



# The Culture of Nursing Homes: An Ethnomethodological Study

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Gerontological Nursing.

A thesis submitted in fulfilment of the requirements  
for the award of the degree of Doctor of  
Philosophy from The University of Adelaide

2000

*In memory of Abby,  
also for Honey and Tippy, who led me down their paths.*

## Statement

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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## **Acknowledgments**

I would like to thank all of the members of the Department of Clinical Nursing for their support and encouragement during the process of writing this thesis.

There have been so many people who have contributed in different ways to this thesis. I am very appreciative of all of the help I have had, and those people will know who they are. They especially include the residents and staff at the nursing homes that were featured in this study. Also, the librarians at the Royal Adelaide Hospital, whose painstaking work it was to find much of the material used in this thesis.

However, special thanks must go to 'Babes', Jim Allen, Karen Walker and Anne O'Connell for their ongoing commitment and support without which this thesis would not be possible. Also to Ysanne Chapman who spent much time editing this thesis and whose critical friendship was an invaluable source of ongoing insight and assistance.

Finally, to Professor Alan Pearson for his generosity in offering me this opportunity to undertake and complete this piece of work.

## **Abstract**

This study examines the culture of two nursing homes using an ethnographic method which is underpinned by ethnomethodology as a philosophical approach. The study shows how older and disabled people are seen to deviate from social norms and how society responds to their situation. The general situation of older people and their growing needs are identified. Two nursing homes were selected for the study and the approaches made to these institutions are explained. Nursing rituals are examined and their relationship to other behaviours in nature identified. Reflexivity and how individuals contribute to the cultures in the two nursing homes is also examined. Two cultural foci of nursing home practice emerge: staff focussed cultural practices and resident focussed cultural practices. Their origins and development are identified through a historical, sociological and political backdrop of aged care and nursing in Western culture, Australia then South Australia specifically. Frameworks of sources of power and feminist change are offered. Future directions for aged care are suggested and include evidence based practice, primary nursing, the evolution of a nurse practitioner model for aged care, further research and the development of a resident focussed model of care with adequate support for nurses. In conclusion, it is suggested that Western culture subsumes nature and natural processes in a way that makes it difficult for people with impairments and the natural world to adapt. This is discussed in relation to the evolution of Cartesian thought and is critically examined. The development of a culture that promotes tolerance, understanding and acceptance of life that deviates from normal expectations is suggested as a means of not only supporting people with impairments but also to ensure survival and environmental health of the world in which we live. It is asserted that we may all individually contribute to a better world for all life by working towards attainment of these values.

## Part One

### Timelessly Ageing

(Naomi Poston)

*Autumn, quietly and gently , cloaked,  
the timeless fields  
Splattering its colours of reds, pink and yellows on  
once lustrous green leaves.*

*Leaves once limber and graceful,  
now brittle and fragile...still...  
dancing softly in the breeze.*

*The leaves glow brilliantly,  
have never shone brighter  
or danced so gently.*

*Leaves aflame proclaiming life  
in whistling whispers to one another.*

*A playful tiny brown squirrel  
skitters to my boughs  
confides its lost safety among my branches*

*Wrinkled beautiful leaves  
whisper aloud of life and breathe the air of earth.*

*And who said old is ugly?*



# Chapter One

## Introduction And The Culture Of Nursing Homes

This study was initially conceived as part of a larger national study funded by the National Health Medical Research Council that addressed the experiences of relatives during the admission of residents to nursing homes in Australia (Pearson et al. 1996 & 1998). Data from the initial study was placed in a theoretical ethnomethodological framework to examine and analyse the culture of two nursing homes which in turn forms the subject of this thesis. Ethnomethodology was chosen as it was considered the best way to describe how society reacts to individuals who differ from social norms.

### ***Statement Of The Problem***

Nursing Homes have been referred to as 'death sentences' (Friedan, 1993: 478) and are often viewed very negatively by the rest of the community (Smallegan, 1981). Most occupants are elderly and for many it is their last place of residence. There have been frequent reports of abuse of the elderly, including those in nursing homes, in both the media and in the literature (Kurrie, 1993; Sadler, 1993; Vladeck, 1980).

It appears that negative ideologies, stereotypes and associated stigma with old age, death and nursing homes are all interwoven and that there is a need to understand the dynamics of this phenomenon more fully. For all of us, death seems to be the ultimate challenge. Therefore, would not the ultimate challenge of working in a nursing home be to learn to accept death and live with it as a natural experience, without resorting to the negative patterns of description and behaviour so frequently reported? The aim of this study is to understand and identify

nursing practices at nursing homes that may contribute to their culture. Alternatives are suggested where appropriate.

