very clear, strict research plan prior to commencing the research and know exactly how the process will proceed. Experimental research, correlational research and survey research as quantitative methodologies will now be discussed.

**3.4.2.1 Experimental Research**

There are three key tenets to experimental research: control, manipulation and randomisation (Bailey, 1997). According to Burns and Grove (2001), the purpose of experimental research is to examine cause-and-effect relationships between independent and dependent variables under a highly controlled environment. Creswell (2003) explained that experimental research uses a power analysis to identify the appropriate sample size and this calculation includes a consideration of the level of statistical significance for the experiment, the amount of power (high, medium or low) for the statistical test of the null hypothesis, and the effect size or the expected differences in the means between the control and experimental groups expressed in standard deviation units.

Polit, Beck and Hungler (2001) also stated that the experimental researcher is an active agent rather than a passive observer and that the characteristics of experimental research include manipulation, control and randomisation. Manipulation involves the researcher doing something to the participants in the
study, control involves using a control group (or group that does not receive the manipulation) and randomisation involves assigning participants to control or manipulation groups randomly (Polit, Beck and Hungler, 2001).

Burns and Grove (2001) stated that experimental designs aim to provide the greatest amount of control possible in order to examine causality. The classic experimental design is described as having two participant groups. One group receives the experimental treatment and the other receives no treatment (known as the placebo). Pre-test scores are gathered. The researcher controls the treatment. The dependent variable is measured twice, before and after the manipulation of the independent variable. Both the independent and the dependent variables are conceptually linked (Burns and Grove, 2001).

3.4.2.2 Correlational Research

Correlational research examines the linear relationship between two or more variables and determines the type (positive or negative) and degree (strength) of the relationship (Burns and Grove, 2001). Polit, Beck and Hungler (2001) stated that this is a form of non-experimental research. Fitzgerald, Rumrill and Schenker (2004) added that correlational research could be conducted for either predictive or explanatory purposes. According to Fitzgerald, Rumrill and Schenker (2004), correlational studies assess the strength of relationships as they occur or have occurred without experimental manipulation. They add that based on the observed relationships, statistical significance tests are then applied to determine the predictive or explanatory power of those relationships under study.

Polit, Beck and Hungler (2001) explained that correlational research may be retrospective, prospective or descriptive. Retrospective correlational research involves the investigator focusing on a currently occurring phenomenon and linking it with the past. The investigator aims to identify antecedent factors. In prospective correlational research the investigator starts with presumed cause and then goes forward to the presumed effect. Descriptive correlational research observes, describes and documents the relationship among variables (Polit, Beck and Hungler, 2001). Correlational research is further explained by Fitzgerald, Rumrill and
Schenker (2004) as that which uses terms such as “predictor” and “criterion” instead of “independent” and “dependent” to discuss the variables.

3.4.2.3 Survey
According to Creswell (2003), a survey provides numerical description of trends, attitudes or opinions of a population by studying a sample of the research population. It involves pre-determining the design, population and sample, choice of instrumentation, identification of variables and approach to data analysis.

Burns and Grove (2001) stated that surveys are also non-experimental and use questionnaires or structured interviews to collect data about the identified population. Coughlan, Cronin and Ryan (2009) supported this and stated that survey research is a non-experimental research approach, which gathers information about the incidence and distribution of, and the relationships that exist between, variables in a pre-determined population. They add that surveys use both total populations and samples of populations to gather the required data.

Survey research may be descriptive, longitudinal or correlational and comparative (Coughlan, Cronin and Ryan, 2009). Descriptive survey research includes gathering data related to attitudes, behaviours and incidence of events. Longitudinal surveys administer a survey a number times over the research period, and correlational surveys compare the relationships between variables.

Polit and Beck (2008) stated that self-administered questionnaires are the backbone of survey research but that response rates can be unpredictable. Coughlan, Cronin and Ryan (2009) stated that a further limitation of this approach is that the questionnaire may not have been completed by the required respondent.

The survey results are presented using statistics. Coughlan, Cronin and Ryan (2009) explained that these may be descriptive statistics or inferential statistics. Descriptive statistics use frequency distributions, central tendency and variability to describe the research variable while inferential statistics use either parametric or non-parametric tests to seek relationships between variables and this is used to predict outcomes.
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3.4.3 Rationale for Research Methodology/Strategy
Following this examination of the methodologies/strategies available to the researcher, the next step involved identifying which methodology would meet the aims of this research study.

The ethnographic approach would not deliver on the aims of this research. While it was recognised that it is holistic in its approach and can reveal new understanding of processes, relationships and connections that may affect resident autonomy, its rejection for this study was due to its methodological limitations. Barton (2008) stated that it is important for ethnographers to acknowledge its methodological limitations, to learn to balance their lived insider perspective against that of their observer, and to acknowledge the connection between their intimate understanding of the research aim and the relationship with the research sample and how this might affect the outcome. Furthermore, ethnography tends to rely on participant observation but this study needs to gather multiple perspectives from multiple sources. Thus the research aims could not be achieved using this approach.

Phenomenology was also rejected. Denscombe (2007) explained that the phenomenological investigation of “homelessness” would focus on the experience of being homeless but it would not try to measure the extent of homelessness, or explain the causes. This research study sought to not only understand the experience of “autonomy”, but to also measure the extent of autonomy and to explain it; thus phenomenology would not be a suitable methodology for this study.

Grounded theorists believe that the researcher should have no pre-conceived ideas and generally should not conduct a literature review prior to commencing a study. However, this researcher worked in residential care for a number of years so already had an understanding of this care environment. Furthermore, the concept of autonomy needed clarification from a literature review and subsequent concept analysis in order to design the data collection tools to conduct the research. Thus grounded theory was not appropriate for the requirements of this study. Furthermore, unlike many grounded theorists this study was not aiming to develop a theory but rather to add to the knowledge that currently exists in relation to resident autonomy. Denscombe (2007) stated that in using grounded theory there is a danger that data in
relation to social, economic and political factors may be ignored. These factors are essential in understanding the contextual issues that may affect resident autonomy.

Case study research was then considered most suitable for meeting the aims of this research study. Walshe et al. (2005) presented the advantages of using case study design when 1)situations are complex, 2)the real-world context of the service is central, 3)multiple perspectives are required, 4)flexibility is desirable, 5)research needs to be congruent with clinical practice, 6)there is no obvious suitable theory, and 7)other methods present practical difficulties.

Zucker (2001) identified case study research for nurses as a method that centralises the patient in the process and this is particularly pertinent for this research, which seeks the resident’s perspective. Yin (1994) further clarified this point by stating that multiple sources of evidence gathered from multiple data collection techniques make the case study design attractive to the researcher (e.g. both staff and resident perspectives). Gerring (2007) added that case study research often employs a great variety of techniques – both qualitative and quantitative – in order to gather evidence for analysis. Thus case study research offers a depth of analysis, a richness, a completeness, a wholeness, and can quite rightly be referred to as a holistic method yielding “thick” descriptions of events. Yin (2009) stated that case studies are very broadly considered qualitative or quantitative or both, depending on the research question. This flexibility enables the researcher to gather data that is in-depth and delve below the surface of the research phenomenon.

Gerring (2007) explained that in case study research the case connotes a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. A case may be created out of any phenomenon so long as it has identifiable boundaries and comprises the primary object of an inference. Its spatial boundaries may be more apparent than its temporal boundaries (we may know where a case begins and ends but maybe not when it begins and ends). In this research study the extent of residents’ autonomy in one long-stay care unit is the case, and this was subdivided into the practices of the individual nurses, caregivers and residents and the context that surrounded the approach to care. According to Luck, Jackson and Usher (2006), an acknowledgment of the particular characteristics of the case, such
as culture, site, geography or resources, enables a detailed evaluation that is embedded in particular contextual characteristics and issues.

Luck, Jackson and Usher (2006) stated that the case study is a bridge across paradigms and is most commonly defined by the choice of case rather than the choice of methods or paradigmatic approach. The theoretical position can then be argued by the researcher within the logic of their epistemological, ontological and methodological approach. With respect to the epistemological, ontological and methodological positions, it can be argued that case study approach fosters integration of research strategies (Jones and Lyons, 2004; Marshall and Rossman, 1995). The flexibility of case study and the potential for its practical application is arguably one of the key strengths of case study (Luck, Jackson and Usher, 2006).

Thus case study methodology was considered at this point to be suitable for phase one of this research. It was then explored further.

### 3.5 Exploration of Case Study Methodology

MacDonald and Walker (1976, pp.2) stated that case study is the “examination of an instance in action” and Merriam (1998) defined case study as an:

> “Intensive, holistic description and analysis of a single entity, phenomenon or social unit. Case studies are particularistic, descriptive and heuristic and rely heavily on inductive reasoning in handling multiple data sources.”
> 
> (Merriam, 1998, pp.16)

Similarly, Stake (1995) stated that:

> “Case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances.”

> (Stake, 1995, pp.11)

Stake (1995) focused his writing on the qualitative approaches to conducting case studies. However, he did acknowledge that case study is not synonymous with qualitative methods and that the research tradition must be clarified in the rationale for choosing the case study approach.
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According to Dempsey and Dempsey (2000), case study may be defined as an intensive, detailed, in-depth study, examination or investigation of a single unit – the case. Stake (2000) added that case studies have the capacity to offer purposive, situational or interrelated descriptions of phenomena, connecting practical complex events to theoretical abstractions, while Remenyi et al.,(2002) stated that the aim of case study research is always to provide a rich, multi-dimensional picture of the situation being studied.

Yin (1994) defined case study research as:

“An empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.”

Yin (1994, pp.15)

He added to this definition in (Yin, 2009):

“The case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion”.

(Yin, 2009, pp.18)

All of these definitions reveal that case study research is in-depth and uses multiple data sources from multiple perspectives.

Further to these definitions, several types of case study design have also been presented. The researcher may focus on single cases or multiple cases (when the same study may contain more than one single case – Figure 3.1) and may also choose a type of case study. Stake (1995, 2000) identified three types of case study: intrinsic, instrumental or collective. Intrinsic case study is used when the researcher has an intrinsic interest and wants a better understanding of one particular case, without the desire to generalise or build theory. Instrumental case study refers to the examination of cases mainly to provide insight into an issue. Collective case study involves collecting data from a number of cases to understand a particular phenomenon or general condition. Yin (2009) identified three further types of case study: descriptive, exploratory and explanatory. Descriptive case studies illustrate examples of a particular phenomenon in question. Thus descriptive approaches present a complete description of a phenomenon within its context. Exploratory case
studies move beyond description and identify the ideas and assumptions behind phenomena. Thus an exploratory approach evaluates a given situation within a context and is a precursor for further studies. Explanatory case studies set out to provide explanations and rigorously test well-defined ideas and assumptions.

There are two types of explanatory case studies: critical/strategic or deviant. The critical/strategic explanatory case study examines the evidence from situations that provide positive illustrations of the phenomenon in question and thus produces recommendations, while the deviant explanatory case study uses findings from case study research to show an exception to the general rule. Thus an explanatory approach focuses on cause-effect relationships, considering how or why something happens. Both Stake (1995) and Yin (2009) stated that case study research focuses on contemporary issues in real-life settings and uses multiple sources of evidence. Both also recognised that there may be single or multiple cases, but Stake (1995, 2000) placed much less emphasis on the methods chosen to study the case and did not insist on the use of theoretical propositions or the development of theory.

The type of case study adopted is dependent upon the depth of analysis required. Simmons (2009) stated that the type of case study adopted should be guided by the purpose of the research and how the case study may help with addressing the research issues or questions. For the purpose of this research study, Yin’s (2009) approach was chosen as it enabled the exploration of the research phenomenon in its real-life context, thus meeting the study aims and objectives.

Conway, McMillan and Solman (2006) stated that when a study is drawn from a real life situation as opposed to a theoretical exploration of a phenomenon, and where a range of data sources are used, then the study is consistent with Yin’s (2009) description of case study design.

To enable the exploration of residential autonomy the case must first be identified. Yin (2009) explained that the case is the unit of analysis. Gilham (2000) stated that this unit is focused on human activity embedded in the real world and Stake (2003) added that the unit or case is an integrated system that is complex and functioning. The case or the unit of analysis for this study was “resident autonomy”.
Having selected the case or unit of analysis it must then be determined whether the study will focus on a single case or multiple cases (Figure 3.1). For this research a single case study approach was adopted. Yin (2009) explained that the single case approach may be adopted if it is “critical” (testing theory), when it represents a “unique” case, when it represents a “typical” case, a “revelatory” case or a “longitudinal” case (studying the same case at two or more different points in time). Yin (2009) defined the “typical” case as one that captures the circumstances and conditions of everyday or commonplace situations. The residential unit for this research study was “typical” of most public residential units in Ireland and hence the unit of analysis, “resident autonomy”, would also be “typical”. Within the single case study the researcher may choose a holistic or embedded design. Examination of the global nature of an organisation warrants a holistic design (Figure 3.1), while the examination of the organisation and its context, issues, staffing, etc. would warrant an embedded design (Figure 3.1). The literature review for this study revealed that residential care and resident autonomy require research from multiple perspectives and multiple data sources. It suggested that staffing, personnel, education, capacity, etc. are all issues that need to be considered. Therefore this study adopted an embedded design as it was going to explore resident autonomy (the case/the unit of analysis) and the organisation and its context (staff and resident profiles, staff rosters, philosophy of the care environment, gather multiple perspectives from multiple data sources).

In contrast, multiple case studies are adopted when more than one case is studied and are usually chosen when the researcher wishes to look at more than one research site and compare or contrast findings. It usually involves replication and is more positivistic in its approach (Yin, 2009). According to Yin (2009), the multiple case study may also be holistic or embedded in its approach. Yin (2009) stated that no broad distinction is made between single or multiple case studies but rather the choice to adopt one over the other is based on research design. Criticisms of the single case study approach are usually directed towards generalisation but as Yin (2009) pointed out, that case study is concerned with analytical generalisation not statistical generalisation, and generalisations from either single or multiple designs are made to theory and not to populations. Simmons (2009) supported this and explained that the purpose of all case study research is not to generalise but to
demonstrate how and in what way the findings may be transferable. Feigin, Orum and Sjoberg (1991) suggested that while proponents of multiple case studies may argue for replication, using more than one case may dilute the importance and meaning of the single case.

In summary, the methodology chosen for phase one of this research was a single (one residential unit) exploratory embedded (the contextual issues) case (resident autonomy) study (Figure 3.2).

Figure 3.1: Types of case study design (Yin, 2009)
3.5.1 Use of Case Study Research in Nursing Research

Luck, Jackson and Usher (2006) stated that the case study approach is particularly suited to nursing research because of its ability to maintain a balance between the rigidity of methodologies and the practicalities of “real-life” settings. Luck, Jackson and Usher (2006) explained that the conduct of case studies may differ according to the context in which they are carried out.

The adoption of a case study approach for this research study is supported by examples from other research studies that also adopted a case study approach in order to understand various phenomena related to older people. Payne et al. (2007) reflected upon three multiple embedded case studies on end-of-life and bereavement. The “case” was the service or healthcare unit. The principal methods of data collection were interviews, observations and documentary data analysis. It was concluded that case study methods may be empowering for participants because they
value their experiences and reveal how their work contributes to teamwork within organisations. The revelation of this empowerment theme is something that may also be relevant to the theme of residential autonomy and it is worth noting that a case study approach was utilised here. Payne et al. (2007) stated that case study methods offer a rigorous and systematic approach to nursing research.

Shiu (2001) adopted a single embedded case study design with four units of analysis in order to investigate how residents perceive a sense of control or lack of control within a home for older people. Data collection included interviews with residents and nursing staff, documentary analysis on the history and philosophy guiding the organisation of the home, and non-participant observation of interaction between residents and staff over a period of two weeks (each one of these data collection methods was identified as a unit of analysis and the “case” was residents’ perspectives of perceived sense of control within a care home). Shiu (2001) stated that there has been little published work on residents’ perspectives of residential care and that studies using this design can contribute to a better understanding of health maintenance. Hence the appropriateness of using the case study approach for this study (case study yields multiple perspectives).

Cant, O’Louglin and Legge (2001) conducted a multiple case study across two sites in order to explore the level of sick leave older people take from work (the sites were identified as “cases”). Individual semi-structured interviews with human resources managers and health and safety officers were undertaken, as well as three focus groups with workers from the local council. Redfern et al. (2002) aimed to investigate links between the levels of work satisfaction and stress of staff and the quality of care and morale of residents. It was found that the single case study approach is useful when a manageable number of nursing homes are to participate in research, and if a large number of homes are to participate then the survey approach is more suitable. Again, this is a useful rationale for the adoption of a single embedded rather than a multiple embedded case study for this research study.

Johansson et al. (2006) used a single holistic case study to describe a first-line manager’s (the case) goal profile in care of older people. Data collection comprised interviews, observations and documentary analysis. It was suggested that the case
study approach was useful in understanding the context. It has already been established that context is important for this research study (embeddedness of the case). This affirms the rationale for choosing the case study approach to inform this research. Similarly, McCormack et al. (2008) aimed to explore older persons’ experiences of “whole systems” and the impact of health and social care organisational structures on these experiences. Phase one of this study involved conducting a detailed literature review of the evidence pertaining to “whole systems” working with older people. Phase two compared and contrasted the data arising from the literature review with those collected in one “whole system” descriptive case study. It was explained that case study methodology is concerned with gaining an in-depth understanding of a phenomenon in a particular setting and contributes to the understanding of individuals, organisations, and social and political phenomena. McCormack et al. (2008) stated that case studies focus on specific contexts and try to understand how a particular issue translates into real situations. It was argued that a descriptive case study allows for the “slicing” of a context into parts, and for the selection of particular parts of that system for in-depth study. Documentation, interviews, focus groups and a service user conference were employed as the data collection methods.

Goodman et al. (2007) adopted a multiple embedded case study design in order to understand how physical activity for older people was promoted (the case) in one geographical area. A documentary review was conducted and in-depth interviews were held with individuals who either had designated responsibility for health promotion with older people and/or were leading on activity-based services. Again, the appropriateness of using a case study approach for research with older people was revealed.

These studies support the use of case study research in nursing. It is evident that many other researchers have chosen to adopt case study research as an appropriate method of inquiry for older person research.
In summary, case study design is useful under the following circumstances:

1) When complex situations need to be addressed, like resident autonomy – what facilitates it and what hinders it. (For example, Shiu (2001) used a single embedded case study to investigate the complex issue of how residents perceive a sense of control or lack of control within a home for older people).

2) When context is central to the study, in this case, the context of residential care in Ireland, and the context of the care environment (multiple data collection methods enable the full picture to be revealed. Johansson et al. (2006) stated that case study enables the understanding of the context).

3) When multiple perspectives need to be recognised, like residents, relatives, and healthcare professionals. (Payne et al. (2007) reflected upon the empowerment potential of case study for its participants).

4) When research needs to be flexible. Working with older people may require adaptations to data collection tools’ initial design, and the researcher may need to work with the pace of the participants and understand that the pace may be different to their own. (Redfern et al., 2002 acknowledged the need to ensure the case study is manageable).

5) When research needs to be congruent with clinical practice. Multiple data collection methods enable the researcher to observe practice and talk to staff/residents/relatives about practice. (McCormack et al., 2008 stated that case studies try to understand how a particular issue translates into real situations).

The findings from phase one of the study suggested that more work needed to be done and hence the researcher added a second phase to the study.

3.6 Exploration and Understanding of Action Research Methodology

Phase two of this study adopted an action research approach. Action research is a form of enquiry that enables practitioners everywhere to investigate and evaluate their work. They ask, “What am I doing? What do I need to improve? How do I improve it?” Action Research (AR) is often referred to as participatory research,
collaborative inquiry, emancipatory research, action learning and contextual action research. However, Lewin (1948) was the first person to coin the term “action research”. AR has since undergone many different formulations and developments (Reed, 2005) but AR originated from Lewin’s work on change theory. Lewin (1948) envisaged a process whereby one could construct a social experiment with the aim of achieving a stated goal. Lewin (1948) conceptualised social change as a three-stage process: dismantling former structures (unfreezing), changing the structures (changing), and finally locking them back to permanent structure (freezing). Lewin (1948) subsequently produced work on group dynamics. This included recognition of conflict and co-operation in groups. Lewin’s conceptualisation of change as a three-stage process is still an influential model for social change. Lewin subsequently established two basic components of action research from his change theory – generating knowledge and changing social systems through interventions. The core idea was to increase the control the participants had over their own situations and to sustain their learning capacities.

Robinson and Street (2004) supported this ideology and stated that action research is not only about interventions but also focuses on knowledge development and action, which leads to practical solutions to clinical problems. Tutton (2005) later explained that AR is a dynamic, cyclical process of planning, action and evaluation, in which knowledge gained in one cycle can be built upon and developed in future cycles. Many researchers have defined AR as a cyclical process of collaborative research (researcher and participants) incorporating reflection and evaluation and using participatory approaches to change (Greenwood and Levin, 1998; McNiff and Whitehead, 2009; Reason and Bradbury, 2008; Robinson and Street, 2004; Winter, 1989). However, Greenwood and Levin (1998) and McNiff and Whitehead (2009) do not place the same amount of emphasis on reflection in the cyclical process as do Reason and Bradbury (2008), Robinson and Street (2004) and Winter (1989).
Winter (1989) provided an overview of the six key principles of AR:

1) Reflecting on issues and processes and making explicit the interpretations, biases, assumptions and concerns upon which judgements are made (reflexive critique).

2) Conceptualising phenomena in dialogue in order to understand the set of relationships between the phenomenon and its context, and between the elements constituting the phenomenon (dialectical critique).

3) Being a collaborative resource whereby participants in an action research project are co-researchers.

4) Identifying that the change process may potentially threaten all previously established ways of doing things (risk).

5) Recognising that the report acts as support for further discussion rather than a final conclusion (plural structure).

6) AR theory informs practice while practice refines theory in a continuous transformation (theory, practice and transformation).

Subsequently, Greenwood and Levin (1998) explained AR as a cyclical process of 1) diagnosing problems, 2) planning interventions (change), 3) applying interventions (making the change), 4) evaluating the interventions (what has been the outcome of the change), 5) reflecting on the learning (what worked well – what didn’t work well) and 6) continuing the cycle again in order to continuously improve the situation (Figure 3.2).

Figure 3.2: Key stages of action research (Greenwood and Levin, 1998)
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More recently, Reason and Bradbury (2008: 5) reiterated that AR is a participatory cyclical process in their definition of action research as a:

“Participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.”

(Reason and Bradbury, 2008, pp.5)

McNiff and Whitehead (2009) also explained that AR involves 1) taking action: doing something in practice in order to improve it, 2) doing research: finding out about and analysing practice to see whether something has actually improved, 3) telling the story, and 4) sharing the findings. Robinson and Street (2004) further explained that AR design is circular or spiral, unlike traditional linear designs. After a preliminary investigation the action is planned, implemented and monitored. Reflection aides the analysis and this yields either an agreed success of the implementation or a modification and beginning of another cycle. These cycles continue until the situation has been improved. The key elements that are evident in all of these explanations are that AR is about identifying practical problems and collaborating with participants in order to introduce changes that may reduce these problems. This is a continuous process.

Further to the cycles or processes of conducting action research there have also been different approaches or types of AR identified. Carr and Kemis (1986) identified three types of AR: technical (investigating issues raised by external researchers that are not the concerns of the practitioners), practical (facilitators collaborate with individuals or groups of practitioners to investigate a problem of mutual interest) and emancipatory (action research is conducted by, with and for people, rather than research on people to effect change). Greenwood and Levin (1998) support an emancipatory approach to AR and explain that action researchers do not apply techniques to a situation but rather bring knowledge and skills to a group of people who collaboratively open up the possibilities of self-managed social change. AR is based on the philosophy that all people have detailed, complex and valuable knowledge about their lives, environments and goals. The participant’s knowledge is
a different and valuable type of knowing to academic knowing, thus having the potential to bridge the two worlds by integrating practitioners and professionals in the same knowledge generation process.

However, AR is not without its critics. Some argue that it is little more than consultancy (Avison, 1993), and others argue that the researcher’s level of involvement in the study can affect the level of objectivity that is required for other approaches (Avison and Wood-Harper, 1991). McKay and Marshall (2001) pointed out that this self-involvement of the researcher is one of the distinguishing features of AR, whereby the researcher is viewed as the key participant in the research process and works collaboratively with participants to bring about change in the problem context. It thus represents a juxtaposition of action and research or practice and theory. The objective stance taken in positivist research, which is suggested to produce generalisable findings, may in fact produce findings that cannot be applied in real life. For example, an experiment conducted in the laboratory may struggle to maintain relevance in the real world. In AR, however, the research is conducted in real life settings, thus avoiding the potential separation between research and practice. It is therefore argued that the strengths of AR may outweigh its weaknesses.

Some argue that AR is just another name for practice development (PD). Carr et al. (2008) discussed the blurred boundaries between AR and PD and explained that practice development is usually context-specific and employed with the specific intention of informing local decision-making or local service provision, while AR is concerned with the generation of new knowledge that has a degree of transferability beyond the local setting. Manley and McCormack (2003) stated that practice development is concerned directly with the world of practice and that it should not be academicised, which is where AR stems from. Reed (2005) added that AR provides a means to bring together practitioners and researchers in a collaborative and inclusive way. Reed (2005) also stated that AR aims to inform and change practice and develop understanding of the particular context in which it takes place.
3.6.1 Use of Action Research in Nursing Research

Reed (2005) stated that AR has gained popularity in nursing research due to its ability to develop practice-based knowledge that can assist in changing practice and democratising inquiry.

Robinson and Street (2004) adopted an action research approach in order to improve networks between acute care nurses and aged care assessment teams. They stated that AR values the participation of all stakeholders in the conduct and decision-making of the research as well as addressing practical problems to improve a situation. For the purpose of this study, decision-making is central to autonomy, and hence the usefulness of using an action research approach in further advancing this research.

Various other researchers have advocated for the benefits of using AR in nursing research (Dickinson, Welch and Ager, 2007; Fenton, 2008; Tutton, 2005). Fenton (2008) used an action research approach to introduce a post-fall assessment algorithm into a community rehabilitation hospital for older adults and offered that as a research design, AR is effective in the implementation of change in a clinical environment, involving collaboration, re-education and changing ways of thinking. Fenton (2008) stated that AR is a practical, problem-solving approach that minimises the gap between research and practice. Fenton (2008) added that because nurses are used to problem-solving in their daily work, AR is particularly applicable to research with this discipline; nurses can learn by doing the research and thus are more likely to incorporate the findings in practice. Again, introducing phase two AR to this study complements the research undertaken in phase one and “minimises the gap between research and practice” (the findings from phase one (research) led to phase two (practice)).

Dickinson, Welch and Ager (2007) also used an action research approach in order to improve the hospital mealtime experience for older people. The ward context was explored at the beginning and at the end of the study using focus groups, interviews, observations and benchmarking. Dickinson, Welch and Ager (2007) stated that AR is an approach that has become a popular method of undertaking research for several reasons, but mainly because of the appeal of undertaking meaningful research in the
context of practice, which therefore has direct relevance to practitioners. This equates with the desire from the residential unit in this study to implement changes in practice based on the findings from phase one (which were directly related and meaningful to them).

Tutton (2005) aimed to explore the meaning of participation for older people in hospital and their healthcare workers, and ways in which staff could enhance patients’ participation in their care. An action research approach was used. It was deemed an appropriate methodology because the research sought to not only explore what participation means but also how staff could enhance it. Tutton (2005) stated that working in this collaborative way enabled the research to be grounded in the daily reality of the practice. Hence it is clear that action research can build on initial findings and problem identification in order to enhance participants’ experiences. Phase one of this research aimed to explore what autonomy means for older people in residential care (case study) and subsequently it aimed to enhance the residents’ experience of autonomy due to the findings that were revealed in phase one. Action research enabled the aims of phase two to be met due to its ability to enhance decision-making opportunities for participants (Robinson and Street, 2004), bridge the gap between research and practice (phase one and phase two) (Fenton, 2008), and enable collaboration, which is integral to autonomy (Tutton, 2005).

Having established that this was a two-phase study requiring two different methodologies, the way these two methodologies (case study and action research) complement each other will now be discussed.

3.7 Adopting the Two Methodologies
Anaf, Drummond and Sheppard (2007) stated that combining two methodologies has advantages in health research by facilitating greater, and potentially more holistic, depths of inquiry. According to Denscombe (2007), case studies are not primarily designed to effect organisational change but they do share some of the characteristics of action research. This is due to the empowering nature of case study findings, which may reveal both positive and negative answers to the research question. In
other words, it may reveal the work practices that are working well but may also pave the way for improvements. Hence a second phase involving action research.

Blichfeldt and Andersen (2006) stated that although both case study and action research deal with context-bound knowledge, action research offers a greater role for the participants in defining the issues to be addressed. Blichfeldt and Andersen (2006) state that the case study approach uses the participants as sources of evidence and then the action research approach uses those same participants to effect the changes identified. This supports the complementary nature of the two approaches – a case study mostly begins with the researcher’s interest in the phenomenon (as was the case in this study where the interest was in exploring autonomy for older people in residential care), whereas an action research project begins mostly with the issues and concerns within the practical situation (again, this was the situation in this study when the case study was complete and the findings suggested that further work could be done). This research study started with the researcher’s interest in the concept of resident autonomy and the case study enabled an exploration of this concept. This exploration revealed approaches to care that were working against positive autonomous experiences and thus action research was used to enhance the level of autonomy experienced. Blichfeldt and Andersen (2006: 3) concluded that both: “Case study research and action research are concerned with the researcher’s gaining an in-depth understanding of particular phenomena in real-world settings. The two types of research seem quite similar in their focus on the field or the world of action”.

Thus the benefits of using both case study and action research approaches in a two-phase study have been explored and this is the approach which this study adopted. The range of options for data collection for phase one of this study will now be discussed. This will be followed by a description of how good quality data analysis can be performed.

3.8 Data Collection Methods

Interviews, observations and documentary data analysis form the foundation of the rich data set necessary to explore cases in their situational contexts (Payne et
al., 2007). Methods in case study refer to the tools, procedures or techniques the researcher employs to gather and analyse data (Crotty, 1998). There is no agreed set of methods for case study; rather, they are selected in relation to the nature of the case study and the research question. Yin (2009) identified six sources of evidence or data collection methods for case study research: direct and participant observations, documentation, archival records, interviews, and physical artefacts. The methods discussed below informed this research study.

### 3.8.1 Interviews
Williams (2007) explained that the interview considers the inter-relationship between the person’s own “inner world” (ontological narrativity), the social context and its expectations (public narrativity), the broad cultural and historical context (master narrativity) and the researcher’s frame of reference (conceptual narrativity).

There are several approaches to interviewing – unstructured, structured and semi-structured (Polit, Beck and Hungler, 2001). Creswell (2009) also stated that this data collection method can be used via the telephone, face-to-face or in a group. According to Polit, Beck and Hungler (2001), unstructured interviewing offers flexibility and is useful when the researcher does not have a set of questions. It is open-ended and enables the exploration of a previously uncharted research topic in depth. In contrast, structured interviews have structured questions and each participant is asked the same questions in the same order (Casey, 2006). There is already some knowledge about the research topic. Semi-structured interviews use a topic guide (not questions but subject areas or probes).

The semi-structured interview is used when the researcher knows most of the issues to explore but cannot predict the answers. Semi-structured interviewing provides the participants with the freedom to explain a situation in their own words and a conversational tone is adopted. The researcher aims to get the participant talking, telling stories, describing incidents and examples. It is these descriptions that yield rich descriptive contexts and make qualitative data so valuable. When developing the questions it is important to ensure that they are not double-barrelled or closed. Probes and prompts should be prepared for each question, should more information be required. Good interviewers listen, have patience act confident, and go at the pace
of the participant, not the researcher. This is especially important when an older adult is being interviewed (Morse and Field, 1996). According to Cormack (2000), there are three main types of data typically generated from an interview – people’s experiences and accounts of events, their opinions, attitudes and perceptions about phenomena, and their biographical and demographic data.

Yin (2009) recognised some potential weaknesses inherent in interviewing as a data collection method and stated that poorly articulated questions may lead to bias. Participants may also give biased responses – there may be inaccuracies due to poor recall, and furthermore the interviewee may give answers they think the researcher wants to hear. However, according to Yin (2009), interviews are the backbone of data for case study research and when designed properly and piloted then they have the potential to be a rich source of data. Gadamer (1976) referred to the importance of asking questions and establishing a dialogue with participants as being vital when searching for understanding. Gadamer (1976) stressed that communication is crucial if meanings are to emerge. By questioning we get the essence of the “story”. Gadamer (1976) stated that questioning involves seeking, asking or making enquiries to obtain information and knowledge. When a poor conversationalist is encountered the researcher must try to keep them engaged and interested, and remember that they are not merely gathering data but are aiming to capture the qualities of the people and their lives (Williams, 2007). Interviews are time consuming (Polit, Beck and Hungler, 2001). They require a researcher to have sufficient interviewing skills, which may be a potential problem if those skills are lacking (Polit, Beck and Hungler, 2001). Furthermore, they rely on the participant to provide accurate information (Yin, 2009). This may be overcome by combining this approach with observations so that the researcher can compare actual activity with reported activity.

3.8.2 Observations
Gold (1958) was one of the first researchers to discuss observational methods for social science research. Gold (1958: 218) stated that “every field work role is at once a social interaction device for securing information for scientific purposes and a set of behaviours in which an observer’s self is involved”. Fundamentally, observations may be categorised as participant or non-participant (Yin, 2009). Gold (1958) explained that there are several roles within participant or non-participant
observation that the observer may adopt: complete participant, participant-asobserver, observer-as-participant and complete observer. The complete participant role requires the researcher to keep their true identity and purpose from those whom he/she observes. The observer interacts as much as possible and as naturally as possible in the research field. This role has ethical implications, i.e. people being observed without consent. Also, the observer may find it difficult to separate their true self from the acting role and may end up “going native” whereby he/she becomes too immersed in the field and thus the findings cannot be used. The participant-as-observer role requires a participant within the research study to take on the observer role. Formal and informal observation periods are used. This can be a difficult role to maintain as the participant also has their job to do and needs to be careful not to damage trust established with their informants who will most likely be clients. The observer-as-participant role is used in studies involving one-visit interviews (Gold, 1958). There is less of a chance of “going native” in this role but the contact time with the informant is so short that it may be considered superficial. The complete observer role entirely removes the researcher from social interaction with informants. The people being observed may not need to know that they are being informants. According to Gold (1958), this role is almost never a dominant choice and may be most appropriate if used in combination with other methods. Gold (1958) stated that the researcher selects and plays a role so that he/she, being who he/she is, can best study those aspects of society in which he/she is interested. Mays and Pope (1995) stated that the degree of observer participation varies according to the nature of the setting and the research question.

Mays and Pope (1995) warn of the potential for the “Hawthorne effect” when choosing to use complete observation, i.e. where participants/informants behave in a certain way in order to look good for the observer – they may behave differently to “normal”. However, Mays and Pope (1995) also stated that the advantage of observation is that it can help to overcome the discrepancy between what people say they do and what they actually do. It may also uncover behaviours or routines of which participants were unaware, or that were so embedded into practice that only an outsider or complete observer can see. The observation skills of watching, listening, counting and identifying patterns of social interaction are processes we tend to take for granted (Morse and Field, 1996). Mays and Pope (1995) stated that the
qualitative researcher systematically watches people and events to find out about behaviours and interactions in natural settings. Yin (2009) stated that the case study approach, which requires the research to take place in its natural setting, creates an ideal opportunity for observations to be used as a data collection tool.

Burns and Grove (2001) discussed the level of structure to observing and explained the key differences between unstructured observations and structured observations. Unstructured observations involve spontaneously observing and recording what is seen with a minimum of prior planning, while structured observation defines carefully what is to be observed. Structured observations may use category systems whereby only the behaviour that is of interest is recorded. Burns and Grove (2001) stated that this approach can prove challenging for the researcher as they need to make decisions about what observations belong to which categories. Casey (2006) summarises from other researchers that the degree of structure may be described as molar or molecular. Molar categories are broad based and used when the category is not well defined, and molecular is used when the categories are detailed and precise (Casey, 2006). Another approach is the checklist approach, which uses techniques to indicate whether or not a behaviour has occurred. This requires the researcher to have a clear idea about what they are looking for in their observations.

Casey (2006) stated that observational data need to obtain a representative example of the phenomenon being examined. For example, if the researcher wishes to look at the approach to caregiving during a morning shift then they will need to observe the morning shift over a period of several days in order to observe if staff determine the routine or if the routine exists regardless of what staff are on duty. The observer may choose to use time or event sampling in order to observe this phenomenon. Time sampling observes for a certain time period and this may be randomly or systematically chosen, whereas event sampling observes a particular event or interaction (Casey, 2006). Casey (2006) advised that in determining the observation period the researcher must choose a long enough period in order to capture what is happening, but a short enough period in order to prevent observer exhaustion. She thus advised from her work that a maximum of two-hour observation periods at any one time is sufficient. Further to these decisions, the researcher must also consider what position they will take up in order to observe. The options include multiple
positioning, single positioning or mobile positioning. Casey (2006) reflected upon other researchers’ approaches to observation and stated that single positioning requires the researcher to occupy just one location and observe in the location alone, multiple positioning requires the researcher to move around and observe from different locations, and mobile positioning involves following a person in the research site. A decision also needs to be made in relation to recording of observations – will a voice recorder be used, or will just field notes be used, or will a combination of these be used?

Polit, Beck and Hungler (2001) stated that observations as a method of data collection enable flexibility for the researcher who may choose the focus of the observation, the level of concealment, the duration of the observation and the method of recording the observation. Polit, Beck and Hungler (2001) also advised that this data collection method requires great skill in order for the researcher to see the world as the study participants see it and thus extract meaning.

In summary, observations may be participant or non-participant, they may be molar (unstructured) or molecular (structured), and may use multiple, single or mobile positioning.

### 3.8.3 Field notes

According to Morse and Field (1996), field notes consist of jottings of salient points that are reworked in detail later on. They take the form of reconstructions of interactions, short conversational excerpts or descriptions of events. They are written accounts of the things that the researcher hears, sees, experiences and thinks in the course of collecting or reflecting on data. It is important to quote what people say rather than summarise what people say.

Stake (1995) highlighted the importance of the description of contexts. Schatzman and Strauss (1973) suggested that keeping journals or logs helps to track methodological, observational and theoretical field notes during data collection. They record feelings and intuitive hunches, pose questions, and document work in progress. Patton (2002) supported this and stated that field notes contain the ongoing data that are being collected and consist of descriptions of what is being experienced.
and observed, quotations from the people being observed, the observer’s feelings and emotions to what is observed, and field-generated insights and interpretations. Patton (2002) added that field notes are the fundamental database for constructing case studies. Morse and Field (1996) stated that field notes from field work provide a learning experience. Having several roles at the researcher’s disposal enables them to pick up much more information that the single role of researcher. This juxtaposition produces very rich sources of data.

3.8.4 Documents

Documentation is stable (can be reviewed repeatedly), unobtrusive (not created as a result of the case study), exact (contains exact names, references and details) and has broad coverage (long span of time – many events and many settings) (Yin, 2008). Yin (2009) stated that documentary information is likely to be relevant to every case study topic and that documentary evidence can be used to corroborate and augment evidence from other sources. Yin (2009) warned that the case study researcher needs to remember that the documents they are reviewing have been written for a different purpose to that of what the case study is being done for. However, they can provide insightful causal inferences and explanations. Denzin and Lincoln (1994) stated that documentary data are central to social science research. Yin (2009) gave examples of some of the possible documentary sources: Letters, memoranda, emails, personal documents, agendas, announcements, minutes from meetings, written reports of events, administrative documents, proposals, progress reports and other internal records, formal studies or evaluations of the same “case”, and news clippings and other articles in mass media and community newspapers.

Patton (2002) stated that documentary data may prove valuable not only because of what can be learned directly from them but also as a stimulus for paths of inquiry that can be pursued subsequently through interviewing or observation.

Following the selection of the methods to be used the researcher must then think about how the data will be analysed.
3.9 Data Analysis

There is a lack of clarity in the literature regarding the way in which data analysis for case study research should be undertaken (Li and Seale, 2007; Yin, 2009; Parkhe, 1993). In this section, different approaches to data analysis will be discussed and a rationale for the data analysis approach selected for use in this study will be presented. Firstly, qualitative data analysis approaches will be discussed and this will be followed by a discussion on quantitative data analysis approaches. Research rigour and ethics will subsequently be discussed.

3.9.1 Qualitative Data Analysis

There is no agreed method to analyse qualitative data (Burns and Grove, 2011; Holloway and Wheeler, 2010; Parahoo, 2006). However, some methodologies use particular frameworks. Colazzi’s framework is typically associated with phenomenology (Moustakas, 1994; Polit and Beck, 2008) while the constant comparative method of analysis tends to be used in grounded theory (Glaser and Strauss, 1967). The analysis of case study data is the least well defined (Li and Seale, 2007; Parkhe, 2003; Yin, 2009,). However, regardless of the methodological approach used by the researcher, the goal of qualitative data analysis is to richly illuminate the experiences of the participants (Speziale and Carpenter, 2003).

Morse and Field (1996) suggest that there are four cognitive processes integral to all qualitative data analysis methods. These processes are comprehending, synthesising (decontextualising), theorising and recontextualising, and they tend to occur sequentially. Comprehending is about making sense of the data and then coding the data. Coding involves assigning a label which captures the essence or meaning of a portion of the data (Saldana, 2009). These codes are then typically grouped together based on the similarity of the content of the coded data, and these grouped codes are called categories. Comprehending also involves reading the data until no new insights emerge (also referred to as data saturation). Synthesising is about being able to confidently describe the data. This is done in two ways. Firstly using inter-participant analysis, which involves comparing transcripts from several participants, and secondly analysing and sorting categories across the data based on their commonalities. Theorising is the process of constructing alternative theories or
hunches to explain the data. The final stage of Morse and Field’s (1996) analysis framework involves recontextualising the data, which involves developing an emerging theory that is applicable to other settings and other populations.

These cognitive processes typically take place regardless of the approach to analysis. Morse and Field (1996) explained that these cognitive processes thus need a structure around them or an approach to guide the researcher. The most frequently used approaches include thematic analysis and content analysis. Thematic analysis involves the search for and identification of common threads/themes that extend throughout the data (Leininger, 1985). The first task is to read and re-read the data in their entirety, and then reflect on the data as a whole. Themes, which are an outcome of this coding and categorisation process, then appear as significant concepts linking substantial portions of the data together. Content analysis is an alternative approach and involves analysis by topic, whereby each data set is segmented into topics and then categories (Babbie, 2001). These categories are typically broad descriptions of the data. Once the categories have ample data the researcher may then subcategorise. The researcher may also look for relationships between categories. Thus a coding hierarchy develops.

Other approaches to qualitative data analysis put forward by other experts also suggest that the analysis is about reducing the data into more manageable quantities and seeing what’s there (Miles and Huberman, 1994). This mirrors the approaches put forward by Morse and Field (1996) and is about reducing the data down to themes or categories. Similarly, Miles and Huberman (1994) suggest that qualitative data analysis should involve three main steps: data reduction, data display, and conclusion drawing and verification.

Data reduction involves assigning codes and coding the data. Codes are tags or labels for assigning units of meaning to the transcribed data. Codes are usually attached to chunks of data rather than individual sentences. These codes may later be categorised in order to organise the data and to make retrieval easier (Saldana, 2009). Miles and Huberman (1994) suggest that the coding process can be made easier by the creation of a “start list” or a list of codes identified prior to the fieldwork. This start list may be compiled from a literature review or from hypotheses. The codes in
the start list should have defining sentences or proposition statements. A proposition statement is a connected set of statements that reflect the meaning of the code. This initial start list with its initial set of codes will most likely change as the research advances, and some initial codes from the start list may even “decay” as they fail to become populated with appropriate data.

Data display is the next step and its aim is to identify patterns within the coded data. According to Miles and Huberman (1994), pattern codes are explanatory codes that pull together a lot of material into a more meaningful unit of analysis. Throughout the analysis the researcher may make notes to themselves, and these are called “memos”. These memos can help to tie together different pieces of data. They may be ideas that strike the researcher while coding, and may be sentences, paragraphs or even page-long notes. Miles and Huberman (1994) state that the reflective remarks, marginal notes, and pattern coding all bring the analysis to a deeper level. Finally in step 3, conclusions and verifications can be drawn.

Essentially, whichever method or approach to analysis is taken, both Morse and Field’s (1996) and Miles and Huberman’s (1994) approaches involve reading the data line by line, assigning codes of meaning, sorting the data into categories, establishing relationships between codes and categories, and providing a clear explanation of the research phenomenon.

3.9.1.1 Rationale for qualitative data analysis approach used in this study
A concept analysis was essential for this research study. This concept analysis produced attributes, antecedents and consequences for resident autonomy; hence it generated a “start list” of codes for analysis. Therefore the Miles and Huberman (1994) approach for qualitative data analysis was deemed most suitable for this study. From the initial start list the data were also re-analysed in order to ensure that other key issues emerging from the data that were not in the initial start list were not missed and were included.

As qualitative research may generate a large volume of data, computer database storage software is often chosen to manage the data. An overview of the different
computer-assisted data analysis software storage packages will be presented next. This will be followed by a rationale for selecting the NVivo package for this study.

### 3.9.1.2 Qualitative Computer-Assisted Data Analysis and Storage

Computer software can be used for the storage of both qualitative and quantitative data. Morrison (1998: 113) stated that “software can be particularly helpful for data storage, searching and retrieval and certain aspects of concept organisation and theory testing but it cannot replace those moments of intuition when the relationships between concepts crystallise in the researcher’s imagination”.

The choice to use or not use computer-assisted qualitative data analysis software (CAQDAS) is usually based on the size of the study, the funds and time available, and the inclination and expertise of the researcher (Basit, 2003; Saldana, 2009). Crowley, Harre, and Tagg (2002) state that many researchers fear that the computer will lose or alter data and are therefore fearful of using software packages. CAQDAS does not actually code the data but it sufficiently stores, organises, manages and reconfigures it (Saldana, 2009). Thus the analysis process is still performed by the researcher. According to Bazeley (2007: 2), “the use of a computer package is not intended to supplant time-honoured ways of learning from data but to increase the effectiveness and efficiency of such learning”.

Many software programmes are available to the qualitative researcher, including NVivo and Atlas.ti. NVivo was designed by Qualitative Software for Research international (QSR) to support researchers to manage and query data and to manage ideas and produce graphical models and reports from the data. Atlas.ti was developed specifically for grounded theorists to manage, extract, compare, explore, and reassemble meaningful pieces of data from large amounts of data (Atlas.ti. User's Manual, 2004).

### 3.9.1.3 Rationale for use of NVivo for this study

Lewins and Silver (2004) state that researchers need to reflect on several issues before deciding which CAQDAS software package to use. These include the kinds and amount of research that the study is going to generate, the researcher’s preferred style of working, the theoretical approach to analysis that the research study has
adopted, and the time required to “learn” the software. Atlas.ti. is considered most appropriate for theory building (Lewis and Silver, 2004), which is not the aim of this study. Therefore NVivo was deemed more suitable. Furthermore, there was training and support available in the university for this package, and this would assist with “learning” the software.

As the data generated from this study will also be quantitative in nature, an overview of different quantitative data analysis approaches will be presented next.

### 3.9.2 Quantitative Data Analysis

According to Meadows (2003), a simple approach to quantitative data analysis is to report on each of the important or individual variables within a study. This can be done using frequency distributions and graphical displays.

Presenting statistical results is the main aim of quantitative data analysis. According to Burns and Grove (2010), the analysis may produce descriptive statistics including measures of central tendency (mean, median and mode) and measures of variability about the average (range and standard deviation). These give the reader a “picture” of the data collected in the research project. Inferential statistics are the results of a more complex analysis of the levels of relationships between variables. Inferential statistics help in making deductions from the data collected, in testing hypotheses and in relating findings to the sample or population (Polit and Beck, 2006). Other tests include producing parametric statistics (statistics used to estimate the characteristic of a population based on assumptions made) or non-parametric statistics (used only to describe the characteristics of a sample, without being able to generalise back to its population—they make no assumptions) (Watson, Atkinson and Egerton, 2006).

As quantitative research involves analysis of numbers, computer software is often chosen to manage the data and produce statistics. An overview of quantitative data analysis software will be presented next. This will be followed by a rationale for selecting the SPSS package for this study.
3.9.2.1 Quantitative Computer-Assisted Data Analysis and Storage
Quantitative data can also be imported into a computer software package. The most commonly used is the Predictive Analytics Software (PASW), formerly known as Statistical Package for the Social Sciences (SPSS). PASW can handle complex statistical procedures (Pallant, 2007). Watson, Atkinson and Egerton (2006: 135) state that researchers rarely calculate results by hand now that computer packages are available to do this “automatically and painlessly and with more precision and accuracy”.

3.9.2.2 Rationale for quantitative data analysis approach used in this study
For the purpose of managing this research study’s questionnaire numerical data it was decided that PASW could be used and that it would also serve to subject the data to statistical testing.

Regardless of the approach to analysis (qualitative or quantitative) ensuring that the research study and its findings are of a high quality is imperative for all researchers. In the next section, the way the quality of the data can be assured and maintained will be discussed.

3.10 Assessing and Maintaining Data Quality
Yin (2009) explained that in order to produce high quality data analysis in case study research the researcher should use their own prior expert knowledge of the case study topic in order to demonstrate an awareness of current thinking and discourse about the case study topic. As advised by Yin (2009), a strategy for analysis must be adopted to add to the validity and rigour of the study. A descriptive strategy can develop the case description. This approach organises the case study, enables analysis of embedded detail, and allows for explanation of implementations. According to Saldana (2009), a descriptive strategy assists the reader to see what the researcher saw and to hear what the researcher heard, thus reassuring the reader that all of the evidence has been attended to. Furthermore, Schofield (2002) stated that “studying the typical” contributes greatly to the validity of a case study and it enhances its range of applicability. Yin (2009) defined the “typical” case as one that captures the circumstances and conditions of everyday or commonplace situations.
Yin (2009) stated that no matter which analytical strategy is chosen, the researcher must do everything to make sure that the analysis is of the highest quality. The next section will first outline rigour in relation to qualitative research. This will be followed by an outline of rigour in relation to quantitative research.

### 3.10.1 Rigour in Qualitative Research

According to Parahoo (2006), all research involves the systematic and rigorous collection and analysis of data, and qualitative research is no exception. Rigour in research is defined as thoroughness and competence (Holloway and Wheeler, 2010). Speziale and Carpenter (2003) acknowledge that much debate has taken place in the literature about how qualitative researchers can demonstrate rigour or goodness in their research. The ultimate goal is to accurately represent research participants’ experiences (Speziale and Carpenter, 2003). This includes ensuring that the research is credible, which means that researcher subjectivity has been acknowledged, multiple realities have been recognised, and reports of the perspectives of participants are as clear as possible.

Several researchers have outlined the criteria necessary for qualitative research to demonstrate its quality (Burns and Grove, 2010; Holloway and Wheller, 2010; Lincoln and Guba, 1985; Patton, 2002; Speziale and Carpenter, 2003). Holloway and Wheller (2010) discuss what they call the “traditional” criteria established by Lincoln and Guba (1985). These criteria (Table 3.1) are considered the “gold standard” and are referred to as rigour in quantitative research or trustworthiness in qualitative research, reliability in quantitative research or dependability in qualitative research, validity in quantitative research or credibility in qualitative research, generalisability in quantitative research or transferability in qualitative research, and objectivity in quantitative research or confirmability in qualitative research. Confirmability is achieved by providing an audit trail, the object of which is to illustrate as clearly as possible that all of the evidence has been attended to and that the thought processes throughout the research led to accurate conclusions. Dependability of the research asks how dependable is the research? It is closely linked to credibility. Finally, transferability refers to the potential of the research to
have meaning in other similar situations or to “fit” in with other situations (Holloway and Wheeler, 2011; Lincoln and Guba, 1985).

Table 3.1 Research quality criteria summarised from Shenton (2002)

<table>
<thead>
<tr>
<th>Research quality judging criteria</th>
<th>Qualitative term</th>
<th>Quantitative term</th>
</tr>
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<tbody>
<tr>
<td>If the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained. The processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results.</td>
<td>Dependability</td>
<td>Reliability</td>
</tr>
<tr>
<td>Demonstrates that all of the evidence has been attended to. As far as possible the work’s findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher.</td>
<td>Confirmability</td>
<td>Objectivity</td>
</tr>
<tr>
<td>How congruent are the findings with reality?</td>
<td>Credibility</td>
<td>Validity</td>
</tr>
<tr>
<td>Can the research have meaning in other similar situations or “fit” in with other situations? The extent to which the findings of one study can be applied to other situations.</td>
<td>Transferability</td>
<td>Generalisability</td>
</tr>
</tbody>
</table>

Much has been written about maintaining rigour in qualitative research (Fossey et al., 2002; Maggs-Rapport, 2000 Polit and Beck, 2006). Easton, McComish and Greenberg (2000) stated that one way to ensure rigour in qualitative research is to avoid pitfalls in the data collection, transcription and subsequent analysis. The areas for potential error are equipment failure, environmental hazards and transcription. Easton, McComish and Greenberg (2000) suggested that it is essential for the researcher to re-listen to the interviews and to re-read the transcriptions. Common mistakes in transcription include mis-interpretation of words, missing words, mis-hearing of words, jargon, language barriers and punctuation mistakes. This is supported by Lincoln and Guba (2002) who added that the quality of the qualitative approach is equally as important to the product, i.e. judging the quality of the process of the inquiry is different to judging the quality of the product of the inquiry. Patton
(2002) explained that Stake (1995, 2000), the founder of case study methods, believed in “naturalistic generalisation”. This type of generalisation creates a knowledge gained from reading rich case descriptions. Thus the quality of the product or the case description adds to the quality of the study. The richer the case description the more likely it is that all of the evidence has been attended to.

Some authors also discuss the role of “reflexivity” in maintaining qualitative research quality (Holloway and Wheeler, 2010; Sandelowski and Barroso, 2007; Parahoo, 2006). Reflexivity is a strategy used in order to make the researcher’s values, beliefs and interpretations transparent. For example, if a nurse with expertise in a specific clinical area undertakes qualitative research in that area then he/she would acknowledge their own values and beliefs at the outset. According to Holloway and Wheeler (2010), and Lincoln and Guba (1985), reflexivity requires the researcher to critically reflect on their own preconceptions, monitor their reactions to participants’ accounts and actions, and monitor their relationships with research participants.

What appears to be central to many of the recommendations in the literature to ensuring rigour in qualitative research is demonstrating that both the data collection processes and the findings are trustworthy and succinct (Easton, McComish and Greenberg, 2000; Patton, 2002; Lincoln and Guba, 1985; Hammersley and Atkinson, 1983; Stake, 1978, 1995, 2000).

Further to maintaining rigour in qualitative research it is also important to maintain reliability and validity in quantitative research.

3.10.2 Rigour in Quantitative Research

The two key concerns when establishing the rigour of quantitative research are reliability and validity. Polit and Beck (2006: 508) define reliability as “the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure”. Kirk and Miller (1986) identified three types of reliability in quantitative research and these are still relevant today. They are the degree to which a measurement, given repeatedly, remains the same, the stability of a measurement over time, and the similarity of measurements within a given time period. In other
words, reliability is about how stable the research instrument is and if it was used repeatedly would the same results be yielded. Validity is defined as “the degree to which an instrument measures what it is intended to measure” (Polit and Beck, 2006: 512). Validity is about demonstrating confidence in the accuracy of the results, or in other words, do the results actually reflect what is happening. There are several types of validity and the main ones referred to in the literature are construct validity, criterion validity and content validity (Burns and Grove, 2010; Parahoo, 2006). Wainer and Braun (1998) explained that the “construct” in construct validity is the initial concept, notion, question or hypothesis that determines which data is to be gathered and how it is to be gathered. It determines the validity of a measure or scale and how meaningful it is. Criterion validity is a measure of how well the measure or scale can test or predict future outcomes or how well the scale’s score correlates with some “gold standard” measurement scale of the same variable. Finally, content validity is the extent to which the items in the scale reflect the measured concept (Patton, 2002).

An additional approach that researchers use in order to add to the rigour of the data analysis for both qualitative and quantitative data is triangulation, and the next section will discuss this.

3.10.3 Triangulation and Rigour
Denzin and Lincoln (1994) stated that triangulation adds rigour, breadth and depth to any investigation. According to Shih (1998), triangulation was first used in the social sciences as a metaphor to characterise the use of multiple methods to measure a single construct. However, Sandelowski (1986) argues that there is no consensus about the use of the term “triangulation”. Shih (1998) explained that there are two purposes for adopting triangulation: for confirmation and for completeness. Triangulation to confirm the data focuses on the measurement of discrete variables, while triangulation for completeness focuses on capturing a more complete, holistic and contextual portrayal of the unit(s) under study. Each data source adds to the overall findings.

Several authors have described the types of triangulation available to the researcher (Polit and Beck, 2006; Adami and Kiger, 2005; Speziale and Carpenter, 2003;
Begley, 1996). Four main approaches are identified: data, investigator, theoretical and methodological. Data triangulation involves using multiple sources of data, all with a similar focus (Polit and Beck, 2006). Within this approach the researcher may choose time, space or person triangulation. Time triangulation involves collecting data about the same phenomenon at different time intervals, space triangulation involves collecting data from multiple sites, and person triangulation involves collecting data from any pair of the three levels of persons – these may be individuals, groups or collectives (Begley, 1996). Investigator triangulation involves two or more skilled researchers examining the data (Begley, 1996). Theoretical triangulation involves developing competing hypotheses from different theoretical backgrounds, which are then tested against each other with the purpose of generating or testing theory (Begley, 1996). Finally, methodological triangulation involves using two or more research methods.

Many authors have discussed the advantages and disadvantages of triangulation in nursing research (Briller et al., 2008; Casey and Murphy, 2009; Redfern and Norman, 1994; Silverman, 2001). Redfern and Norman (1994) state that triangulation is ideal if one is investigating complex social issues and seeking to provide rich explanations of phenomena. They state that the advantages include achieving completeness from the research, achieving confidence in the research results, and confirmation that the data collection tools are valid and that overall it can overcome the bias inherent in using one single method. Redfern and Norman (1994) also acknowledge that the disadvantages of triangulated research studies include the high costs associated with using multiple methods of data collection and the potential for error in the use of any one of the methods. Begley (1996) argued that some of the highlighted disadvantages may in fact be limitations of any type of research, and are not specifically related to triangulation. Begley (1996) further explained that the researcher choosing triangulation must choose it for the correct reasons and give an adequate rationale and adequate description of the planning and method employed. Finally, Speziale and Carpenter (2003) suggested that triangulation is particularly suited to nursing research due to the complexity of nursing phenomena.
3.10.4 Rationale for using triangulation in this study
In order to explore autonomy for older people in residential care, triangulation of data collection methods will be employed in this study to ensure completeness. This will enable a complete, holistic and contextual description of the unit of analysis for this case study.

Further to ensuring rigour in the research process, the researcher must also ensure that they conduct ethical research.

3.11 Research Ethics
The ethical principles which guide all research projects were outlined in the Belmont report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The basic ethical principles are respect for persons, beneficence and justice.

Research ethics may also be described as:

“A set of practical philosophical tools that a researcher draws upon to help reflect on and explore the possible implications of the research for participants and for the integrity of the research process.”

(Swinton, 2009, pp.26)

The Belmont report states that respect for persons acknowledges that individuals should be treated as autonomous agents and those with diminished autonomy are entitled to protection. According to Beauchamp and Childress (1994), autonomy in research ethics involves respecting the decision-making capacities of the individuals involved; in other words, it relates to informed consent (the person who is participating is fully informed). The Belmont report explains that beneficence is about treating people in an ethical manner by not only respecting their decisions but also by protecting them from harm and making efforts to secure their well-being. Beauchamp and Childress (1994) state that beneficence assures reciprocity in relationships whereby paternalistic attitudes or practices are avoided. The researcher must be very clear about why the research is being done and precisely what benefits it will bring (or won’t bring) to the participants and those who will read the report. Beauchamp and Childress (1994) explain that the principle of beneficence resonates
with the Hippocratic oath, which promises to do no harm, and therefore research should not cause harm either intentionally or unintentionally. The question of justice, according to the Belmont report, is about who ought to receive the benefits of research and bear its burdens. Beauchamp and Childress (1994) further state that justice is about fairness and treating people equally.

3.11.1 Ethical issues in undertaking research with older people

For the purpose of this study research ethics are discussed in relation to older people in residential care. Older people are considered to be a potentially vulnerable research population (Aselage et al., 2010). The USA National Bioethics Advisory Commission (2001) explain that people may be vulnerable due to intrinsic rather than situational characteristics. In other words, their intrinsic disease process such as dementia may make them more vulnerable. Holloway and Wheller (2010) state that older people are particularly vulnerable due to their ill health, chronic disease, and/or fatigue, and because of this they may be unable to give fully informed consent. Therefore additional strategies to ensure informed consent is obtained may be needed. Hagerty-Lingler et al. (2009) propose that consent for research participation in a residential care unit for older people should be sought not just from the resident but also from the organisation and from the staff. Disclosures at resident level must ensure that residents do not perceive that refusal would compromise interpersonal relationships with staff or other residents. Disclosures at the organisation level should incorporate the extent to which the research study will disrupt the daily routines of residents and staff who will or will not directly participate in the research study. Disclosures at staff level must assure staff that participation is voluntary.

Many older people living in residential care may also have dementia. This makes obtaining informed consent from residents more challenging, yet important to achieve. Aselage et al. (2010) discuss the importance of including residents with dementia in the inclusion criteria for research studies in residential care settings. They stated that “it is a widely held belief that persons with dementia should be included rather than excluded in studies that would benefit themselves or others” (p. 11). Yet no internationally recognised guidelines exist for conducting research studies with this population. Federal guidelines in the USA do not go beyond stating that “additional safeguards” should be taken. Aselage et al. (2010) confirm that there
are no “specific instruments or standards to guide researchers in this process” (p. 12). Hence the general strategy taken by researchers is to determine the person’s decisional capacity. Aselage et al. (2010) state that while some researchers may use the MMSE (mini-mental state exam) in order to determine a person’s cognitive abilities or capacity, this has become increasingly inadequate based on the recognition that it does not take into consideration the abilities of the person with dementia to expressly talk about his or her life, needs and experiences, but rather is a snapshot of the ability to recall present day facts (Hellstrom et al., 2007).

Aselage et al. (2010) recommend a partnership approach to consent whereby the researcher and participant spend time getting to know one another and that consent is gained at each point of contact. Aselage et al. (2010) adds that this partnership approach promotes thoughtful and respectful consideration of the person behind the cognitive impairment. The Belmont report concurs with this approach and advises that special provision may need to be taken when potential participants’ comprehension is severely limited, but that even people with reduced comprehension should be given the opportunity to choose whether or not they wish to participate and the extent to which they are able to participate.

The lack of consensus on how to attain and maintain consent for this vulnerable population of older people in residential care and older people with dementia led Black et al. (2010) to produce some guidelines. In their qualitative study in the USA, Black et al. (2010) recruited nationally known experts on dementia and research ethics, dementia researchers, and dementia caregivers and advocates. They used interviews and focus groups with 40 experts and used content analysis to elicit ethical guidelines for undertaking research with older people. This work concluded that assent is an individual’s expression of approval and/or agreement while dissent is an expression of disagreement or non-approval. Assent requires the ability to indicate a meaningful choice and at least a minimum level of understanding, and dissent might be used in the context of seeing informed consent from persons with dementia. Black et al. (2010) advised that assent and dissent should be defined broadly and based on an assessment of how adults who lack consent capacity can express or indicate their preferences to be involved in research verbally, behaviourally, or emotionally. Standards for seeking assent and respecting dissent
should not be linked to the risks or potential benefits of a study. In addition, lacking the ability to assent and/or dissent should not automatically preclude research participation (Black et al., 2010). For people with dementia, consent by proxy can also be used. This facilitates their family member to consent to their participation.

Holloway and Wheller (2010) recommend study recruitment procedures that are sensitive to the needs of older people. These include information sheets with large font, reassurances that their voice is important, and conducting the research at a pace suitable for the older person. Fried (2003) stresses the importance of establishing trust in order for older people to “open up” and talk. Fried (2003) states that trust is especially important in the older age population as some people, but by no means all, may be more vulnerable due to compromised functional status, frailty and/or disease. Truglio-Londrigan et al. (2006) concur that older people will only be willing to share information about themselves when trust has been established. Trust can be maintained by respecting the research relationship and ensuring mutual closure (Truglio-Londrigan et al. 2006).

3.11.2 Dual role of the nurse researcher
Holloway and Wheeler (2010) explain that nurse researchers on the one hand are committed to advancing nursing knowledge but on the other hand they are dedicated to the care and welfare of clients. The comprehensive nature of case study research often means that the researcher adopts many roles, i.e. collecting data, observing, reporting, interacting, etc. Landau (2008) suggested that these multiple roles can be ethically challenging and Holloway and Wheeler (2010) state that they may raise problems of identity. Powell et al. (1999) stated that the role of a researcher is essentially paradoxical in qualitative research in that the researcher needs to be close to the participants, but must also recognise the impact of their own perspectives on data analysis and achieving a detached view might be difficult to maintain (Ensign, 2003). Hammersley and Atkinson (1995) recognise that characteristics such as gender, age, ethnicity, education and previous experience as well as professional background may affect the researcher’s perspective.

Observational work carried out by nurse researchers can also create dual role conflict as they observe practices in the clinical setting with which they are familiar. It is
important that they have clear guidelines of what to do should they observe unsafe practices. The role conflict may arise as a result of the nurse researcher’s commitment to the research simultaneous with their commitment to the patient.

Thus the researcher may establish a research ethical protocol specific to their study prior to commencing the research (Houghton et al., 2010; Casey, 2006; Cerinus, 2001). This protocol may help the researcher to balance professional and researcher identity and requires that the researcher make decisions about the level of their participation in the research, their role in the research and the intensity of involvement of participants (Kite, 1999; Powell et al. 1999). A research ethical protocol may take the form of a written guideline, a written acknowledgment of their professional knowledge, or a discussion of their thoughts and knowledge base through a reflective journal.

Parahoo (2006) also recognised that nurse researchers act in a range of roles when undertaking research. However, Brook (1991) and Powell (1999) state that the researcher’s level of involvement in case study research can serve a case study well and explained that the researcher’s experiential knowledge is necessary in order to understand the complexities and peculiarities of the research phenomenon. This experiential knowledge also helps with site selection and can help in reducing research access issues (Grigg et al., 2004).

When adopting multiple roles such as data collector and data analyser, Brook (1991) advised of the need to reconcile insider and outsider perspectives. The researcher must adhere to the principle of reciprocity and must deal with potential subjectivity appropriately in order not to compromise interpretations. Brook (1991) suggested that reflection helps to reduce subjectivity. Ladkin (2007) supported this and stated that the active involvement of the researcher in the research process should not be considered a threat to validity, but rather as a dimension which can produce more insight. Reflection can enable the researcher to rigorously examine and question their position (Ladkin, 2007).

Therefore maintaining a reflective journal and being reflexive has been recommended as a useful tool for balancing the multiple roles of a case study.
researcher and for contributing to research rigour (Polit and Beck, 2006; Speziale
and Carpenter, 2003). Reflexivity is the process of becoming self-aware whereby
researchers consider their own thoughts and actions in light of different contexts. It is
an ongoing critique of one’s own reactions and potential areas of bias throughout the
research journey. It enables a transparency both of the knowledge discovered and of
how it was discovered (Holloway and Wheeler, 2010; Mills, Eurepos and Wiebe,
2010). Reflection and reflective journals give the researcher the opportunity to
account for their influence on the research process and to give examples of how their
background affects the way they view phenomena, and this enables the reader of the
research to establish whether or not the researcher maintained all ethical principles.

3.12 Chapter Summary
This chapter has discussed how the research framework for this research study was
developed. This included providing a rationale for the pragmatic paradigm
underpinning it, discussing the case study and action research
methodologies/strategies chosen, and the subsequent options available for data
collection. This was followed by an exploration of data analysis approaches that are
also available to the researcher. Specific focus was given to case study analysis. The
importance of maintaining rigour was discussed and the chapter concluded with an
examination of the procedures required to maintain research ethics with a potentially
vulnerable population.
4. Research Method

4.1 Introduction
This chapter describes the research study method. The first steps required in order to conduct the research are described at the outset. These include gaining and maintaining access to the research site, listing the inclusion criteria for the research, describing the research ethics, and explaining the role of reflection in this research study. The data collection methods and their analysis are then described. Firstly, the documentary data collection and analysis are described. Secondly, the interview and observation data collection methods are described. The analysis of both of these methods is subsequently described as they were analysed together. Thirdly, the distribution and analysis of the attitude survey is described. A description of how research rigour was achieved is presented throughout.

4.2 Gaining and Maintaining Access to the Research Unit
The researcher had initially been invited by the staff of the research unit to work with them on enhancing resident care. Ethical approval was sought and granted. Following ethical approval for the research study, the researcher arranged to meet with the Director of Nursing of the hospital and the Divisional Nurse Manager of the research unit. The aim of this meeting was to seek consent to commence the research and to answer any questions. It was agreed that the research could proceed. Subsequently a meeting on the research unit was arranged in order to inform the staff that ethical approval had been granted and that written consent for participation was now required. The staff had requested the research project so this meeting was not held to discuss the aim of the study, but rather to explain the data collection methods and the need for signed written consent from all participants. Maintaining access was achieved through regular researcher presence in the research unit.
4.3 Inclusion Criteria

The research unit was deemed to be “typical” of public residential care facilities in Ireland. It met the following criteria for a “typical” residential unit:

- Shared wards: more than one bed in each ward.
- Communal bathrooms.
- Communal day room.
- One dining room.
- Range of staff to include nurse managers, nurses, healthcare assistants, laundry personnel, administrative personnel and portering personnel.

The following is a list of the inclusion criteria for staff, residents and residents’ families:

**Staff:** Assigned to work on the research unit only and part of the duty roster. Involved in direct delivery of care to the residents in the research unit.

**Residents:** For the documentary analysis and the observations all male or female residents on the research unit were included. For the interviews, residents needed to be able to converse and engage with the researcher during the interview.

**Family:** Resident must be a relative and must be living in the research unit.

4.4 Ethical Considerations

The research protocol involved four main areas for consideration: 1) Ethics committee approval, 2) Informed consent from participants, 3) Ensuring privacy and confidentiality of participants, and 4) Keeping everyone informed.

4.4.1 Ethics Committee Approval

Ethical approval was sought and obtained (Appendix 5) from the hospital ethics committee, which consisted of medical and nursing personnel.

4.4.2 Informed Consent from Participants

An information sheet was distributed to all staff, residents and residents’ families (Appendix 6). Large font size and simple vocabulary were used for the residents’
benefit. The information sheet outlined the aim of the study and the level of involvement that would be required by participants for the data collection. It was explained that the project would involve several methods of data collection such as looking at residents’ nursing notes, observing the working day, conducting surveys, and interviewing staff, residents and residents’ families. Signed written consent was then obtained from all staff and residents for the entire study (Appendix 7). Some residents were unable to sign consent and thus their families were asked to sign consent on their behalf (proxy consent). Additional signed consent was sought for the interviews and this was obtained at least 24 hours before the interviews were conducted (Appendix 8). An information sheet for the interviews was distributed to staff, residents and residents’ families and this outlined how long the interview may take, where it would take place, and how both written notes and audio recordings would be used.

### 4.4.3 Ensuring Privacy and Confidentiality of Participants

All participants were assigned a numbered code instead of their name. Specific codes identified the type of participant, e.g. staff nurse = S followed by the number. No data were removed from the research unit with any identifiable information on them. Only coded information was entered into the research PC and laptop. The research PC and laptop were both password protected. The coding list was stored separately to the data in a locked filing cabinet in the researcher’s locked office. The researcher had the only key to the filing cabinet and thus was the only person who had access to the coding list.

### 4.4.4 Keeping Everyone Informed

In order to ensure that all visitors to the unit and all staff and residents were informed about the study, information posters were displayed on the notice boards and corridor walls of the unit. These posters explained the study and provided visitors with the researcher’s contact details should they wish to discuss the study further. This was not a recruitment strategy but rather a means to communicate to people that there was a study in progress. Newsletters were given to all staff, residents and residents’ families at various intervals throughout the study and this served to keep people informed.
4.5 The Role of Reflection
Throughout the research study a reflective journal was maintained. The aim of this journal was to help the researcher to think about how previous clinical experiences might affect or influence the research. The journal also enabled reflection on how issues or events observed/learned in the research site might affect the researcher, e.g. seeing care provided differently to the way it was thought it should be done.

The next section will give an overview of the data collection and analysis descriptions to follow.

4.6 Phase One: Data Collection and Analysis
Phase one was a case study design and thus required multiple methods of data collection. These methods will be described individually in the following sections. The rationale for using multiple data collection methods was for completeness and to sufficiently inform the case study and contribute to the holistic nature of case study research, e.g. how was resident autonomy written about? How did people describe it or talk about it? How was it observed in practice? Firstly, the documentary data collection method and its analysis will be described. Secondly, the observation method will be described. Thirdly, the interview method will be described and then the approach to the analysis of these two methods will be explained. Finally, the staff survey will be described and its analysis will also be explained. The steps taken to ensure rigour in all of these data collection methods will also be discussed throughout.

4.7 Documentary Data Collection and Analysis
This section describes how documentary data were collected. This involved collecting data from relevant documentary sources on the research unit. These sources included nursing notes, staff rosters and the philosophy of care displayed on the research unit’s wall.

4.7.1 Nursing Notes
For the purpose of this study, each resident’s set of documentation was defined as the nursing assessment, care plan and daily nursing notes. A total of 38 sets of
documentation were gathered by the researcher (one set for each resident). In order to ensure confidentiality and anonymity each resident’s set of documentation was assigned a code. These sets were then photocopied on the unit and all identifiable information was erased on the copies and replaced with the assigned code. The copies were then removed from the unit for analysis.

4.7.2 Development of the Documentary Analysis Tool
The audit tool for the documentary analysis of the residents’ sets of documentation was developed from the concept analysis. The elements of resident autonomy were delineated from the concept analysis of resident autonomy and these became part of the audit tool. Each resident’s set of documentation was examined for the presence or absence of these elements using this audit tool (Appendix 9). Some of the elements of the concept analysis were two fold and therefore these were separated into two items for audit. For example one attribute of autonomy is that “a) residents delegate care needs based on the b) right to self-determination and the rights of older people”. Therefore in the audit tool this attribute became two auditable items: a) residents delegate care needs and b) self-governing, self ruling and self determining. For the purpose of the documentary analysis each attribute was described in terms of what would be evident within the residents’ set of documentation. Examples were provided on the audit tool which detailed what the researcher needed to look for in order to confirm whether or not the attribute was evident. For example the attribute “self-governing, self ruling and self determining” provided the example “evidence that resident has been involved in making choices. Resident chose to stay in bed. Resident requested a different dinner. Resident chose clothing. Resident chose to go to day room etc.”

This audit tool specifically stated what the researcher needed to see written/documented in the sets of documentation. The tool itself was photocopied 38 times (one for each resident). If an element was evident it was ticked on the tool and examples were also written onto the tool. The findings from each audit tool could then be collated in order to determine which elements of autonomy were in practice in the unit and which weren’t. The results from this analysis will be discussed in the findings chapter.
4.7.3 Adding Rigour to the Documentary Analysis Tool

A random sample of 10 sets of documentation were analysed by another researcher in order to ensure consistency and thus contribute to the reliability of the findings. Table 4.1 outlines the criteria used to recruit the second researcher for this process:

Table 4.1: Criteria for the second researcher for the documentary audit tool consistency check

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be a registered nurse.</td>
<td>Will understand the nursing process (assessing, planning, implementing, documenting, evaluating) and An Bord Altranais requirements for documentation.</td>
</tr>
<tr>
<td>Must have knowledge of older people’s services.</td>
<td>Will understand the context, e.g. residential standards.</td>
</tr>
<tr>
<td>Must have understanding of the culture and climate of residential care for older people.</td>
<td>Will recognise that approaches to residential care are different from acute care.</td>
</tr>
<tr>
<td>May be employed in nurse education or practice development.</td>
<td>Will be familiar with all of the above.</td>
</tr>
<tr>
<td>Must have previous experience of conducting research or assisting in a research project.</td>
<td>In order to appreciate and understand the importance of rigorous, systematic approaches.</td>
</tr>
</tbody>
</table>

The analysis of the sample of 10 sets of documentation by two researchers ensured that the tool could be applied consistently and reliably. The tool was amended when any of the criteria had been interpreted differently. There was 95% consistency between the researchers. The two researchers found that “ethos of maintaining dignity” was not always possible to examine fully in documentation and this accounted for the lack of consistency in auditing 5% of the documentation. It was agreed that this could be further explored during the observations.

4.7.4 Staff Rosters

Copies of staff rosters were collected over a four-month period. The interviews were conducted over a three-month period with an additional month (four months’ data collection in total) for recruitment, and it was during this time that staff rosters were collected. Hence the staff rosters were collected simultaneous to the interviews. Daily allocation sheets from the duty roster were photocopied and these displayed how many staff were on duty, whether or not anyone was on sick leave, and whether or not
relief staff were supplied. A total of 123 daily rosters were collected. In order to obtain a full picture of the staffing levels and skill mix, the rosters were analysed for the total number of staff on duty at morning report and the total number of staff on duty at evening report. The number of staff nurses, healthcare assistants, clinical nurse managers and relief staff on duty was analysed. The number of staff on sick leave and the relief provided was also analysed. The staff turnover during this four-month period was subsequently analysed. The results of this analysis are presented in the findings chapter.

4.7.5 Philosophy of Care
A philosophy of care was displayed in a picture frame on the wall just inside the front door of the unit. This philosophy of care was developed by the staff with the aim of outlining the ethos of the unit (Appendix 10). This was photocopied in order to conduct a content analysis on it. The content of the philosophy of care document was analysed for the presence or absence of the attributes, antecedents and consequences of autonomy as delineated from the concept analysis of autonomy (Chapter 2). Therefore it was analysed line by line for any element of resident autonomy.

Following the collection of the documents relevant to this research study, observations were recorded and the next section describes how these observations were conducted.

4.8 Observation Data Collection
This section describes how observational data were collected in order to observe for resident autonomy in the practice setting and thus inform the case study. This section first describes how the observation guide was developed and then explains how the observations were conducted and subsequently analysed.

4.8.1 Development of the Observation Guide
Non-participant structured (molecular) and mobile (positioning) observations were carried out over a two-day period. In order to develop the observation guide the researcher analysed the literature that discussed using observations as a data collection method. The observation guide was developed from the concept analysis of resident
autonomy (Appendix 11). The concept analysis revealed what attributes, antecedents, and consequences would indicate that residents were autonomous. This enabled the development of an observation guide that focused the observations directly on resident autonomy. The guide was then photocopied so that there was a separate guide for each observation period, and so that the researcher could take written notes.

### 4.8.2 Pilot of the Observation Guide

The observation guide and recording equipment were piloted on the research unit. The purpose of the pilot was to check the recording equipment for sound quality and to test the observation guide for ease of use and for appropriateness. A small mini-disk recorder was attached to the lapel of the researcher’s blouse. The researcher also held a clipboard and a pen. The clipboard was used to hold the observation guide and provided a physical support for note taking. It was found that the observation guide was very useful in keeping the researcher focused on autonomy, and contained the appropriate cues and examples. No problems were encountered with the equipment or with using the guide. It was found that the clipboard was a good idea and served well for writing notes.

### 4.8.3 Observation Setting

The observations took place on the research unit over two consecutive days (in order to capture the entire shift). Staffing levels and staff demographic details were gathered for the observation periods. Resident demographics and dependencies were also recorded on the observation days. This served to contribute to the contextual discussion of the findings. Time sampling was adopted. In order to observe the day in its entirety the total time observed spanned a full daily shift from 07:30hours to 20.30hours. The observation periods were as follows (Table 4.2):
Table 4.2: Observation periods

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.30 – 08.30</td>
<td>Observation</td>
<td>Break</td>
</tr>
<tr>
<td>08.30 – 10.30</td>
<td>Break</td>
<td>Observation</td>
</tr>
<tr>
<td>10.30 – 11.30</td>
<td>Observation</td>
<td>Break</td>
</tr>
<tr>
<td>11.30 – 13.30</td>
<td>Break</td>
<td>Observation</td>
</tr>
<tr>
<td>13.30 – 14.30</td>
<td>Observation</td>
<td>Break</td>
</tr>
<tr>
<td>14.30 – 16.30</td>
<td>Break</td>
<td>Observation</td>
</tr>
<tr>
<td>16.30 – 17.30</td>
<td>Observation</td>
<td>Break</td>
</tr>
<tr>
<td>17.30 – 19.30</td>
<td>Break</td>
<td>Observation</td>
</tr>
<tr>
<td>19.30 – 20.30</td>
<td>Observation</td>
<td>Break</td>
</tr>
</tbody>
</table>

4.8.4 Observation Method

As previously stated, the observations were non-participant molecular and used multiple positioning. The multiple positioning enabled free movement around the unit and therefore the general activity of the unit and the interactions between staff and residents could be observed. The researcher observed in four different areas of the unit: the day room, the nurses’ station, the residents’ individual rooms and the wards. A clipboard with the observation guide was used and each observation period had a separate guide on which observed activities were ticked and additional information or comments recorded. Thus there were nine completed observation guides at the end of the observations. The mini-disk recorder was used to verbally record what was happening. This captured the researcher’s commentary, any conversations between staff, residents and staff, visitors and the general sounds and activity on the unit.

At morning report the researcher explained to all staff on duty each day how the observations would work, e.g. observation periods and break periods, the use of written notes and recordings, and the role of the observer. It was requested that they go about their day as normal and try to ignore the presence of the observer. They were asked not to interact with the observer. It was at this point that the researcher also answered any questions the staff had about the observations. Posters were displayed on the corridor to explain the observations to residents and visitors, and consent had previously been obtained at the start of the study. Casual clothing and soft-soled shoes
were worn as this enabled the researcher to blend into the background and minimise disruption. The researcher’s face was familiar to the residents and staff at this stage in the research study, and thus it was hoped that the Hawthorne effect would be minimised.

The observation break periods greatly helped and served to re-focus the researcher for each observation period. The researcher felt that after a short time the staff did not notice her presence and behaved as they normally would. One staff member did not relax throughout the process and it was clear that she felt uncomfortable being observed. The residents also adapted quickly and nodded, waved or smiled when the researcher was in their range of vision, but largely did not try to engage in conversation. At the end of each day’s observation the researcher thanked the staff for their co-operation and participation.

This section has described the observation method and the next section will describe the interview method.

4.9 Interview Data Collection

This section describes how interview data were collected in order to inform the case study and further explore resident autonomy. A total of 30 semi-structured interviews were conducted. This included 14 interviews with nursing staff, four with healthcare assistants, one with support staff, seven with residents and four with residents’ families (see Table 4.3).

<table>
<thead>
<tr>
<th>Nursing Staff</th>
<th>Healthcare Assistants</th>
<th>Support Staff</th>
<th>Residents</th>
<th>Residents’ Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>04</td>
<td>01</td>
<td>07</td>
<td>04</td>
</tr>
</tbody>
</table>

The development of the interview guide, the pilot interviews and the subsequent recruitment to and conduct of the research interviews will now be described.
4.9.1 Development of the Interview Guide

Three interview guides were developed from the concept analysis of resident autonomy (Appendix 12). One was for staff, one was for residents and one was for residents’ families. The concept analysis revealed the attributes of resident autonomy and these was developed into a question that was a) appropriate for staff, b) appropriate for residents and c) appropriate for residents’ family members. Various probes and prompts were also developed for each question. Below is an example of how the questions were developed (Figure 4.1).

![Diagram of interview question development](image)

**Figure 4.1: Example of how interview questions were developed from the concept analysis**
Chapter 4 Research Method

Pilot interviews were conducted prior to the main study.

4.9.2 Pilot Interviews
The suitability of the interview guide for staff (nurses and healthcare assistants) and for residents (male and female) needed to be tested prior to commencement of the interviews in the research site. Four pilot interviews were conducted (one with a nurse, one with a HCA, one with a female resident and one with a male resident) (Table 4.4).

<table>
<thead>
<tr>
<th>Table 4.4: Participants for pilot interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Staff</td>
</tr>
<tr>
<td>01</td>
</tr>
</tbody>
</table>

The purpose of the pilot interviews was to examine the extent to which the interview guide elicited the information sought, to identify any other important related issues, and to assess the effectiveness of the interview technique and recording equipment. The pilot was undertaken in another residential unit so that the researcher could still recruit from the entire population of the research unit. This residential unit was similar to the actual research unit. It was a public long-stay facility with wards, day rooms and the same staffing structure. Again it was “typical” of a public residential facility. Information sheets were distributed to the staff that explained the purpose of the pilot and invited participation. Anonymity was guaranteed. Two staff members subsequently volunteered (one nurse and one healthcare assistant) and written consent was obtained.

The staff nurses on the pilot unit suggested residents who may be interested in participating. These residents were then approached by the researcher and following introductions, the pilot was explained to the residents and they were given an information sheet. The researcher answered any questions that they had. The residents were then asked to think about whether or not they wanted to participate and were given at least 24 hours to contemplate this. Two residents subsequently volunteered and written consent was obtained.
4.9.2.1 Pilot interviews with residents
The pilot interviews with the residents took place separately in their own rooms in the residential unit. One male and one female resident participated. The researcher sat on a chair at eye level with the residents and made sure they were comfortable before the interview commenced. The researcher asked the residents if they would like a cup of tea or a glass of water. The interviews were tape recorded and lasted approximately 20-30 minutes. Supplementary written notes were also taken. The residents were encouraged to relax and to talk freely. Questions were open and enabled free responses. On completion of the interview the researcher asked the resident again if they would like a cup of tea or if they wished to return to the day room. The researcher thanked them for their participation.