The philosophy of ethnomethodology was selected as it can offer explanations for socially negative reactions to behaviour or individuals who are perceived as deviating from social norms. By developing a theory of ethnomethodology, Garfinkel (1967) was able to demonstrate many ways that individuals react negatively to those people or situations that do not fit in with their expectations. It appears that confrontation with death was possibly driven from the community into institutions because the broader population found it too difficult to incorporate it into their social norms. Consequently, death tends to be concentrated in places such as nursing homes, which then come to be regarded with fear and anguish (Friedan, 1993). Negative sanctions directed towards older people and institutions such as nursing homes may apply as they did in Garfinkel's (1967) findings, because nursing homes and older people are seen to deviate from widely held social norms of youth, vitality and productivity (Friedan, 1993).

To identify whether beliefs, behaviours, and nursing practices endorse this view, the method of ethnography was chosen as this method allows the nurse researcher to theorise whilst participating in the culture. Although prior ethnographic studies have been conducted in nursing homes, this research is original in that it incorporates ethnomethodology as a conceptual framework as a means of understanding the culture of nursing homes along with ethnography as a method. A discussion follows that may assist the reader to counter identified negative patterns of behaviour and a way forward for nursing practice is proposed.

The thesis is divided into three main parts. The first part (*Chapters 1 to 7*) introduces a study of older people in Australia, then reviews the literature of the history and politics of aged care internationally and nationally, with a focus on nursing care. The second part (*Chapters 8 to*

12) examines power, change and the philosophy of ethnomethodology used during the study. A presentation of subsequent findings follows. The third part (*Chapters 13 to 19*) is a major discussion of the results with an analysis of rituals and culture in the specific institutions of the study. Finally, an ecological context is provided for aged care in Australia, with recommendations for change.

### **Overview Of Thesis**

Part One of this thesis begins with an introduction to the situation of older people in contemporary Australia, and leads specifically into institutionalised care. This part gives the reader a summary of current issues that affect the lives of older people. The historical and political events that have led to the current situation are explored in four chapters, starting with the introduction in Chapter One. In Chapter Two, the history of social and cultural constructs of ageing is presented. This includes a presentation of the many philosophical, historical and political forces that impact on the social process of ageing. The period covered includes pre-industrial society to the present day and the roles of various social and cultural groups are examined to illustrate the evolution of present day systems. Chapter Three focuses on how older people are controlled and constrained socially. The process of ageing as a career or trajectory is considered in Chapter Four and it is during this chapter that some of the negative consequences of ageing are considered. In Chapter Five, the Australian welfare and residential care systems are considered in relation to aged people and the institutional care available to them. The history of nursing home standards and policy introduces the main concepts in the research study that follows in Chapter Six.

Chapter Seven introduces the historical background of aged care nursing from the earliest known community of monks who provided this care in Egypt before the birth of Christ. The history sketches the evolution of aged care from here, throughout the middle ages, the

Elizabethan age, and the nineteenth century through to the present day. The impact of the British poor law system is considered, as it also had a significant impact on the Australian aged care system. The evolution of care in Colonial Australia follows, starting with a discussion of the initial voyage of Captain Cook, and the first penal settlement at Port Jackson. The evolution of the Rum Hospital, its routines and dependence on convict labour is described. Special attention is given also to early mental institutions, as they were involved in the care of the aged who suffered from mental infirmity. The focus of the history is then narrowed down to the beginnings of supported aged care in South Australia. Here, there is a comparison of the political and social development in South Australia and that of its eastern neighbours; both in terms of the absence of convict settlement and the decision not to introduce the Poor Laws. The development of a group of early settlers affected by poverty and the efforts of the government to assist them are discussed briefly. A description of The Destitute Asylum, which was constructed to assist those who were in need of assistance, is included in this section, along with discussion of other caring bodies that were developed for the aged. Finally, the development of nursing in Colonial South Australia is presented. This covers the time from the domestic nurses of the first settlers through to the first hospital nurses and care of the mentally ill. Nursing care of the aged in contemporary South Australia becomes the specific focus, setting the scene for the study.

Part Two of this thesis moves away from discussion of the current and historical context of aged care to philosophical and practical considerations of the research. Chapter Eight considers power and change, more specifically, the opportunities for nurses to effect change in their working conditions. Possible mechanisms through which power may be channelled and change evoked are suggested. The question remains: can nurses take advantage of current opportunities to advance the positions of their care recipients and the profession as a whole? Garfinkel's ethnomethodology, the philosophy, which underpins this study, is introduced in Chapter Nine. This methodology provides a theoretical structure for understanding how



behaviours that are perceived as deviant are negatively sanctioned by the community as a whole. The method of the study, participant observation in ethnography, is introduced in Chapter Ten. Here, different research methods are discussed and leads to a description of particularistic ethnography. Chapters Eleven and Twelve examine the environment and the daily lives of the residents at the two nursing homes studied, to set the scene for the analysis and discussion of the results.