4.9.2.2 Pilot interviews with staff
The pilot interviews with staff took place in the Clinical Nurse Manager’s office. One nurse and one healthcare assistant participated. The interviews were tape recorded and lasted approximately 20-30 minutes. Supplementary written notes were also taken. The questions were open and enabled the participants to talk freely. Occasionally probes and prompts were required. When the interviews were complete and the tape turned off, the researcher asked the participants if they had any comments or advice to add about the interview technique. Most questions elicited the information that was expected; one question, however, posed difficulties for staff and was therefore changed to ensure that the information sought was clear. Hence one question (see Table 4.5 below) in the staff interview guide was re-phrased following the pilot.

Table 4.5: Post-pilot modification of interview question.

<table>
<thead>
<tr>
<th>Original Question no.5</th>
<th>Question no. 5 after the pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you define autonomy for older people in residential care?</td>
<td>I’m interested in finding out what autonomy for older people in residential care means – what do you think it is about?</td>
</tr>
</tbody>
</table>
4.9.2.3 Analysis of the pilot interviews
The interviews were transcribed verbatim and an analysis of the content and interview technique was undertaken. Attention was paid to how questions were asked, the use of probes and prompts, the extent to which participants were encouraged to share their perspectives, and the balance between researcher questions and participant responses. The research supervisor also read the transcripts in order to ensure that the questions were eliciting the required responses. The pilot identified a number of issues, including the need for some further training on interview technique. This was focused on techniques for probing participants further and allowing more pauses and time for the participants to think about their answers. An analysis of the data revealed that the questions were eliciting the responses needed to answer the research question and therefore the rest of the questions remained unchanged.

4.9.3 Interview Sample
Following the pilot interviews and further interview technique training, the researcher began interviewing in the research unit. The entire residential unit formed the population for the interview sample. This included all staff (nurses, managers, healthcare assistants and support staff), residents, and residents’ families.

4.9.4 Staff Interviews
All staff (n=34) of the research unit met the inclusion criteria and were invited to participate (Table 4.6). Fifty-six per cent participation (n=19) was achieved.

Table 4.6: Staff invited to participate in interviews

<table>
<thead>
<tr>
<th>Staff of Research Unit</th>
<th>Invited for Interview</th>
<th>Agreed</th>
<th>Refused</th>
<th>No Response</th>
<th>Percentage Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse Managers</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Staff Nurses</td>
<td>18</td>
<td>13</td>
<td>1</td>
<td>4</td>
<td>72%</td>
</tr>
<tr>
<td>Healthcare Assistants</td>
<td>11</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>36%</td>
</tr>
<tr>
<td>Support Staff</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>19</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>
A letter was distributed to each staff member inviting them to be interviewed (n=34). This contained an information leaflet outlining how long the interview may take, where it would take place and how both written notes and audio recordings would be made (Appendix 6). Staff were invited to contact the researcher by phone or email if they wished to participate and thus give verbal consent. Twenty-four hours before the interview a mutually convenient time for the interview was arranged with the staff member wishing to participate and written consent was obtained (Appendix 8). All participating staff chose to be interviewed at work during working hours and thus scheduled an appropriate time for the interview to take place on their next shift.

It was important that if staff were to be interviewed at work they could be free from disturbance for the duration of the interview. It was also important that they could be interviewed in a private place. Hence the staff interviews took place in the “special needs” room (see Appendix 13 – floor plan) on the unit which was quiet, largely free from disturbance and had comfortable couches. The researcher prepared this room in advance, ensuring the chairs and the tape recorder were suitably positioned and drinking water was made available. The interviews lasted about 20-30 minutes. Staff were on duty on the day they were interviewed and no staff member came in on their day off. It is often argued that staff feel more comfortable talking when they do not have to think about the work they have to do when the interview is over. However, it was their choice not to be interviewed on their day off. The researcher aimed to create a relaxed environment and began the interview by obtaining the participant’s demographic information.

The first question asked was also aimed at enabling the participant to relax and reflect on the focus of the interview. It asked the participant to tell the researcher about one of the residents they had looked after that morning. It can be seen in Figure 4.2 that this question stemmed from one of the attributes delineated from the concept analysis. This attribute is around residents being involved in decision-making and their capacity being encouraged and maintained. The theme of the question was to ascertain whether or not residents were involved in making decisions on a daily basis. If the participant found this difficult to answer the researcher would use probes and prompts like asking them what options or choices are available to
residents for washing/dressing/toileting/eating/activities, etc. or to what extent do they think the residents can actually make decisions.

![Diagram of interview guide]

**Figure 4.2: Question 1 from the staff interview guide**

The researcher then progressed from question to question (Appendix 12) when the participant had completed each response. The same format was used for all interviews. Occasionally a participant appeared nervous and the researcher paused, gave them time to gather their thoughts and their breath, offered them water, and recommenced when the participant was ready to do so.

Three staff nurses chose not to be tape recorded for the interviews. Detailed written notes were taken for these interviews, and these were read back to the staff participant at the end of the interview in order to ensure that all the information provided had been accurately recorded.

### 4.9.5 Resident Interviews

All residents (n=38) formed the potential interview population (Table 4.7). However, only 13 residents met the inclusion criteria for the interview data collection. These 13 residents were invited to participate, and of these seven agreed to participate. Twenty-five residents were severely cognitively impaired (with little or no ability to
converse) and did not therefore meet the inclusion criteria. It was rationalised that these residents’ perspectives could be gathered from the other data collection methods. Of the 25 residents unable to participate, 12 of these had family members who could be invited to participate on their behalf.

Table 4.7: Residents invited to participate in interviews

<table>
<thead>
<tr>
<th>Total number of residents</th>
<th>Number of residents who matched the full inclusion criteria</th>
<th>Number of residents who did not match the full inclusion criteria</th>
<th>Number of residents who agreed to be interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>13</td>
<td>25</td>
<td>7</td>
</tr>
</tbody>
</table>

The 13 residents were approached by the researcher and given an information sheet about the interviews (Appendix 6). This was read out to them and their questions answered. They were then left for a minimum of 24 hours to think about whether or not they wished to participate. If they wished to participate then a convenient time was scheduled for the interview and written consent was obtained (Appendix 7). Seven residents volunteered to be interviewed. Occasionally a resident was not able to participate at the agreed time due to some other activity on the ward and thus further re-scheduling took place.

Residents were interviewed in their own rooms/wards or in the special needs room if there was insufficient privacy in their own rooms/wards. The researcher ensured that the resident was comfortable before the interview commenced, offered them a cup of tea and checked that they didn’t need to use the bathroom. The researcher also checked that they could hear sufficiently and understand what was being said. The researcher aimed to create a relaxed environment and began the interview by asking the residents their demographic information.

The first question was also aimed at enabling the resident to relax and reflect on the focus of the interview. It asked the resident to tell the researcher about their previous day. It can be seen in Figure 4.3 that this question stemmed from one of the attributes delineated from the concept analysis. This attribute is around residents being involved in decision-making and their capacity being encouraged and
maintained. The theme of the question was to ascertain whether or not residents were involved in making decisions on a daily basis. If the resident found this difficult to answer the researcher would use probes and prompts like asking them what they had done so far today, or if they chose the clothes they were wearing, or if they needed any help with that, or had they chosen what to eat and did they need assistance with their meals. Prompts around social activities were also used, e.g. “what about your past-times or hobbies?”

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Residents involved in decision making and capacity encouraged and maintained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question Theme</td>
<td>What decisions do you make on a daily basis?</td>
</tr>
<tr>
<td>Question</td>
<td>Tell me what you did yesterday?</td>
</tr>
<tr>
<td>Probes</td>
<td>Do you choose what clothes to wear? Does anyone help you with that? What about meals? Can you choose what to eat? What about past-times/activities?</td>
</tr>
</tbody>
</table>

**Figure 4.3: Question 1 from resident interview guide**

The researcher then progressed from question to question (Appendix 12) when the resident had completed each response. The same format was used for all interviews. Occasionally a resident would start talking about other things like their family or their life before they were admitted to the unit. The researcher would listen to this with interest and respect, and then when they were finished would bring them back to the interview guide.

One resident chose not to be tape recorded. Detailed written notes were taken for this interview, and these were read back to the resident at the end of the interview in order to ensure that all the information provided had been accurately recorded.

### 4.9.6 Family Interviews

Thirteen residents from a population of 38 residents were eligible to participate and of the remaining 25 residents, 13 did not have family members. This left 12 residents
who were not eligible to participate but who had family who could be invited on their behalf. Four family members subsequently volunteered to be interviewed.

**Table 4.8: Family members invited to participate in interviews**

<table>
<thead>
<tr>
<th>Residents who couldn't participate/ Residents who couldn't participate and who had no family members</th>
<th>Residents who couldn't participate but who had family members</th>
<th>Family members invited for Interview</th>
<th>Family members who agreed to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>13</td>
<td>12</td>
<td>4</td>
</tr>
</tbody>
</table>

Residents’ families’ contact numbers and addresses (n=12) were obtained from the nursing notes and information sheets were sent to the families explaining the study and inviting them to participate (Appendix 6). Some of the family members already knew about the study from regular visits to the unit. The researcher’s contact details were contained in the information sheet and the families were asked to contact the researcher by phone or email should they wish to participate. Written consent was obtained from the family participants (Appendix 8).

Three of the residents’ family members were interviewed in the resident’s own ward or in the special needs room if there was insufficient privacy in the ward. The interview was conducted with the resident and their family member, and even if the resident could not speak they were included in the conversation through listening. One resident nodded his head several times in agreement with what his brother was saying. The researcher aimed to create a relaxed environment and began the interview by asking the resident’s family member what their relative’s demographic information was.

One family member was interviewed at their place of work. This was in an office and was free from disturbance.

Two family members chose not to be tape-recorded. Detailed written notes were taken for these interviews, and these were read back to the family participants at the
end of the interviews in order to ensure that all the information provided had been accurately recorded.

### 4.9.7 Summary

In total 30 people (including staff nurses, healthcare assistants, support staff, residents and residents’ families) consented to being interviewed and this data collection method took place over a four-month period. Demographic information was gathered from the participants on the day of the interviews. The researcher maintained a reflective diary throughout and wrote up observations immediately after each interview. All interviews were then transcribed verbatim and prepared for analysis.

The analysis of the interview and observation data will now be described.

### 4.10 Analysis of Interview and Observational Data

Phase one of the research study yielded four primary data sets: observations, interviews, documents and an attitude survey. This section will describe the analysis of the interviews and the observation data. The next section will describe the analysis of the attitude survey. The analysis of the documents has previously been described. Managing the data involved ensuring that the data sources, i.e. interviews and observations were clearly recorded in each transcript and clearly identifiable. To facilitate this it was decided to allocate the letter “S” to staff nurse interviews, “H” to healthcare assistant interviews, “R” to resident interviews and “F” to family interviews. Observations were labelled per day, e.g. day 1. To ensure anonymity all identifiable information was removed from the transcripts.

#### 4.10.1 Steps of Data Analysis

The first step was to transcribe the data. After each data collection period (observations and interviews) the audio-recorded data were transcribed. The accuracy of the transcription was checked by listening to each tape whilst reading the transcribed copy and any corrections were made before the transcripts were coded. All documents were then imported into NVivo.
Chapter 4 Research Method

The second step was to read through the transcripts of the interviews and the observations, the observational notes and the reflective journal in order to obtain a sense of the whole and to allow the researcher to be immersed in the data. Notes were kept of initial thoughts and stored as memos in NVivo, with a link to the particular passage of transcript or observational record. In accordance with Miles and Huberman (1994), organisation of the qualitative data was achieved by editing with the use of codes. In NVivo, nodes hold data which have been coded from sources (interviews and observations). These “nodes” are repositories for codes. Three types of nodes were used to structure the storage of the data: free nodes, tree nodes and case nodes.

Free nodes are a stand-alone repository used for initial coding. Tree nodes are similar to free nodes with two exceptions: they can have relationships with other nodes and thus may be grouped into themes. They can have “children” and thereby have a hierarchy imposed on them. Case nodes are used to generate a case file, which holds all data related to an individual participant and is physically linked to their demographic details. It is designed for tracking participants.

4.10.2 Data Analysis

When all of the data collection was complete the researcher analysed the sets of data both within the sets and across the sets. Within-data-set analysis meant that each interview was analysed in the context of all interview data and likewise observational data were analysed in the context of all observational data. Across-data-set analysis meant that the interview data were contextualised by the observational data and this added to the analysis.

The strategies developed by Miles and Huberman (1994) were used for the analysis of the interview and observation data. The analytical steps and methods are summarised in Figure 4.4.

4.10.3 Step 1: Data Reduction – Assigning Codes and Coding the Data

The first step was about reducing the data.
4.10.3.1 Coding

For exploratory case studies such as this, Yin (2003) recommends that the study purpose and objectives direct the analysis and that a coding guide or “start list” (Table 4.9) can be used to guide the first phase of analysis. The coding guide or “start list” for this research study was developed from the concept analysis of resident autonomy which had also informed the interview and observation guides. The coding guide had 10 initial codes defined and explained by 10 initial proposition statements.

Table 4.9: Coding guide/start list

<table>
<thead>
<tr>
<th>Initial Code</th>
<th>Initial Proposition Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine versus Flexibility</td>
<td>Refers to an atmosphere of openness and flexibility in the residential unit. It refers to how much routine exists in the day and can that routine be altered when required? It looks at who dictates the routine.</td>
</tr>
<tr>
<td>Self-Determination</td>
<td>Refers to “Self-governing, self-ruling, self-determining” which is about the automatic right to live your life as you choose based on UN Rights of Older People (therefore residents are consulted and asked) while “Residents delegate care needs” is delegating the action of that choice – in other words, they may know what they want to do but may be physically unable to do it so it is delegated.</td>
</tr>
<tr>
<td>Role of Family</td>
<td>Refers to family or significant others being included when resident is cognitively impaired. What role do families play in care provision? Do they visit often?</td>
</tr>
<tr>
<td>Maintaining Dignity</td>
<td>Refers to an ethos of maintaining resident dignity. Staff are non-paternalistic. Positive attitudes and values for older people are evident.</td>
</tr>
<tr>
<td>Residents Delegate</td>
<td>Refers to “Self-governing, self-ruling, self-determining” which is about the automatic right to live your life as you choose based on UN Rights of Older People (therefore residents are consulted and asked) while “Residents delegate care needs” is delegating the action of that choice – in other words, they may know what they want to do but may be physically unable to do it so it is delegated.</td>
</tr>
<tr>
<td>Making Decisions</td>
<td>Refers to residents’ involvement in decision-making.</td>
</tr>
<tr>
<td>Knowing the Resident</td>
<td>Refers to how staff get to know who the residents are and what the residents can and can’t do for themselves. Are care plans used? When and where does writing occur?</td>
</tr>
<tr>
<td>Resident Capacity</td>
<td>Resident capacity is a factor in experiencing autonomy and is enhanced when it is encouraged and maintained.</td>
</tr>
<tr>
<td>Communication</td>
<td>This refers to all types of communication: verbal, non-verbal, staff communicating with each other, with residents and with family. It also refers to residents communicating with each other and with staff and visitors.</td>
</tr>
<tr>
<td>Defining Autonomy</td>
<td>Refers to what staff, residents and residents’ families think about autonomy – how do they define it?</td>
</tr>
</tbody>
</table>
In addition, any emergent codes were also included. Each initial code in the coding guide was defined by an initial proposition statement. A proposition statement is a connected set of statements which reflect the findings from a study, or in this case the findings from the concept analysis, e.g. Resident Capacity is a factor in experiencing autonomy and is enhanced when it is encouraged and maintained. Each interview and observation transcript was read line by line and critically reviewed to ascertain if the data could be attributed to a code (free nodes, Table 4.10).

Table 4.10: Example of data reduction – assigning codes and coding the data

<table>
<thead>
<tr>
<th>Start list: Initial code from concept analysis</th>
<th>Initial proposition statement</th>
<th>Example of coded data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident capacity</td>
<td>Resident capacity is a factor in experiencing autonomy and is enhanced when it is encouraged and maintained.</td>
<td>“If they can function at all, to promote whatever functions they have” (S13)</td>
</tr>
</tbody>
</table>

On completion of this the data were then re-analysed to ensure that all data had been represented in the coding. This produced three additional emergent codes: motivation for the job, recreational activity and ward atmosphere (Appendix 14).

4.10.4 Step 2: Data Display - Identifying Patterns Within the Coded Data
Step 2 involved collating all the material in order to make it more meaningful. Two approaches to achieving this were used: identifying patterns within the coded data and attaching memos to the codes.

4.10.4.1 Pattern coding
The initial codes were compared for differences and similarities and pattern codes (Tree nodes) were thus developed. These were checked against the initial proposition statements to ensure that categorisation was appropriate. Codes and pattern codes were validated by examining the transcripts again.
The initial codes developed and populated in step 1 were “coded on” into their constituent parts. This process resulted in a “hierarchical coding tree”. Hence the proposition statements were elaborated on (they went from being initial proposition statements to outcome proposition statements) in order to acknowledge this new hierarchical structure. An example of an outcome proposition statement is: “Resident capacity is a factor in experiencing autonomy and is enhanced when it is encouraged and maintained. It is about knowing the residents’ abilities and about staff sharing control”. From the initial start list the data were also re-analysed at this point to ensure that other key issues emerging from the data that were not in the initial start list were not missed and were included (Appendix 15).

4.10.4.2 Memoing
Memos (description notes) were then attached to the codes in order to explain each code and each newly developed pattern code. This stage was particularly important for the analysis of the observations. It enabled the inclusion of all additional written comments and reflections from the fieldwork into the analysis. Adding memos meant that context could be added to the data sources, for example if the unit had been short-staffed on the day of the observations.

4.10.5 Step 3: Conclusion-Drawing and Verification
This phase of analysis involved further distilling of the codes and pattern codes by cross-checking their content and ensuring that all of the transcripts had been accurately analysed. The data were then synthesised into coherent, well-supported outcome proposition statements and the data were grouped into themes and sub-themes (Appendix 16). Table 4.11 provides an example of an initial code, its pattern codes, its initial and outcome proposition statements and its subsequent themes for the interview and observation data analysis. An expert data analysis consultant for the university ensured that the process was succinct and that the themes accurately represented the findings.
Table 4.1: Example of initial codes, pattern codes, initial and outcome proposition statements and subsequent themes for the interview and observation data analysis

<table>
<thead>
<tr>
<th>Code from coding guide/start list developed from concept analysis</th>
<th>Initial proposition statement</th>
<th>Pattern codes</th>
<th>Outcome proposition statement</th>
<th>Theme</th>
<th>Sub-theme</th>
</tr>
</thead>
</table>
| **Resident capacity** | Resident capacity is a factor in experiencing autonomy and is enhanced when it is encouraged and maintained. | 1) Independence versus dependence  
*Pattern Code 1(a):* Dependent on staff not own ability.  
*Pattern Code 1(b):* Staff taking control.  
*Pattern Code 1(c):* Don’t presume dependence.  
2) Knowing the residents’ abilities.  
*Pattern Code 2(a):* Encouragement.  
*Pattern Code 2(b):* Resident apathy. | Resident capacity is a factor in experiencing autonomy and is enhanced when it is encouraged and maintained. It is about knowing the residents’ abilities and about staff sharing control. | Theme 1: The Personal | Sub-theme 1a: The Person: “You are being so hands on for them and there was no need”. |
The final data collection method to be discussed is the staff attitude survey.

4.11 Staff Attitude Survey

The concept analysis revealed that staff attitudes toward older people is an antecedent for resident autonomy. Therefore it was important to establish the attitudes of the staff on the research unit and thus inform the case study. This section describes how these data were collected including the survey used and its distribution and subsequent analysis.

4.11.1 Choosing the Survey

Kogan’s (1961) Attitude toward Old People scale (KAOP) was chosen from the literature review. The instrument’s reliability has been found to be alpha 0.79 and it is deemed to have good psychometric properties (Lambrinou et al., 2005). This KAOP uses a Likert scale contains one set of 17 items expressing negative sentiments about older people and a second set of 17 items expressing the reverse positive statements. The positive and negative paired items are separated and distributed at random across the scale. Positive items are scored from left to right with “strongly disagree” being one point and “strongly agree” being six points. Negative items are scored from right to left with “strongly disagree” being six points and strongly agree being one point (Figure 4.5). The range of scores for the KAOP is
34 to 204, with the higher scores representing a more positive attitude toward older people.

**KOGAN’S ATTITUDES TOWARD OLD PEOPLE SCALE**

Directions: Circle the LETTER on the scale following each statement, according to the following key, that is closest to your opinion of old people.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Slightly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Slightly Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A..................</td>
<td>B..................</td>
<td>C........</td>
<td>D.......</td>
<td>E.................</td>
<td>F..............</td>
</tr>
</tbody>
</table>

**SCORE**

1. It would probably be better if most old people lived in residential units with people their own age. **NEGATIVE**
   - A..................B..................C..................D.................E.................F 3

2. It would probably be better if most people lived in residential units with younger people. **POSITIVE**
   - A..................B..................C..................D..................E..................F 5

**Figure 4.5: Example from Kogan’s attitude survey**

### 4.11.2 Distribution of the Survey

An email was sent to Professor Kogan seeking permission to use the survey and permission was granted (Appendix 17).

Thirty-four surveys were distributed – one to each staff member and 22 returned. A code was assigned to each staff member that replaced their name, and this was stamped onto the survey. The survey was then placed in a white envelope and distributed to each staff member. A letter explaining the survey and requesting voluntary participation was included. A box was provided on the research unit for completed surveys to be returned.

### 4.11.3 Analysis

The completed surveys for each participant were scored and imported into the quantitative analysis software programme SPSS Version 18.
4.12 Summary of Chapter
This chapter has explained how phase one of this research study was conducted. It began with an overview of the initial steps taken in order to conduct the research. It then individually described the methods employed for data collection and the subsequent analysis for each of these methods. These individual methods included documentary data collection of residents’ sets of documentation, staff rosters and the residential unit’s philosophy of care, interviews with residents, staff and residents’ families, observations within the residential unit, and a survey of staff attitudes. The next chapter will discuss the findings from this phase of the research.
5. Findings

5.1 Introduction
This chapter describes the findings from the phase one case study. They are presented in four sections. Firstly, a description of the case study site (research unit) is presented including a description on the days when the observations were carried out. Secondly, the findings from the documentary analysis are reported. Thirdly, the findings from the interviews and observations are reported, and finally the findings from the staff attitude survey are presented. The chapter concludes with a table summarising an integration of the findings across the data sets.

5.2 Description of the Research Unit
The research unit was a 42-bedded unit for residential care for older people. It was managed as part of an acute hospital that serves the Western seaboard of Ireland. It represents a “typical” public facility for residential care for older people in Ireland (as per “Design guide for community nursing units”, 1986. Irish health repository and as per the “typical” criteria established at the beginning of this research). It shares the same characteristics as other public residential facilities such as communal wards, day rooms, lack of multi-disciplinary services and comparable resident dependency levels (Murphy et al., 2006). In order to assist the reader in understanding what the research unit was like, the physical environment will now be described followed by a description of the staff profile and the resident profile.

5.2.1 Description of the Physical Environment of the Research Unit
Originally built in the 1950s, this research unit was designed to care for people with tuberculosis. Later it was adapted for residential care for older people. At the time this research was conducted its layout comprised an extremely long corridor with a kitchen, staff room (where report was given and breaks taken), day room and wards on the left side of the corridor. The wards were laid out as six, 7-bedded wards (not all were fully occupied), two 2-bedded wards, one single room, one isolation room (for residents with infections) and one special
needs room (used for sick residents or dying residents). All wards and rooms had one wash-hand basin. The day room was opposite the nurse’s station and not far from the front door, which could be opened by a key code. The day room was bright and had a high ceiling. It had many chairs (typical hospital-style arm chairs) lining the walls, which the residents sat on throughout various parts of the day. The day room was usually fuller and busier in the morning to early afternoon than it was in the evening. In the day room there was a fish tank, a TV and a traditional dresser, and the walls were decorated with pictures painted by the residents, and pictures and literature about past times. In the centre of the room was a large table where some residents sat for their meals. On the right side of the corridor was a nurse’s station (mostly occupied by the ward clerk, a very small space and used mainly to store folders with policies, etc. and nursing notes – report was given in the staff room, which could facilitate more people and had seating), a sister’s office, a medication store room, a staff shower room and toilet, two shower/bath rooms, a clinical room, a sluice room, a laundry room and a residents’ smoking room. The walls of the corridor contained more paintings and art work completed by the residents, along with thank-you cards and letters from residents’ family members. Each ward had a TV (usually provided by families) and some residents had their own radio and had decorated their bedsides with photographs and personal memorabilia. Each resident had a small single bedside locker/wardrobe. The overall look of the research unit was that of a traditional hospital ward. Each resident had a bed space and spaces between beds were divided by curtains when moments of privacy were required. This space was small, and when staff needed to use extra equipment like hoists and linen trolleys the wards would become cluttered in a matter of seconds (see floor plan in Appendix 13).

5.3 Staff Profile

Demographic data were gathered from all staff on the research unit. This included their age, qualifications, contracted hours and length of time working on the unit. When the research was conducted the site had 34 staff members (head count) which comprised 1 x clinical nurse manager (Grade 2, whole time equivalent (WTE)), 1 x clinical nurse manager (Grade 1, WTE), 18 x staff nurses
(10 WTE), 11 x healthcare assistants (9 WTE), 1 x porter, 1 x laundry attendant and 1 x ward clerk. The porter was the only male staff member (Table 5.1).

### Table 5.1: Grades of staff and numbers employed on the research unit

<table>
<thead>
<tr>
<th>Staff grade</th>
<th>Total headcount</th>
<th>Whole time equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse Manager</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nurses</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Healthcare assistants</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Support staff</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

#### 5.3.1 Staff Recruitment

As mentioned previously, the research unit was managed as part of an acute hospital; therefore staff were recruited to the hospital rather than specifically to work in residential care. This meant that not all staff chose to work in this specialty and some were on transfer request lists should a vacancy in another unit arise. It also meant that staff could be moved at any time according to the hospital’s resource requirements. Three nurses had been recruited from India.

#### 5.3.2 Education

The educational qualifications of both nursing staff and healthcare assistant staff will now be presented.

##### 5.3.2.1 Healthcare Assistants’ Education

Seventy-three per cent (n=8) of the HCA staff had completed the Further Education and Training Awards Council Level 5 programme for Healthcare Assistants (see Chart 5.1). FETAC is the statutory awarding body for further education and training in Ireland. FETAC makes quality assured awards that are part of the National Framework of Qualifications from levels 1-6. This FETAC training is recommended in the National Standards for Residential Care. Twenty-Seven per cent (n=3) had completed a pre-nursing course. In addition to or instead of the FETAC level 5 for Healthcare Assistants, staff had completed
other courses and these included a Diploma in Social Gerontology (n=1), FETAC level 5 Childcare (n=1), Certificate in Social Care (n=1) and FETAC level 5 Palliative Care module (n=1). One HCA had no course completed. All staff had completed mandatory manual handling, fire safety and CPR training.

Chart 5.1: Educational qualifications of healthcare assistant staff (National Standards for Residential Care)

5.3.2.2 Registered Nurses’ Education

All staff nurses were registered general nurses. Six nurses held dual registrations: One psychiatric, one children’s and four midwifery. Some staff had undertaken post-registration education. Five had completed a Higher Diploma or Postgraduate Diploma in Gerontology (recommended in the National Standards for Residential Care) (Chart 5.2) while one had completed a Diploma in Social Science and three had completed a Bachelor in Nursing Science (General). In addition, some nurses had undertaken further professional development in management (n=4), complementary therapies (n=1), occupational health and safety (n=1), incontinence management (n=1) and manual handling instruction (n=1). Thus fourteen nurses had an academic qualification additional to their registration and six nurses had no other academic qualifications other than their registration. All staff had completed mandatory manual handling, fire safety and CPR training.
5.3.3 Age Profile of Staff
Charts 5.3 and 5.4 represent the percentage age profile of the staff on the research unit.

5.3.3.1 Healthcare Assistants’ Age Profile
The majority (n=6; 55%) of the HCAs were aged 30-39 years. The least number of HCAs (n=2; 18%) were aged 21-29 years (Chart 5.3).
5.3.3.2 Nursing Staff Age Profile

The nursing staff had an older age profile than the HCAs with 10% (n=2) being 60-65 years of age and 25% (n=5) (Chart 5.4). Similar to the HCA staff, the least number of nursing staff were also the youngest.
5.3.4 Length of Time Assigned to the Unit

The collation of staff demographics also included the length of time staff had been assigned to the unit (Charts 5.5 and 5.6).

5.3.4.1 Healthcare Assistants’ Length of Time Assigned to the Unit

The majority of HCA staff were also the longest working on the research unit with four HCAs employed there for 6-8 years and four HCAs working there for 9-12 years. Two HCAs had worked on the research unit for 3-5 years. One HCA had recently joined the team (Figure 5.1).

![Number of HCA Staff and Length of Time Assigned to the Research Unit](image)

**Figure 5.1: Length of time HCAs assigned to the research unit**

5.3.4.2 Nursing Staff Length of Time Assigned to the Unit

Similar to the HCAs, four nurses had also worked on the research unit for 9-12 years (including the clinical nurse manager 2). Five nurses had worked there for 6-8 years and four for 3-5 years. Three nurses had worked for 1-2 years on the research unit (including the clinical nurse manager 1) and there were a number of new nursing staff to the research unit (four nurses had worked there for less than a year)(Figure 5.2).
5.4 Resident Profile

Thirty-eight residents were living in the research unit when the research commenced and the research unit had a maximum capacity for 42 residents. The majority of the residents were female (n=22). The residents were admitted for a variety of reasons. Six had been diagnosed with dementia and seven with Alzheimer’s disease. One of the residents with Alzheimer’s was a new admission and was presenting with challenging behaviour. Four residents were diagnosed with mental health illnesses such as schizophrenia and depression, one was diagnosed with Huntington’s Chorea, three were post-cerebrovascular accidents (CVAs), one resident was a bilateral amputee, one had Parkinson’s disease, one had an intellectual disability and the remainder were social admissions (nowhere else to go and not managing at home). All were diagnosed with a combination of medical illness and chronic diseases.

The Barthel Index (Appendix 18) was used to establish the residents’ level of independence or dependence. The Department of Health and Children uses classifications for older people ranging from low dependency to maximum dependency. The following Table 5.2 gives the numbers and percentages of residents according to their Barthel scores and according to the Department of
Chapter 5 Findings


Table 5.2: Dependency of residents on the research unit

<table>
<thead>
<tr>
<th>Barthel Category</th>
<th>National Dependency Classification</th>
<th>Number of Residents (n=38)</th>
<th>Percentage of Unit Population</th>
<th>Percentage in National Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4: Very Severely Dependent</td>
<td>Maximum</td>
<td>19</td>
<td>50%</td>
<td>34.5%</td>
</tr>
<tr>
<td>5-9: Severely Dependent + 10-14 Moderately Dependent</td>
<td>High</td>
<td>9 + 3</td>
<td>23.5% + 8%</td>
<td>29.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>= 31.5%</td>
<td></td>
</tr>
<tr>
<td>15-19: Mildly Dependent</td>
<td>Medium</td>
<td>6</td>
<td>16%</td>
<td>22.9%</td>
</tr>
<tr>
<td>20: Independent</td>
<td>Low</td>
<td>1</td>
<td>2.5%</td>
<td>13%</td>
</tr>
</tbody>
</table>

The dependency figures for the research unit are largely comparable to national statistics for resident dependency in long-stay care, whereby the majority of older people in residential care are highly dependent on care staff.

This section has described the case study site based on an analysis of its staff and resident profiles. The next section reports the findings from the documentary analysis.

5.5 Findings from Documentary Analysis

This section will describe the findings from the documentary analysis. The documents analysed were the staff rosters, the research unit’s philosophy of care, and the residents’ sets of documentation.

5.5.1 Analysis of Staff Rosters

One hundred and twenty-three daily rosters with daily allocation sheets were analysed (Appendix 19). Content analysis was performed. The daily allocation sheets displayed how many staff were on duty, whether or not anyone was on sick leave, and whether or not relief staff were supplied. These were analysed for the
number of days the research unit had its full complement of staff. The breakdown of staff nurses, healthcare assistants, clinical nurse managers and relief staff was also analysed. The number of staff on sick leave and the relief provided was also analysed. The staff turnover during this four-month period was subsequently analysed.

5.5.2 Shift Patterns
Two main shifts were in operation on the research unit – a day shift and a night shift. There were several finishing times for the day shift and these are illustrated in Table 5.3. The duty roster for the nursing staff was compiled by the clinical nurse managers but staff could request days off and this was facilitated as much as possible. The duty roster for the HCAs utilised a self-rostering approach, i.e. the HCAs filled out what days they wished to work, mindful that each day must have the required number of staff on duty. This roster was then sent to nursing administration for approval. If it was not possible to meet the staffing requirements for any particular day (due to annual leave requirements or sick leave) then a request for relief staff was sent to nursing administration.

Table 5.3: Shifts in operation on the research site

<table>
<thead>
<tr>
<th>Daily Shift Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.30 – 20.30</td>
</tr>
<tr>
<td>07.30 – 14.15</td>
</tr>
<tr>
<td>07.30 – 15.30</td>
</tr>
<tr>
<td>07.30 – 16.15</td>
</tr>
<tr>
<td>07.30 – 17.15</td>
</tr>
<tr>
<td>07.30 – 18.15</td>
</tr>
<tr>
<td>07.30 – 17.45</td>
</tr>
<tr>
<td>07.30 – 18.45</td>
</tr>
<tr>
<td>20.00 – 08.00</td>
</tr>
</tbody>
</table>

5.5.3 Daily Complement of Staff
Based on resident numbers and dependencies, the morning complement of staff sanctioned for the research unit was five nurses and four healthcare assistants
(nine staff in total 07.30hrs to 17.00hrs). If one of the nurses in that complement was a clinical nurse manager they usually attended to office work and were not clinically allocated. For the evening time (between 17.00hrs and 20.00hrs) the roster allowed for two nurses and three healthcare assistants to be on duty. At night time there were two nurses and one healthcare assistant and one “twilight” healthcare assistant who worked until 12 midnight and who was not a unit staff member but a relief staff member (there was a core group of staff who provided this relief).

Over the four-month period of analysis it was found that nine staff came on duty for morning report 50% of the time (62 times). Occasionally the unit had extra staff and on one occasion 12 staff were on duty at morning report (0.8%). Eleven staff were on duty on three occasions (2%) and 10 staff were on duty on 25 occasions (20%). There were also times when the unit was under-staffed: on 25 occasions there were eight staff on duty at morning report (20%), seven staff on duty on five occasions (4%) and six staff on duty twice (1%). Thus the unit was over-staffed 29 times in a 123-day period and under-staffed 32 times in the same period (Chart 5.5).

![Occurrence of Full Complement of Staff](chart)

Chart 5.5: Number of staff on duty during the four month period analysed
By evening time these numbers had changed and the number of staff going off duty at evening report was six on eight occasions (7%), five on 102 occasions (83% the number of staff required), four on 11 occasions (9%) and three on two occasions (2%).

5.5.4 Staffing Levels at Morning Report
The breakdown of nurses and HCAs on duty at morning report is illustrated in the Charts 5.6 and 5.7 below.

Six nurses were on duty at morning report 23 times (19%). The nursing complement of five nurses on duty occurred 77 times (63%) while four nurses came on duty 20 times (16%) and three nurses came on duty three times (2%) (Chart 5.6).

Three HCAs were on duty at morning report 17 times during the 123-day period (14%). The full complement of four HCAs on duty occurred 90 times (73%), while five HCAs came on duty 14 times (11%) and six came on duty twice (2%) (Chart 5.7).
5.5.5 Staffing Levels at Evening Report

The full complement of two nurses finishing day duty at evening report occurred on 115 occasions (93%). Three nurses were on duty at the end of the day on one occasion (2%) and one nurse finished day duty at evening report on seven occasions (5%).

The full complement of HCAs going off duty at evening report was three on 102 occasions (83%). Two HCAs went off duty on 10 occasions (8%). One HCA went off duty at evening report on two occasions, and on nine occasions four HCAs went off duty at evening report.

5.5.6 Sick Leave

From the 123 days analysed, the total number of sick days taken was 53. Nursing staff accounted for 21 of the sick days and HCAs accounted for the remaining 32. Nursing administration supplied relief nursing staff for 12 of the 21 days required, and supplemented the other days with HCA cover. On some occasions relief staff were only partly supplied (not filling a full shift requirement, e.g. supplied until 11am when the shift needed was until 4pm).
5.5.7 Management of the Research Unit
The research unit was managed as part of an acute hospital. It was thus managed by two clinical nurse managers: Grade 1 and Grade 2. They reported to an Assistant Director of Nursing. A consultant geriatrician was assigned to the unit and supported by a team of junior doctors who managed the medical day-to-day needs of the residents (e.g. medication review, prescriptions, referrals, etc.).

The clinical nurse managers when on duty attended to office and management issues. If the duty roster had 9 staff allocated, and if two of these were managers, then there were 7 staff members attending to resident care. This meant that workload varied from day to day.

Of the 123 days analysed the clinical nurse managers were on duty for 82 days (67% of the time). Thus there were 41 days with no manager on duty (33%). Fourteen of the 82 days had two managers on duty and of the 68 remaining days there was one manager on duty (Chart 5.8).

Chart 5.8: Proportion of days a clinical nurse manager was on duty

5.5.8 Staff Turnover
Over the period of the research study the staff turnover was also analysed. One nurse went on maternity leave, one nurse was transferred to another unit, one
nurse retired, one healthcare assistant left the unit, two staff members were often off on sick leave (one nurse and one HCA) and three new nurses and one healthcare assistant joined the unit.

Following an analysis of the duty rosters the researcher examined the research unit’s philosophy of care and residents’ sets of documentation.

5.6 Findings from the Analysis of the Philosophy of Care

Mission statements and philosophies of care generally aim to reflect the ethos of a care environment and the literature review indicated that this may reflect the type of care provided in a unit. The research unit’s philosophy of care (Appendix 10) was displayed on the wall at the front entrance and a content analysis was undertaken on this. The attributes, antecedents and consequences of autonomy as delineated from the concept analysis (Appendix 2) were used to guide this content analysis (referring each statement in the philosophy of care to the attributes, antecedents and consequences and assessing whether or not they were comparable). The aim was to ascertain whether or not resident autonomy and its attributes were recognised within the philosophy of care. The areas circled in the text below illustrate and provide evidence that the philosophy contained attributes, antecedents or consequences of resident autonomy (red circle= antecedent, red circle=attribute and blue circle=consequence).
Philosophy of Care

Our aim is to ensure that each resident receives care of the highest standard, which is tailored to suit individual needs and embraces the core values of dignity, choice, independence and privacy. This is achieved by ensuring the delivery of a personal approach to nursing care with the most up-to-date research-based practice. On admission, a holistic health assessment of each resident is carried out by a qualified staff nurse and an individualised care plan developed to meet their assessed needs. The physical, emotional and spiritual care needs are negotiated in order to deliver the expressed wishes of the resident. Family are also encouraged to participate in this process. All staff members of X strive to create a relaxed environment where compassion and understanding for the needs of the resident are paramount to our delivery of care.

The findings from the content analysis of the philosophy of care revealed that two antecedents of resident autonomy were present, four attributes were present and one consequence were present in the statement (Table 5.4).

Table 5.4: Results from content analysis of philosophy of care

<table>
<thead>
<tr>
<th>Concept Analysis</th>
<th>Philosophy of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antecedent:</strong> Resident assessment is robust.</td>
<td>On admission, a holistic health assessment of each resident is carried out by a qualified staff nurse and an individualised care plan developed to meet their assessed needs.</td>
</tr>
<tr>
<td><strong>Consequence:</strong> Evidence of negotiated care plans.</td>
<td></td>
</tr>
<tr>
<td><strong>Attribute:</strong> Family or significant others included.</td>
<td>Family are also encouraged to participate in this process.</td>
</tr>
<tr>
<td><strong>Attribute:</strong> Negotiated care plans.</td>
<td>The physical, emotional and spiritual care needs are negotiated.</td>
</tr>
<tr>
<td><strong>Attribute:</strong> Residents involved in decision-making.</td>
<td>In order to deliver the expressed wishes of the resident.</td>
</tr>
<tr>
<td><strong>Attribute:</strong> Atmosphere of flexibility within an ethos of maintaining dignity.</td>
<td>Relaxed environment. Embraces core values of dignity.</td>
</tr>
<tr>
<td><strong>Antecedent:</strong> Respect for dignity.</td>
<td>Embraces core values of dignity.</td>
</tr>
</tbody>
</table>
5.7 Findings from Analysis of Nursing Notes

The analysis of the residents’ sets of documentation involved conducting a content analysis on each resident’s nursing assessment, care plan and daily nursing notes. Each resident’s set of documents was analysed using the documentary analysis audit tool designed from the concept analysis (Appendix 9).

The findings presented here are reported under the headings used in the documentary analysis tool. It is important to acknowledge that the data in this section relate only to documented care and that documented care may not fully reflect the actual care given.

Overall it was found that very few residents actually had a “careplan” (a set of documentation including an assessment of their needs, a plan to meet their needs, interventions needed to fulfil their needs and an evaluation of the plan of care with re-assessment as required). Some had assessment documentation (n=14) but were without any plan of care, and many just had the traditional one or two page “kardex” and masses of daily notes (n=8). Many of the residents’ original admissions pages were old and barely legible – they had not been updated from their admission (some admissions were seven years previously) and were still in use. No scientific assessments for pressure ulcers, dependency, falls risk or nutrition were in use. “Sexuality/individuality” assessment sections had biro lines drawn through and some nurses had written “not applicable” (n=14) on this section.

The findings from each element of the documentary analysis will now be presented: Element 1: Resident is self-governing, self-ruling, self-determining. Element 2: Care plans are negotiated and family are involved. Element 3: Residents delegate care needs. Element 4: Residential unit has an atmosphere of openness, motivation and flexibility. Element 5: Values and beliefs of staff are non-paternalistic (positive in relation to older people). There is an ethos of maintaining dignity. Element 6: There is open and respectful communication between residents and staff and sharing of information. Element 7: There is
recognition of the resident’s past and present life, which may shape the resident’s wishes. There are life histories.

Figure 5.3 reveals the overall results from the analysis of the residents’ sets of documentation (blue column is evident and red column is not evident). It can be seen that the element most lacking in the documentation was element 6 (“There is open and respectful communication between residents and staff and sharing of information”), whilst the most evident element was element 7 (“There is recognition of the resident’s past and present life, which may shape the resident’s wishes. There are life histories”). These findings will now be described in detail and further examples from the residents’ sets of documentation can be found in Appendix 2. Pseudonyms to protect anonymity are used throughout.

![Figure 5.3: Results from analysis of residents’ sets of documentation](image)

**5.7.1 Element 1: Self-Governing, Self-Ruling, Self-Determining**

This was judged to be evident if the resident had been involved in making choices or decisions about their day or treatment. Examples included documented preferences for time of getting up or bed time, meal preferences, hygiene preferences, and preferences for treatment or refusal.
The analysis revealed that 40% of notes (n=15) had documented evidence of residents being self-governing, self-ruling and self-determining (Chart 5.9) and 60% (n=23) of sets of documentation showed no evidence of this element of resident autonomy.

Chart 5.9: Element 1

While some residents clearly exercised choice and control over how they spent their day, these were largely choices in relation to personal care (whether to get up or stay in bed, have a shower or bed bath, etc.) and not how they wished to socially/recreationally spend their day.

“Shower refused. Mobilising around the ward independently.”

“Did not wish to get out of bed today. Remained in bed.”

However, in the example below it is not clear from the documentation whether or not the resident was actually offered a choice about having a shower:

“Personal Hygiene attended to: shower given, hair washed and blow dried.”

In the following example, the resident’s ability to self-determine was enabled:
“Dr. spoke to John informing him of probable cancer. Asked if he wanted son/family informed but refused. Also refused to get pastoral care involved.”

“Independent with ADLs” was written in many of the residents’ daily nursing notes suggesting that the resident is self-governing, self-ruling and self-determining. This was deemed to be evidence of the attribute but it is not known for certain if this level of self-rule experienced by these residents was due to their level of independence with activities of living or due to being enabled to self-rule by the staff of the unit.

Hence the analysis revealed that this element (self-governing, self-ruling and self-determining) was more evident in the notes for residents who were more physically independent.

5.7.2 Element 2: Care Plans are Negotiated and Family are Involved

This was judged to be evident if there was documented evidence that staff had assisted a resident in verbalising their needs or had advocated for them to ensure that their needs were met. Examples included documented compromises and negotiations and documentation of family wishes.

The analysis revealed that there was little evidence of this element. Only 13% (n=5) of resident notes had any documented evidence (Figure 5.13). In these notes actions identified as examples of the element related to doing something for a resident that they had requested, e.g. sending a resident’s hearing aid for repair. In some notes staff had noted a referral to another member of the healthcare team:

“Complained of chest tightness – Dr. on call informed.”

In one note the nurse stated that it was important to:

“Ensure that resident x reaches their full potential by liaising with physiotherapist.”
In another set of documentation a nurse had documented that staff respect the resident’s wishes for care:

“Patient informed that his wishes will always be taken on board.”

However, overall this element of resident autonomy was not evident in 87% (n=33) of documentation.

Chart 5.10: Element 2

5.7.3 Element 3: Residents Delegate Care Needs

This element was judged to be evident if there was evidence of promoting resident capacity, and that residents subsequently delegated care based on that capacity. The criterion stated that a resident’s level of independence would be documented and the level reviewed over time. Specific evidence was required in relation to what a resident can and cannot do for themselves, e.g. “can brush own hair, can do zips but not buttons”.

The analysis of the documentation revealed a lack of specificity in relation to what residents could or could not do for themselves. While the level of independence was usually documented at the initial admission assessment, it was noted to lack a detailed account of what a resident could or could not do for
themselves. In 76% (n=29) of notes all that was documented was “needs assistance”, “minimal assistance required”, “full assistance required” or “independent in activities of living”. It was judged that this lack of specificity made it more difficult to promote resident capacity. Twenty-four per cent (n=9) of the residents’ sets of documentation were judged to have evidence (Chart 5.11) of promoting independence, as detail was present of what a resident could or could not do for themselves. However, there was no care plan to support how this could be maintained.

Chart 5.11: Element 3

5.7.4 **Element 4: An Atmosphere of Openness, Motivation and Flexibility**

This was judged to be present if a resident’s requests in relation to care were documented and acted upon. Documentation of how decisions were reached, including risky decisions, and how staff responded to this in a flexible way needed to be evident. Analysis of the documentation revealed mainly two documented issues: cot-side use and use of mobility aids. In order for this element to be judged as evident, the documentation needed to reveal decision-making processes and actions taken as a result of these decisions.

Analysis of documentation revealed that 78% (n=30) of residents’ documentation had no evidence (Chart 5.12) of resident requests, openness for receiving
requests or flexibility around ensuring requests were met. The other 22% (n=8) of notes included some reference to preferences in relation to cot side use, or requests in relation to mobility aids. It was noted in these plans:

“Cot sides used for personal safety as requested by resident.”

“Uses left cot-side to pull himself up.”

“On ultra-low bed with mats on the floor.”

![An atmosphere of openness, motivation and flexibility](chart.png)

Chart 5.12: Element 4

5.7.5 **Element 5: Values and Beliefs of Staff are Non-Paternalistic. Ethos of Maintaining Dignity.**

This was judged to be present if a resident’s requests were respected and recognised. It was acknowledged that this element may be more easily detected from observational analysis than from documentary analysis and thus when “maintain dignity and privacy” was written in the notes then it was accepted as evidence of this element. Hence this element was deemed to be evident in 22% (n=8) of the sets of documentation (Chart 5.13).
The type of language used in documenting care was largely functional and focused on physical care. This included comments like:

“Bed-bath given and hoisted out onto chair.”

However, some aspects of maintaining residents’ dignity were also evident:

“Curtains drawn around patient while being attended to.”

“Provide a private area for washing.”

“Ensure patient has clean clothes at all times.”

Even though the word “patient” is used here instead of “resident”, it does reveal that the resident’s requests/wishes were recognised and respected:

“Patient likes her appearance and her clothes.”

Values and beliefs of staff are non-paternalistic. Ethos of maintaining dignity.

Chart 5.13: Element 5
5.7.6 Element 6: Open and Respectful Communication and Sharing Information

This was judged to be evident if there were comments that revealed power sharing and negotiation between residents and staff and information sharing about health and well-being.

Analysis of the notes revealed that evidence of sharing information or negotiated care was not evident in 91% (n=35) of the documentation (Chart 5.14). There was some evidence in 9% (n=3) of notes and one example of this was the documented advice given to a resident about the benefits of making alterations to her wheelchair.

![Open and respectful communication and sharing of information](chart514.png)

Chart 5.14: Element 6

It was revealed that residents’ capacity to receive information and engage in open and respectful communication was not assessed for each individual situation:

“Unable to make decisions.”
In the following example the nurse documents sharing of information but it appears to be one-way communication:

“Advised re: benefits of same.”

5.7.8 Element 7: Recognition of Past and Present Life, Which May Shape Residents’ Wishes. Life Histories.

Recognition of hobbies and interests in past and present life was judged to be evident where activity interests were noted and planned for, or where family and community relationships were noted. Evidence of named care staff was deemed part of this element if life histories, etc. were to be gathered.

Analysis of documentation revealed that 64% (n=24) of notes (Chart 5.15) had documented the resident’s interests on admission:

“Likes to listen to music tapes.”

However, in all of these assessments there was no further reference to these interests in the daily nursing notes or care plans. Thirty-six per cent (n=14) of residents did not have interests or hobbies documented on admission and no further reference to these were made. In some notes there was evidence of family relationships:

“At times family members take Mary out for the day.”

There was some evidence of what a resident did and did not like to do. There was very little evidence of the resident’s previous life, e.g. occupation, etc. The examples provided here show assessments and comments but no detailed plans.
5.7.9 Summary
This section described the case study site. It also reported the findings from the documentary analysis which served as one source of evidence to inform the case study. The documents analysed included the staff rosters, the residential unit’s philosophy of care, and the residents’ sets of documentation. The next section will report the findings from the interviews and observations.

5.8 Findings from Interviews and Observations
This section describes the findings from the interviews and observations undertaken in phase one of this study. Firstly, an overview of the residents and staff in the research unit on the days the observations were undertaken is provided. Secondly, the findings from the analysis of the interview and observation data are reported.

5.9 Observations Day One
One CNM2, one CNM1 and four staff nurses were rostered on duty. Four HCAs were rostered. The staff ranged in age from 29 years to 57 years. The length of time working on the unit ranged from two years to 12 years and the contracted hours of each staff member on duty were a mix of those working reduced hours (n=3) and those working full-time hours (n=7).
Thirty-three older people were resident on day one of the observations. Two residents had been transferred to medical wards, leaving 31 residents present on the first day of observation on the research unit. Table 5.5 details the Barthel scores of these 31 residents.

Table 5.5: Barthel Scores for the residents on day one of the observations

<table>
<thead>
<tr>
<th>Barthel Category</th>
<th>Number of Residents (n=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 Very Severely Dependent</td>
<td>11</td>
</tr>
<tr>
<td>5-9 Severely Dependent</td>
<td>11</td>
</tr>
<tr>
<td>10-14 Moderately Dependent</td>
<td>3</td>
</tr>
<tr>
<td>15-19 Mildly Dependent</td>
<td>5</td>
</tr>
<tr>
<td>20 Independent</td>
<td>1</td>
</tr>
</tbody>
</table>

5.10 Observations Day Two

Five nurses and four HCAs were rostered and on duty. The staff ranged in age from 29 years to 60 years. The length of time working on the unit ranged from two years to 11 years and the contracted hours of each staff member on duty were a mix of those working reduced hours (n=1) and those working full time (n=8).

One resident had been transferred to a medical ward for physiotherapy post-CVA, leaving 32 residents on the research unit on the day of observation. Table 5.6 details the Barthel scores of these 32 residents.
Table 5.6: Barthel Scores of the residents on day 2 of the observations

<table>
<thead>
<tr>
<th>Barthel Category</th>
<th>Number of Residents (n=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>11</td>
</tr>
<tr>
<td>Very Severely Dependent</td>
<td></td>
</tr>
<tr>
<td>5-9</td>
<td>11</td>
</tr>
<tr>
<td>Severely Dependent</td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td>4</td>
</tr>
<tr>
<td>Moderately Dependent</td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>5</td>
</tr>
<tr>
<td>Mildly Dependent</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Independent</td>
<td></td>
</tr>
</tbody>
</table>

The findings from the analysis of the interview and observation data will now be reported.

5.11 Data Analysis

Two main themes emerged from the coded data and these are illustrated in Table 5.7. The first theme, “The Personal”, emerged from both the interview and observation data. There were three sub-themes in this theme. *Sub-theme 1a*: The Person – “You are being so hands-on for them and there was no need”; *Sub-theme 1b*: The Personality – “People who work here should want to work here”; *Sub-theme 1c*: Person to Person – “They don’t think of me as a person”.

The second theme, “Being Personal”, had two sub-themes. *Sub-theme 2a*: Being Impersonal – “If they don’t fit into our pattern”; *Sub-theme 2b*: Being Personalised – “There is more to their lives than physical care”.

Table 5.7: Themes from analysis of observations and interviews

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: The Personal</td>
<td>1a: The Person: “You are being so hands on for them and there was no need.”</td>
</tr>
<tr>
<td></td>
<td>1b: The Personality: “People who work here should want to work here.”</td>
</tr>
<tr>
<td></td>
<td>1c: Person to Person: “They don’t think of me as a person.”</td>
</tr>
<tr>
<td>2: Being Personal</td>
<td>2a: Being Impersonal: “If they don’t fit into our pattern.”</td>
</tr>
<tr>
<td></td>
<td>2b: Being Personalised: “There is more to their lives than physical care.”</td>
</tr>
</tbody>
</table>

5.12 Reporting the Findings

As explained previously there were multiple participant groups in this study (residents, staff and residents’ families). Table 5.8 illustrates the code by which each group is identified in this report. Barthel scores are also included in the excerpts from the transcripts, in order to reveal the residents’ assessed level of ability and to contextualise the findings.

Table 5.8: Participant type and code

<table>
<thead>
<tr>
<th>Participant Type</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Assistant and Support Staff</td>
<td>This refers to staff on the research unit who were employed as Healthcare Assistants. Each individual participant was individually numbered.</td>
<td>H01-H04</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>This refers to staff employed on the research unit who were nurses. Each participant was individually numbered.</td>
<td>S01-S14</td>
</tr>
<tr>
<td>Family Member</td>
<td>This refers to residents’ family members. Each participant was individually numbered.</td>
<td>F01-F04</td>
</tr>
<tr>
<td>Resident</td>
<td>This refers to an older person who had been living in the research unit for more than six months. Each participant was individually numbered.</td>
<td>R01-R07</td>
</tr>
</tbody>
</table>
Chapter 5 Findings

Theme 1: The Personal
This theme generated from the findings describes autonomy in many domains. “Personal” is defined by the Oxford English Dictionary as “belonging to or affecting a particular person rather than anyone else.” The analysis of the data revealed that this theme consisted of three sub-themes: The Person, The Personality and Person to Person. These will be described individually.

Sub-theme 1a: The Person: “You are being so hands on for them and there was no need”
There are many “persons” in residential care. These include residents, staff and family persons. The resident person’s capacity was considered to be a factor in whether or not they experienced autonomy, and it was suggested that capacity is enhanced when it is encouraged and maintained by staff persons. Staff spoke about the need to know the residents’ abilities and about the difficulties they experience in negotiating and sharing control with residents. Staff talked a lot about a person’s independence and dependence in relation to their capacity, and residents spoke about relying on staff to help them. Staff participants talked about trying to encourage resident capacity by not doing things for residents that they can do for themselves, whilst some resident participants expressed a lack of confidence in their own abilities. This sub-theme is complex as it describes how a resident person’s capacity is often diminished or not encouraged, even though this negates their personal human rights, i.e. the right to self-determination and the right to make decisions. While staff were aware of these rights they also struggled with facilitating them, e.g. providing choice.

Staff participants described residents’ abilities/capacity and their desire to encourage them to maintain their abilities:

“If they can function at all, to promote whatever functions they have”
(S13)

“I always say we’re here to encourage independence not dependence”
(S14)
Resident participants described relying on staff:

“Well, you see, the way it is with me is that I have to be helped out of bed and I have to be helped into bed. That’s something I have to depend on the staff. …usually they’re very good, very good but then there’s so many they might be way up the top they mightn’t see me.”

(R02) (Barthel 16)

One resident participant was adamant that they would remain independent:

“No, no. I do it all myself because opposite me in the toilet there’s a wash basin and I turn it on while I’m undressing and the water will be warm by then so I’ll give myself a good wash then and the occasional time then I’ll get a shower, you know in between.”

(R04) (Barthel 12)

It was also revealed that capacity was not always determined by what a resident actually could or could not do, but by staff facilitation and encouragement for them to maintain their actual capacity. Sometimes residents just wanted a small bit of help and did not want to be fully dependent on staff.

While some resident participants only wanted a small bit of help or assistance, the majority of staff and resident participants talked about how staff take control of the daily activity:

“I mean automatically it’s just done for them.”

(H02)

“We just washed her and dressed her and sat her out in the chair ready for the physio.”

(H02) (Barthel 8)

A nurse participant recognised the dilemma of encouraging residents to do things for themselves by not taking control:

“And I’m thinking the easy option is to go up and give it to him but I left it and I kept watching him and he drank half the cup himself.”

(S02)
One resident participant recognised that staff try to keep them safe but in so doing often reduce their capacity and control, in her description of using a motorised wheelchair:

“I do but unfortunately you know this bit in it ‘we’re responsible for you’ and don’t go into the walls and they cut down your speed and the result is I just crawl along and I’m not very happy about that and I can’t do anything then”
(R01) (Barthel 8)

Further to understanding and knowing a resident person’s abilities it was also acknowledged that dependence should not be assumed by staff persons:

“Sometimes people come in here and you think there are things that they cannot do and then some day you will see them doing it and you realise you are being so hands on for them and there was no need.”
(H03)

One healthcare assistant acknowledged the importance of knowing what each resident can and can’t do for themselves:

“She could do some bits, maybe wash her hands and face, but getting dressed now would be a problem. Her shoulders and joints aren’t the best.”
(H02) (Barthel 2)

“There are patients that can’t do a lot for themselves but wash all the top half and some of them put on the top half of the clothes and then maybe they’re not great on their legs so you would have to help them with their trousers and whatever, but the whole top half they can do.”
(H02)

One nurse participant acknowledged that it is only by working closely with the resident that you really understand their abilities:

“You could be looking at them all the time but it’s only when you go in in the morning and deal with them that you get a feeling of their abilities and what they can and can’t do and what they are like as a person.”
(S08)
The observations recorded staff assisting residents where necessary:

“It is breakfast time and the staff are assisting the residents and asking them if they need sugar or milk, etc. They make sure their trays are in front of them and sit them up in bed if required.”
(Obs – Day 2: 07.30-09.30hrs)

The observations also recorded staff chatting with residents in order to elicit from them what they felt their abilities were:

“In this ward a nurse asks a resident ‘how are you getting on with the walking?’ she replies ‘I’m slow with it’ and the nurse asks her ‘does it hurt when you walk’ to which she replies ‘no’.”
(Obs – Day 2: 10.30-12.30hrs)

Staff participants in the interviews acknowledged that encouragement is important if a person’s capacity is to be maintained:

“If someone can open their packet of sugar I will encourage them to do it, I would or any other thing as well.”
(H03)

“Some of them don’t try hard I’d say. I’d say ‘come on, it will do you good’.”
(H04)

“It might be simple things even get them to brush their own teeth or, you know.”
(S07)

The observations did record staff encouraging residents to do personal care things for themselves:

“The nurse is reassuring and asking the resident to help them put his jumper on, ‘put your hands in there for us’.”
(Obs – Day 2: 07.30-09.30hrs)

Some nurse participants, while acknowledging that encouragement is important, also believed that residents lacked confidence in their own abilities:

“There are so many of them that can’t really do much. For any of them who can, I think there’s opportunity.”
(S08)
“She’s….and she could do so much more than she is doing.”
(S02) (Barthel 12)

“Well, I asked her to wash her face and that’s all she did.”
(S03) (Barthel 2)

“A lot of them feel useless as well, if they could make themselves feel useful.”
(S13)

The resident person’s capacity and independence were also described in relation to their ability to be involved in decision-making. It was stated that autonomy in making decisions is about first having the availability of choices for residents in order for them to actually make decisions. It was revealed that the majority of decisions that residents actually made were in relation to physical care. It was suggested that making decisions involves compromise--it may depend on what staff persons are on duty and it may be dependent upon a resident person’s mental capacity. It was revealed in the observations that the residents have little or no choice about the food they eat. Staff acknowledged that residents are more involved in daily decision-making now than in the past, but that this involvement could be further enhanced. It was acknowledged that some residents are capable of making decisions and should be provided with opportunities to do so. However, staff spoke about their struggles with challenging the status quo in order to enable more resident decision-making.

Staff and family participants stated that confused residents or residents with dementia were incapable of making decisions and that only those who were “compos mentis” should be consulted:

“He’s not able, maybe others with their minds could have other options.”
(F03) (Barthel 8)

“But I don’t think the patients know what they want to do.”
(S03)

“If they are alert and orientated we can ask them what they want.”
(S09)
Staff participants also spoke about the dilemma of enabling choice whilst protecting the resident from harm:

“I suppose the first thing you do have to look after there is their safety isn’t it really? If they’re confused and if they’re going to do something that isn’t a good idea, there isn’t a choice for them in that.”
(H03)

A family participant talked about choices they had observed:

“‘Oh, you’re up late tonight or this evening?’ and they’ve said ‘Oh, we’ve asked him a few times and he didn’t want to go into bed’.”
(F04) (Barthel 2)

One staff participant felt this was not enough and that more choices should be available to the residents:

“I suppose I would have to say, when I came first I noticed, I really felt that sometimes patients do not have a lot of choice and I found that difficult and I sort of wondered should I make a stand about my feelings?”
(H03)

A family participant felt that a menu would be nice for her relative and a nurse participant also supported this and felt that food variety was important. A staff participant also stated that:

“Well maybe people who are in charge of the diet could do a bit better and give them a second choice, not two rices but something different.”
(H03)

The observations revealed that there were not a lot of food choices available:

“It is breakfast time. There is porridge and white bread with butter, jam or marmalade.

It’s 4pm and tea/supper is being served. Residents requiring a soft diet have been served shepherd’s pie. One female resident gets a salad and one other lady gets ham as this is what they have requested. Residents that don’t need a soft diet get rashers and eggs.
The shepherd’s pie and the rashers and eggs are served every Wednesday and the lady who gets the ham and the lady who gets the salad get that every day….

It is now 7pm and a snack is being served. Residents are offered a choice of tea or milk, bread, biscuits, bananas, brack or yoghurts and one HCA asks a resident “would you like a ham sandwich?” (Obs – Day 1)

Staff participants talked about the lack of choices available to residents, but yet they didn’t recognise what they could do to change that and they still determined the routine:

“There are certain residents who could be asked a lot more what they think or what they want to do and when they want to do it, like when they want to get up or even if they want to get up or what they like to eat or what they want to wear or if they would like to get their hair done or….some of them never go outside at all.” (S03)

“I don’t think they have an awful lot of choices, if you want me to be completely honest. I don’t think they are actually asked. I like to get them up if at all possible.” (S12)

The resident participants didn’t have a lot to say about their choices but offered that those who can choose do, but these are usually minor choices like whether or not to get up. Others just go along with the routine of the day:

“Sometimes if I’m in bad form I’m mightn’t get up or get out.” (R02) (Barthel 16)

“I don’t make any decisions from day to day. I just let the day come and go because of my disability.” (R06) (Barthel 4)

Some staff participants did talk about the choices they offer residents but these were mainly in relation to physical care. This was also observed:

“You’d always question them, always suggest something and if they don’t want to do it, even if you feel they would benefit from it, you might suggest it again or encourage it in a different way. But I
mean, if they know or if they walk away or if they become agitated you’d know.”
(S13)

“A HCA is dressing a lady and asks her ‘would you like a scarf on?’ The resident replies ‘no’.”
(Obs – Day 2: 10.30-12.30hrs)

“Further down the ward one HCA asks a lady if she would like to lie down or sit in an armchair and adds ‘would you like to use the bathroom or anything?’”
(Obs – Day 2: 13.30-15.30hrs)

It was observed that some staff did not offer residents choice or assess them for what they may wish to do:

“Nurse and HCA say to each other ‘will we put x back into bed?’ ‘Sure we might as well’ (Barthel 6). The resident wasn’t asked.”
(Obs – Day 1: 12.30-13.30hrs)

“The staff discuss what to do with one of the residents (Barthel 0). ‘Was she out yesterday?’ ‘We will get her out today.’ They do not consult the resident. The nurse then goes to her and says ‘Good morning x – how are you? Let’s get out of the bed, ok, and give you a wash, ok.’”
(Obs – Day 2: 10.30-12.30hrs).

“Many of the residents were got out of bed and dressed nicely and left sitting in chairs at their bedside. Very few were taken out of their ward. Most were put back to bed shortly after dinner (1pm). The residents were not consulted about this and they were the most dependent residents so it is difficult to ascertain whether staff put the residents back to bed based on their previous knowledge that this is what the resident wished or whether they just did it out of convenience and routine.”
(Obs – Day 1 Reflection)

Staff and resident participants expressed that the level of choice offered on a daily basis was largely dependent on who was on duty and how busy they were:

“I find some are really good at it and then others it’s a ritual – you always put the jumper on. Why don’t you ask them do they want to put the jumper on? …he might get hot and I did see one day and he was baking and he could have said ‘oh, I don’t need the jumper’. Some don’t and some are very good.”
(H04)
“Every single morning I ask them if they want to get up.”
(S01)

“It would be nice to offer them the choice but sometimes there is the practice of everybody has to get up or everybody has to stay in bed.”
(S11)

“I get choice with clothes. But making other decisions it can be difficult. Some are very obliging but once again it’s the time limit.”
(R07) (Barthel 8)

Choices available and unavailable seemed to centre around basic physical care:

“Well the main choice for them is whether they are going to get up out of bed or not, that’s the main thing they have, or whether they want a shower or a bath. Other than that they don’t have a choice.”
(S07)

“We went in and we gave him a bed bath and we sorted his bowels out and he was very appreciative.”
(S11) (Barthel 11)

The following quote really summarises how and why compromises around the choices available are made in residential care:

“But as I settled into the work and being involved in it physically on a full-time hours a week basis, I can see sometimes unless there is a compromise somewhere we can’t do everything. We can’t have people in bed at a certain time and have the energy to put more people in bed later and get all the work done if there isn’t compromise somewhere, and sometimes that compromise is to come with saying to the patient: ‘Really I need to put you back at 5 o’clock, I’d love to leave you up until half six but this is the situation, we have two other gentlemen that have to go back as they are heavy and the night staff need a certain amount of this work done by 8pm’. So that is where the compromise is and unfortunately it’s more for the patient giving up their choices than for us.”
(H03)

The sub-theme “The Person”, whilst describing the independence and dependence of the resident person and the staff person’s ability to encourage their capacity to be involved in their care and in making decisions, also describes the conflict between “doing for” residents and enabling “self-doing”, which is a person’s basic human right. Being “self-governing, self-ruling, self-determining”
is about the automatic right to live one’s life as one chooses based on the UN Rights of Older People. The analysis of the data revealed that the participants spoke about a person’s right to choice, right to have high expectations, right to refuse treatment or care, right to one’s own clothes, and right to a voice.

The majority of care seemed to be applied to residents rather than them being involved in accepting it or refusing it:

“I did her on my own, sometimes it takes two people but this morning she kind of cooperated, you know.”
(S04)

“I think that some of the residents, they have to get showered at least once a week.”
(S04)

“They’re all the same to me. There’s one now she put on the cream on my legs a couple of nights ago and she’ll come and she’ll say ‘put up your leg there now on the chair now, I’m the boss’ she’ll say, and she done it for three nights and she gave it a good going over alright. But she can’t understand me sitting outside there. Then the few days that I get her gone, I can be sitting outside in comfort. She can’t understand me sitting outside.”
(R04) (Barthel 12)

Some did make big decisions, but it was observed that one resident refused cataract surgery after initially agreeing to it:

“The female resident who was supposed to have the cataract surgery returns after refusing to have the surgery. Her family did not turn up at the hospital. It is unclear why she refused as it was a procedure she had requested and had stated that she was ‘looking forward to being able to read again’.”
(Obs – Day 2: 13.30-15.30hrs)

Staff participants discussed whether or not residents can choose how they spend their day, and this had a bit of a mixed response:

“Ahm, maybe one or two, the ones that are able to speak for themselves, they certainly are able to do things the way that they want it done but if they can’t they tend to fall into the routine, basically.”
(H02)
“I think within a certain degree it’s very good here like I think it’s …to stay up all night really and they can say ……and there is no problem really.”
(S07)

“The way I feel is that if somebody doesn’t want to get up until 12 o’clock in the day or 1 o’clock in the day, well why is that person not allowed to rest on in bed like they probably did at home and get up at that time?”
(S14)

Observations revealed that it is not possible for the residents to choose to go into the garden themselves as they need staff to unlock the doors to do so:

“The day room looks out onto the garden but has locked patio doors.”
(General Observation)

One resident participant described how she had no real choice about entering residential care:

“I used to get an awful lot of kidney infections and the doctor used to come out and he’d give me an injection and ’twas a bit far away for him to be coming….Then after a while he said ‘d’you know I’ll make it easier for you. I’ll put you into a home’ and he said ‘would you like that?’ ‘Well’, I said, ‘it depends on the home!’ ‘I’ll get you a nice place now’ he said. ‘X’, he said, ‘is nice and there are a lot of people there you’d know’, and that’s how I got in first.”
(R04) (Barthel 12)

Participants stated that older people are adults and should be entitled to have high expectations for residential care as they would for any other type of care:

“They are all adults.”
(S01)

“You know simple things. I do painting and music and I’m happy with that – what do you expect in a home.”
(R07) (Barthel 8)
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Staff participants felt that those who could speak up for themselves were able to spend their day as they wished:

“Well I wouldn’t call her headstrong but she knows what she wants and she is determined that she is going to get it.”
(S04)

“And as well as that I think that those who can voice their opinions are happy enough, they are sort of left.”
(S07)

However, one resident participant stated that they did not always feel comfortable verbalising their wishes:

“I feel very vulnerable.”
(R01) (Barthel 13)

Many of the participants talked about the resident person’s clothing as a personal right and stated that:

“All the patients would have their own clothes for a start,…I think that’s a very basic right.”
(S03)

This sub-theme explored “The Person” as it relates to autonomy. It is a complex theme as it describes the resident person’s rights and capacities, which are often in conflict with the staff person’s capacity to encourage those rights and capacities. The resident’s rights as a person, including the right to self-determine and to make decisions, were explored by the participants. However, the difficulties staff experienced with achieving this were also described and it was acknowledged that an older person’s capacity to self-determine may be altered by physical or mental health impairments. Resident and staff participants explored the possibility that staff persons also need to have the capacity to encourage and maintain an older person’s right to self-determine.
Sub-theme 1b: The Personality: “People who work here should want to work here”

This sub-theme that emerged from the data revealed that there are personality attributes which motivate one to work with older people. It was explained that staff members’ personality and interest in the job can ultimately affect an older person’s level of autonomy in residential care.

A primary motivation for working with older people in residential care was being interested in older people. Nursing and healthcare staff participants spoke about the need for staff working in residential care to have an interest in older people:

“I have a lot of interest in people. I’ve been here eight years and I still have an interest in them, you know, like an interest to make sure that they’re cared for.”
(H01)

“Yes, more nurses that would be interested in care of the elderly...not necessarily more nurses that there would be...nurses that would have an interest or respect for care of the elderly.”
(S03)

However, one staff participant was observed commenting that it was difficult for staff to maintain their interest in the specialty:

“….talks about the morale of the staff and states that it is very low at the moment and she doesn’t know why. Said staff seem disinterested in reading anything or updating their awareness and knowledge.”
(Obs – Day 1)

It was clear that the majority of staff believed that working with older people in residential care should be a career choice made by the professional:

“**People who work here should want to work here**……how it operates depends on staff wanting to be here.”
(S01)

“I think if they have an interest. I think a lot of people come down and they go ‘oh, this place’, because I did myself before I was down
here (laughs)….said ‘oh, Jesus’ when I heard when I was put down here I thought I was put down here for punishment, I didn’t think I’d like it at all, but I do like it, but I do find it heavy going though, but I do like it so there is that like, and then you’d have the ‘oh, my God you’re doing geriatric nursing’.”

(F07)

Family participants and staff participants expressed the need for staff working with older people to have the right skills for the job:

“There wasn’t one person that I didn’t think wasn’t up to the mark, they’re all excellent. The reason why I’m saying that is because they’re a cut above nursing care in other places because I saw that it was the patient they cared about and it was obvious they were good at the job, they’re human beings, they’re likeable, decent human beings. They knew what was needed. It’s nursing care at its best.”

(F01) (Barthel 8)

“Well I think that they maybe if they have the course done and people come down and spend some time with them then maybe.”

(S07)

As well as the right skills the participants recognised that the right personality was also required for people to work in residential care:

“The courtesy of the nurses.”

(F01) (Barthel 8)

“I would say the staff there are very, very hard working and very, very professional and I wouldn’t like to ever end up in the situation but if I had to they’re very nice people to be looking after you.”

(F04) (Barthel 2)

“I love to see younger staff nurses because they add a bit of life into the place and they have more go……. they’d need people that are very driven you know.”

(H01)

“Be lively and have a laugh.”

(S04)

There was consensus in this sub-theme that one’s personality is critical to motivating one to work with older people. A strong interest in older people was
deemed essential if one wishes to work in residential care. Bringing this interest into the workplace resulted in family and resident satisfaction.

**Sub-theme 1c: Person to Person: “They don’t think of me as a person”**

This sub-theme is about staff members’ abilities to communicate both verbally and non-verbally with residents. It is also about being approachable to residents, families and visitors. Overall it is about how good communication can build relationships through getting to know the resident. The role of the family was also discussed and how this contributes to a resident’s autonomy. Staff spoke about families’ involvement in care and families spoke about how they interact with staff. The importance of respect between one person and another was described and resident dignity was considered a priority.

Many staff felt that if they spent time talking and listening to residents that their colleagues would think they weren’t pulling their weight or “working”. Equally, while residents spoke about their desire for staff to have more time to talk to them instead of the quickly captured moments when they were attending to their care. Interestingly, a few staff members talked about the level of resident dependency and how it affects communication – they felt that their working day was less fun when there were fewer residents to interact with. It was observed that staff spoke to each other largely about “who will we do next” rather than communicating any formal care planning. Occasionally staff did talk to each other on a social level but this was often over a resident while attending to their care and thus missing out on valuable opportunity to interact with the resident. It was observed that staff really struggled to interact with very dependent and non-verbal residents.

Some nurse participants felt that talking to residents is important:

> “Most important is talking to the residents”  
> (S01)

and that talking is just as important as any other activity:
“I feel that communication is every bit as important an activity as giving them their medicines.”
(S13)

Another nurse participant felt that listening was important too:

“You see when we talk to the patient we have to listen to them, what they are saying, and we have to take time with them.”
(S05)

However, it was observed that some opportunities for communication and interaction were missed:

“A HCA attending to a man with Alzheimer’s behind the curtain who needs full care. No verbal interactions or communication can be heard.”
(Obs – Day 1: 09.30-11.30hrs)

And sometimes these opportunities were maximised:

“One HCA has showered a female resident. She is chatting to her and drying her hair with the hairdryer.”
(Obs – Day 2: 07.30-09.30hrs)

Participant accounts revealed that many issues impacted upon person-to-person communication. Staff participants emphasised the importance of communication but were concerned that other colleagues were more focused on doing physical work rather than on listening and talking to the residents:

“I also think the perception of some staff may be that if you’re sitting chatting to somebody or if you’re chatting to them when you’re doing a bed bath then you’re delaying, it’s a mindset and I think it’s trying to change that.”
(S11)

“She likes to talk but there really isn’t that much time for talking. Maybe there is but I feel people would be saying ‘you’re not doing anything in here but talking’.”
(S08)
Staff participants acknowledged the importance of talking to residents but struggled to find the time to do so:

“...I think that we need more staff to communicate with the patients because I know the lady in that corner she is always lonely in that corner and she called me this morning to talk to her and I do not have time to talk to her and she needs someone to sit with her and talk to her but we never have the time to do so.”
(S05)

Staff participants described the difficulties they had communicating with residents who cannot speak, but one nurse participant reflected on her experience that morning when a resident was looking at her nursing pins on her uniform and she recognised the power of non-verbal communication:

“...It’s like as if there was communication there without there being communication, and I said ‘you’ve had medals like this haven’t you?’ and you could see in him, and then just gone again. I suppose it’s me getting to understand and trying to communicate with him or understand how to communicate with him, maybe some of the others are better at it.”
(S11)

However, challenges still remained:

“...It can be very difficult especially take x, for example, it can be very difficult and very frustrating for her and for us. Her only way of communicating is by this awful screeching and you really don’t know whether she is happy or not that’s the only reason and it is very difficult. I think it is hit or miss a lot of the time.”
(S11)

Observations revealed that staff do try to communicate non-verbally:

“A nurse is observed communicating with a resident even though she cannot speak. The nurse waits for her to nod her head.”
(Obs – Day 2: 07.30-09.30hrs)

Sometimes though, staff just don’t know what to do or don’t understand the health state of the resident:

“A nurse attends to a resident who cannot speak. She asks her if she would like a wash and she nods in agreement. However, as she starts to wash her she starts to cry quietly. A HCA comes to join her
and the nurse says ‘I think she has pain, will we wait?’ But the HCA replies ‘oh, she always cries’ and they carry on washing and dressing her.”
(Obs – Day 2: 07.30-09.30hrs)

Staff participants acknowledged that it is only when they get to “know” the residents through communication that they can build relationships with them:

“Well I mean there has to be effective communication to build up a mutual relationship with them and to get to know them better.”
(S11)

Having fun with the resident also helps to build relationships:

“One male resident is calling the HCA ‘the lady with the smiles’. They are having a laugh with him.”
(Obs – Day 2: 10.30-12.30hrs)

It was observed that residents often talk to non-direct care team members:

“The laundry staff member is often able to stop and chat with the residents as she puts their clothes in their wardrobes and the residents appear to have a good relationship with her. Perhaps they see her as different to the other staff as she is not visibly rushing as much as the others and they seem to trust her with their clothes.”
(Obs – Reflection on Day 1 – morning time)

Staff participants acknowledged that they feel they don’t always have enough time to talk to the residents but it was also observed that there are many residents who don’t interact with each other either:

“There are seven residents participating in art activity with an art tutor. They appear to be enjoying it but are not communicating with each other. They are working on their individual paintings. They appear to get on well with the tutor.”
(Obs – Day 1: 15.30-16.30hrs)

“Two of the ladies occasionally communicate with each other but one is very deaf and one is very confused so the conversation tends to not go very far.”
(Obs – Day 1: 18.30-19.30hrs)
The lack of care planning as a form of team communication was also evident and it was observed that:

“Some residents have notices around their beds such as ‘family take laundry home’.”
(Obs – Day 2)

Examples of communication were also revealed when residents delegate care needs to another person. This is when residents delegate the action of their choice, so while they may know what they want to do they may be physically unable to do it and so they delegate to a staff person. Some staff assume what a physically dependent resident wants rather than waiting for the resident to delegate their care needs:

“I mean automatically it’s just done for them.”
(H02)

“Some of them if they want water they will ask for it.”
(S10)

Some residents are observed delegating, e.g. “did you plug that in?” a resident asks a HCA if they have plugged in their electric razor.

The majority of staff participants spoke about the role of the family for person-to-person interaction and communication. The role of family in helping residents to remain autonomous was acknowledged. Families were observed to play a social role, a care planning role and a practical role, e.g. the provision of clothing for residents.

Overall, family participants felt that the staff on the research unit were approachable:

“You can ask them anything”
(F03) (Barthel 8)

and that they share information freely:

“Now I don’t make any demands on them or anything – but they’re very forthcoming if I do want anything or want to know anything.”
(F03) (Barthel 8)
Chapter 5 Findings

The observations revealed that staff did interact in a friendly, approachable manner:

“Staff enter the room/ward and say ‘good morning’ in a warm, friendly tone.”
(Obs – Day 2: 07.30-09.30hrs)

When family visit they often use the time to do little jobs for their relative or to help out:

“Every day I come up to shave him and do my own little things. I don’t expect a nurse that has a lot of work to do to come in and shave him and I come up and put cream on his face and I look after those things and that’s a very small input in comparison to other stuff the nurses do because there are times when I come up and maybe they are changing his diapers or things like that and they’re things that I wouldn’t be capable of doing and sure enough people would be capable of doing it.”
(F01) (Barthel 8)

It was observed:

“There is one male resident being helped with his dinner by his wife.”
(Obs – Day 1: 12.30-13.30hrs)

Many family participants felt that the proximity of their relative’s care facility was a big factor in how often they could visit:

“The fact that my husband is now much nearer, and I don’t have to travel the distance to visit him.”
(F03) (Barthel 8)

It is also possible that regular visiting keeps the resident in touch with their home life and a total of 12 visitors were observed on Day 2 of the observations:

“My father at one stage he said, ‘you get to a certain age now I think they just send you off on a trip to Dublin and I think they shoot you or something!’ So I just wondered did he feel he was just left. That could have been when he went in there first he probably thought his family just left him.”
(F04) (Barthel 2)
While some residents did have family, many did not. Those who did often felt let down by their families or did not receive regular visits. This affected their person-to-person interactions:

“A lot of the families you don’t see them from one year to the next….. A lot of families are great at giving out but that’s guilt a lot of the time I think. They should be in here you know participating with us.”
(H01)

“Families have a history of leaving them in and letting them be forgotten about.”
(S11)

“She just feels like they don’t bother, and I feel they don’t really. She got all dressed up…”
(S08, talking about family who did not visit a resident on her birthday)

Nurse participants described how some family members take their relatives out of the research unit and also how others need encouragement and support to do the same:

“Some families play quite a good role really because they come and visit and they take them out on trips or bring them for a day or whatever to get their hair done or bring them out to see the chiropodist.”
(S14)

“Encouraging their relatives, I’m sure there’s great fear of taking them home because they can’t manage but maybe they should be offered to go out for an hour or two and spend time at home and come back in.”
(S11)

“I think we should, well I suppose we’re reluctant to take him out because he’s so immobile but even coming into the hospital last week he was so much, you know, very interested and he was really more alert and I thought ‘oh!’ and then I thought ‘oh, I might just get a taxi to take him out to the prom for an hour’ just to have a change of environment.”
(F04) (Barthel 2)
However, more participants described families not taking residents out:

“I think her family, maybe her children have a lot to do with it. I think she feels a burden on them if she asks them for a day out.....you know she’d love a day out.”
(S02)

“She was quite upset this morning because her family didn’t take her out for the confirmation. She could go out for an hour or two but she never gets out really. They meet her here, all the family, but she’s quite upset about that.”
(S08)

Staff participants described their reliance on family members to help them plan the resident’s care according to their wishes and their past lives:

“That’s one of the reasons why it would be hard to do that history with the fact that they don’t come to visit, the relatives.”
(H01)

“Oh, definitely, and getting to know their background. Rarely I find would I have time to sit and look at the chart and read their history, just when you get on, and it’s nobody’s fault you’re just going all the time but I happened to meet his wife and she was showing me photographs and it’s then that I got that little bit of history.”
(S11)

“Getting to know their families and communicating with their families and listening to the families and the resident as regards what their pattern was at home and why they shouldn’t do in here what they did at home in as far as is reasonably practical.”
(S14)

Staff spoke about their person-to-person communication and how it is key to getting to know the resident. Staff talked about how they get to know who the residents are and about how this is difficult to do if they can’t tell you themselves or have no relatives or have little family involvement. However, a lack of structured and negotiated care planning was evident in the observations. The continuity of staff was revealed as being essential in this process of getting to know residents and in person-to-person interaction and communication.

Staff participants described the difficulty of getting to know the resident when they know very little about their past:
“You know nothing about their past which makes it hard.”
(H01)

“You don’t know a lot about their past which makes it hard. Even though they don’t speak you feel like you would like to be able to communicate to them and talk to them about their past and about themselves and about things they like but you don’t know anything, you know.”
(H01)

However, families that do visit spoke about being aware of staff asking their relative about their life:

“But it often came about ‘where did you work?’, ‘what did you do?’”
(F04) (Barthel 2)

Staff participants acknowledged that they don’t know enough about the residents:

“We don’t know their interests and things and we need to take time with them.”
(S05)

They also recognised that this was important:

“……and getting to know their background.”
(S11)

However, residents who were capable of talking felt that they were not asked about their lives and that their past lives were not recognised:

“When I came in here they shut off my life with no respect.”
(R01) (Barthel 13)

“I think there should be more interest in the patient.”
(R06) (Barthel 4)

Some staff participants described how they get to know residents when they can’t talk or are confused:

“Take X, you’d know from her facial expression, non-verbal. You’d know her from changing her now and everything else. Or take Y, one day I gave him a bowl of custard and he said that wasn’t custard and started bawling crying….maybe that was something that triggered something from years ago, the custard, oh
that must have been what they got and the roast – the Sunday roast the same thing, it brings it back to them. He was bawling crying and he refused to have the custard. It was kind of like ‘No, I’m here, I don’t want that’.”

(H04)

One resident participant felt that staff did not interact or communicate with him as a person:

“They don’t think of me as person, just a patient”

(R07) (Barthel 8)

One nurse participant suggested that if there were photos around then it might help to get to know the residents better:

“And I’d like as well to see more pictures of them when they were younger around.”

(S07)

Some staff participants described how they get to know the residents’ likes and dislikes:

“And you have to know what they like and what they don’t like and you have to wait for them and observe them, how they behave and what they expect from us.”

(S09)

“They kind of feeling I get from them.”

(S10)

While family confirmed that the staff do try to find out what a resident likes:

“And it was the food and they used to make a great effort in finding out what his likes and dislikes were.”

(F04) (Barthel 2)

Some staff participants described the importance of understanding how age affects the resident and how this affects the approach in the person-to-person communication and interaction:

“You have to get to know the patient and because they’re elderly they do want things done their way and that took time and I had to
say to myself a couple of times ‘be patient with yourself, it’s going to take time here just as much as it would in another ward maybe for other reasons’.”

(H03)

Staff participants described the benefits of working in one place for a long time:

“It’s lovely because you can build up a relationship with them and I didn’t have that in other places”

(H03)

“I went into him and he didn’t say anything at all and then he was like ‘oh I know your voice’ and I said ‘oh ya I was on holiday’, ‘oh that’s right, you’ve got a nice colour’ and then he got washed and changed….. he recognised my voice even though I was two weeks gone.”

(H04) (Barthel 8)

Resident participants described how they can make friends with regular staff:

“I’m an open type and that is how they get to know me. I like to have the craic and I have nicknames for most of them.”

(R07) (Barthel 8)

The analysis of the data also revealed that person-to-person care involves respecting the resident and maintaining their dignity. This includes maintaining privacy and managing their wardrobe and clothing. All staff talked about the frustrations of managing the residents’ wardrobes and clothing and the need for non-communal clothing. Some staff felt that ongoing education would help staff to remember the privacy and dignity needs of the residents, which is an essential part of their autonomy.

One family participant expressed dismay at their relative not wearing the right clothes:

“Well now, I put his clothes in outfits….and then sometimes I come in and he has non-matching clothes on and I think ‘oh’.”

(F04) (Barthel 2)
Staff participants also expressed their frustrations:

“They’re all the same track suits and they’re all the same. I mean I’d say half the women in here never wore trousers in their life and they’re all put into trousers… The whole ‘lets wear it’.”
(H02)

One resident participant felt like he had lost control of the clothing issue:

“I used to be very fussy about what I wore and always had everything matching and a suit going to work but since I got sick I just don’t care. I never would have worn those tracksuits though.”
(R07) (Barthel 8)

However, on one of the days of observation it was observed that the female residents were:

“Well dressed and have nice clothes and scarves on.”
(Obs – Day 1: 09.30-10.30hrs)

Staff participants felt strongly about the practice of providing communal clothing:

“I think the other thing is in terms of, you know, they don’t have their own wardrobes and like they do share clothes and I think that’s wrong.”
(S07)

Similarly, staff participants felt that the residents’ dignity could be maintained by paying attention to the detail of appearances:

“I mean putting a few rollers in their hair or…”
(H02)

It was observed that staff participants did attempt to help the residents with their appearance and consequently their dignity by washing and blow-drying their hair.

The observations revealed that, where possible, staff did try to maintain privacy:

“Dignity appeared to be maintained throughout as curtains were drawn around beds when attending to care and all bibs except for one had been removed after breakfast.”
(Obs – Day 1: 09.30-10.30hrs Reflection)
Staff participants described the need to respect the residents as individuals:

“That they are treated as individuals rather than a person in an institution and while they’re elderly that doesn’t mean that we forget about or that there’s no say and they’re not to be treated with respect.”

(S11)

The observations revealed that the laundry trolley had shower gels and hairbrushes that were used for all residents – they were not individualised.

Another resident participant described how staff don’t always show respect for her things:

“On the whole the staff are nice but there’s some of them they’re careless or something. I don’t know what it is, you know….”

(R01) (Barthel 13)

One resident participant spoke about an undignified experience:

“Last night I asked to use the bottle and the nurse said ‘I looked everywhere but can’t find one so you will just have to pass it in the pad’ and that really annoyed me.”

(R07) (Barthel 8)

Some staff participants expressed that residents would be treated with more dignity if staff were aware of who they were prior to their admission to residential care:

“They weren’t always like this”

(H01)

Some staff participants felt that education may help staff to recognise the dignity and privacy needs of residents:

“Maybe there’s something like in other situations, in other workplaces maybe sometimes people need ongoing training or reminders about things and maybe we would need to be reminded every now and again, this is someone who needs to be respected.”

(H03)
This sub-theme related to person-to-person interaction. It revealed that it is about communication between staff and residents, between residents and residents, between staff and staff, and between staff and families. It was suggested that all levels of communication could be enhanced. Overall it suggested that good communication can build relationships, and that knowing the resident is about really knowing them as a person and about who they are and about understanding the ageing process. It is about having an awareness of the resident’s life prior to entering residential care, gathering information about their likes and dislikes and together planning their care through effective person-to-person interaction, which respects the resident, maintains their dignity and includes family members.

Summary of Theme 1

Theme 1 was labelled “The Personal”. The term personal can mean many different things and can be defined as pertaining to the person or personality and the personal person-to-person interaction and communication – hence the sub-themes. The initial coding of the interview and observation data generated chunks of text that could be categorised to each sub-theme. From the data it emerged that autonomy for older people in residential care is affected by people – both the residents themselves and the staff who care for them. It was also found that individual personalities can shape one’s experience of autonomy. Person-to-person interaction needs to be respectful, dignified and capable of multiple approaches to communication in order to facilitate resident autonomy.

Theme 2: Being Personal

This theme further describes autonomy. It has two sub-themes: Being Impersonal and Being Personalised. These will now be described individually and quotes from the interview and observation transcripts will be included to aid the description.

Theme 2a: Being Impersonal: “If they don’t fit into our pattern”

This sub-theme reveals that impersonal factors that can impact upon a resident’s autonomy include the daily ward routine not being negotiated with residents and lack of staff flexibility. Both the interviews and the observations revealed that a
lack of flexibility in the daily routine can impact negatively on resident autonomy. Some staff explained that resident dependency can impact upon the level of routine and flexibility. Furthermore, individual staff members may also determine the routine of the residents’ day and affect the ward atmosphere. The observations revealed a friendly atmosphere but also routinised practice.

Staff participants recognised that there was a strong sense of routine – some questioned it but didn’t attempt to change it while others welcomed it:

“The likes of me are like, I’m here on a long day, I’m here until 8 O’clock at night and it doesn’t bother me if people want to stay up until 7 or 8 O’clock, they can stay up to what time they want to stay up to you know……No I think it’s just set the routine that’s been going on for so long this way.”

(H02)

“I don’t know but it’s just that everyone has to be put back at a certain time and to be got up at a certain time. It’s just that…”

(H01)

“Yeah, if they don’t fit into our pattern or our timetable…”

(S03)

“Routines are good because…..I can follow it but if there is no routine everybody is different day …..stuff so it’s when the new people come I have a look and no need to think ‘what shall I do the next’, I don’t need to ask….know, every time so it’s…”

(S05)

There was a sense that there is no real care planning; rather, residents conform to the impersonal system:

“But they don’t change when they come in here, they adapt.”

(S08)

“Well I don’t give it thought when I know it has to fall in line. I just go along with it.”

(R06) (Barthel 4)

Resident dependency was considered to be an important element in the level of flexibility possible in the daily routine:

“I would say that in the last few months with the level of patients it has changed a lot, it wasn’t as routine. There was more time for the
bits, the extra little bits, like even to do their hair and take your time.”
(S02)

“X is not totally dependent but quite dependent on our system.”
(S11) (Barthel 2)

The observations revealed that many residents are back in bed by evening report time – that is the routine:

“There are now 21 residents in bed. Those that are still up are relatively independent and need minimal assistance. One lady who is still up is left up at her family’s request. The night staff arrive for report at 7.45pm and handover is given in the staff room.”
(Obs – Day 2: 19.30-20.30hrs)

Staff participants expressed that the routine or the flexibility of the day is determined by who they are working with:

“I’ve seen where routines fall out and people get excited then. I wouldn’t be too excited if a routine fell out, there would be staff who would like – if someone gets sick it’s mayhem.”
(H01)

“Very routine, everything done at certain times of the day and even now some of the staff they just can’t go away from that…. I say ‘oh they’re alright leave them up for a while’ or I’ll say ‘they don’t want to go back to bed’ and then next thing you turn around five minutes later and they’re back in bed, someone’s, you know and they’ve heard what you said but they just go straight on and do it anyway.”
(H02)

“And then you could work with someone who is very – really wants to give the patient every bit of space and you know because you’re going like this you don’t want to talk and it’s good for you because it makes you flexible and that.”
(H04)

“You know it really depends on who you are on with…”
(S02)
The majority of staff participants felt that they were rushing, hurrying and physically challenged in the morning time:

“Like a regime it has to work on routine and kind of like a fast routine.”
(H01)

“All going like the hammers.”
(H03)

And some staff participants couldn’t understand why it had to be so:

“When you’re here all day you have all day to, it’s not like you have to rush off anywhere you know.”
(H02)

“Well this is it there is a huge rush here and that is one of the most frustrating things.”
(S02)

Resident and family participants also observed this state of rushing and hurrying:

“They are always busy.”
(R06) (Barthel 4)

“Like a shop or a factory floor.”
(F02)

The staff participants felt that the lack of time that they have is one impersonal factor which prevents them from being flexible:

“We need more time for the highly dependent patients, especially most of them in the ward isn’t it most of them so we need time and we can’t be rushed with them because we are not working in a factory we are working with people and they have sensation and everything.”
(S05)

And resident participants felt that staff haven’t a lot of extra time for them:

“Even the staff don’t have a lot of time to do things. There should be more time given to the patients.”
(R06) (Barthel 4)

“There is no sense to time. They say five minutes and it could be one hour….some are very obliging but once again it’s the time limit.”
(R07) (Barthel 8)
The interview and observation data did not reveal how staff plan care or include residents or each other in the planning of the day:

“Well I suppose it’s all very structured here, you don’t have to get or do very much. You are told what section you’re going into and you’ll be working with whoever else is in it and it’s all structure then. At half eight we’re going to feed the patients so cleaning and washing and all that stops. Then that’s usually all done by 11.30 and then we all have our own little jobs. It’s all laid out for you, it’s not like we have to plan it as such. That’s really the way it is here.”
(H03)

“Staff start their morning work and there is no verbal planning of the day. A routine or a pattern is evident.”
(Obs – Day 2: 07.30-09.30hrs)

“At 3pm there were 13 residents back in bed and only three of these were observed making that decision themselves.”
(Obs – Day 2)

However, despite the impersonal nature of routinised care the interview and observation data revealed a friendly ward atmosphere. Two family participants expressed that they found the staff friendly and welcoming:

“I think the atmosphere here is friendly.”
(F01)

Some staff participants held positive opinions of the unit:

“But there is, there’s a lovely atmosphere here and you have your ups and downs but I think there are a lot of patients and a lot of give and take and I really do I think it’s a very positive, warm, caring atmosphere.”
(H03)

Other staff participants held negative opinions:

“It is just so hospitalised you know, and it shouldn’t be.”
(H03)

“A few people that knew I was coming here said ‘what are you moving out there for?’.”
(S11)
Day one and day two of observation felt very different in atmosphere and the following reflection excerpts describe the observed atmosphere. It was quite different across both days and across different observation periods:

“The day room is warm and cosy. So all of the activity is centred around the day room now and the rest of the unit is very quiet. The mood changes as you walk down the corridor to one of quietness.”
(Obs – Day 1)

“Breakfasts arrive out at 08.30hrs and there is a lot of hustle and bustle……. Loud hoover being used and phone rings intermittently with a loud shrill ring tone…. First staff breakfast break starts at 9am. Some staff from each section go. Second break at 9.30am. Staff usually go to the staff room on the unit for their break. The hustle and bustle is less obvious now but the staff that are still on the wards are still involved in personal care…. The unit is quiet at this time and feels quite sedentary. The curtains are closed in most of the wards and just one or two residents are pottering about…. the day has seen many different levels of activity from busyness this morning to music fun in the afternoon to total wind down this evening.”
(Obs – Day 2)

It was suggested that the staff on duty contributed to the ward atmosphere.

“It’s an awful thing to say but some people come on and you can see by their faces you’re going to have a tough day with them.”
(S02)

Despite this, family and staff participants felt that the general approach to the care provision was in a spirit of teamwork:

“They all have a leg in and a hand in they are all participating somewhere or other.”
(F01) (Barthel 8)

“It’s always been quite good at team work.”
(S14)

“Well, there’s a nice bunch of staff here and that probably adds to the good side of it.”
(H03)
Several negative impersonal factors were identified. Participants spoke about the nature of the work and how that affects their motivation:

“Day in and day out it’s very tiring. There’s no change or, you just know it’s going to be the same every single day, you know.”
(H02)

Staff participants acknowledged that the job is physically demanding:

“I think the type of work is hard work, it’s physical work and you can’t get away from that and if you’re committed to doing it, you’re doing it.”
(H03)

“I do find it heavy going though, but I do like it.”
(S07)

The HCA participants expressed a feeling of not being appreciated:

“. . .hard work. Sometimes you can have a bit of craic but not always because the work is so hard and you do a lot of it and you feel that there is no thanks for it, you know. You don’t feel appreciated a lot of the time.”
(H01)

“I might some mornings even suggest something and I’ve nearly been looked at as if to say ‘who do you think you are, having an opinion?’ you know, and then complete ignore what I said and just carried on with what they were doing so I thought. Somebody said to me ‘we’re only paid from the neck down’.”
(H02)

There were some staff participants, however, who felt that not all members of the team were contributing in the same way:

“I wish everybody was of the same work mode, you know, just to say that we are looking after patients at the end of the day and if everybody came in and just worked the same with no bitching and just did the work.”
(S02)

And one staff participant felt left out of the team:

“Sometimes you don’t feel part of the team.”
(S06)
Many nurse participants expressed dissatisfaction with the management’s contribution:

“I have a big problem with two managers sitting in the office.”  
(S12)

“I possibly would like to see ward managers getting more involved with the ward.”  
(S13)

The observations revealed that while managers do have a distinct administrative role they were rostered as part of the daily allocation of staff, so this altered the staff/resident ratio:

“There are six nurses rostered and all are clinically involved. However, yesterday there were also six rostered but two of these were clinical nurse managers. The CNM1 assisted for a short period with direct resident care but the CNM2 was involved in administrative work. Therefore there is a very different workforce in operation today and the staff/resident ratio for direct resident care is different.”  
(Obs – Day 2)

One staff participant felt that the residents’ ability to interact and their level of dependency was something which made working on the unit more impersonal:

“It’s a lot of fun then when you get to know them and you can have a rapport with them and you’d have a good laugh and you’d have good craic with some of them but I find that lately because they’re all getting older that’s going a little bit as well. There’s no-one really to have the craic with.”  
(S07)

This sub-theme explored the impersonal factors that may impact upon a resident’s autonomy. These include the management structures, the approach to the organisation of the day, the individual staff members’ approach to care, and the residents themselves. The ward atmosphere may be personal or impersonal as a result of these factors. It was revealed that balancing routine with flexibility is a constant struggle and this was discussed by all staff participants. Staff members’ unwillingness to change routine and “going with the flow” begs the question – “whose flow?” Staff members’ obsession with physical care drives the routine,
contributes to the rushing and hurrying, and dictates the time available to do or to not do other things. It was also revealed that gerontological care is often perceived negatively and that this can affect the overall atmosphere.

Sub-theme 2b: Being Personalised: “There is more to their lives than physical care”
This sub-theme suggested that staff should acknowledge the importance of recreational activities and see them as part of the residents’ day. It was suggested that participation in meaningful activity would enhance residents’ autonomy.

There was some debate about who should provide or facilitate the activity – is it the staff member’s role or should an activities person be employed? And what do residents actually want to do? It was also debated whether or not activities should be scheduled and whether or not residents would like to leave the unit for activities. It was recognised that at times there is nothing happening for residents.

Four out of six participants who talked about this issue expressed that the residential unit should have a dedicated activities person:

“I think the best way would be an activities person – separate because I think if that role was built into a nurse’s day or a care assistant’s day that sometimes it could be forgotten about if the place was busy and then the activities would be missed.”
(S13)

One nurse participant felt that:

“It doesn’t need to be from the outside. The staff can do it.....you know.”
(S05)

Another nurse participant wasn’t sure what difference it would make:

“But then again you’d question how many of them would participate.”
(S07)

Some staff participants felt that if the residents could be involved in “normal” daily living and activity that this would be just as effective as scheduled activities:
“I think...go into the kitchen and make a cup of tea for themselves....brush the floor, things they would have done at home.”
(S04)

The observations revealed that some staff automatically seize the moment to brighten up the day:

“A nurse comes in and chats to the residents individually. She starts a lady knitting. The nurse states that ‘it would be nice to have a table cloth for the dinner.’ She goes off and gets a sheet and some nice napkins and it makes the residents smile.”
(Obs – Day 2: 10.30-12.30hrs)

Interestingly, staff participants use the phrase “get out” when they talk about the residents having opportunities to leave the unit. All staff participants spoke about their desire to take residents on outings but expressed remorse at not being able to do this due to staffing levels and lack of resources:

“I’d love to see a bus for the unit out there.”
(H04)

“Bring them on holidays [said with enthusiasm]. Out of here – anywhere. X has not seen the outside of here in 22 years! They all talk about going home. One trip we did before, they were talking about it for years.”
(S01)

“The day room looks out onto the garden but has locked patio doors. There is a ramp down into the garden and raised flower beds. It is not very well maintained. There are some old machinery on display like ploughing machines. There are potatoes growing and wild rabbits can be seen.”
(General Observation)

The observations revealed that about four residents regularly leave the unit:

“She is gone to mass which is at 1pm in the hospital chapel in the grounds of the hospital.”

“One lady from that ward is gone out to day care in another unit.”
“A male resident is going out with the Brothers of Charity and the laundry staff member makes sure he has a warm coat on him before he goes. ‘Fine coat for the weather and the ducks’.”
(General Observation)

Staff participants described the lack of activity for the residents and the observations revealed an environment low in activity and stimulation:

“I wouldn’t like to be in here you know.....looking at the four walls and up at the ceiling.”
(H01)

“I think that there should be more activities – more activities that they want. I know we have a certain amount of activities but I think there isn’t enough activities because sometimes the residents are just sitting there in the day room.”
(S14)

“The residents in the wards are not communicating with each other. The highly dependent residents are back in bed and are not being provided with an alternative past-time or being stimulated in any way. There is a TV on but it doesn’t look like anyone is actually watching it.”
(Obs – Day 2)

“It is 09.30hrs. The TV is on in the day room and one man is watching it, there is another man reading a magazine and he is sitting in a wheelchair at the table. There is also a lady sitting in a big chair faced looking out the window.”
(Obs – Day 2)

One resident confirmed this lack of stimulation:

“It’s more or less the same day after day.”
(R06) (Barthel 4)

However, a music session was observed on day two of the observations:

“Two musicians (one male and one female) have arrived to the day room and they visit every Thursday. The nurses are gathering up as many residents as possible to participate. Residents have shakers, tambourines and other various musical instruments. There is a lively atmosphere. One lady is singing and dancing and appears to be enjoying every minute of it. This same lady stayed at her bedside at the bottom of the ward all day yesterday. The residents seem to interact well with the musicians. They play around with the instruments first and then they start singing.”
(Obs – Day 2: 13.30-15.30hrs)
Meal times have the potential to be a sociable and enjoyable activity. One nurse participant recognised this. The observations revealed that many meals are eaten at residents’ bedsides. It is another task for staff to do the “feeds” as many of the residents need assistance with their meals:

“Because in years gone by we used to set up tables down there and bring in, say, a husband or a wife and light candles and have it real romantic on Sundays or for birthdays or different occasions and that was down the bottom and it was lovely. You see we lost all this space.”
(S14)

“Most residents are having their dinner at their bedside or in bed.”
(Obs – Day 1)

However, one resident participant stated that they like eating on their own:

“I’d sooner have my dinner or tea on my own because of the sickness of some of the patients.”
(R06) (Barthel 4)

Very often staff ideas about what residents might want or wish for are very different from residents’ ideas:

“So he was never a very social…. He’s by the window, he loves nature, looking at the trees and looking at the rabbits and they grow potatoes outside his window…. They were doing a gardening thing and he was a farmer so he grew some peas and everything and watched them grow.”
(F04) (Barthel 2)

“You know they used to love a game of cards you know it’s just the little thingsthat.”
(H02)

“The day room is not my scene – if it’s a nice day I go out in the sun.”
(R01) (Barthel 13)

“Well, if I was at home, I would be doing things around the house. I was a tradesman, that’s it….. Well I would say the more items that the patients can do. If it was laid out in a rota the patients could do something.”
(R06) (Barthel 4)

“He loves the golden moments.”
(F04)
Chapter 5 Findings

“You know simple things. I do painting and music and I’m happy with that – what do you expect in a home.”
(R07) (Barthel 8)

“A lot of them are institutionalised, very institutionalised in here.”
(S07)

Staff participants recognised that social engagement and activities were important for the residents and should be part of the routine just as physical care is:

“Over Christmas there was a lot going on. The patients seemed to enjoy it. When the mass is on they enjoy it.”
(S08)

“I think the most important thing for everyone to understand is that it is a home away from home. There is more to their lives than physical care.”
(S11)

Yet the observations revealed that two residents who were visibly enjoying a music activity were taken out of the day room and back to bed because staff were adhering to routine:

“One nurse and one HCA come in and take two residents from the session (Barthels 0). They appeared to be enjoying the music but the staff appear to be bringing them back to bed without any consultation – they are wheeled in their armchairs.”
(Obs – Day 2: 13.30-15.30hrs)

One nurse participant recognised the need to plan care and how this is dependent on knowing the resident:

“To ‘plan the care’ that they are going to give with the resident and depending on the needs of the resident and what care they need they have to carry out that care.”
(S14)

The same nurse participant stated that what often happens is that the resident is not included in the care planning process:

“As regards planning the care, ‘we’ll’ get this resident out now, ‘we’ want to get her out now and ‘we’ will get her out tomorrow.”
(S14)
It was observed that there was no formalised care planning process:

“No nurse has been observed writing care plans with residents or writing care plans at residents’ bedsides.”
(Obs – reflection from both days)

Sometimes no further care planning for activities is done after admission:

“Well on admission they are asked what activities they like, television or reading or what time they like to get up or what time they like to go to bed.”
(S03)

This sub-theme revealed that personalising an older person’s care around their hobbies and interests is something that staff recognise as important but find difficult to implement. There was a sense of frustration from residents that they were unable to do the things that mattered most to them – the little things.

Summary of Theme 2
Theme 2 was labelled “Being Personal”. From the data it emerged that personalised care involves negotiating daily care plans and providing meaningful activity. It was suggested that autonomy is more likely to occur if impersonal factors are made positive such as an approach to care that is not routinised, and management structures that foster a flexible atmosphere, encourage openness and develop work structures that recognise the physical impact of caring for ageing older people.

The next section will describe the findings from the staff attitude survey.

5.13 Findings from the Staff Attitude Survey
A total of 22 surveys were returned yielding a response rate of 65%. The range of scores for the KAOP is 34 to 204, with higher scores representing a more positive attitude. The scores from the attitude survey distributed to the staff on the research unit ranged from 95 to 164. The mean score for nurses was 137 (standard deviation (SD) 15.87) and the mean score for HCAs was 122 (SD 26.99). T-tests were performed to establish whether or not those with specific education had more positive attitudes. There was no statistically significant
difference \( t(9)=1.944, p=0.89 \) in scores between HCAs with a FETAC qualification (mean 121.17, SD 21.52) and HCAs without this qualification (mean 123.80, SD 35.18). The nurse’s scores were also tested to establish if there was a difference in scores between those who had completed the diploma in gerontology (mean 144.50, SD 17.71) and those who had not (mean 133.88, SD 14.72). Again there was no statistically significant difference \( t(10)=0.005, p=0.35 \). There was also no statistically significant difference between the scores of those who worked full-time hours and those who worked reduced hours. Nurses who worked full-time hours had a mean score of 139 (SD 20.04) and those who worked reduced hours had a mean score of 136 (SD 13.73). HCAs who worked full time had a mean score of 120 (SD 27.43) and those who worked reduced hours had a mean score of 144.

5.14 Summary of Chapter

The findings from the data collection for this case study, which aimed to explore resident autonomy, have been reported in this chapter. Firstly, the research unit was described. Secondly, the findings from the documentary analysis were reported. Thirdly, the findings from the interviews and observations were reported, and finally the findings from the staff attitude survey were reported. Table 5.9 displays an example of how some of the findings are represented across the data sets and how resident autonomy was explored from interview, observation and documentary sources. Column one identifies the elements from the concept analysis of autonomy for older people in residential care, which were used to design the data collection tools. Column two presents one example of how these were reported from the interviews. Column three presents one example of how these were or were not observed, and column four identifies the extent to which the elements were evident in the documentary analysis. The next chapter describes how the case study site responded to these findings.
## Chapter 5 Findings

<table>
<thead>
<tr>
<th>Evidence from Concept Analysis</th>
<th>Example of Evidence from Interviews</th>
<th>Example of Evidence from Observations</th>
<th>Example of Evidence from Documentary Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Governing, Self-ruling, Self-determination.</strong></td>
<td>Sub-theme 1a: The Person: “Am maybe one or two that are able to speak for themselves”</td>
<td>Sub-theme 1a: The Person: The majority of care seemed to be applied to the residents rather than them being involved in determining it.</td>
<td>40% evident</td>
</tr>
<tr>
<td><strong>Care plans negotiated.</strong> <strong>Family involvement.</strong></td>
<td>Sub-theme 2b: Being Personalised: “As regards planning the care, ‘we’ll’ get this resident out now, ‘we’ want to get her out now and ‘we’ will get her out tomorrow.”</td>
<td>Sub-theme 2b: Being Personalised: No nurse has been observed writing care plans with residents or writing care plans at residents’ bedsides.</td>
<td>13% evident</td>
</tr>
<tr>
<td><strong>Residents delegate care needs.</strong></td>
<td>Sub-theme 1a: The Person: “Well the way it is with me is that I have to be helped out of bed and I have to be helped into bed”.</td>
<td>Sub-theme 1a: The Person: The majority of care seemed to be applied to the residents.</td>
<td>24% evident</td>
</tr>
<tr>
<td><strong>Values and beliefs of staff are non-paternalistic. Ethos of maintaining dignity.</strong></td>
<td>Sub-theme 1b: The Personality: “More nurses to be interested the care of the elderly”. Sub-theme 1c: Person to Person: “Maybe sometimes people need on-going training and reminders…this is someone who needs to e respected”</td>
<td>Sub-theme 1c: Person to Person: Dignity appeared to be maintained throughout. Curtains drawn when attending to personal care. Residents dressed appropriately.</td>
<td>22% evident</td>
</tr>
<tr>
<td><strong>An atmosphere of openness, motivation and flexibility</strong></td>
<td>Sub-theme 2a: Being Impersonal: “Very routine, everything done at certain times of the day and even now some of the staff they just can’t go away from that….”</td>
<td>Sub-theme 2a: Being Impersonal: “Staff start their morning work and there is no verbal planning of the day. A routine or a pattern is evident.”</td>
<td>22% evident</td>
</tr>
<tr>
<td><strong>Open and respectful communication and sharing of information</strong></td>
<td>Sub-theme 1c: Person to Person: “She likes to talk but there really isn’t much time for talking”.</td>
<td>Sub-theme 1c: Person to Person: “Nurse asks a resident “does it hurt when you walk” to which she replies “no” then the nurse and HCA carry on talking to each other”.</td>
<td>9% evident</td>
</tr>
<tr>
<td><strong>Recognition of past and present life which may shape their wishes. Life histories.</strong></td>
<td>Sub theme 1c: Person to Person: “I think there should be more interest in the patient”</td>
<td>Sub theme 1c: Person to Person: A HCA is attending to a resident with Alzheimer’s. No verbal interactions can be heard.</td>
<td>64% evident</td>
</tr>
</tbody>
</table>

Table 5.9: An illustration of the integrated findings across main data sets.
6. Phase Two

6.1 Phase Two: Enhancing Autonomy

The findings from phase one of this research led to a second phase of research. Phase one adopted a case study approach and phase two adopted an action research approach. Phase two of this research will now be described.

6.1.2 Introduction

The case study for phase one of this research explored autonomy for older people in one residential care unit. Problems with resident autonomy were identified from the documentary analysis and confirmed by the findings from the observation and interview data. It was observed that residents who were more independent were more likely to experience autonomy, whereas those who were more dependent were least likely. The interviews revealed that the majority of staff felt that it was important to give choices to residents and to document and accommodate their preferences. However, the observations revealed that daily work often followed a routine and that direct resident care was clustered into peak times as staff rosters ensured that staff were not evenly spread across the working day. Therefore the capacity to facilitate choice was less likely to be present across the day. Interviews with residents also revealed that they often felt that staff did not know who they really were, what their values were and did not always feel that they were treated as individuals with their own personalities, wishes and desires. The researcher presented these findings from phase one to the staff participants. Following discussion of the findings, the staff participants identified that there was a problem with the residents’ autonomy in their residential care unit and thus expressed a desire to enhance the residents’ autonomy. At this point the relationships between the researcher and the research participants were such that the researcher was motivated to help them to address the problems with resident autonomy which were identified. Hence, the researcher agreed to help with addressing one of the problems identified. Thus phase two of the research commenced. The researcher discussed the various research approaches which could be adopted for this phase of the research. All agreed that the principles of action research (AR) could be used to guide a small
scale change in practice in order to enhance resident autonomy. The first step in AR is about diagnosing, identifying and defining a problem. The second step is action planning or considering alternative courses of action for solving a problem. The third step is action taking or selecting a course of action. The fourth step is evaluating or studying the consequences of the action and the fifth step is specifying the learning and identifying general learning and making it public. Thus the AR approach would enable a change to be designed, planned, implemented and evaluated in a real world setting (Cohen and Manion, 1994).

Excerpts from the researchers reflective journal are included in this chapter, these excerpts are fundamental to understanding the action research phase of this study and to “specifying the learning” (McNiff and Whitehead, 2009). Reflection “lies at the core of action research” (Somekh, 1995, pp,347) and Elliot (1991) suggests that the process of reflection is representative of the action research process. Kemmis (1985) explains that as we look inward at our thoughts and processes and outward at the situation we find ourselves in, our reflection orientates us for further thought and action. The spiral of action research follows a process of action, observation and reflection to achieve greater understanding, followed by further action and reflection (Bryant, 1996). Reflection excerpt no.1 describes the decisions made in relation to writing up this phase of the research.
Reflection Excerpt no.1

Phase two of this research study is a change initiative guided by action research principles and when it came to writing up this phase of the research I didn’t really know where to start. It didn’t fit into the same structure used for phase 1. The literature review and methodology had already been discussed but now I needed to write a “method” section, a “findings” section and a “discussion” section for phase 2. This immediately presented a challenge because the method, findings and discussion were inter-related and one informed the other in the AR cycle of action, reflection, evaluation, action, reflection, evaluation. Furthermore, elements of discussion were also emerging in the reflections and in the evaluations of each step in this phase of the research. McNiff, Lomax and Whitehead (2003) advise that the challenge for action researchers lies in presenting their work in a form that is going to serve their particular purpose as well as represent their work authentically. Perry and Zuber-Skerritt (1992) suggest considering the thesis for action research as separate to the action research project i.e. the thesis project uses data from the action research project. McNiff, Lomax and Whitehead (2003) explain that traditional research methodologies follow linear forms of thinking but that new scholarships such as AR tend to use non-traditional ways of thinking or non-linear forms of reporting. They add that the aim of this non-traditional approach is to show how processes of enquiry lead to improved practices. They suggest that the best way to do this is creatively and using non-linear approaches. For action research theses, McNiff, Lomax and Whitehead (2003) suggest using diary excerpts, representing dialogue, telling stories, using poetry or personal pronouns, using multimedia or adopting the patchwork approach. The patchwork approach enables the researcher to present a traditional report in conjunction with a creative report. I felt that this approach along with writing in the first person would help me to both organise the data and report on the research. I decided to write a thesis report detailing the steps involved in the change initiative guided by AR principles and to support this with my reflective journal abstracts which would specify the learning which took place along the journey.

6.1.2 Study Sample

The same group of residents, staff and residents family members who had been involved in phase 1 agreed to participate in phase 2.

6.1.3 Study Site

The same case study site from phase 1 was the research site for phase 2.

6.1.4 Research Ethics

Ethical approval previously obtained for phase 1 was approved for extension into phase 2 and informed consent was obtained verbally from all participants. As in
phase 1, anonymity, privacy and confidentiality of all participants were
guaranteed.

6.2 Step 1: Diagnosing: Identifying or defining a problem
Step one in the action research cycle involves diagnosing the research problem
and subsequently identifying and defining what needs to be changed.

6.2.1 Diagnosing
The findings from phase one revealed that there were problems with the
residents’ autonomy. The interview data revealed that staff struggled with
understanding who the residents are. The observation data revealed that residents
had little choice over how they spent their day and made very few meaningful
decisions and the documentary data revealed a distinct lack of evidence of all of
the attributes of autonomy in the residents’ sets of documentation.

6.2.2 Identifying the problem
Across the data sets it was evident that resident assessment, goal setting and
planning were not focused sufficiently on the resident and therefore it was
difficult to facilitate their autonomy. Staff participants were particularly struck
by the results from the documentary analysis. When we looked at the themes and
sub-themes from the interview and observation data we could see that a common
issue throughout was in relation to care planning. The sub-theme “The Person”
highlighted the importance of knowing what each resident can and can’t do for
themselves, and while there was evidence that the residents level of
independence (e.g. independent or dependent) was documented there was no
evidence of detailed descriptions of their abilities or agreed level of assistance.
The sub-theme “Being Personalised” described care that was not individualised
and participants recognised that there were problems with personalised care
planning for the residents. The sub-theme “Person to Person” suggested that it
was important to properly get to know both the residents past and present lives
and to build relationships with them and with their families. The concept analysis
revealed that communication between staff and between staff and residents and
staff and families is important for resident autonomy but the observation data
revealed that the communication methods and processes did not always facilitate opportunities to gather appropriate information about the resident. The sub-theme “Being Impersonal” related to the challenges which staff felt they had with trying to provide choice and individualised care planning against limited resources and ritualistic practices and routines. Finally the sub-theme “The Personality” revealed that staff had knowledge deficits in relation to care planning. Thus the staff participants considered that the first step needed to increase resident autonomy was to enhance the approach to care planning. It was agreed that a resident focused care plan aimed at realising the attributes of autonomy would be introduced. It was also agreed that the staff participants from phase one of the research would now become the co-researchers for phase two.

6.3 Step 2: Action planning: Considering alternative courses of action for solving a problem

Step 2 of the AR therefore focused on identifying how resident care planning could be changed in order to enhance resident autonomy. I worked with the staff to help them to identify what should be done and what the best way of doing this was. I met with the clinical nurse manager in order to discuss this proposed phase of the research and to propose ways of working within the unit in order to support the change. The manager who was now also a co-researcher gave full support for this phase of the research and this was an essential first step for this phase of the research.

Staff participants in phase one of the research identified knowledge deficits in relation to care planning and resident participants confirmed that they felt that staff didn’t really try to get to know them. Therefore I suggested providing on-site care planning education sessions as an initial step (Appendix 21) for all of the staff to attend and the staff welcomed this. The rationale for this was based on the theory of “emancipation through education” whereby the co-researchers would gain newly acquired knowledge which would help them to commence a change in their practice. The education sessions were repeated four times over one month in order to facilitate the duty roster and in order to ensure that all co-researchers had the opportunity to attend. Following the education sessions my
co-researchers were asked to look at various models and approaches to care planning in order to reach agreement about what they thought might work best for enhancing resident autonomy. At the same time and as recommended by Reason and Bradbury (2000) I wrote down my own background and reflected on how this might influence this phase of the research (reflection excerpt no. 2).

Reflection Excerpt no. 2
I started my nursing career fifteen years ago. All through my undergraduate training I worked part time with older people in their own homes in the community. Then when I became a registered nurse I worked in palliative care also in the community and later began working in a large acute hospital where I worked on a surgical ward with breast cancer patients and vascular patients. All through these years I continued to study part time. Then my grandparents who were very special to me became sick and whilst still working full time and studying I looked after both of them in their own home until they passed away. When they were gone I missed them terribly and suddenly found myself drawn to work in residential care. I was offered a management position in a nursing home which I really enjoyed and from there I took up a clinical link facilitator and lecturing role in gerontology in a national university. The clinical link facilitator role involved working with 19 residential care homes and undertaking change initiative projects with them. I thrived in this role and felt I had found my niche. I developed my project management skills, my facilitation skills and my mentoring skills. I discovered critical companionship and emancipation through education theories during this employment. It was during this time that the way in which residential care was provided began to change. Whilst these changes were warranted and needed it was a difficult and challenging time for residents and staff. I started to realise that care was often not resident centred and that institutional care practices were still very apparent. My research question evolved from this time. I started to read more and more and when I analysed person centred care I noticed that autonomy was one of its integral ingredients. One of my work briefs was to introduce person centred care but in order to do this I needed first to ensure that the integral ingredients were present. However when I went to the literature to see what resident autonomy actually was, I could find no consensus and hence this study began – because if we are ever to truly have person centred care and subsequent quality of life we must first have autonomy. I applied for a national HRB fellowship for which I was honoured to receive.

The care planning education focused on the history of care planning and the future directions for care planning for gerontological care. We discovered that care planning has its roots in the nursing process which dates back to the 1970’s. It involves assessment, planning, implementation, evaluation and documentation. All healthcare professionals automatically carry out this process in their everyday
work but find it difficult to document it in a formal way (a care plan). A care plan “is a written, structured, plan of action for patient care based on holistic assessment of patient need, identification of specific patient problems and the development of a plan of action for their resolution” (Mason, 1999, pp.380). The care given should be reflected in the care plan thus demonstrating a level of professionalism as it clearly shows how care is approached in a rational, evidence-based, and holistic manner. The written plan is thus goal-orientated, efficient, effective and individualised. According to Cheevakasemsook et al (2006) nursing documentation serves many purposes including ensuring continuity and quality of care through communication, furnishing legal evidence of the process and outcomes of care, supporting the evaluation of the quality, efficiency and effectiveness of patient care, providing evidence for research, financial and ethical quality-assurance purposes, providing the database infrastructure supporting development of nursing knowledge, assisting in establishing benchmarks for the development of nursing education and standards of clinical practice, and providing the database for other purposes such as risk management and protection of patients rights. For residential care, Lidz, Fischer and Arnold (1992) suggest that personalised care plans are essential for resident autonomy.

I gave my co-researchers hard copy examples of care plans which are in use both nationally and internationally in other health care settings. We then collectively reviewed the literature with the aim of identifying what care planning approach might contribute to enhancing the residents’ autonomy. The literature encouraged new and imaginative designs (Cheevakasemsook et al, 2006; Mason, 1999) which could be developed at ward level, tailored to meet the needs of the resident as a human being and the needs of the staff, and recognise the context of care and the world outside the care environment (Nolan et al.2004; Tutton, 2005, Pearson and Peels, 2009; Kellet et al. 2010). The new HIQA quality standards for residential care for older people in Ireland recommend that the residents care plan should meet each resident’s assessed needs which are set out in an individual care plan, developed and agreed with each resident, or in the case of a resident with cognitive impairment with his/her representative. Nolan et al (2004) support the view that care planning with older people is underpinned by
successful relationships between the older person and the healthcare professional. The success of the relationship is determined by the level of negotiation and mutual recognition of each others beliefs. Kellet et al. (2010) and Cook (2010) suggest that care planning for older people should adopt a biographical approach which aims to understand the older person, look beyond their diagnosis and better explain their presenting behaviours whilst improving communication and relationships with care staff and families. Tutton (2005) also stated that understanding personal histories creates opportunities for knowing what is important to the person. It also provides an insight into how the person is experiencing their present situations. However, Pearson and Peels (2009) reported that there appears to be conflict between documentation to meet the care needs of residents and documentation to meet the needs of management and administration, and that current approaches are inappropriate. They conclude that further research is “urgently” required in this area. Based on this literature we decided that it would be appropriate to design our own care plan rather than adopt one currently in use elsewhere.

The co-researchers decided to begin by looking at various models used for care planning in order to determine which was the most appropriate for realising the attributes of resident autonomy. Collectively we examined four models and summarised our findings (Table). According to Pearson (1996) at a basic level, there are three key components to a nursing model:

- A set of beliefs and values.
- A statement of the goal the nurse is trying to achieve.
- The knowledge and skills the nurse needs to practise.

While Fawcett (1995) suggests that the central concepts are:

- Person: the recipient of nursing actions.
- Environment: the recipient’s specific surroundings.
- Health: the wellness or illness state of the recipient.
- Nursing: actions taken by nurses on behalf of or in conjunction with a recipient.
Table 6.1: Summary of nursing models examined

<table>
<thead>
<tr>
<th>Nursing Model</th>
<th>Summary of the Model</th>
</tr>
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<tbody>
<tr>
<td><strong>Roper, Logan and Tierney Model</strong></td>
<td>This describes the person as being capable of performing 12 activities of living along an independence/dependence continuum throughout their lifespan.</td>
</tr>
<tr>
<td><strong>Orem’s Model</strong></td>
<td>Nurses would assess patients for their individual self-care deficits and plan an appropriate set of interventions to help them to overcome and restore their self-care deficits as much as possible.</td>
</tr>
<tr>
<td><strong>Neuman’s System Model</strong></td>
<td>Emphasises the need to assess the patient for the stressors affecting them and provide appropriate interventions to offset the effects of these stressors.</td>
</tr>
<tr>
<td><strong>Hodges Model</strong></td>
<td>The purposes, processes, policies and practices which affect the health domain.</td>
</tr>
</tbody>
</table>

According to Kenny (1993) and Hodgson (1992) Orem’s model and Neuman’s model may be criticised for their frequent use of jargon and complex concepts. For example, Neuman (1995) uses the terms *intra*, *inter* and *extra-personal* stressors which have the potential to affect the system (or the person) which has a central core, lines of resistance and two lines of defence. In addition, Orem (1991) includes a number of complex terms such as health deviation, universal and developmental self-care requisites, self-care deficit, dependent-care deficit, and wholly, partly compensatory and supportive-educative nursing systems.

Further exploration of the literature yielded an additional, less well known but more recently developed model called Hodges model (2000) (Figure). The co-researchers felt that the Hodges model uses more straightforward terminology such as purposes, processes, practices, and policies.
Together we decided that “Hodges Model” (2000) was a suitable model to inform the care plan design. The co-researchers chose Hodges Model over the “Roper, Logan and Tierney Model” (1996) as they collectively felt that this model suited residential care better than the traditional Roper, Logan and Tierney Model which was originally designed for acute hospital care. The literature had revealed that the Roper, Logan and Tierney model has been criticised for not enabling explicit documentation of client goals and nursing interventions and nurses report that it is constraining and physically orientated (Murphy et al., 2000). In contrast, the co-researchers felt that Hodges Model is essentially concerned with the person (resident) in a social context. It derives from the intervention of the nurse being future orientated, increasing the health choices, health chances or health prospects of individuals or groups (including families) and taking cognisance of the biography of the person or persons being helped.
We all felt that Hodges model recognises that the resident already has a biography that has been influenced by their physical and psychological make-up, the kinds of families and social networks they have experienced and the culture or geographical location in which they live. Hodges model recognises that the nurse is also influenced by his or her own personal factors such as their individual physical or psychological origin and factors relating to their social world and the policies that govern their daily life. Hodges model directs the nurse (assessor) to take cognizance of the attributes the person (resident) brings with them in their current presentation and how this affects their future choices both in terms of ability to make them and the range of choices available. All of these components were mirrored in the attributes of autonomy and therefore we felt that this model would work best with helping to enhance the residents autonomy.

Furthermore, choosing Hodges model was in support of the literature which encouraged new and imaginative designs (Cheevakasemsook et al., 2006; Mason, 1999). Having agreed on the theoretical model which would underpin the new care plan we then further reviewed the literature in order to identify a guideline which could inform the design of the care plan template. It was agreed that the “New Zealand Guidelines for Assessment for Older People” (2003) (Table x) was the most suitable. The New Zealand guidelines for assessment for older people suggest that there are five domains of most importance to older people. These domains are: Personal care, Social participation, Daily life – promotion of choice, Safety and Food. Traditional care plans using the Roper Logan and Tierney Model have 12 domains or activities of living: Maintaining a safe environment, Communicating, Breathing, Eating and drinking, Eliminating, Personal cleansing and dressing, Controlling body temperature, Working and playing, Mobilising, Sleeping, Expressing sexuality and Dying. We felt that the New Zealand domains of care were more aligned to older people and therefore potentially more facilitating of resident autonomy. For example the domain of care “daily life – promotion of choice” would facilitate the attribute of autonomy “resident involved in decision making” (Table 6.2).
Table 6.2: Matching the attributes of resident autonomy to the model and the guideline

<table>
<thead>
<tr>
<th>Attribute of Autonomy</th>
<th>New Zealand Guidelines</th>
<th>Hodges Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents capacity is encouraged and maintained.</td>
<td>Personal care. Social participation.</td>
<td>Mechanistic Individual Science Practices</td>
</tr>
<tr>
<td>Residents delegate care needs based on the right to self-determination and the rights of older people.</td>
<td>Daily life – promotion of choice.</td>
<td>Mechanistic Individual Sociology Political</td>
</tr>
<tr>
<td>Residential unit has culture and atmosphere of flexibility within an ethos of maintaining resident dignity.</td>
<td>Daily life – promotion of choice. Social participation. Safety.</td>
<td>Humanistic Group Practices Sociology</td>
</tr>
<tr>
<td>Negotiated care plans encouraged through open and respectful communication.</td>
<td>Daily life – promotion of choice.</td>
<td>Mechanistic Group Interpersonal and Science Processes</td>
</tr>
<tr>
<td>Family or significant others included when resident is cognitively impaired.</td>
<td>Social participation. Safety. Food.</td>
<td>Humanistic Group Sociology Purposes</td>
</tr>
</tbody>
</table>

The next step was to design and implement the new care plan aimed at enhancing resident autonomy.

6.4 Step 3: Action taking: Selecting a course of action

For step 3 the newly designed care plan was implemented. Firstly I drew up a Gantt chart template, we then collectively agreed our timelines and put them into the Gantt (Appendix 22). I also designed action plan templates (Appendix 23) which we completed together and which we used for focusing ourselves on each step of the implementation. Coghlan and McAuliffe (2003) explain that the most
important element in implementing change is a smooth transition from an old system to a new one. Adequate time and planning need to be allocated for this transition period, especially for identifying key people to help implement change, and for identifying possible areas of conflict (Coghlan and McAuliffe, 2003).

We then drafted the care plan templates and when we were all in agreement with their content, the templates were printed into a complete care plan (Appendix 24). The five main domains from the New Zealand guidelines were used as the main care plan templates and were to be used alongside assessment tools e.g. falls risk assessment informed the “safety” domain (Table 6.3).

**Table 6.3: Assessment tools which informed the care planning**

<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Domain of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterlow pressure ulcer risk assessment</td>
<td>Personal care and Safety</td>
</tr>
<tr>
<td>Falls risk (FRASE)</td>
<td>Safety</td>
</tr>
<tr>
<td>Mini nutritional assessment (MNA)</td>
<td>Food</td>
</tr>
<tr>
<td>Barthel dependency</td>
<td>Personal care</td>
</tr>
<tr>
<td>Continence assessment</td>
<td>Personal care</td>
</tr>
<tr>
<td>Activities/Interests past, present, future</td>
<td>Social participation</td>
</tr>
</tbody>
</table>

It was decided to phase the new care plan in ward by ward (each ward had between 5 and 6 residents each). Each nurse was paired with a health care assistant so that they too could be part of the care planning process. This phased introduction enabled all staff and residents to be part of the care plan development and to identify strengths and/or weaknesses in the design at an early stage. Following introduction of the care plan in the first ward we decided to distribute a simple questionnaire (Appendix 24) the purpose of this questionnaire was to solicit the views of the new approach to care planning from all co-researchers. This questionnaire was returned anonymously. Seventy per-cent of the co-researchers agreed that they wanted to continue with the new care planning approach and thus we commenced a second action cycle and extended the introduction of the care plans to the rest of the site. While there was full buy-in and support from the staff to implement this change, there were many barriers.
to be overcome. Hence the focus of cycle two was to overcome these barriers. This included finding time to introduce this change in practice and developing individual nurse’s competence and confidence with care planning. The actions for this cycle included education and facilitation in order to help the co-researchers to develop their care plan skills especially to enable autonomy for very dependent and cognitively impaired residents. Involving families was essential in this process. I decided to adopt a “critical companionship” approach at this point (a description of critical companionship is included in Appendix 26) in order to support the co-researchers with the implementation of this new change in their practice.

Critical companionship (Wright and Titchen, 2003) is similar to mentoring in that an expert or facilitator works closely with a staff member supporting them and guiding them through a change process. I worked alongside the co-researchers in order to help them to engage with the residents in introducing the new approach to care planning and to help them in developing their negotiation skills. Furthermore by doing this we could identify together what was working well in the implementation and what wasn’t working so well. Cheevakasemsook et al (2006) state that some of the barriers to successful care planning include limited nurses’ competence, motivation and confidence, ineffective nursing procedures and inadequate nursing audit, supervision and staff development. Martin, Hines and Felix (1999) reported that nurses find it difficult to get the balance between a professional style to their writing and capturing the emotional and spiritual style necessary when recording peoples daily lives (cited in Pearson and Peels, 2009). Thus critical companionship aims to help with reducing some of these barriers. Regular meetings on the unit were scheduled so that the progress of the change could be discussed and evaluated and so that everyone could continue to drive the change and feel part of it. Reflection excerpt no.3 gives a snapshot account of the implementation stage of this research.
Reflection Excerpt no. 3
It is a difficult time for staff to focus on any type of change to practice at the moment because the national health-service provider has imposed a recruitment freeze on the service and this has really taken its toll on staff morale. Maternity leave and sick leave are not being replaced and vacant posts are not being filled. Needless to say the research unit is also feeling the pinch. However the clinical nurse manager remains passionate about the change and is definitely one the “champions” for keeping this going. Getting time with the staff for facilitation is difficult due to the staff shortages and time constraints. The inclusion of the resident in the care plan is essential due to its design. This should enhance their autonomy and I hope that the critical companionship can help the staff to develop their negotiation skills. I think wearing my uniform when I visit the unit has really helped and I feel the staff no longer see me as an outsider - the academic removed from reality who doesn’t understand but a nurse who understands what the working day is like and what frustrations and time constraints exist with trying to introduce changes in practice. I overheard one staff participant comment that “she is doing research but she works too”. Not only have I gained an insiders perspective but I have also identified how individuals as well the whole team can be helped to develop. I think that the critical companionship has been essential in role modelling to the staff how they can meaningfully engage the residents in asking them what they would like and in finding out about their interests and who they are as a person. We have designed care plan templates which are deliberately open and simple as the staff care plan skills are only developing and therefore we must begin the process slowly. The staff seem to have enjoyed picking out the new care plan folders, trolleys and equipment especially because this was a time when other resources are cut.

6.5 Step 4: Evaluating: Studying the consequences of the action

Step four of an action research cycle requires the researchers to evaluate whether or not the action has actually changed practice. Hence once all of the care plans had been implemented for all residents, the documentary analysis from phase one of the research study was repeated to examine the extent to which the new approach to care planning had impacted upon resident autonomy. It was never the intention to repeat the data collection methods from phase one of this study on completion of phase two of this study however the nature of the intervention in phase two lended itself well to using the documentary analysis audit tool from phase one. The documentary analysis audit tool had been developed from the elements of resident autonomy and hence could be used to examine whether or not the newly implemented approach to care planning had impacted positively on resident autonomy. The findings revealed that all of the elements of resident autonomy which were originally examined in the documentary analysis in phase
one were now more evident in the residents sets of documentation (Table 6.4). Negotiated care had the most significant increase with a 61% improvement while evidence that residents could delegate their care needs improved by 74%. These attributes were now documented in the “Daily life – promotion of choice” domain and the “Personal care” domain. Residents past, present and future interests, life histories and social activities were now being documented in the “Social participation” domain. Promotion of resident capacity was encouraged by commencing each care plan domain with a positive statement of the residents’ abilities. Non-paternalistic language was now evident, residents first names were used in the care plans and the goals were all agreed goals, care was planned as “doing with” rather than “doing to”.

Table 6.4: Documentary evidence of resident autonomy: Before and after phase 2 action research

<table>
<thead>
<tr>
<th>Element of Resident Autonomy</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-governing, self-ruling, self-determining.</td>
<td>40% evident</td>
<td>55% evident</td>
</tr>
<tr>
<td>2. Care plans negotiated. Family involved.</td>
<td>13%</td>
<td>74%</td>
</tr>
<tr>
<td>3. Residents delegate care needs. Staff promote resident capacity.</td>
<td>24%</td>
<td>98%</td>
</tr>
<tr>
<td>4. Values and beliefs of staff are non-paternalistic. Ethos of maintaining dignity.</td>
<td>22%</td>
<td>87%</td>
</tr>
<tr>
<td>5. An atmosphere of openness, motivation and flexibility.</td>
<td>22%</td>
<td>66%</td>
</tr>
<tr>
<td>6. Open and respectful communication. Sharing information.</td>
<td>9%</td>
<td>58%</td>
</tr>
<tr>
<td>7. Recognition of past and present life which may shape residents wishes. Life histories.</td>
<td>64%</td>
<td>69%</td>
</tr>
</tbody>
</table>

In addition one of the empirical referents from the concept analysis of autonomy for older people in residential care is: “Observation of residents expressing their wants, needs, wishes and desires. Evidence that staff strive to meets these needs. Evidence of family involvement. Recognition of the residents past and present life, which may shape their wishes. Care plans to reflect this” and hence it
suggested that this phase of the research has contributed to the operationalisation of the concept. Reflection excerpt no. 4 describes the progress and how it was made.

**Reflection Excerpt no.4**

Well there has been lots of progress made in recent times and I am starting to feel like we are really getting somewhere. At times it was difficult for staff to stay motivated but I think we managed to overcome this by constant facilitation. I started to be on the unit more often - both in uniform and out of uniform. I scheduled more structured action planning meetings for the days I am not in uniform and repeat these in order to meet everyone. These meetings have greatly added to the action research approach. They give an opportunity to brainstorm ideas and deal with any issues, queries or concerns so that everyone can be part of the research process. I am constantly encouraging open communication and it seems to be really enhancing the project. The critical companionship approach really helped to and it also helped me to understand each staff member better and I also got to know the residents better too. Staff got very excited about the arrival of the new care plan trolleys and folders. The unit administrator has been very helpful with this part of the project and I realise that internal support is invaluable for the success of change projects. Staff decided to put photographs of the residents on the front of their care plan folder and it is amazing how much excitement it aroused. Comments like “aren’t they lovely”. “It really finishes them off”. “It makes them more individualised” and “it makes them more personal”. One male resident noticed the new folders on the ward and was visibly proud of his picture and his folder and proceeded to remind me not to forget to add in about his interest in gardening!

**6.6 Step 5: Specifying the learning**

There was much learning from this small change in practice which was guided by action research principles. Staff learned how to care plan for the enhancement of resident autonomy, how to negotiate with residents, how to gather life stories from residents and communicate with them more effectively. Anecdotally, it helped staff to reflect on the routine of the day and the approach to task-based care. Most importantly, a repeat documentary analysis revealed an increase in resident autonomy. The findings demonstrate that there was an improvement in all aspects of autonomy.

While the research participants from phase one of this research had decided that they wished to enhance resident autonomy by implementing this change in practice there were many barriers to be overcome. These included helping staff
to become co-researchers and to find time to introduce this change in their practice whilst developing individual nurse competence and confidence with care planning and care plan documentation. Education, facilitation and critical companionship were fundamental to helping staff to care plan and encourage autonomy for very dependent and cognitively impaired residents. Involving families and health care assistant staff was essential in this process.

The researcher recognises that commencing resident centred care planning only enhances some aspects of resident autonomy and phase one of this research identified many other problems in relation to resident autonomy which need to be addressed in the case study site. It is argued however that resident focused care planning can be a useful first step in enhancing resident autonomy. The cyclical nature of this type of research means that the staff and the residents will continue to work on enhancing the residents autonomy based on the findings from phase one and the newly acquired skills for making change. Reflection excerpt no. 5 is taken from one of the reflections towards the end of this phase of the research.

Reflection Excerpt no.5
Many nurses wonder why a care plan which works well somewhere else will it not work in their area. I believe from this experience that it is because it doesn’t suit or match their care environment, patient profile and services available. If care plans are to be successful a bottom-up approach is called for whereby all staff are involved in designing, piloting and evaluating the documentation. We saw from this research that this led to a user-friendly document which staff embraced with pride. This user-friendliness will enable the care plan to be kept active and not just left in a folder on a shelf gathering dust. Keeping care plans active will enable healthcare professionals to see their benefits rather than viewing them as another piece of documentation that just needs filling out. There is also a better chance that if the documentation is designed by the staff it will not require the same level of repetition or duplication of information. Mason (1999) supports this by offering that two important factors are involved in successful care plan introduction: being clinically driven and having local ownership.

It is also recognised that there are some limitations with action research methodology. Critics question how the AR cycles can be made clear and how the researcher differentiates from one step to another. Tutton (2005) explained that AR is a dynamic, cyclical process of planning, action and evaluation, in which
knowledge gained in one cycle can be built upon and developed in future cycles. The report from this phase of the research included reflection excerpts in order to describe how the research progressed from step to step. Avison and Wood-Harper (1991) argue that the researcher’s level of involvement in the study can affect the level of objectivity that is required for other approaches (Avison and Wood-Harper, 1991) and while this may be true it may also be argued that AR does not aim to be objective and furthermore for the purpose of this study the researcher described her own background and reflected upon how this may impact upon the research. McKay and Marshall (2001) pointed out that this self-involvement of the researcher is one of the distinguishing features of AR, whereby the researcher is viewed as the key participant in the research process and works collaboratively with participants to bring about change in the problem context. For example by adopting an open communication approach and holding many meetings the research process was informed not only by the researcher but also by the co-researchers,

6.10 Summary

This chapter has described phase two of this research study. The findings from the case study in phase one of this study informed the design of phase two. Phase two was undertaken in order to address one problem with resident autonomy in the case study site. A small targeted change initiative guided by action research principles was used to enhance the approach to resident care planning. This new approach involved residents in choosing their care preferences and determining how they would like to spend their day. It equipped staff with the knowledge and skills of how to negotiate this care and how to gather information which would tell them more about the biography of the residents for whom they cared for.

The researcher used an action research approach as a systematic way of involving staff, introducing change and evaluating the outcomes. Open communication was maintained throughout and this was key to the collaborative nature of the research. A small element of resident autonomy has now been enhanced in this case study site.
7. Discussion, Recommendations and Conclusions

7.1 Introduction
In this chapter, the key findings of this study are discussed in the context of relevant and current literature and the literature reviewed. The findings are discussed according to the two main themes that emerged from this research. In addition to the findings from the observation and interview data, the discussion also includes reference to the attitude survey and the documentary analysis. The findings from the documentary analysis were also discussed in phase two of this research. The limitations of this research and the contributions of the study to current knowledge regarding autonomy for older people in residential care are highlighted. The chapter concludes with recommendations for future work.

7.2 The Personal
The findings will now be discussed under the two main themes generated from phase one of the research study. These are theme 1: The Personal and theme 2: Being Personal.

7.2.1 The Personal: The Person
One of the aims of this research was to explore resident autonomy from multiple perspectives. The literature revealed that there are three main groups of people who are influential in resident autonomy. These are residents themselves, staff, and residents’ family members. Similarly, three main groups of people were identified as stakeholders in this study. These were the residents’ group, the staff group and the family group. Thus perspectives were gathered from each of these groups and documentary analysis of their demographics was undertaken.

For the staff group, some researchers have identified a link between resident autonomy and gerontological education (Hunter and Levett-Jones, 2010; Jang, 1992). The findings from phase one of this study revealed that the staff group had a mix of education and qualifications. Five (25%) of the nursing staff had undertaken a Postgraduate Diploma in Gerontology. Jang’s (1992) research suggests that lack of education may prohibit resident autonomy. Jang (1992)
found that nursing staff who had little gerontological nursing education impacted negatively upon residents’ experiences of autonomy and Hunter and Levett-Jones (2010) added that it is imperative for nurses working with older persons to have expertise as well as highly developed skills and knowledge. An Bórd Altranais (2009) professional guidance for nurses working with older people also recognises that working with older people is specialised and outlines six nursing standards and relevant competencies that nurses working with older people should be competent in. These are standards for person-centred holistic care, therapeutic relationships, the care environment, end of life care, professional development and quality of caring. The competencies are judged on the nurse’s professional/ethical practice, holistic approaches to care and integration of knowledge, interpersonal relationships with clients and clients’ families, approach to organisation and management of care and their maintenance of personal and professional development. In support of Hunter and Levett-Jones (2010) and Jang (1992) only 25% of nursing staff in this study had specialist gerontological education and a lack of resident autonomy was found across the data sets.

In contrast, however, Moseley and Paterson (2008) argue that regardless of educational qualification, the age of the nurse is also important and that older nurses contribute a wealth of knowledge and experience to their employing organisations. In this research study, analysis of the age profile of the nursing staff revealed that the majority of nurses were aged 31-59 years (75%). The nursing staff had an older age profile than the HCAs with 10% of nurses aged 60-65 years. However, while the age profiles may have been high in this study the interviews revealed that many of the nurses in the older age category acknowledged that they were unfamiliar with negotiating care with residents, and that care planning which facilitated resident autonomy was particularly challenging for them. The observations supported this and revealed an approach to care that was not always resident-centred or focused on enhancing resident autonomy. Consequently, phase two of the research began with an educational programme for all staff in order to bridge this knowledge practice gap.
It was also important to analyse the demographic profile of the resident group in order to judge whether or not the findings of this study could be compared with other studies. Analysis revealed that the dependency figures for the resident participants were comparable to national statistics for resident dependency in long-stay residential care and that 50% of the residents were in the “maximum” dependency category (“typical”). The literature suggests that an older person’s level of independence or dependence can affect their ability to manage their routine self-care (Blackwell’s Dictionary of Nursing, 2010; Boyle, 2008). Decreasing independence is often a factor that leads to admission to residential care, wherein barriers to residents’ autonomy and participation in self-care are created (Scott-Peterson and Borell, 2004), therefore suggesting that resident dependence is a prohibiting factor for resident autonomy. McCormack (2001) and Nolan et al. (2004) suggest that autonomy which only recognises one’s level of independence, such as functional independence, is “unteachable”. However, this research observed that residents with low Barthel scores (low levels of independence) were also observed to exercise the least amount of autonomy. Similarly, from the interview data, residents stated that “if you can walk you are ok” and the analysis of the residents’ sets of documentation revealed that nurses placed little or no emphasis on maximising residents’ independence or on planning care based on the residents’ delegation of care if they were functionally dependent.

Hanford et al. (1999) acknowledged that the promotion of independence and autonomy for older people is a major policy driver but this research found that the most dependent residents were least likely to experience autonomy over their everyday lives. Hence this research found that there was a link between residents’ functional independence and autonomy. The staff participants in this study acknowledged that resident independence and autonomy are important, but also talked about their difficulties with enabling autonomy when residents’ dependency increased. The interviews and observations supported this and found that the resident person’s independence was considered to be a factor in whether or not they experienced autonomy. It was suggested that the residents’ capacity for independence is enhanced when it is encouraged and maintained by staff.
persons. McCormack (2001) supports this in his discussion of staff members trying to get the balance between “doing for, doing to and enabling self-doing”.

This research also revealed that there was a difference between espoused care and actual care in relation to the resident person’s ability to make decisions. The interview participants recognised the rights of the resident to self-determine, self-govern and self-rule but analysis of the residents’ sets of documents revealed that only 40% of notes had documented evidence of residents being self-governing, self-ruling and self-determining and 60% of sets of documentation showed no evidence of this element of resident autonomy. Langer (1983) suggests that older persons perceive that they lack ability to exercise control over their lives but Scott et al. (2003) argue that suffering an illness or having limited personal capacity should not automatically affect older people when making decisions concerning their health. They further state that autonomous actions result from autonomous decisions and thus autonomy applies to both decisions and actions. Hofland (1994) states that decisional incapacity on some dimensions does not mean decisional incapacity on all dimensions. Thus the capacity to make a decision is decision-specific and while an older person may not have the independence or capacity to make all decisions, they may in fact be capable of making some decisions, thus contributing to their autonomy. It is suggested that enablement of decision-specific capacity promotes resident autonomy. In contrast, in a study by Scott et al. (2003) it was reported that there were significant differences in the perceptions of patients and nursing staff regarding opportunities for patients to make decisions regarding their daily care. A much higher percentage of nursing staff always, frequently or occasionally offered decision-making opportunities to patients, than patients reported being offered such opportunities. In this study recognising the resident as a person with rights to self-determine and with capacity to do so was not evident from the documentary analysis. Residents expressed that on the one hand they needed staff but on the other they felt too protected. Staff expressed the challenges they have with trying to facilitate decision-making and with “getting the work done”. The observations revealed that in some cases, mostly with the more independent residents, they were observed to self-govern, self-rule and self-determine. At times nurses and care staff were observed encouraging residents to do things for
themselves. However, they were also observed bringing residents back to bed without consultation. Freedom to move around and outside of the research unit was limited to those who could do so independently.

Davies, Laker and Ellis (1997) state that even making small day-to-day decisions can impact greatly on the residents’ sense of control and autonomy. Persson and Wasterfors (2009) state that residents often have restricted opportunities to make decisions about everyday matters. This study found that some staff and family participants felt that confused residents or residents with dementia were incapable of making decisions and that only those who were “compos mentis” should be consulted. The majority of participants spoke about the restricted number of choices available to the residents for decision-making, but yet staff did not recognise that they could take a more active part in changing those options. Gaventa’s (1980) model of power suggests that if there is a shift in the power relations then a challenge occurs: there must be a loss of power by A or a gain of power by B for a change to occur; B must take some steps to overcome his powerlessness. A can interfere with B’s plans, can interfere with B obtaining resources and developing abilities, and can incite against the opening up of issues. This study suggests that staff need to be more proactive about resident autonomy and reflect upon what is within their power to change in order to enhance that autonomy. Phase two of this research demonstrated how staff can promote resident autonomy by working together to bring about changes that can enhance resident decision-making through negotiated care planning.

Family participants spoke about their desire for the residents to have more choices. The literature suggests that family members do want to be involved in planning care and making decisions about their relatives (Hertzberg and Ekman, 2000; Ryan and Scullion, 2000). However, this research also found that some family members expressed a level of apathy and disbelief that the residents were capable of doing more for themselves, if the choices were made available. Phase two of this research commenced the process of including family members in care planning for their relatives in order to enhance their autonomy.
7.2.2 The Personal: The Personality

In this study it was suggested that certain personality attributes are needed for one to work with older people. The sub-theme “The Personality” refers to the type of individual who should work with older people in residential care. The participants in the interviews described the right personality as one that is fun, interested in older people and flexible in their approach to care. The literature suggests that staff members’ interpersonal skills and commitment to the job can ultimately affect and promote an older person’s level of autonomy in residential care (McCormack and McCance, 2006). It is their motivation that enables flexible and innovative approaches to care and their commitment that drives them to want to understand the person they are caring for (Reed et al., 2007; McCormack and McCance, 2006). The concept analysis for this study also revealed that motivation and flexibility are antecedents for resident autonomy. Johnstone (2004) suggests that a healthcare provider’s personality should hold an attitude that patients are human beings with needs and interests. Johnstone (2004) suggests that the attitude affects the level of participation that patients have in decision-making related to their care. In support of this the results from the KOP attitude survey in this study revealed mean scores that were only slightly positive, and perhaps this accounts for the observations whereby residents’ autonomy was prohibited and residents engaged in very little decision-making related to their care.

The participants in the interviews for this study stated that “staff who work here should want to work here” and the documentary analysis revealed that despite the fact that staff did not directly choose to work in the case study site, rather they had been assigned there by hospital management, the retention rates were high. The concept analysis identified the importance of staff retention for resident autonomy. It is suggested that this retention rate was a contributing factor in enabling phase two of this research, whereby staff were motivated to make a change to their practice in the interest of enhancing resident autonomy. The largest number of staff in this research study were also the longest working on the unit, with eight HCAs working on the ward for a minimum of six years and eight nurses a minimum of five years. Hertzberg and Ekman (2000) suggested that reducing staff turnover improves patient care and satisfaction and also
reduces stress on remaining staff, thus reducing the turnover cycle. The concept analysis of resident autonomy indicates that staff retention is a consequence of an environment that encourages resident autonomy. Retaining staff is also suggested to improve standards of care and reduce mortality (Moseley and Paterson, 2008; Lovgren, Rasmussen, and Engstrom, 2002). Hertzberg and Ekman (2000) reported that a consequence of high staff turnover is a feeling of exhaustion for relatives of residents. Relatives struggled with finding the energy to start yet another relationship with new staff members. The retention rates in this study were not an issue as the majority of staff had worked in the case study site for a number of years. However, it was observed that not all opportunities to engage with residents’ families were maximised. Phase two of this research therefore focused on building upon those relationships in order to include family members in enhancing the residents’ autonomy.

Moseley and Paterson (2008) state that in addition to staff personality and a desire to work with older people, retention factors include the need for respect and recognition of achievements, empowerment, valuing expertise, providing challenges, creating a sense of community within the organisation, providing education and peer development, and offering flexible shift patterns. The interviews revealed that the majority of staff felt satisfied working with older people but they also felt that at times it was difficult to maintain morale during difficult budgetary constraints in the health service and against negative perceptions from colleagues who worked elsewhere. Similar sentiments have been found in the literature (The RCN for Age Concern UK, 2008). Mann’s (1986) power theory suggests that budgets and resources are important for sharing power, for those who possess the organisational advantage will always succeed in overcoming those who lack organisational resources. Despite these challenges families in this study spoke highly of staff commitment and of their fun and lively personalities. However this research also reported that some of the staff participants felt frustrated with their managers and at times they did not feel supported. Transformational leadership has been recognised as an appropriate leadership method for health care (Sofarelli and Brown 1998; Kouzes and Posner 1995; Demings 1987). It can potentially inspire and motivate staff. Its principles include; vision, trust, participation, learning, diversity, creativity, integrity and
Chapter 7 Discussion

community (Sofarelli and Brown, 1998). Burns (1978) suggests that the transformational leadership style seeks to “satisfy needs” by involving the “whole person and followers”, resulting in reciprocal relationships between leader and followers. Transformational leadership theory suggests that leaders use their “charisma” to provide vision and direction for their followers and ultimately, to achieve transformation of organisations. Encouragement and praise for achievement are essential to the success of this leadership style, and can help to gain trust and respect from team members and consequently improve their motivation and morale. These characteristics were not described by the research participants in this study and hence this may have affected the residents autonomy whereby staff retention and flexible approaches to care are essential.

7.2.3 The Personal: Person to Person

Findings from this study suggest that communication from person to person is essential for resident autonomy. Residents expressed that staff made little effort to get to know who they were and had little understanding of their past lives, their present wishes or their future desires. Horanson-Hawks (1991) highlights the importance of communication in order to share power and suggests that individuals should acquire power skills such as trust, communication, knowledge, concern, caring, respect and courtesy. This study revealed that the relationship between one person and another is essential for successful communication and subsequent resident autonomy. This includes the relationship between residents, between staff and residents, between staff and families, and between staff. Davies, Ellis and Laker (1997) reported that communicating and providing information or explanations about care results in positive effects for older people in relation to their autonomy. In this study, sharing of information as a form of communication to the resident was evident in only 9% of the residents’ sets of documents.

Horanson-Hawks (1991) suggests that in order for power to be shared there must be communication for the mutual establishment of goals. Yet the observations in this study revealed little or no communication between staff, between staff and residents, or between staff and families in respect of care planning for the mutual establishment of goals. Interviews revealed that staff believed that their
colleagues would think they weren’t “working” if they sat talking to residents. Observations further revealed that staff often missed opportunities to communicate with residents, particularly very dependent or cognitively impaired residents, and that at times they spoke to each other when providing care rather than to the resident. Similarly, Patterson (1995) observed that nurses did not engage in chit-chat with residents but did spend their free time talking amongst themselves. Staff participants in the interviews for this study explained that they communicate with the resident as they get to know them over time and that this informs them of the resident’s care preferences. However, there was little or no evidence of this in the residents’ sets of documentation. Hence phase two of this research aimed at enhancing this element of autonomy. In this study one nurse participant spoke about the value of listening to residents. Tuckett (2005) suggests that speaking with and listening to residents is the only way to facilitate autonomous decision-making and that socially isolating environments and lack of interpersonal relationships can hinder residents’ autonomy. Tuckett (2005) also suggests that residential care homes are inadequate sites for communication and decision-making. Nolan (1997), Davies et al. (1999), Nolan et al. (2001, 2002, 2004) and Cook (2010) all suggest that person-to-person interaction is essential for a successful relationship between the healthcare professional and the older person. This successful relationship subsequently leads to resident autonomy as their care can be discussed and negotiated together with the healthcare professional.

The Health Advisory Service (1998) reported that negative interactions between patients and staff could be exacerbated by other pressures such as poor physical environments, workload, staff shortages and lack of basic equipment. Reflection excerpts from this research study describe the staff shortage problems during the research project, and staff spoke about their frustration at not having the time to interact with the residents. Resident interviews made reference to the little time that staff seemed to have for them and to the constant rushing and hurrying, which prevented meaningful interaction and communication from person to person. The description of the research unit’s physical environment and the floor plan (Appendix 13) also reveal that there was very little physical space for one-
to-one conversations. Observations recorded few examples of meaningful interactions.

In order for meaningful interactions from person to person to take place, whereby residents can engage in autonomous decision-making, healthcare staff need to know the person and how they like to communicate (Cook, 2010). The value of knowing the person for realising autonomy through residential care planning has been suggested to also raise residents’ self-esteem and self-integration and improve their quality of life (Moos and Bjorn, 2006; Clarke, Hanson and Ross, 2003; Hansebo and Kihlgren, 2000). The literature review by Pearson and Peels (2009) revealed that most papers published about documentation/care planning in residential care are expert opinion papers (level E4). These published opinions state that the relationship between documentation and direct care delivery is poorly understood by practitioners, that effective documentation should incorporate recordings related to assessment, care planning, progress and evaluation, and that education in nursing documentation improves the quality of the data recording. Phase two of this study aimed to enhance resident autonomy by introducing a more resident-centred approach to care planning. It aimed to improve the relationship between documentation and direct care delivery by incorporating assessments, progress and evaluation recordings, and by providing educational sessions on effective care planning for resident autonomy. Phase two, while only aiming to enhance one aspect of resident autonomy, reported an increase in all of the attributes of resident autonomy. Pearson and Peels (2009) conclude that current approaches to documentation are inappropriate for aged care. Two studies in this review found that nursing care plans in aged care are directed from a medicalised, illness perspective rather than focused on the daily lives of residents, which tends to be discarded. They recommend further research into this area and in support of this phase two of this research adopted Hodges’ model and a new approach to care planning that is not medicalised. It also included a domain of care that focused on the residents’ daily life and ultimately enhanced their autonomy.

Person-to-person interaction in residential care involves gathering life histories, which Kenyon and Randall (2001) view as being essential in “knowing the self”
in older age. Alabaster (2006) stated that care that denies older people of their own histories excludes them from autonomous participation. McCormack (2006) suggests that life histories can capture the essence of many experiences over time that are truly authentic and invaluable in understanding the person for whom we care. Clarke, Hanson and Ross (2003) and Cook (2010) state that in order for practitioners to learn more about the patient as an individual they must take the biographical (life history) approach to care planning. Taking the biographical approach enables the practitioner to see behind the “mask” of ageing, illness or disability (Clarke, Hanson and Ross, 2003). In phase one of this study one resident stated that staff “don’t think of me as a person” and felt that it was only his disability that was cared for. Clifford (1999) describes life histories as useful in social assessment for understanding how individuals could be understood by others who may have different historical and social circumstances. Bartol (1989) proposed that listening to a person’s life story is a powerful way of showing that they are valued as an individual. This approach is viewed as a low-cost intervention that can be incorporated into everyday care activities, thus improving the quality of life of residents and the self-esteem of health workers (Pietrukowicz and Johnson, 1991). It is viewed as useful for assessing the older person, in communicating with the older person, and in completing the care planning process (Clarke, Hanson and Ross, 2003). Staff in this study expressed their dismay at knowing very little about some of the residents’ past lives and how this made caring for their wishes difficult, especially when the resident could not communicate themselves. Phase two planned to address this in order to enhance the residents’ autonomy.

Many years ago Agich (1990) called for a refurbished concrete concept of autonomy which would systematically attend to the history and development of persons. “We need to learn how to acknowledge their habits and identifications (Agich, 1990: 12). Yet more recently, Pearson and Peels’ (2009) review revealed that most papers published are expert opinion papers rather than papers reporting change initiatives, interventions, or examples of how to acknowledge residents’ habits and identifications, and we still have research that reports that residents feel staff do not know them or communicate with them as “persons” rather they treat them as “patients”.

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Rodgers and Neville (2007) remind us that older people enter residential care with a lifetime of culturally embedded individual experiences and coping strategies, and that these experiences influence their decision-making and desire for autonomy in residential care. Hofland (1994) reminds us that people with dementia also have a past and a life history, and it is knowledge of this aspect of their personhood that enables us to facilitate their present autonomy. Furthermore, the concept analysis of autonomy for older people in residential care also delineated the importance of knowing the past life of the resident with cognitive impairment in order to plan for their present needs. All of the staff participants in this study spoke about their difficulties with communicating and understanding the needs of residents with cognitive impairment. It is suggested in the literature that this can be overcome by getting to know who the person was in their past and how that might shape their current wishes and desires (Cook, 2010; Rodgers and Neville, 2007; Clarke, Hanson and Ross, 2003; Clifford, 1999; Hofland, 1994; Agich, 1990).

In person-to-person communication and interaction another person who is integral to maintenance of a resident’s autonomy is the family person and how they interact with staff. Lynn-McHale and Deatrick (2000) discuss the importance of residents’ families building trusting relationships with care providers in order to help them to get to know the resident. Robinson (1994) suggests that family involvement in nursing homes serves to individualise care and to provide a continuing link to the residents personal history and preferences, and may ultimately influence quality of life for residents. Family involvement in care planning has been advocated by numerous authors (Hertzberg and Ekman, 2000; Ryan and Scullion, 2000; Duncan and Morgan, 1994; Robinson, 1994; Ekman and Norberg, 1988). Swagerty, Lee and Smith (2005) reported that family members provide important support to residents and to care planning. Hertzberg and Ekman (2000) suggested that family involvement in nursing homes serves to individualise care and provide a link between the residents’ personal history and preferences. Relatives in this study also expressed that it is of utmost importance for their care preferences or requests for their family member to be taken seriously.
However, Nay (1998) argues there are impersonal factors in healthcare provision that reduce the opportunities for care providers to communicate with residents and their families and to subsequently develop successful interpersonal relationships with them. These impersonal factors are time-poor, task-orientated and socially isolating environments. Nay (1998) argues that it is these impersonal factors that prevent the healthcare professional from addressing the residents’ needs, interests and entitlements for decision-making.

### 7.2.4 Summary
Discussion of the findings at this point suggests that there are various promoting and prohibiting factors for autonomy for older people in residential care. Sub-theme 1a, The Person, identified promoting factors such as education and gerontological specialism, resident independence, enablement of resident decision-specific capacity and sharing of power. Prohibiting factors were identified as a lack of education, resident dependence, prevention of resident decision-specific capacity and not sharing power. Sub-theme 1b, The Personality, identified promoting factors such as a desire to work with older people, positive attitude toward older people and being open, motivated and flexible. Prohibiting factors were identified as not choosing to work with older people, negative attitude toward older people and being closed, demotivated and inflexible. Sub-theme 1c, Person to Person, identified promoting factors such as good interpersonal skills, good relationships (between residents, between staff and residents, between staff, and between staff and family members), listening, knowing the person (their past, present and future) and biological care planning. Prohibiting factors were identified as poor interpersonal skills, poor relationships (between residents, between staff and residents, between staff, and between staff and family members), not listening, not knowing the person (their past, present or future) and medicalised care planning.

### 7.3 Being Personal
The second theme, Being Personal, will now be discussed.
7.3.1 Being Personal: Being Impersonal

The concept analysis of resident autonomy suggests that residential care should be flexible and non-routine in order to promote resident autonomy. Historically, gerontological nursing was recognised as being largely about routine, and was associated with work of a heavy nature that focused on “getting the work done” (Norton et al., 1962). Miller (1994) suggested that healthcare staff contribute to this by imposing routinised systems of work upon older people, thus creating a culture of “getting the work done”. The interview participants in this study concurred and spoke at length about the routine, and some indicated that it was certain members of staff who enforced and drove the routine. Higgs et al. (1998) concluded from their study of 377 nursing home residents and 291 patients on long-stay geriatric wards that the difference between nursing homes and hospital wards in terms of their institutionalising capacities is not as profound as policy-makers believe.

Hooks and Roberts (2007) found that staffing levels tend to dictate the routine of the day. Similar to this study, staffing levels were considerably higher in the morning, thus reducing the scope to negotiate evening care delivery with the residents. Foucault’s power theory refers to “governmentality”, which refers to the processes that individuals and groups use to assert power. Whether or not one accepts the institution’s routines or not reflects whether or not they are willing to be passive about their governmentality. Tuckett (2005) described older persons passively accepting ward routines and according to Brown, McWilliam and Ward-Griffin (2006), nurses tend to enact their status as “professional expert” within the hierarchical medical structure that continues to dominate health care. The expert approach allocates more power to nurses and less to clients. This was also reflected in this study where residents spoke about “falling into line” and staff talked about residents adapting to the routines.

Tuckett (2005) reported that a residential care worker described their work as “production line nursing” where work practices and culture take precedence over the residents’ individual needs. This ultimately prohibits resident autonomy. They reported that staff felt “time-starved” due to staff shortages. This was also reflected in this study whereby a family participant compared the care approach
to being like “a factory floor” and a resident spoke about the constant hurrying and rushing of staff and their apparent lack of time to do anything other than follow the routine. Tuckett (2005) argues that work practices and a culture that prioritises “doing-for” over “being-with” cannot claim convincingly to be meeting the needs of residents. The observations of this study reported many missed opportunities for residents to do things for themselves due to the staff members’ approach to care, and observations where staff talked over the residents rather than spending time “being with” them. Fundamentally, Murphy (2007) reported that lack of time, resistance to change and being bound by routine ultimately affect a resident’s quality of life and Whitaker (2004) reported that everyday life in nursing homes is controlled more by staff routines than by residents’ needs. This was also found to be the case in this study, both from the interview data and the observation data. Davies, Laker, and Ellis (1997) suggest that one of the most effective actions nurses could take to promote greater autonomy for patients would be to campaign for greater flexibility around the provision of care. However, nurse participants in this study described a passivity with trying to challenge the approaches to care. The overall feeling was one of acceptance and frustration with the impersonal routines, the impersonal environment and the impersonal staffing issues.

Interestingly, Whitaker (2004) described the nursing home environment as both a place where older people are living the last days of their life and a workplace for staff. The staff live in a hurried or pressed culture and the older people live in a waiting or expecting culture. Whitaker (2004) states that these two cultures never interact. Hodges’ model, which was used for phase two of this research, recognises the interrelatedness of groups and individuals for the purposes, practices, policies and processes that influence care. Alabaster (2006) suggested that routine is determined by the organisation’s approach to care provision. If the organisation provides impoverished environments and low staffing levels then it reinforces routines and prohibits autonomy. Phase two of this study was conducted at a time of national cuts to staffing levels. Hodges’ model recognises that these political decisions can be an outside influence on care. Phase two reflection excerpts describe the initial challenges of finding a way to implement a change in practice during a time of reduced resources. Providing support and
adequate time for planning needed to be allocated (Coghlan and McAuliffe, 2003). It was found that there were changes that could be made to promote and enhance resident autonomy that are not over-reliant on resources.

Persson and Wasterfors (2009) add that staff struggle to enable resident autonomy when there are fixed impersonal schedules such as meal times. Staff in this study referred to the day as “structured”. It was also stated by Persson and Wasterfors (2009) that residents are allowed to exercise influence only as long as it does not conflict with the efficient running of the institution as a whole. In theory residents could make decisions, but in reality this was often not the case. For example, it was stated that residents could choose what time to go to bed, but there were limits placed on the number of residents who could still be up when the night staff came on duty. Similar observations were noted in this study and many residents were put back to bed early in the afternoon as this was the “routine”.

Many researchers agree that in order for autonomy to be realised there must be a degree of flexibility in the approach to caregiving (McCormack et al., 2008; Faulkner and Davies, 2006; Hofland, 1994; Agich, 1990; Collopy, 1988). Rodgers and Neville (2007) explain that diminished autonomy is experienced when an individual is controlled by others, as is often the case when communal interests are involved; hence impersonal organisational needs are privileged over the rights of the individual. Barkay and Tabak (2002) also state that the degree of institutional flexibility affects one’s autonomy and ultimately one’s quality of life, and Scott et al. (2003) suggest external constraints have a direct impact on the exercise of autonomy. Persson and Wasterfors (2009) explain that staff often find themselves “between a rock and a hard place” when they try to balance efficiency and standards of care with honouring autonomy. Staff in this study referred to this as “not working in a factory….working with people” and described the challenges of trying to reduce the “rushing” culture in order to promote resident autonomy.

Organisational needs such as reducing staffing levels may impact on the overall atmosphere of a residential unit and reduce staff willingness to invest time and
energy into making changes to practice. The concept analysis indicated that atmosphere is important for resident autonomy. Phase two of this research encountered this when the progress of the planned change was slow due to staffing shortages and low staff morale. Impersonal external factors such as the national staffing embargo impacted negatively on the research unit. A creative organisational climate has been shown to support patient autonomy (Mattisson and Andersson, 1995) but in the early days of phase two the climate both nationally and in the research unit was strained. Furthermore, associations between job satisfaction and work environment have been made (Lovgren, Rasmussen and Engstrom, 2002) and thus it became paramount to nurture the staff and support them during such a difficult time. It was at this point that the researcher commenced the critical companionship approach to the implementation of the intervention and began to spend more time on the research unit. The staff participants in the interviews spoke about not feeling appreciated or valued, and expressed their dismay at the way the unit was staffed and managed. Flynn and McCarthy (2007) suggest that Irish hospitals need to take greater focus on valuing the nurses currently employed and that greater uniformity would perhaps contribute to higher staff retention rates. The concept analysis for resident autonomy revealed that staff retention was important. Flynn and McCarthy (2007) also suggest that Irish hospitals would benefit from adopting the USA “Magnet hospitals” approach. Magnet hospitals are defined as organisations able to attract and retain a staff of well-qualified nurses and therefore consistently able to provide quality care. Magnet hospitals focus on the leadership attributes of nursing administration along with the professional attributes of staff nurses, whilst maintaining an environment that supports professional practice. It is important to realise and understand the impersonal factors in order for resident autonomy to be promoted and enhanced.

7.3.2 Being Personal: Being Personalised

In this study it was found that personalised care is essential for resident autonomy. Observations revealed that some residents had personalised their bed space with family photos, etc. However, space was limited and thus the opportunity to personalise their space was also limited. Higgs et al. (1998) suggest that an older person’s “attachment” is to their home and their personal
possessions rather than to a “homely” atmosphere. This may account for why some of the residents personalised their bed spaces with their personal possessions. Cook (2010) adds that personalised objects can be useful aids for communicating with residents with cognitive impairment. The concept analysis revealed that a homely atmosphere is a consequence of resident autonomy.

The documentary analysis revealed that the majority of the residents did not have a personalised care plan even though Davies, Laker and Ellis (1997) have suggested that individualised assessment and care planning underpins the realisation of autonomy. The interviews and observations revealed that a resident’s autonomy can be affected by the level of personalised daily life they experience. In other words, how the resident spends their day and whether or not it is according to their wishes and hobbies. All participants felt that the residents were not experiencing enough meaningful activity and that this was prohibiting their autonomy. Cook (2010) refers to the “social death” in residential care whereby meaningful activity for the resident is not facilitated. The observations revealed long periods during the day when nothing really happened for the residents. Staff expressed their dismay at not being able to take residents out or to do activities with them due to time constraints. Residents expressed apathy and loss at no longer being able to do the things they enjoyed doing at home. Similarly, Armstrong-Esther et al. (1989) observed in their study that staff did not engage in any social activities with residents at any time and Erlander, Drechler and Wallin Pearson (1993) found that residents may have little choice over daily activities that are of importance to them unless the staff attach a similar degree of importance to a particular activity. An emergent theme from this study was also about recreational activity and its importance for resident autonomy. Hofland (1994) added that people with dementia also require age appropriate activities. Higgs et al. (1998) found that respondents felt isolated or lonely and felt that they had nothing to do all day but sit around. This study affirmed this and one resident commented that every day is the same.

Nolan et al. (1995) found that many patients continue to spend most of their time inactive. They further add that nurses do not perceive providing activity as a legitimate part of their role. Observations from this study would support this
view as it was observed that there were long periods of inactivity for some residents even though many of the staff participants in the interviews recognised the importance of providing meaningful activity as part of their role. Langer (1983) suggests residents’ passivity in their day may be due to the older person’s perception that they lack ability to exercise control over their lives. However, Scott et al. (2003) pointed out that not all older patients want to be active. One of the antecedents from the concept analysis for resident autonomy identifies the importance of robust resident assessment and it is suggested that this level of assessment can inform the healthcare professional about what level of activity the resident wishes to have or what recreational activities are important and meaningful to them. Ostlund (2009) suggested that TV viewing can be considered to be a meaningful activity for older people in residential care. It was suggested that TV is useful for coping with disengagement, for adapting to new technologies, as a reference to the rest of the world and can be a social and private experience. However, in this study it was observed that few residents had access to their own TV and that communal TV’s were often left on all day with nobody really watching them. It has been suggested that assessment of past and present life situations may shape residents’ current recreational wishes (Atkins, 2006; Quill and Brody, 2006; Tutton, 2005; Davis, Ellis and Laker, 2000; Beauchamp and Childress, 1994; Lidz, Fischer and Arnold, 1992; Gillon, 1990; Kant, 1989; Meyers, 1989; Feinberg, 1989; Collopy, 1988) and contribute to personalised care which realises autonomy.

One resident in this study stated that “if I was at home I would be doing things around the house….I was a tradesman”. He expressed frustration at the lack of personalised care for him. Whitaker (2004) describes how older peoples’ tiredness is not always related to ageing but is influenced by the inactive care culture in nursing homes. Similarly, one resident in this study commented “what would you expect in a home” which suggests that older people have low expectations of the type of activity they can experience in residential care. Another resident commented that the day room was not her “scene” while one resident stated that “it’s the same every day”. Staff participants described their wishes to “get the residents out” but could not suggest ways to meet this resident need. Phase two of this research introduced a care plan which had a “social
participation” domain which directed staff to discuss with the resident the recreational activities which were important to them. The aim of this was to enhance the residents’ autonomy as this element was an emergent theme in this study. Horanson-Hawks (1991) suggest that one attribute of power is mutually working toward goals and hence the new approach to care planning could contribute to sharing the power as both the resident and the nurse engage in mutually discussing, negotiating and planning goals of care.

7.3.3 Summary
Discussion of the findings at this point suggests further promoting and prohibiting factors for autonomy for older people in residential care. Sub-theme 2a: Being Impersonal, identified promoting factors such as agreeing routines, negotiating care, being flexible and being with the resident, staff having sufficient time, a calm ward atmosphere, sufficient staffing levels, being motivated and the resident is recognised as the expert. Prohibiting factors identified included imposed routines, lack of negotiation, inflexibility and doing for the resident, staff having little or no time, a hurried ward atmosphere, insufficient staffing levels, being unmotivated and the professional being the expert.

The discussion of the findings of this research enabled the identification of the factors that impact on resident autonomy. These factors were analysed in the context of the international literature and both promoting and prohibitive factor were identified. A summary of these factors is provided in table 7.1.
### Table 7.1: Factors affecting resident autonomy.

<table>
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<tr>
<th>Theme 1: The Personal</th>
<th>Promoting Factors</th>
<th>Prohibitive Factors</th>
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<tr>
<td><strong>Sub-theme 1a: The Person</strong></td>
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<tr>
<td></td>
<td>Education/specialism</td>
<td>Lack of education/specialism</td>
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<td>Resident independence</td>
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<td>Enable decision-specific capacity</td>
<td>Prevent decision-specific capacity</td>
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<td>Sharing power</td>
<td>Not sharing power</td>
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<td><strong>Sub-theme 1b: The Personality</strong></td>
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<td></td>
<td>Desire to work with older people</td>
<td>Does not choose to work with older people</td>
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<td></td>
<td>Positive attitude toward older people</td>
<td>Negative attitude toward older people</td>
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<td></td>
<td>Being open, motivated and flexible</td>
<td>Being closed, demotivated and inflexible</td>
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<td><strong>Sub-theme 1c: Person to Person</strong></td>
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<td>Good interpersonal skills</td>
<td>Poor interpersonal skills</td>
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<td>Good relationships between residents, between staff and residents, between staff and between staff and family members</td>
<td>Poor relationships between residents, between staff and residents, between staff and family and family members</td>
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<td></td>
<td>Listening</td>
<td>Not listening</td>
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<td></td>
<td>Knowing the person: past, present and future</td>
<td>Not knowing the person: past, present or future</td>
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<td>Biographical care planning</td>
<td>Medicalised care planning</td>
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<th>Theme 2: Being Personal</th>
<th>Promoting Factors</th>
<th>Prohibitive Factors</th>
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<td><strong>Sub-theme 2b: Being Impersonal</strong></td>
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<td>Negotiation</td>
<td>Lack of negotiation</td>
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<td>Agreed routines</td>
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<td>Care planning</td>
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<td>Flexibility</td>
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<td>Time</td>
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<td>Friendly ward atmosphere</td>
<td>Unfriendly ward atmosphere</td>
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<td>Good skill mix</td>
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<td>Motivated</td>
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<td>Teamwork</td>
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<td><strong>Sub-theme 2b: Being Personalised</strong></td>
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<td>Meaningful recreational activity</td>
<td>Meaningless recreational activity</td>
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<td></td>
<td>Appropriate language e.g. care plans are non-paternalistic and write about “doing with”</td>
<td>Inappropriate language e.g. care plans are paternalistic and write about “doing to”</td>
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<tr>
<td></td>
<td>Including the resident and their family member in care planning</td>
<td>Not including the resident and their family member in care planning</td>
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</table>
7.4 Summary, Recommendations, Limitations and Conclusions

It was established at the outset that there was no consensus on the meaning of autonomy for older people in residential care. A subsequent problem identified was whether or not older people in residential care actually experience autonomy. Thus the central aim of this research was to explore autonomy for older people in residential care. Firstly, a concept analysis of resident autonomy was undertaken in order to clarify its meaning. Secondly, the concept analysis was used to inform the development of research data collection tools. Research suggests that autonomy can be viewed from many perspectives and hence both objective and subjective data was collected in one case study site from interview, observation and documentary sources. Two core themes emerged: The Personal and Being Personal. This then generated a secondary aim for the research which was to enhance one aspect of resident autonomy in the case study site. An action research approach was adopted in order to meet this aim.

The findings provide information for practitioners, educators and researchers about resident autonomy. For practitioners, the research describes resident autonomy from many perspectives in the real world setting. For educators, it describes the knowledge, skills and attitudes that health care professionals working with older people in residential care need to possess in order to enhance resident autonomy. For researchers, it demonstrates one way in which the concept of autonomy for older people in residential care may be operationalised and paves the way for further research. Therefore the final recommendations are made on the basis of these collective findings.

7.4.1 The Personal

As early as the nineteen seventies Mill (1975) suggested that autonomy was about “one’s own conception of the good life” and yet this research found that nurses today still struggle with understanding, negotiating and documenting what this conception is for each resident for whom they care for. This research found that the residents autonomy was affected by the lack of the nurse participants care planning skills. It was found that the nurses did not always focus on what matters to the resident, did not try to get to know the resident as a person and
often allowed routine to dominate their work. Therefore it is recommended that staff working in residential care receive training and education focused on the development of skills which can be used to engage the resident in order to negotiate care and encourage resident autonomy. Phase two of this research demonstrated how resident centred care planning can enhance resident autonomy. The initial step in this process was care planning education. Equipped with this knowledge there was subsequent exploration of care planning approaches that can facilitate residents autonomy by taking account of their needs and wishes.

The findings from this study also reported that residents often felt that staff did not know them as a “person” therefore it is recommended that nurse education programmes should focus on developing nurses skills so that they can undertake biographical care planning. These include a range of interpersonal skills such as listening, communicating verbally and non-verbally and being approachable to family members.

The concept analysis of autonomy for older people in residential care revealed that residents with reduced capacity should be facilitated to delegate the actions of their decisions. This research also reported links between residents physical ability to perform tasks independently and the level of autonomy they experienced. It is therefore recommended that practitioners strive at all times to facilitate residents to delegate their wishes appropriately. For example, if a resident wishes to go to the dining room but cannot physically walk there themselves then staff would ensure that the resident has the opportunity to ask them for assistance. The documentary analysis in phase one of this research found that while the staff had documented the residents level of independence-dependence they did not provide any detail about what they can and can’t do without assistance and therefore what they may wish to delegate. It is recommended that all practitioners should use positive care plan statements about what residents can do for themselves and subsequent to that they should detail what assistance has been agreed. For example: Mary will comb her own hair if she is given her hair brush and Mary is in agreement of assistance from one person for the remainder of her personal care needs. For phase two the care plan
templates included prompts for positive statements and incorporated language which promotes negotiation and agreement. Furthermore, the use of critical companionship mentoring in phase two of this research supported the staff with developing their negotiation and capacity building skills with the residents. Thus it is recommended that residential care units seek out potential critical companions in order to facilitate changes in practice which may enhance resident autonomy.

The findings suggest that management structures can promote or prohibit resident autonomy. Frustrations were expressed in relation to the management structures and it was suggested that this in turn affects morale and motivation to change. Flexible, open and supportive approaches to care were viewed to positively impact upon resident autonomy. On the basis of these findings it is recommended that all managers or leaders in residential care for older people adopt this flexible, open and supportive approach to care. Transformational leadership may help in achieving this.

This research found that some staff felt that their colleagues held negative perceptions about working with older people. The concept analysis also revealed that positive attitudes toward older people are important for resident autonomy. It is therefore recommended from this research that nurses and other health care professionals must engage in and promote activities which may reduce negative stereotypes about older people. In addition this research found that all staff of all grades who work with older people should choose to work with older people and hence employers in residential care should actively seek out potential staff members who have a desire to work with older people.

In summary it is recommended in order to enhance resident autonomy that nurse educators should focus on improving nursing knowledge and skills for biographical care planning, negotiation and resident capacity building. In practice, organisations should foster a flexible, open and supportive approach to care which is managed by transformational leaders, supported by critical companions and delivered by staff with positive attitudes about ageing and older people.
7.4.2 Being Personal

This research suggests that knowledge of who the resident was in their past can be used to inform their present or future wishes particularly if they are unable to presently determine or verbalise this due to cognitive impairment. Therefore it is recommended that staff and family members in residential care units need to work together on determining how a residents past way of life might determine how they wish to spend their present day in residential care. For example if they liked being outdoors, if they liked company or being on their own and if they liked to say up late etc.

Staff and family members in this research revealed that they weren’t sure what the residents were really capable of and residents themselves expressed low expectations of what they could do in “a home”. Observations revealed that residents made very little meaningful decisions throughout the day. It is recommended that staff and family members of residential care units need to engage the resident in meaningful decision making and need to understand that older peoples inability to make some decisions does not inhibit them from making all decisions. For example, a resident may not be able to decide whether or not they want to go out to their home for a visit or who to vote for in a government election but they may be able to decide which colour jumper to wear today. It is imperative that staff and family members of residents in residential care units maximise these opportunities to facilitate a resident in decision making which is an element of resident autonomy.

In summary it is recommended that in order to enhance resident autonomy that staff, family and resident members of residential care units should work together on getting to know who the resident is today based on who they were yesterday (in the past). This process should encourage resident decision-specific capacity.

7.4.3 Contribution to Knowledge

This study provides a comprehensive analysis of the background, issues and challenges relevant to autonomy for older people in residential care.
This research has provided the first specific in-depth analysis of autonomy for older people in residential care in Ireland. It produced the first and only concept analysis for autonomy for older people in residential care. This research study demonstrated how data collection tools can be designed from a concept analysis. The subsequent exploratory single embedded case study was adopted for the purpose of gaining a better understanding of resident autonomy from multiple perspectives and multiple data sources. A systematic approach to data collection and analysis ensured the rigour of the study and enhanced transferability of the findings.

The findings have significance both nationally and internationally and for researchers, practitioners and educators. Resident autonomy was not only explored but it was also enhanced and the learning from phase two of this study was specified.

The original contributions to knowledge made by this research:

- Presents the first and only concept analysis of autonomy for older people in residential care.
- Explored autonomy for older people in residential care using data collection tools designed from the concept analysis. No other Irish nursing research has explored this issue in the context of practice.
- Identifies the promoting and prohibiting factors for resident autonomy.
- Demonstrates the benefits of combining case study research design to explore a phenomenon and action research design to enhance a phenomenon.
- Presents autonomy focused care plans which can be adopted by other residential care homes.

7.5 Limitations of the Research

This section identifies some limitations of this research and suggests possible future research directions. A critique of methodological approaches was already provided in chapter three and a review of the study’s rigour was also addressed.
This section will consider the limitations imposed by the research design and potential weaknesses are examined and discussed.

7.5.1 Issues related to credibility and trustworthiness of the data
The extent to which the current findings may be transferred to other residential care units for older people may be questioned. However, from an Irish perspective this research was undertaken in a “typical” residential unit for older people and therefore it is expected that other residential units will share many of the same issues. The detailed descriptions supplied coupled with the reflection excerpts throughout should indicate to the reader the appropriateness of the findings to other residential care settings. Furthermore, as already noted the purpose of qualitative research approaches is not to develop empirical generalisations but rather theoretical propositions or naturalistic generalisations. This study provides an understanding of the complex nature of resident autonomy and the promoting and prohibiting factors which can influence it.

7.5.2 Methodological issues
Phase one of this study was a single embedded exploratory case study aimed at exploring resident autonomy. As an exploratory case study it provided insight into many issues previously unexamined. Large amounts of data are generated from case study designs and the researcher must ensure that realistic timeframes are planned.

Phase two of this study was guided by action research principles. In order to adopt this approach for research it is desirable that the researcher has professional experience and success with change management, facilitation and project management. It is recognised that change at the organisational level was not addressed rather the change was implemented at the clinical level. Action research report writing is challenging and does not always suit traditional linear approaches and some researchers may consider this a limitation. This thesis adopted a patchwork approach in order to report on the action research phase of this study and reduce this limitation.
7.5.3 Method issues

Phase one data collection methods were designed and developed from the concept analysis of resident autonomy. This enabled consistency in the exploration across the data sets. Interviews as a data collection tool on their own may not always provide accurate details of real world practices, rather they provide subjective interpretations of those practices. Therefore a combination of interviews, observations and documentary data collection methods were used. If a researcher chooses interviews as a data collection method then their interview technique must be practised. The use of pilot interviews ensured that the technique was sufficient to elicit the relevant information. The quality of the interview is dependent on the skills of the interviewer. The researcher availed of one-to-one tuition on research interview technique in order to develop these skills prior to collecting the data. At times during the course of the interviews, some participants tended to move away from the discussion topic and talk about their own individual concerns. It was decided to allow the participant to talk as it would be insensitive to show a lack of interest, and refocusing was done when the participant was ready.

For the observational data collection, some interactions were not observable due to the privacy needs of the resident (curtains around beds etc.) and the ethical principles of the research. It is also recognised that observational data may be vulnerable to the “Hawthorne effect” whereby people behave differently when being observed. The researcher believes that her familiarity with the people in the case study site helped to reduce this effect. However the researchers familiarity with the environment may also be seen as a limitation this was overcome by maintaining a reflective journal which helped the researcher to look at issues with “new eyes” and therefore reduced the likelihood of missing important data. It could be argued that observing for longer time periods may have generated more data and different findings. However, given the experience from the pilot, longer time periods may have yielded more data in terms of quantity but less in terms of quality. Furthermore the time sampling employed ensured that an entire shift was observed.
Issues of confidentiality were key for the documentary data collection and again this required sufficient time to be factored in for this stage of data collection as no data could be removed from the case study site with any identifiable information on it. All of the residents sets of documentation were photocopied on site and all information which identified them was erased prior to the documents leaving the case study site.

7.5.4 Issues related to validity of data collection tools

It was the first time for these interview, observation and documentary data collection tools to be used in a research study however all of the data collection tools were designed from the literature and subsequent concept analysis. Furthermore all of the data collection tools were piloted prior to use in the main study. Future research studies may contribute to the validation of these data collection tools. The KAOP as a data collection tool has recently been re-affirmed by Doherty et al, (2011) and its reliability has been found to be alpha 0.79 (Lambrinou et al, 2005).

7.6 Conclusions

To conclude the chapter and thesis, the following are suggested as directions for future work.

7.6.1 Future Research Directions

Hollander and Kane (2003) suggest that research can improve practice in residential care. They suggest that research can contribute in four ways: 1) By developing new concepts and methods that help define fundamental goals, 2) By designing practical tools that document the nature and magnitude of problems to be addressed and the outcomes that are achieved, 3) By assessing interventions and strategies for improving care and finally 4) By evaluating new models, programs, or systems of service delivery. While this research was the first to specifically explore autonomy for older people in residential care in Ireland, phase two only focused on enhancing one small element of autonomy. Therefore, now that there are attributes of resident autonomy identified, future research could focus on ways in which resident autonomy can be further enhanced.
Research could also be undertaken to further develop the data collection tools by testing them in other residential care units in other countries.

While this research gathered staff, residents and resident families perspectives further research could be undertaken with registered providers of residential care in order to gather their understanding of the issues of importance for older people in their residential care facilities and in order to gather their understanding of the importance of resident autonomy.

This research study found that both staff and residents felt there was little or no time for meaningful engagement in order to get to know and understand the residents wishes. Gubrium (1997) argued that staffs statements about being rushed is not linked to the absolute time they have to do their work but rather to the amount of time they wish to allocate to sharing the company of other staff members. Further research could analyse time management and workload in residential care and could individually examine the promoting and prohibiting factors for resident autonomy as identified in this research.

This research found a link between the residents level of independence and the amount of autonomy they experienced, this suggests that further research is needed in order to explore ways in which staff and families involved in residential care can better facilitate residents to delegate their needs when their independence is impaired.

### 7.6.2 Concluding comment

This thesis presented the findings of a two phase study carried out to address the research objectives. The primary aim of this research was to explore autonomy for older people in residential care. This was the first exploration of this phenomena in Ireland. The secondary aim was to enhance one aspect of resident autonomy in the real world of practice. Some important conclusions were made regarding these issues, and the insights obtained provide a clearer picture regarding resident autonomy, which may usefully inform nursing practice, education and research.
References


Blackham, & S. V. E. Probert (Eds.), Systems thinking in Europe (pp. 591-596). New York: Plenum Press.


References


References


References


Melbourne: Australian Housing and Urban Research Institute, Queensland Research Centre.


References


Royal College of Nursing (1997) *What a difference a nurse makes: a report on the benefits of expert nursing to the clinical outcomes of nursing older people.* London: RCN.


References


References


Appendix 1: HIQA Standards Summary
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<td>Standard 18: Routines and Expectations</td>
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<td>Standard 19: Meals and Mealtimes</td>
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<td>Standard 20: Social Contacts</td>
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<td>Standard 23: Staffing Levels and Qualifications</td>
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<td>Standard 24: Training and Supervision</td>
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<th>Section 6: The Care Environment</th>
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<td>Standard 25: Physical Environment</td>
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<td>Standard 26: Health and Safety</td>
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<th>Section 7: Governance and Management</th>
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</thead>
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<tr>
<td>Standard 27: Operational Management</td>
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<tr>
<td>Standard 28: Purpose and Function</td>
</tr>
<tr>
<td>Standard 29: Management Systems</td>
</tr>
<tr>
<td>Standard 30: Quality Assurance and Continuous Improvement</td>
</tr>
<tr>
<td>Standard 31: Financial Procedures</td>
</tr>
<tr>
<td>Standard 32: Register and Residents’ Records</td>
</tr>
</tbody>
</table>
Appendix 2: Concept Analysis Illustration
RESIDENT AUTONOMY

Attributes

Antecedents

Resident autonomy

Consequences

Empirical Referents

Staffs attitudes are positive in relation to ageing and older people.

Values and beliefs of staff are person-centred and non-paternalistic.

Staff communicate effectively with each other, with residents and with visitors.

Resident assessment is robust and involves gathering life histories.

An atmosphere of openness, motivation and flexibility.

Respect for dignity and for fellow human beings evident between staff and between staff and residents.

Staffs attitudes are positive in relation to ageing and older people.

Values and beliefs of staff are person-centred and non-paternalistic.

Staff communicate effectively with each other, with residents and with visitors.

Resident assessment is robust and involves gathering life histories.

An atmosphere of openness, motivation and flexibility.

Respect for dignity and for fellow human beings evident between staff and between staff and residents.

Residents capacity encouraged and maintained.

Residents delegate care needs based on the right to self-determination and the rights of older people.

Resident assessment is robust and involves gathering life histories.

An atmosphere of openness, motivation and flexibility.

Respect for dignity and for fellow human beings evident between staff and between staff and residents.

Residents express an enhanced quality of life, increased satisfaction in daily routine and participate in social activity.

Staff retention.

Homely atmosphere.

Evidence of negotiated care plans which include a focus on the resident's social and recreational needs.

Life histories of the resident - knowing the person.

Observation of effective communication between staff, residents and visitors.

Negotiated care plans encouraged through open and respectful communication.

Family or significant others included when resident is cognitively impaired.

Residential unit has culture and atmosphere of flexibility within an ethos of maintaining resident dignity.

Residents involved in decision making.

An observable change in the way staff work e.g. a change from routinised and ritualistic practice to a more person-centred, flexible and continuously negotiated care delivery.

Observation of residents expressing their wants, needs, wishes and desires. Evidence that staff strive to meet these needs. Evidence of family involvement. Recognition of the residents past and present life which may shape their wishes. Care plans to reflect this A clear resident focus.

Observation of encouragement to maintain capacity and participate socially in daily life.

Observations, interviews, documentary analysis, assessments of quality of life, staffs attitudes.
Appendices

Appendix 3 : Model Cases
**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 armchair 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 covered with 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.
Appendix 4: Methodologies
<table>
<thead>
<tr>
<th>Research question</th>
<th>Paradigm/ Theoretical Perspective</th>
<th>Ontology</th>
<th>Epistemology</th>
<th>Methodology</th>
<th>Methods</th>
<th>Strengths/ Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the truth? What is a plausible explanation? What can we establish with certainty?</td>
<td>Positivism</td>
<td>&quot;Real&quot; ordered &amp; regular world.</td>
<td>Objective/Dualist</td>
<td>Experimental, manipulative, Scientific, verification of hypotheses.</td>
<td>Quantitative, e.g. experiments, surveys. Strong focus on reliability &amp; validity.</td>
<td><em>Strength:</em> The researcher can add control to the experiment. <em>Limitation:</em> Does not account for subjective variables.</td>
</tr>
<tr>
<td>How do people cope/deal with describ their situation?</td>
<td>Pragmatism</td>
<td>Practical world/situational responsiveness.</td>
<td>Subjective/Practical</td>
<td>Different methods are appropriate for different situations – mixed methods.</td>
<td>Qualitative &amp; quantitative approaches e.g. interviews, observations, questionnaires.</td>
<td><em>Strength:</em> In the real world of practice. <em>Limitation:</em> Researcher needs various skills for multiple data collection and analysis.</td>
</tr>
<tr>
<td>What is the meaning of the lived experience of this phenomenon for this group of people?</td>
<td>Interpretivism/ Pragmatism</td>
<td>The lived experience.</td>
<td>Objective/Subjective</td>
<td>Phenomenology</td>
<td>In-depth interviews. Narratives.</td>
<td></td>
</tr>
<tr>
<td>What can participants reveal in order to generate a theory?</td>
<td>Interpretivism</td>
<td>Open to new ideas – no fixed assumptions.</td>
<td>Objective/pragmatic</td>
<td>Grounded Theory</td>
<td>In-depth &amp; open interviews.</td>
<td></td>
</tr>
<tr>
<td>How can understanding &amp; meaning from multiple perspectives explain an experience?</td>
<td>Interpretivism/ Constructionism</td>
<td>Individuals attach meaning to their actions.</td>
<td>Multiple perspectives.</td>
<td>Case study</td>
<td>Multiple e.g. interviews, observations, documentary analysis etc.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5 : Ethics letter
Dear Claire,

I have considered this project, and I am happy to grant Chairman’s approval to proceed.

Yours sincerely,

Dr. S. T. O’Keeffe
Chairman Research Ethics Committee.
Appendix 6: Information Sheet
Information Sheet

I would like to let you know that a research study is commencing on this unit. It is hoped that the outcome of this study will contribute to understanding resident care needs.

This study will involve several methods of data collection. These include interviews with staff, residents and residents’ families, observations of the working day, staff surveys, and looking at nursing documentation. Within this study all participants’ anonymity and confidentiality will be guaranteed. The unit will remain anonymous and people’s names will be replaced with numbers.

I am happy to answer any of your questions, both now and as the study progresses. Your participation is wholly voluntary; if you do decide to participate you will be free to withdraw at any time. Your decision to participate or not in this study will be fully accepted and will not affect your employment or care.

Yours Sincerely,

Claire Welford

Tel: 087 - 9034110
Email: claire.welford@nuigalway.ie
Appendix 7: Consent for Whole Study
CONSENT FORM

As you are aware, we are currently carrying out a research study on this unit. It is hoped that the outcome of this study will contribute to improving resident care. This study will involve several methods of data collection. These include interviews with staff, residents and residents’ families, observations of the working day, staff surveys and looking at nursing documentation.

Within this study all participants’ anonymity and confidentiality will be guaranteed. The unit will remain anonymous and people’s names will be replaced with numbers.

I am happy to answer any of your questions, both now and as the study progresses. Your participation is wholly voluntary; if you do
decide to participate you will be free to withdraw at any time. Your decision to participate or not in this study will be fully accepted and will not affect your employment or care.

I ____________________________ (Signature)
___________________________ (Print Name)

agree to participate in this study.
Appendix 8: Consent for Interviews
Informed Consent Form

This form seeks your consent to use the information generated from this conversation to guide the current research project, which is looking at residential care.

All information relating to your identity will be kept anonymous and only I will have access to this information.

Declaration

I am aware of this project and this consent form has been explained to me.

I have read this consent form and I have had the opportunity to ask questions that have been answered to my satisfaction. I freely and voluntarily agree to the use of a tape recorder and to the use of information generated in this conversation to guide further work on the above
project. This does not affect my legal and ethical rights.

Participant’s Name:

______________________

Participant’s Signature:

______________________

Date: ______________

Statement of Researcher’s Responsibility
I believe that the participant understands my explanation of their consent to allow data to be used from this conversation and has freely given informed consent. I agree to maintaining the participant’s anonymity.

Researcher’s Name: ____________________

Researcher’s Signature: ____________________

Date: ______________
Appendix 9: Documentary Analysis Audit Tool
# Documentary Analysis

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Evident (Yes/No)</th>
<th>Frequency</th>
<th>Cite Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-governing, self-ruling, self-determining.</td>
<td></td>
<td></td>
<td><em>e.g.</em> Evidence that resident has been involved in making choices. Resident chose to stay in bed. Resident requested a different dinner. Resident chose clothing. Resident chose to go to day room, etc.</td>
</tr>
<tr>
<td>Care plans are negotiated. Family involvement.</td>
<td></td>
<td></td>
<td><em>e.g.</em> Evidence that staff have assisted resident in verbalising their needs. Resident demonstrated that he/she wanted or needed something and staff ensured this was made possible. Compromises reached. Family wishes documented.</td>
</tr>
<tr>
<td>Residents delegate care needs. Staff promote resident capacity</td>
<td></td>
<td></td>
<td><em>e.g.</em> Evidence documented of resident’s level of independence. Continuum of no assistance to full assistance. What resident can and can’t do for themselves, e.g. brushes own hair, shaves himself, can do zips but not buttons, etc.</td>
</tr>
<tr>
<td>Attribute</td>
<td>Evident (Yes/No)</td>
<td>Frequency</td>
<td>Cite Example(s)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-----------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Values and beliefs of staff are non-paternalistic. Ethos of maintaining dignity.</td>
<td></td>
<td></td>
<td>e.g. Resident treated as an equal with needs and wishes respected and recognised. Language use may denote preservation of dignity.</td>
</tr>
<tr>
<td>An atmosphere of openness, motivation and flexibility.</td>
<td></td>
<td></td>
<td>e.g. Evidence of cot sides/enablers use – how was this decision reached, mobility aids, acceptance of risky decisions. Evidence of being able to move freely around the unit and outside.</td>
</tr>
<tr>
<td>Open and respectful communication and sharing of information.</td>
<td></td>
<td></td>
<td>e.g. Evidence of negotiated care. Power is shared between resident and staff in relation to decisions about daily care needs and information sharing about health and well-being.</td>
</tr>
<tr>
<td>Recognition of past and present life, which may shape their wishes. Life histories.</td>
<td></td>
<td></td>
<td>e.g. Evidence of relationship between staff and resident, and between residents. Visitors. Ward activities – recreational. Documentation of residents’ likes and dislikes.</td>
</tr>
</tbody>
</table>
PHILOSOPHY OF CARE

Our aim is to ensure that each resident receives care of the highest standard, which is tailored to suit individual needs and embraces the core values of dignity, choice, independence and privacy. This is achieved by ensuring the delivery of a personal approach to nursing care with the most up to date research based practice. On admission, a holistic health assessment of each resident is carried out by a qualified staff nurse, and an individualised care plan developed to meet their assessed needs. The physical, emotional and spiritual care needs are negotiated in order to deliver the expressed wishes of the resident. Family are also encouraged to participate in this process.

All staff members of strive to create a relaxed environment where compassion and understanding for

The needs of the resident are paramount to our delivery of care.
Appendix 11: Observation Guide
### Observation tool

**Observation Period:** _______________________

<table>
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<tr>
<th>Attribute</th>
<th>Tick if observed</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-governing, self-ruling, self-determining.</strong></td>
<td></td>
<td>“Self-governing, self-ruling, self-determining” is about the automatic right to live your life as you choose based on UN Rights of Older People (therefore they are consulted and asked) while “Residents delegate care needs” is delegating the action of that choice – in other words, they may know what they want to do but may be physically unable to do it so it is delegated.</td>
</tr>
<tr>
<td>The resident is recognised to have rights to choose how they would like to spend the day.</td>
<td></td>
<td><strong>Residents delegate care needs.</strong></td>
</tr>
<tr>
<td>E.g. <em>Staff are observed asking the residents whether or not they would like to get up, have a shower, go to day room, etc. Resident is observed choosing their dinner and what clothes they are going to wear.</em></td>
<td></td>
<td>If the resident is unable to attend to their own care needs they ask for or direct staff to do it for them or assist them. Staff do things based on what they know the resident would want (e.g. residents with dementia).</td>
</tr>
<tr>
<td>E.g. Resident requests a staff member to turn the TV on for them, or change their clothes, or asks for a shower, etc. or staff bring a resident with dementia to the day room because they know he/she likes company.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Care plans are negotiated. Family involvement.

Where do staff sit to do their writing? Are there care plan meetings or do staff talk to each other about care plans? Do they talk to the residents or the families about the care plans?

*Example:* Staff are observed listening to residents’ requests and meeting and documenting these requests. Staff are observed encouraging residents to talk and answer questions about what they would like. When family visit it is observed that staff communicate with them about what the resident may like or dislike; negotiation and compromises are openly discussed.

### Values and beliefs of staff are non-paternalistic. Ethos of maintaining dignity.

The comments made by staff to each other and to the resident respect the resident. Care is approached in a respectful and dignified manner.

*Example:* Staff do not use language like “will we have a shower?” or “let’s do the feeds” or “who will we do next?”. Staff engage with the residents in adult conversation. Curtains drawn and doors closed when required. Bibs removed after dinner. Clothes on residents are appropriate.
### An atmosphere of openness, motivation and flexibility.

Where do staff start their work in the morning? Is it the same everyday? Do they plan together and include the resident? If a resident requests something different to the routine, how do staff respond? Do staff appear motivated?

*e.g.* Residents are enabled to leave the unit to go to the garden or to church, etc. Staff ask residents what suits them and plan their morning according to their wishes rather than a set way of doing things. “Well I can’t do that for you now but how about this evening, would that suit?” Residents are observed talking to staff about issues that are on their mind – this reflects an openness.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Tick if observed</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>An atmosphere of openness, motivation and flexibility.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Communication. Capacity encouraged and maintained.

Do staff communicate in more ways than the spoken word? Body language, eye contact, non-verbals. How do they speak to each other? Do they automatically do things for the resident or encourage them to do it for themselves?

*e.g.* “Would you like to go to the art class? Go on, you know you can do that yourself. Would you like to go for a walk? You can wash your own face then I will be back to you. Will I get your razor and you can shave yourself? Would you like me to open the garden doors?”
### Recognition of past and present life, which may shape their wishes. Biographies/life histories.

There may be photos around the residents' beds, they may be wearing an item of clothing that they always wore like a cap, etc.

**e.g.** Staff are observed chatting to residents about their family or their hobbies and interests, “oh he used to love playing the violin”. Recreational activities are observed such as art, music, gardening, reading, etc. High-dependency residents are also observed to receive some recreational stimulation like playing them some music (if that is what they used to like), hand massage, etc.
Appendix 12: Interview Guides
Staff Interview Guide

Attribute
Residents involved in decision-making and capacity encouraged and maintained.

Question Theme
What decisions do residents make on a daily basis?

Question
Tell me about one of the residents in your allocation this morning?

Probes
What options are available to the residents for washing/dressing/toileting/eating/activities, etc? To what extent can the residents make decisions?

Attribute
Residents delegate care needs based on the right to self-determination and the rights of older people.

Question Theme
Do residents ask for assistance or how do they demonstrate that they need assistance?

Question
Think about one of the residents you have cared for today?

Probes
How do you know their abilities? Do they ask for help? Do you encourage them to do things for themselves?

Important Probes

Decision-making

Flexibility of routine

Autonomy
Attribute
Negotiated care plans encouraged through open and respectful communication

Question Theme
How do you get to know the residents’ likes and dislikes?

Question
I’m interested to find out how you get to know what the residents can and can’t do for themselves.

Probes
How do you find out what food they like/dislike, their hobbies or interests etc. Where is info stored? Do all staff use residents’ notes to guide care? If not then what are the notes used for? What do you think is important to record?

Attribute
Culture and atmosphere of flexibility within an ethos of maintaining resident dignity

Question Theme
How do you decide how to organize the day?

Is there a pre-determined routine to the day and if so how is that determined and what do you think of it?

Question
Tell me about your day so far?

Probes
Is this different to other days? What determines your approach to the day? Is there anything you would like to do differently?

Final Question

Question Theme
Autonomy

Question
I’m interested in finding out what autonomy for older people in residential care means - what do you think it is about?

Probes
How much input does a resident have in their care? Can you give an example? What do you think enables or hinders it?
<table>
<thead>
<tr>
<th>Number/Code</th>
<th>Age</th>
<th>Sex</th>
<th>Job Title</th>
<th>Length of time working on the unit</th>
<th>Education/Professional development</th>
</tr>
</thead>
</table>

*Each participant was assigned a numbered code instead of using their name, e.g. S01*
Resident Interview Guide

Important Probes

Decision-making

Flexibility of routine

Autonomy
<table>
<thead>
<tr>
<th>Number/Code</th>
<th>Age</th>
<th>Sex</th>
<th>Barthel Score</th>
<th>Date admitted and length of time on the unit</th>
<th>Reason for admission/ Clinical diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The researcher assigned a code to the resident instead of their name, e.g. R01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Notes
Family Interview Guide

Attribute
Residents involved in decision-making, and capacity encouraged and maintained.

Question Theme
What decisions does your relative make on a daily basis?

Question
Can you tell me how your relative spends their day?

Probes
Does your relative choose what clothes to wear? Does anyone help them with that? What about meals? Can they choose what to eat? Or what pastimes/activities to do?

Attribute
Residents delegate care needs based on the right to self-determination and the rights of older people.

Question Theme
How do you or your relative seek assistance and do you receive the assistance desired?

Question
Tell me what help your relative gets from staff and how they get that help?

Probes
Does your relative get too much/too little help? Do staff help them to do things the way they like or the way you request? How do you and your relative get on with the staff?

Attribute
Negotiated care plans encouraged through open and respectful communication.

Question Theme
Do all staff members show an interest in your relative’s likes and dislikes? Are they asked how they would like to spend their day?

Question
Tell me how do staff know what your relative likes to eat/wear/spend their time doing? And what they can and can’t do for themselves.

Probes
Do staff ask your relative on a daily basis? Do you think all staff know what your relative likes or dislikes? Do you or your relative chat about these things with the staff?
**Important Probes**

**Decision-making**

**Flexibility of routine**

**Autonomy**
### Appendices

<table>
<thead>
<tr>
<th>Number/Code</th>
<th>Age</th>
<th>Sex</th>
<th>Barthel Score</th>
<th>Date admitted and length of time on the unit</th>
<th>Reason for admission/ Clinical diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The researcher assigned a code to the family member instead of their name, e.g. F01</td>
<td></td>
<td></td>
<td>Researcher scored this</td>
<td></td>
<td>Further information obtained from medical chart</td>
</tr>
</tbody>
</table>

### Additional Notes
Appendix 13: Floor Plan
Appendix 14: Data Reduction
## Data Reduction: Start List Codes, Emergent Codes

<table>
<thead>
<tr>
<th>Start List Codes Including Emergent Codes</th>
<th>Proposition Statement</th>
<th>Units of Meaning Coded</th>
<th>Sources</th>
<th>Type of Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity</td>
<td>This node contains reference to residents capacity and whether or not it is encouraged and maintained.</td>
<td>60</td>
<td>24</td>
<td>Start List</td>
</tr>
<tr>
<td>Communication</td>
<td>This node refers to all types of communication - verbals, non-verbals, staff communicating with each other, with residents and with family. It also refers to residents communicating with each other and with staff and visitors.</td>
<td>58</td>
<td>15</td>
<td>Start List</td>
</tr>
<tr>
<td>Defining Autonomy</td>
<td>This node refers to what staff and residents and residents families think about autonomy - how do they define it?</td>
<td>25</td>
<td>14</td>
<td>Start List</td>
</tr>
<tr>
<td>Knowing the Resident</td>
<td>This node refers to how staff get to know who the residents are and what the residents can and can’t do for themselves. Are care plans used? When and where does writing occur?</td>
<td>70</td>
<td>27</td>
<td>Start List</td>
</tr>
<tr>
<td>Maintaining Dignity</td>
<td>This node refers to an ethos of maintaining resident dignity. Staff are non-paternalistic. Positive attitudes and values for older people are evident.</td>
<td>24</td>
<td>13</td>
<td>Start List</td>
</tr>
<tr>
<td>Making Decisions</td>
<td>This node refers to residents involvement in decision-making</td>
<td>74</td>
<td>26</td>
<td>Start List</td>
</tr>
<tr>
<td>Motivation for the Job</td>
<td>This node refers to a consequence of autonomy which is staff retention. Are staff motivated, enthusiastic and interested in their work? What factors affect motivation and hence retention?</td>
<td>48</td>
<td>23</td>
<td>Start List</td>
</tr>
<tr>
<td>Recreational activity</td>
<td>This node refers to residents being involved in activities other than personal care. Meal times are a sociable occasion. Residents hobbies and interests may be visible around their bedside or in their rooms. Staff acknowledge the importance of recreational activities and see it as part of the residents day.</td>
<td>69</td>
<td>21</td>
<td>Emergent</td>
</tr>
<tr>
<td>Residents delegate</td>
<td>This node refers to “Self-Governing, Self-Ruling, Self-Determining” which is about the automatic right to live your life as you chose based on UN Rights of Older People (therefore residents are consulted and asked) while “Residents delegate care needs” is delegating the action of that choice in other words they may know what they want to do but may be physically unable to do it so it is delegated.</td>
<td>8</td>
<td>4</td>
<td>Start List</td>
</tr>
<tr>
<td>Role of Family</td>
<td>This node refers to family or significat others being included when resident is cognitively impaired. What role do families play in care provision. Do they visit often?</td>
<td>50</td>
<td>21</td>
<td>Start List</td>
</tr>
<tr>
<td>Routine V's Flexibility</td>
<td>This node refers to an atmosphere of openness and flexibility in the residential unit. It refers to how much routine exists in the day and can that routine be altered when required? It looks at who dictates the routine.</td>
<td>91</td>
<td>25</td>
<td>Start List</td>
</tr>
<tr>
<td>Self-Determination</td>
<td>This node refers to “Self-Governing, Self-Ruling, Self-Determining” which is about the automatic right to live your life as you chose based on UN Rights of Older People (therefore residents are consulted and asked) while “Residents delegate care needs” is delegating the action of that choice in other words they may know what they want to do but may be physically unable to do it so it is delegated.</td>
<td>46</td>
<td>23</td>
<td>Start List</td>
</tr>
<tr>
<td>Ward atmosphere</td>
<td>This node refers to the general atmosphere of the residential unit - is it homely, lively, interactive, visitors etc.</td>
<td>36</td>
<td>12</td>
<td>Emergent</td>
</tr>
</tbody>
</table>
Appendices

Appendix 15: Data Display
# Appendices

## Data Display

<table>
<thead>
<tr>
<th>Top Level Codes</th>
<th>Outcome Proposition Statement</th>
<th>2nd Level Codes</th>
<th>3rd Level Codes</th>
<th>Units of Meaning Coded</th>
<th>Sources Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defining Autonomy</strong></td>
<td>Nurses believed that resident autonomy is about residents having choices, calling their own shots, being able to speak up for themselves, making their own decisions, having freedom of speech, having a say in their care and doing what they want. Nurses also stated that autonomy is dependent upon the approachability of staff and staff's attitudes, that it is about empowering residents, treating them with respect and doing what's in the best interest for the resident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Knowing the resident</strong></td>
<td>Really knowing the resident is about understanding the ageing process, having an awareness of the residents life prior to entering residential care, gathering information about their likes and dislikes and together planning care. The continuity of staff is essential for this process to succeed.</td>
<td></td>
<td></td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Knowing the residents past</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What if they can't tell you</td>
<td></td>
<td>7</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgetting the person</td>
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<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likes and dislikes</td>
<td></td>
<td>15</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acknowledging age</td>
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<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of staff</td>
<td></td>
<td>7</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care planning</td>
<td></td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When and where</td>
<td></td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capacity</strong></td>
<td>Resident capacity is about encouraging them, knowing their abilities and about staff sharing control.</td>
<td></td>
<td></td>
<td>60</td>
<td>24</td>
</tr>
<tr>
<td>Independence V's Dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent on staff not ability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff taking control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing the residents abilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't presume dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouragement</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Resident apathy</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

351
<table>
<thead>
<tr>
<th>Maintaining dignity</th>
<th>Respecting the resident maintains their dignity and this includes maintaining privacy, doing the little things for them and managing their wardrobe and clothing.</th>
<th>24</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wardrobes &amp; clothing</td>
<td></td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Communal clothing</td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Its just the little things</td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Privacy</td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Respecting the resident</td>
<td></td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>They weren't always like this</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>On-going education</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Residents delegate</td>
<td>Staff should not assume what a physically dependent resident wants rather should wait for care needs to be delegated.</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Motivation for the job</td>
<td>Staff need to feel appreciated, need to have the right skills and need to be interested in older people. It must be appreciated that it is difficult to maintain motivation due to the hard physical nature of the work which is tiring. The job requires the right personality and good teamwork.</td>
<td>48</td>
<td>23</td>
</tr>
<tr>
<td>Interested in older people</td>
<td></td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Choose to work in residential care</td>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Teamwork</td>
<td></td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Not participating</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Feeling appreciated</td>
<td></td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>The right skills</td>
<td></td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>The right personality</td>
<td></td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Tiring and boring</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hard work</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Residents dependence</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Role of Family</td>
<td>The family play an important role in getting to know the resident and in subsequent care planning. Some provide clothes, take residents out and visit.</td>
<td>50</td>
<td>21</td>
</tr>
<tr>
<td>Providing clothes</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Visiting</td>
<td></td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Not visiting</td>
<td></td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Taking residents out</td>
<td></td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Not taking</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
## Appendices

### Ward Atmosphere

The ward atmosphere seems to depend on what staff are on-duty, it also depends on the level of care residents require or how interactive they are. It has friendly staff. Gerontological care is often perceived negatively.

<table>
<thead>
<tr>
<th>Pre-Conceptions</th>
<th>6</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depends on staff on-duty</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Friendly</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Positive</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Negative</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depends on residents</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Observed</td>
<td>18</td>
<td>2</td>
</tr>
</tbody>
</table>

### Routine V's Flexibility

This is a constant struggle discussed by all participants. It includes how care is planned, resident dependence and the staff on duty. Staff's unwillingness to change routine and going with the flow begs the question - who's flow? Staff's obsession with physical care drives the routine, contributes to the rushing and hurrying and dictates the time available to do or not do other things.

<table>
<thead>
<tr>
<th>Going with the flow - who's flow</th>
<th>24</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident dependence</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Rushing or hurrying</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Depends on staff</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Time and timing</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Care planning</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>No planning</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

### Communication

This is not only about how staff communicate with residents but also about how they communicate with each other. It is about staff's abilities to communicate non-verbally with residents, be approachable to residents, families and visitors. Overall it is about how good communication can build relationships.

| Not just physical care | 7 | 5 |

| residents out | 10 | 6 |

| Different levels of activity | 8 | 2 |

| Care planning | 36 | 12 |

353
Appendix 16: Conclusion-Drawing and Verification
## Conclusion Drawing and Verification

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Units of Meaning Coded</th>
<th>Sources Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Being Personal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a - Being Impersonal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine V's Flexibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care planning</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Depends on staff</td>
<td>12</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Going with the flow - who's fit</td>
<td>24</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Not just physical care</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Resident dependence</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Rushing or hurrying</td>
<td>12</td>
<td>10</td>
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</tr>
<tr>
<td>Time and timing</td>
<td>11</td>
<td>7</td>
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</tr>
<tr>
<td>Ward atmosphere</td>
<td>36</td>
<td>12</td>
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</tr>
<tr>
<td>1b - Being Personalised</td>
<td></td>
<td></td>
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<tr>
<td>Recreational activity</td>
<td>69</td>
<td>21</td>
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<tr>
<td>Residents delegate</td>
<td>8</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>1c - Person to Person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>117</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Approachable staff</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Building relationships</td>
<td>13</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>No time to communicate</td>
<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>Not all residents can talk</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Staff to staff communication</td>
<td>8</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Talking &amp; listening to the resident</td>
<td>21</td>
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<td></td>
</tr>
<tr>
<td>Knowing the resident</td>
<td>119</td>
<td>27</td>
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</tr>
<tr>
<td>Acknowledging age</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>Care planning</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>When and where</td>
<td>4</td>
<td>4</td>
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</tr>
<tr>
<td>Continuity of staff</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Knowing the residents past</td>
<td>19</td>
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<tr>
<td>Forgetting the person</td>
<td>3</td>
<td>3</td>
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<tr>
<td>What if they can't tell you</td>
<td>7</td>
<td>6</td>
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<tr>
<td>Likes and dislikes</td>
<td>15</td>
<td>10</td>
<td></td>
</tr>
<tr>
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<td>47</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Its just the little things</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Privacy</td>
<td>3</td>
<td>2</td>
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<td>8</td>
<td>7</td>
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</tr>
<tr>
<td>Wardrobes &amp; clothing</td>
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<tr>
<td>2a - Role of Family</td>
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<tr>
<td>2b - The Personality</td>
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<tr>
<td>Capacity</td>
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<td>24</td>
<td></td>
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<tr>
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<td>26</td>
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<tr>
<td>Self-Determination</td>
<td>46</td>
<td>23</td>
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<tr>
<td>Motivation for the job</td>
<td>67</td>
<td>23</td>
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<tr>
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<tr>
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<td>1</td>
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<td>8</td>
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<td>Tiring and boring</td>
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<tr>
<td>Communication</td>
<td>117</td>
<td>19</td>
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<td>7</td>
<td>5</td>
<td></td>
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<tr>
<td>Building relationships</td>
<td>13</td>
<td>6</td>
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<tr>
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<td>3</td>
<td>3</td>
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<tr>
<td>Not all residents can talk</td>
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<td>Staff to staff communication</td>
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<tr>
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<td>When and where</td>
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<tr>
<td>Forgetting the person</td>
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<td>3</td>
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<tr>
<td>What if they can't tell you</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Likes and dislikes</td>
<td>15</td>
<td>10</td>
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<tr>
<td>Maintaining dignity</td>
<td>47</td>
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<tr>
<td>Its just the little things</td>
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<tr>
<td>Residents delegate</td>
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<td>5</td>
<td></td>
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<tr>
<td>Role of Family</td>
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<td></td>
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</tr>
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<td>Care planning</td>
<td>10</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Providing clothes</td>
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</tr>
<tr>
<td>Taking residents out</td>
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</table>
Appendix 17: Kogan’s Attitudes Survey, and Letter of Permission
KOGAN’S ATTITUDES TOWARD OLD PEOPLE SCALE

Directions: Circle the LETTER on the scale following each statement, according to the following key, that is closest to your opinion of old people.

Key:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Slightly Agree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Slightly Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td>F</td>
</tr>
</tbody>
</table>

1. It would probably be better if most old people lived in residential units with people their own age.
A ... B ... C ... D ... E ... F

2. There is something different about most people; it’s hard to find out what makes them tick.
A ... B ... C ... D ... E ... F

3. People grow wiser with the coming of old age.
A ... B ... C ... D ... E ... F

4. Most old people get set in their ways and are unable to change.
A ... B ... C ... D ... E ... F

5. Most old people would prefer to quit work as soon as pensions or their children can support them.
A ... B ... C ... D ... E ... F

6. Most old people tend to let their homes become shabby and unattractive.
A ... B ... C ... D ... E ... F

7. Most old people are very relaxing to be with.
A ... B ... C ... D ... E ... F

8. Old people have too much power in business and politics.
A ... B ... C ... D ... E ... F

9. Most old people make one feel uneasy.
A ... B ... C ... D ... E ... F
Appendices

10. It would probably be better if most people lived in residential units with younger people.
   A...............B.............C..................D.............E.............F

11. Most old people are capable of new adjustments when the situation demands it.
   A..................B...............C.................D..............E..................F

12. Most old people bore others by their insistence on talking “about the good old days”.
   A..................B...............C.................D..............E..................F

13. Most old people spend too much time prying into the affairs of others and giving unsought advice.
   A..................B...............C.................D..............E..................F

14. Most old people can generally be counted on to maintain a clean, attractive home.
   A..................B...............C.................D..............E..................F

15. Old people should have power in business and politics.
   A..................B...............C.................D..............E..................F

16. If old people expect to be liked, their first step is to try to get rid of their irritating faults.
   A..................B...............C.................D..............E..................F

17. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.
   A..................B...............C.................D..............E..................F

18. In order to maintain a nice residential neighborhood, it would be best if not too many old people lived in it.
   A..................B...............C.................D..............E..................F

19. There are a few exceptions, but in general most old people are pretty much alike.
   A..................B...............C.................D..............E..................F
20. Most old people should be more concerned with their personal appearance; they’re too untidy.
   A..................B..................C..................D..................E..................F

21. Most old people need no more love and reassurance than anyone else.
   A..................B..................C..................D..................E..................F

22. Most old people are irritable, grouchy, and unpleasant.
   A..................B..................C..................D..................E..................F

23. One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.
   A..................B..................C..................D..................E..................F

24. It is foolish to claim that wisdom comes with age.
   A..................B..................C..................D..................E..................F

25. Most old people are really no different from anybody else; they’re as easy to understand as younger people.
   A..................B..................C..................D..................E..................F

26. Most old people are cheerful, agreeable, and good humored.
   A..................B..................C..................D..................E..................F

27. Most old people tend to keep to themselves and give advice only when asked.
   A..................B..................C..................D..................E..................F

28. Most old people are constantly complaining about the behavior of the younger generation.
   A..................B..................C..................D..................E..................F

29. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.
   A..................B..................C..................D..................E..................F

30. When you think about it, old people have the same faults as anybody else.
   A..................B..................C..................D..................E..................F

31. It is evident that most old people are very different from one another.
   A..................B..................C..................D..................E..................F
32. Most old people make excessive demands for love and reassurance than anyone else.
   A.................B.......................C...................D....................E.............F

33. Most old people seem quite clean and neat in their personal appearance.
   A.................B.......................C...................D....................E.............F

34. One seldom hears old people complaining about the behavior of the younger generation.
   A.................B.......................C...................D....................E.............F

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Dear Ms. Welford:

I am very pleased to grant you permission to use my OP Scale in your doctoral research project. It is also encouraging to hear that you are making good progress on your collaborative research with Patricia Fuehr in Michigan. I look forward to learning more about it.

Best wishes,

Nathan Kogan, PhD
Professor Emeritus
New School for Social Research
And
Visiting Scholar
Educational Testing Service
Princeton, NJ 08541
Appendix 18: Dependency Categories and Reliability of the Barthel Index
Resident Dependency

Using the Barthel Index, values were assigned to each resident based on time and amount of actual physical assistance required. For example, a resident scoring 20 is continent, feeds him/herself, dresses him/herself, gets up out of bed and chairs, bathes him/herself and is mobile. However, this does not mean that he/she can live alone, remain unsupervised, cook or interact socially. Middle scores (15-19) imply that the resident can supply over 50% of the effort. A score of 0 means that the resident cannot perform any of the activities of living unaided and requires up to two people for assistance with care. This tool has good reliability and, according to Hartigan (2007), the validity of the Barthel Index has been extensively evaluated and demonstrated.

The Department of Health and children of Ireland categorises older people as low, medium, high and maximum dependency.

**Low Dependency**: Persons who need some support in the community and the more independent residents in residential accommodation who require little nursing care. They are usually independently mobile but may use a walking stick and have difficulty managing stairs.

**Medium Dependency**: Person whose independence is impaired to the extent that he or she requires residential care because the appropriate support and nursing care required by the person cannot be provided by the community. Mobility is impaired to the extent that the person requires supervision or a walking aid.

**High Dependency**: Independence is impaired to the extent that the person requires residential care but is not bed bound. The person may have a combination of physical and mental disabilities, may be confused at times and be incontinent. He/she may require a walking aid and physical assistance to walk.

**Maximum Dependency**: People whose independence is impaired to the extent that he/she requires nursing care. The person is likely to be bed bound, requires assistance with all aspects of physical care and may be ambulant but confused, disturbed and incontinent.
Reliability of the Barthel Index

Inter-rater and intra-rater Spearman rank-order correlation coefficients of 0.91 to 1.00 with a median of 0.96 were found with percentages of agreement ranging from 69% to 100%; and Kappa coefficient values ranging from 0.47 to 1.00 for the initial evaluation were also found. Intra-rater reliabilities were reported as: excellent agreement range for 83% of Kappa values; and Spearman rank-order correlation coefficients of 0.95 to 1.00 with a median of 0.99.

(Mahoney, Barthel and Surya, 1965).
## Barthel Index

Please tick appropriate score:

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<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td>Unable</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Needs help cutting, spreading butter etc or requires a modified diet</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Independent</td>
<td>2</td>
</tr>
<tr>
<td>Bathing</td>
<td>Dependent</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Independent (in shower)</td>
<td>1</td>
</tr>
<tr>
<td>Grooming</td>
<td>Needs help with personal care</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Independent face / hair / teeth / shaving (implements provided)</td>
<td>1</td>
</tr>
<tr>
<td>Dressing</td>
<td>Dependent</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Needs help but can do about half unaided</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Independent (including buttons, zips, laces, etc)</td>
<td>2</td>
</tr>
<tr>
<td>Bowels</td>
<td>Incontinent (or needs to be given enema)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occasional accident</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Continent</td>
<td>2</td>
</tr>
<tr>
<td>Bladder</td>
<td>Incontinent, or catheterised and unable to manage alone</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occasional accident</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Independent</td>
<td>2</td>
</tr>
<tr>
<td>Toilet use</td>
<td>Dependent</td>
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<tr>
<td></td>
<td>Needs some help, but can do something alone</td>
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</tr>
<tr>
<td></td>
<td>Independent (on and off, wiping)</td>
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<tr>
<td>Transfer (bed to chair and back)</td>
<td>Unable, no sitting balance</td>
<td>0</td>
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<tr>
<td></td>
<td>Major help, (one or two people physical) can sit</td>
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</tr>
<tr>
<td></td>
<td>Minor help (verbal or physical)</td>
<td>2</td>
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<tr>
<td></td>
<td>Independent</td>
<td>3</td>
</tr>
<tr>
<td>Mobility (on level surfaces)</td>
<td>Immobile or &lt; 50 meters</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Wheelchair dependent including corners, &gt;50</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Walks with help of one person (verbal or physical) &gt; 50 meters</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Independent (but may use any aid, for example stick) &gt; 50 meters</td>
<td>3</td>
</tr>
<tr>
<td>Stairs</td>
<td>Unable</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Needs help (verbal, physical, carrying aid)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Independent</td>
<td>2</td>
</tr>
<tr>
<td>Total score</td>
<td>.../20</td>
<td></td>
</tr>
</tbody>
</table>

1 20 = independent, 19 – 15 = mildly dependent, 14 – 10 = moderate dependent, 9 – 5 = severely dependent and 4 – 0 = very severe dependent.

Resident’s name: ........................................ Date of birth: ....../.....
Assessor’s name: ........................................ Date: ....../.....
Signed by: ........................................
Appendix 19: Documentary Analysis of Duty Rosters
## Documentary Analysis of 123 Daily Duty Rosters

<table>
<thead>
<tr>
<th>Total number of staff at morning report</th>
<th>Clinical Nurse Managers</th>
<th>Staff Nurses from unit</th>
<th>Sick leave</th>
<th>Nurse Relief</th>
<th>Health-care Assistants from unit</th>
<th>Sick leave</th>
<th>HCA Relief</th>
<th>Total at evening report</th>
<th>Nurses</th>
<th>HCA</th>
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<tbody>
<tr>
<td>9</td>
<td>1</td>
<td>4</td>
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<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1 until 11am</td>
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<td>10</td>
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<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1 until 10am only</td>
<td>4</td>
<td>2</td>
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<tr>
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<td>4</td>
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<td>0</td>
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Appendices

Appendix 20: Residents’ Documentation
## NURSING ASSESSMENT

### OBSERVATIONS ON ADMISSION:
- **Diagnosis:**
- **Temperature:** 36°C
- **Blood Pressure (BP):** 169/84
- **Pulse:** 80

### HOME CONDITIONS:
- **Lives Alone:** Yes [ ] No [x]
- **Who Lives With Patient:**
- **Type Of House:**
  - Yes [ ] No [ ]
  - Bungalow [ ]
  - Two Storey [ ]
- **Relations With Patient on Admission:**
  - Yes [ ] No [ ]

### PREVIOUS ADMISSIONS:
- **Consent for Operation Obtained:**
  - Yes [ ] No [ ]
- **Parent/Guardian Consent:**
  - Yes [ ] No [ ]
- **Procedures/Operation Explained to Patient:**
  - Yes [ ] No [ ]
- **By whom:**

### LIST PROCEDURES TO BE CARRIED OUT ON PATIENT:
- **Items:**
  - Whole Blood Count
  - Urea
  - Electrolytes
  - Full Blood Count
  - ECG

### Additional Notes:
- **Procedure Taken:**
  - 25/01/94
- **Results:**
  - **Blood:**
    - **WBC:** 9.2 x 10^9/L
    - **Hb:** 13.5 g/dL
    - **Platelets:** 250 x 10^9/L
  - **ECG:**
    - Normal sinus rhythm
  - **Blood Investigations:**
    - Normal
  - **Other Comments:**
    - **Blood:**
      - Slight anemia
      - Raised WBC
    - **ECG:**
      - Normal sinus rhythm
    - **Blood Investigations:**
      - Normal
## Nursing Assessment

**Patient:** Mr. Lib  
**Diagnosis:** CVA  
**Age:** 65  
**Gender:** Male  
**Operation:** Right Hemiparesis  
**Date of Operation:** March 05  
**Date:** 4/4/96  
**Time:** 12:30 PM

### General Appearance
- Normal ✓  Thin  Chubby
- Personal Hygiene: Good ✓  Poor
- PATIENT's EMOTIONAL STATE: Relaxed ✓  Apprehensive
- Other Comments:

### Mobility (Amount of Help Needed With)
- Walking: Used Electric Wheelchair
- Can Stand With Walking Frame
- Dressing: Needs Assistance
- Feeding: Laid by Nurse  Feeds Self
- Bathing: Needs Assistance to Shower
- Independent Daily Toilet

### Elimination
- Urine: Normal Frequency
- Incontinence
- Bowel Habits (Comments): Uses a toilet at night.

### Hearing
- Good ✓  Poor
- Other Comments:

### Sleep
- Uses Airing: Yes ✓  No
- Sleep Pattern: Normal

### Oral Inspection
- Condition of Teeth: Good
- Dentures: Yes ✓  No
- Other Comments:

### Vision
- Good ✓  Poor
- Wears Glasses: Yes ✓  No
- Other Comments:

### Pain
- Yes ✓  No
- Other Comments:

### Other Comments:
- Has undergone various medical treatments.
- Can understand all verbal communications.

### Signature:

### Nurses Name:

---

**NURSING ASSESSMENT (See Reverse of Sheet)**
<table>
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<tr>
<th>DATE And Time</th>
<th>Problem Number</th>
<th>EVALUATION OF CARE</th>
<th>SIGNATURE</th>
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<tr>
<td>18/6/06</td>
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<td>Completed bed, took complaints mild</td>
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<td>19/6/06</td>
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<td>Am. Verbalized, Encouraged to mobilize, Mobiling in wheelchair</td>
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<td>sleeping when observed overnight.</td>
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<td>10. Shower given last evening.</td>
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<td>Sitting out in wheelchair.</td>
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<td>No flap wound.</td>
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<td>Each late. when asked saying television</td>
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<td>in day hall no complaint raised.</td>
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<td>Pts. He needs some assistance in ADLs.</td>
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<td>He is very co-operative.</td>
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<td>took his diet and fluids independently</td>
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<td>No. Medication given as ordered</td>
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<td>Into the toilet without any problem</td>
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<td>Medications given</td>
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<td>as ordered no complaints</td>
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Appendix 21: Care Planning Presentation
Care Planning

- The aim of this session is to:
  - Review nursing theory on care planning.
  - Discuss the legal implications of documentation.
  - Discuss the new way of thinking in care planning for older people.

Care Planning

- In your own words write down what you think care planning means.

What is the difference between care planning and care plans?

- Care planning is the term used to describe all the activities that nurses undertake.
- Care plans are the written records of the care planning process.
- Care planning is a clinical skill.

The Nursing Process

- A systematic method that directs the nurse and Client as they:
  1. Determine the need for nursing care
  2. Plan and implement the care
  3. Evaluate the results

- It is client-centred and goal-orientated. The steps are inter-related and dependent on each other.

ASPIRE

- Assess
- Systematic nursing diagnosis
- Plan
- Implement
- Evaluate
- Recheck
Care Planning

- This is about identifying client goals and expected outcomes, which if achieved prevent, reduce or eliminate the problems identified in the nursing diagnoses and identify the interventions necessary. The plan of care is then communicated.
- It should be underpinned by a framework — which one are you using?
- How many nursing models have you heard of? Write down which ones you remember and how they worked.

Can you identify similarities between the two?
Why might this be?

RLT
- Maintaining a safe environment
- Communicating
- Breathing
- Eating and drinking
- Eliminating
- Personal cleansing and dressing
- Eliminating
- Controlling body temperature
- Working and Playing
- Mobilising
- Sleeping
- Expressing sexuality
- Dying

OREM
- Sufficient intake of air
- Sufficient intake of water
- Sufficient intake of food
- Satisfactory eliminative functions
- Activity balanced with rest
- Balance between solitude and social interaction
- Prevention of hazards to human life, human functioning and human well being
- Promotion of human functioning and development within social groups in accordance with human potential, known human limitations and the desire for normalcy.

Care Planning

- Initial Planning
- Ongoing Planning
- Discharge Planning

The written plan should be goal-orientated, efficient, effective and individualised.

Why Care Plan?

- Good care planning and care plans can help nurses to demonstrate that decisions about care were based on comprehensive assessment of the patient, systematic nursing diagnosis, planning of care, evidence based implementation of care checking and re-checking and evaluating.
Assessing

- This is the first step in the nursing process. It involves the systematic and continuous collection, validation and communication of client data.

Assessment Tools

- Are only one piece of evidence – also need to use your own assessment skills.
- Screening: identify the presence or severity of a particular problem.
- Diagnosis: identify the presence or severity of a particular problem.
- Description: describes a client's abilities
- Prediction: predicts the possibility of problems arising
- Think about the tools you use – which category are they?

Assessment Tools

- On their own they are not holistic – only assess one part of the person. But used with a nursing model they can be holistic.
- Write down how you think the Stratify tool can be applied holistically to the Activities of Living in a care plan.

12 Activities of Living

- Maintaining a safe environment
- Communicating
- Breathing
- Eating and drinking
- Eliminating
- Personal cleansing and dressing
- Eliminating
- Controlling body temperature
- Working and Playing
- Mobilising
- Sleeping
- Expressing sexuality
- Dying

Assessing

- Establish the database, which includes, history, physical assessment, review of the client's record, consultation with the family and the other members of the health care team.
- Actual and potential problems/needs.
- This is vital because the remaining steps depend upon accurate, complete, factual and relevant data.

Why Assess?

- Comprehensive, multidimensional assessment improves outcomes in terms of the health and well-being.
- Lack of assessment can result in avoidable health impairment and disability.
Benefits of Assessment

- A proactive assessment would have the aim of detecting problems at an early stage in order to initiate interventions designed to improve health, reduce disability and functional decline, improve social participation and improve the residents quality of life.

Needs Planning

- A written statement in terms of a residents problem, alteration in health state or client strength for which caring provides the primary therapy.
- The resident should have ownership of the statement – it should be written in terms that they understand.

- A medical diagnosis identifies the disease and remains the same.
- A nursing diagnosis focuses on identifying human responses to health and illness. It may change from day to day as the clients responses change.

The purpose of diagnosing is to identify:

1. Actual and potential needs in the way the resident responds to health or illness.
2. Factors that contribute to or cause these needs.
3. Strengths that the resident has which he or she can use to prevent or resolve these needs.

Can you identify which ones are essential for life maintenance and which enhance quality of life? Do any fall into both categories?

- Maintaining a safe environment
- Communicating
- Breathing
- Eating and drinking
- Eliminating
- Personal cleansing and dressing
- Eliminating
- Controlling body temperature
- Working and Playing
- Mobilising
- Sleeping
- Expressing sexuality
- Dying
The Dependence-Independence Continuum

- Maturity
- Social and economic circumstances
- Cultural background

Biologically determined or Socially and Culturally determined?

- Biological e.g. Ability to breathe is determined by genetics e.g. Asthma or Can be affected by the environment influence e.g. Pollution
- Socially or culturally e.g. Values and beliefs – what you eat and drink.

The Dependence-Independence Continuum

Therefore to say someone in independent with eating and drinking tells us very little because firstly we need to know what their values and beliefs are. e.g. Do they eat meat. Is their culture to eat alone or in groups etc. Do they believe that one must wash everyday?

Needs Planning: Setting Goals

- Goals should be short, directive statements as to the outcome of the nursing care.
- Can be short or long term
- Should be measureable.

"Even the longest journey must start where you stand – the journey of a thousand miles begins with one step".

SMART

- A number of milestones with small goals along the way.

Short term to Long term goals

PRODUCT

- Patient centred: is the goal tailored to the patients needs?
- Recordable: can you document the progress?
- Observable and measurable: can you evaluate the progress?
- Directive: who, what and how?
- Understandable and clear: is it written in a simple way?
- Credible: can it be realistically achieved?
- Time related: when is the goal meant to be achieved?

Implementing

- The nursing planning is carried out. This can be nurse independent, dependent or collaborative.
- It promotes self-care.
- The health care professional must be competent to perform the stated intervention.
- It is individualized.
Implementing

The health care professional plays many roles in implementing the goals:
- Caregiver
- Communicator
- Teacher
- Counsellor
- Leader
- Researcher
- Advocate

Think Point

Lily is one of your residents and she has a temperature of 39.8. Her face is hot to touch but pale and she has a dry mouth and sore throat. She complains of a headache and shivers, she is quite listless. The GP diagnoses an upper RTI and prescribes antibiotics, increased fluid intake and paracetamol. The nurse writes into the care plan:
- Note and report any further pyrexia.
- Give prescribed medication for 48hrs and record effect.
- Record temp.
- Use a fan or tepid sponge where appropriate.

Can you identify the strengths and limitations in this care plan?

Lily is one of your residents and she has a temperature of 39.8. Her face is hot to touch but pale and she has a dry mouth and sore throat. She complains of a headache and shivers, she is quite listless. The GP diagnoses an upper RTI and prescribes antibiotics, increased fluid intake and paracetamol. The nurse writes into the care plan:
- Note and report any further pyrexia.
- Give prescribed medication for 48hrs and record effect.
- Record temp.
- Use a fan or tepid sponge where appropriate.
- The directions are not clear in terms of who is to deliver the care, what are they meant to do and when and where are they mean to do it.
- There is no justification or rationale provided (evidence based).
- It does discuss how this illness affect the other AL’s.
- Although a time frame is put on the evaluation there is no indication of the re-checking status.
Reflect

• If I was an agency nurse would I know what care to provide to a resident from your care plans?

Re-checking and Evaluating

• Re-checking relates to the process of gathering information after carrying out a nursing intervention.
• It is specific and targeted and linked to a specific problem or goal.

Evaluating

• The health care professional and resident measure how well the resident has achieved the planned goals. It is decided to either terminate the plan, modify the plan or continue the plan.
• Identify factors which have contributed to the success or failure.

Think Point

• Think about some of your residents: list five activities that you carried out that could be considered to be re-checking?
• Give an example of evaluation.

Documenting

• This documentation is a legal document and provides a record of the care given to the resident.
• Care not documented is care not given.

Danger!

When does a record become a legal document?

• Whenever a document is relevant to an issue arising in court then it can be lawfully required to be produced in evidence.
• The court can subpoena the disclosure of Kardex or the nursing-process documents.
• Nurses are increasingly liable for improper documentation of client care because the law presumes that if the work was not documented, it was not done.

Documentation

• The clients chart is a permanent legal record that can powerfully defend or easily discredit the nurse when questions arise.
• Documenting medical records is often done hurriedly leading to documentation which is barely legible, unbelievably incomplete and perhaps legally indefensible.

(Allen, 1994)
Who Should Sign?

- The person who carries out the treatment.
- Thus even un-registered staff who have first hand knowledge of events may document.

Think Point

- A part time nurse noticed that the heels of an 87 year old female resident were red and dry. The nurse was not very familiar with the care plan system. She handed her observation over to the night nurse who told her not to worry about the care plan.
- The following morning the night nurse went on annual leave for two weeks.
- When the part-time nurse returned to duty 8 days later the resident had developed a gangrenous heel and was in pain.

Think Point

- Is there a case for negligence here?
- Who is responsible?
- Legally a case could be taken stating that the patient suffered “foreseeable harm”.
- Think about your own written records of care, does your documentation give enough information to justify your actions, omissions and decisions?

Protection

- Nurses must guard against liability by keeping up-to-date on every aspect of their practice, identifying risk factors associated with documentation, implementing risk factors associated with documentation, implementing risk-reduction practices and following these practices until they become second nature.
Appendix 22: Gantt Chart Phase Two
<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Following identification of a problem</td>
</tr>
<tr>
<td>2</td>
<td><strong>Action Planning</strong></td>
</tr>
<tr>
<td>2.1</td>
<td>On-site care planning education (Emancipation through Education)</td>
</tr>
<tr>
<td>2.2</td>
<td>Literature review and model identification</td>
</tr>
<tr>
<td>2.3</td>
<td>Reflection</td>
</tr>
<tr>
<td>3</td>
<td><strong>Action Taking</strong></td>
</tr>
<tr>
<td>3.1</td>
<td>Named nurse and HCA with residents</td>
</tr>
<tr>
<td>3.2</td>
<td>First draft of the template piloted with six residents</td>
</tr>
<tr>
<td>3.3</td>
<td>Questionnaire and reflection</td>
</tr>
<tr>
<td>3.4</td>
<td>Roll-out to rest of unit with critical companionship</td>
</tr>
<tr>
<td>3.5</td>
<td>Purchase care plan folders and shelving</td>
</tr>
<tr>
<td>3.6</td>
<td>Reflection and evaluation</td>
</tr>
<tr>
<td>3.7</td>
<td>Further changes to the template</td>
</tr>
<tr>
<td>3.8</td>
<td>Liaise with printers</td>
</tr>
<tr>
<td>3.9</td>
<td>Purchase care plan trolleys</td>
</tr>
<tr>
<td>3.10</td>
<td>Reflection</td>
</tr>
<tr>
<td>4</td>
<td><strong>Evaluating</strong></td>
</tr>
<tr>
<td>4.1</td>
<td>Repeat documentary analysis</td>
</tr>
<tr>
<td>4.2</td>
<td>Feedback results to the research unit</td>
</tr>
<tr>
<td>4.3</td>
<td>Reflection</td>
</tr>
<tr>
<td>5</td>
<td><strong>Specifying the Learning</strong></td>
</tr>
<tr>
<td>5.1</td>
<td>Report writing</td>
</tr>
</tbody>
</table>

**Phase 2** Commencing March 2010
Appendix 23: Action Plan Template
## Action Plan

**Statement of Objective/Goals:**

<table>
<thead>
<tr>
<th>What to Change or Implement</th>
<th>Enabling Activities</th>
<th>Person(s) Taking the Lead</th>
<th>Resources Required</th>
<th>Timeline</th>
<th>Assessment (evidence)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Results:**

<table>
<thead>
<tr>
<th>What to Change or Implement</th>
<th>Enabling Activities</th>
<th>Person(s) Taking the Lead</th>
<th>Resources Required</th>
<th>Timeline</th>
<th>Assessment (evidence)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendices

Appendix 24: Care Plans and Daily Notes
1. **Personal Care**

List Current Abilities – Washing/Dressing/Toileting

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

List Agreed Assistance Required

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Agreed Short-Term Goals

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Agreed Long-Term Goals

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Additional Comments

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Review Comments

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Signature: ___________________ Date:____________
Review Signature: _______________ Date:____________
Review Signature: _______________ Date:____________
Review Signature: _______________ Date:____________
Review Signature: _______________ Date:____________
Appendices

2. Social Participation

(Gather the resident’s life history and attach here)

Describe Communication Deficits (if any)

List Expected Visitors

List Agreed Activities

Agreed Short-Term Goal

Agreed Long-Term Goal

Additional Comments

Review Comments

Signature: ___________________________ Date: ______________
Review Signature: ___________________ Date: ______________
Review Signature: ___________________ Date: ______________
Review Signature: ___________________ Date: ______________
2. Daily Life – Promotion of Choice

List Interests/Hobbies

Discuss with the resident how they would like to spend their day

(3a) Sleep Pattern and Measures to Promote Sleep

Agreed Short-Term Goals

Agreed Long-Term Goals

Review Comments

Signature: ___________________________ Date: _______________  
Review Signature: ___________________ Date: _______________  
Review Signature: ___________________ Date: _______________  
Review Signature: ___________________ Date: _______________  
Review Signature: ___________________ Date: _______________
3. Safety

List Any Assessment Tools In Use and Their Scores

MNA______________________________________________________________
Barthel____________________________________________________________
FRASE______________________________________________________________
Other_______________________________________________________________

(4a) Waterlow______________________________________________________
Pressure area description____________________________________________

Pressure area maintenance plan_______________________________________
Repositioning_______________________________________________________

Agreed Short-Term Goals______________________________________________

Agreed Long-Term Goals______________________________________________

Additional Comments_________________________________________________

Review Comments_____________________________________________________

Signature: _____________________________ Date:__________________________
Review Signature: _______________________ Date:__________________________
Review Signature: _______________________ Date:__________________________
Review Signature: _______________________ Date:__________________________
Review Signature: _______________________ Date:__________________________
4. Food

List Any Food Likes/Dislikes

___________________________________________________________________________________
___________________________________________________________________________________

List Any Dietary Illness/Requirements

___________________________________________________________________________________
___________________________________________________________________________________

List Any Difficulties With Eating/Drinking

___________________________________________________________________________________
___________________________________________________________________________________

Agreed Short-Term Goals

___________________________________________________________________________________
___________________________________________________________________________________

Agreed Long-Term Goals

___________________________________________________________________________________

Additional Comments

___________________________________________________________________________________
___________________________________________________________________________________

Review Comments

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Signature: _____________________________ Date: __________
Review Signature: ____________________ Date: __________
Review Signature: ____________________ Date: __________
Review Signature: ____________________ Date: __________
Review Signature: ____________________ Date: __________
Appendices

1 = Personal Care.  2 = Social Participation.  3 = Daily Life.  3a = Sleep.  
4 = Safety.  4a = Pressure area care and repositioning.  5 = Food.  6 = Acute Episode.  
Ticking the box certifies that all care has been provided in accordance with the care plan. Comment lines are for use when there has been a deviation from the care plan.

Daily Nursing Record: Name of Resident: ____________ DOB: ____________

Date:  

1.  2.  3.  4.  4a.  5.  6.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Night-Time

1.  2.  3.  3a.  4.  5.  6.

_____________________________________________________________________

_____________________________________________________________________

Signature:

Date:  

1.  2.  3.  4.  4a.  5.  6.

_____________________________________________________________________

_____________________________________________________________________

Night-Time

1.  2.  3.  3a.  4.  5.  6.

_____________________________________________________________________

Signature:

Date:  

1.  2.  3.  4.  4a.  5.  6.

_____________________________________________________________________

Night-Time

1.  2.  3.  3a.  4.  5.  6.

_____________________________________________________________________

Signature:

Date:  

1.  2.  3.  4.  4a.  5.  6.

_____________________________________________________________________

Signature:
Appendix 25: Care Plan Questionnaire Post-Pilot
Appendices

How do you find working with the new care plans on ward 1?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Are you aware of the new National Standards requirements for documentation? (brief summary enclosed)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Would you agree to extending/applying the care plans to more residents?
Yes: ☐ No: ☐

If no then have you any other suggestions?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Any other comments?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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Appendices

Appendix 26: Critical Companionship
BEING A CRITICAL COMPANIONSHIP TO AN INDIVIDUAL, GROUP OR TEAM
(After Titchen, 2000)

REFLECTIVE SELF-ASSESSMENT

RELATIONSHIP DOMAIN

Particularity
- How can I get to know and appreciate the person I am helping?
- How do I recognise the uniqueness of the person I am helping?

Reciprocity
- What are the benefits/learning I have gained from interacting with the person I am helping?

Mutuality
- How do I and the person I am helping:
  - Negotiate our relationship?
  - work together?
  - understand the situation and what is likely to happen?
  - share responsibility for learning and decision-making?
  - negotiate the involvement of others?

Graceful care
- How do I promote personal and professional growth in the person I am helping by:
  - Being congruent?
  - Being generous?
  - Being physically and emotionally present?
  - Creating a culture where others feel valued?
  - Dealing with my own or others’ negative or inappropriate responses?
  - Comforting where there is distress?
  - Using humour to provide support?
- How do I identify areas for my own development in relation to the above?

RATIONALITY-INTUITIVE DOMAIN

Intentionality
- What are the strategies I am deliberately using in my helping relationship?
- What are the intended purpose of these strategies?

Saliency
- How do I identify the most salient issues in my helping relationships?
- What strategies do I use to address the salient issues?

Temporality
- How do I help the person to link learning from the past to the present and the future?
- How do I use timing and pacing to help the person?
Appendices

FACILITATION DOMAIN

Concept: Consciousness – raising
- What questions can I ask to help the person I am working with increase their awareness/insight of:
  - their own feelings?
  - the judgements and decisions they have made and how they have made them?
  - the impact of the context on their actions their values, beliefs and assumptions?
  - the contradictions between their values and beliefs held and personal actions?
  - the knowledge and evidence informing their decisions and actions?
  - The contradictions between their espoused theory/knowledge and that in use? the consequence of their actions for self and others?
- How can I alert the person I am helping to relevant theories and evidence that they may appear unaware of?

Concept: Problematization
- What questions can I ask to help the person I am helping identify the:
  - key issues in their story?
  - priority questions he/she needs to ask?
  - the dilemmas faced in the situation?
- How can I alert the person I am helping to perceived problems, issues, inconsistencies, dilemmas or contradictions that he/she may not have acknowledged or be aware of?

Concepts: Self-reflection & Collaborative Critique
- How can I help the person I am working with to:
  - reflect on their own experiences of learning about self and learning from their own practice
  - identify the salient features of their own actions
  - the barriers preventing action
  - develop new understanding of their role and practice

Strategy: Articulation of craft knowledge
- How can I help the person I am helping to talk about their craft knowledge and their own professional expertise?
- How can I bring in my craft knowledge in a way that is helpful?

Strategy: Observing, listening and questioning
- What do I observe in and hear from the person that I am helping that I would like to probe/explore further?
- How do I ask questions that help the person to articulate the taken-for-granted or the knowledge embedded in their practice (i.e. their craft knowledge)

Strategy: Feedback on performance
- How do I give feedback to the person I am helping from observing, listening and questioning in a way that does not include interpretations and judgements.
- How do I help the person I am working with to self-evaluate?
- How do I help the person I am working with to learn from the feedback?
- How and when should I give feedback about perceptions of what went well and what did not?

Strategy: High challenge/high support
- What are the assumptions, values, beliefs, expectations, perceptions, judgements, actions I should challenge in the story?
- How can I provide high challenge but also high support?
- How were my high challenge and high support interventions perceived by the person I am helping in terms of the level and nature of challenge and support?
- What are my own insights into what is challenging and supportive for the person I am helping?
Strategy: Critical dialogue

- What questions can I ask to help the person I am working with to critique research-based and theoretical knowledge in light of their own situation and experience?
- What questions can I ask to generate new understandings about the situation/practice/context etc to be changed and the change process?

Strategy: Rolemodelling

- What examples can I draw on that demonstrate good role modelling?
- What do I role model in my critical companionship relationship?
- How do I help the person I am helping to explicitly learn from my role modelling

Reference


Kim Manley 8/7/2000
Version 3: 20/7/2004