Part Three of the thesis comprises the discussion of the results, analysis and conclusion. The discussion starts with Chapter Thirteen. Here, the social institution of impairment is examined and some of the continual struggles of people with cognitive impairments are identified. Chapter Fourteen extends the discussion and identifies current definitions of culture and some of the rituals that are embedded in them. Parse's nursing theory of human becoming and specific nursing rituals are introduced in Chapter Fifteen with an introduction to new concepts in describing rituals. The cultures and rituals of the nursing homes studied are also discussed, along with those rituals that were common to both resident and staff focussed cultures.

Chapter Sixteen presents the characteristics of a staff centred cultural focus that are elucidated during the course of this study. Likewise, Chapter Seventeen describes a resident focussed culture and its characteristics. The primary care model as suggested in the literature is introduced in Chapter Eighteen and discussed in terms of its suitability for the aged care industry. Finally, the notion of culture and what is meant by it is reconsidered in terms of the environment in which it is situated. In conclusion, the need to re-evaluate human culture and its inherent values is identified. A nurse practitioner model is advocated as an effective means for providing a leadership role for nurses in aged care.

## ***Older People In Australia—An Overview***

This section comprises a broadly descriptive overview to illustrate the concerns and needs of this large group of people and to introduce the study of older people in Australia. In 1997 the Australian Institute of Health and Welfare and the Office for the Aged in the Commonwealth Department of Health and Family Services produced a summary of the health, well-being and social circumstances of older Australians and their associated services. The booklet was called 'Older Australia at a Glance' and the data gathered illustrates trends in ageing and aged care at that time (Australian Institute of Health and Welfare and the Office for the Aged, Commonwealth Department of Health and Family Services ,1997). Information from this booklet and other relevant sources (as cited), follows.

### **Population**

Australia has a population of about 18.3 million people. About 70 percent of the population is concentrated in the largest ten Australian cities. The growth rate of the Australian population has declined since 1989 reflecting a decline in net population. The average life span of Australian women is about 80 years and for men, 74 years (Australian Bureau of Statistics, 1996a).

There are increasing numbers of older Australians in society and their numbers are expected to continue to rise. It is also reflected overseas where by 1993, 18 percent of people in Sweden and 16 percent in Norway and Denmark were aged 65 years or older, compared to 13 percent in the USA and 12 percent in New Zealand. The growth rates of the aged population are expected to increase substantially during the period 2006-2016 as the peak of the Australian baby boom population reaches retirement age. The annual rate of growth of the older population in Japan and China is about 3 percent and for Australia, Canada and Germany between 1.7 and 1.8 percent. The rate of growth for those aged 80 and over in

Australia is 3.9 percent, about the same for Japan and China, followed by Canada at 3 percent. Australia, although young in the international context, seems to be experiencing a comparatively rapid rate of population ageing. In the mid 1970s, 9 percent of the population were aged 65 and over. By 2016 this is projected to increase to 16 percent of the population. In the mid 1970s, one in six older people were aged 80 and over and by the mid 1990s it was one in five. By 2016 one in four of the aged population will be older than 80 years (Australian Bureau of Statistics, 1996b).

In 1996, of the total population of 18.3 million people in Australia, 2.2 million or 12 percent were aged 65 years and over. People aged 65 to 69 years comprised almost a third of all older people and those aged 80 and over comprised almost a quarter. Women make up the majority of older people (57 percent) and this is particularly evident in those people aged 80 and over where women comprise 66 percent of the group. Family support is provided primarily on a non-paid voluntary basis and is the largest source of support for older people (Australian Bureau of Statistics, 1996b).

Although in the 1996 census, 8 percent of people lived alone, this proportion is dramatically higher for older people. For those under 65 years, 6 percent lived alone. However, for the age group 65-79 years, 27 percent lived alone as did 45 percent of those aged 80 and over. Because of women's tendency to live longer than men and their greater likelihood of not getting married at an older age, they are more likely to live alone than men. For example, 55 percent of women aged 80 and over were living alone compared to only 27 percent of men (Australian Bureau of Statistics, 1996b).

### **Indigenous Australians**

In 1991 an estimated 283,000 people were of indigenous origins in the population and tended to be younger than non-indigenous Australians. In 1994, 88 percent of indigenous

Australians were under 45 years of age compared to 68 percent of non-indigenous Australians. Almost 2 percent of indigenous Australians were aged 70 and over compared with 8 percent of the non indigenous population (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 1997).

For the 1990s life expectancy at birth for Aboriginal and Torres Strait Islanders was up to 20 years shorter than that for non-indigenous Australians. Because they have a shorter life expectancy and a higher incidence of illness and disability than other Australians, indigenous people tend to make use of aged care services at an earlier age. This sector of the population tend to use community based services in preference to residential services as they are more likely to wish to remain on the land with their families in old age (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 1997).

The health status of indigenous Australians tends to be much poorer than their non-indigenous counterparts. They are two to three times more likely to be hospitalised. They are at higher risk of illness due to factors such as poor nutrition, obesity, substance abuse, exposure to violence, inadequate housing and education (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 1997).

### **Voluntary Work And Older Australians**

Voluntary work is a major source of satisfaction for many older Australians. Included in this definition of voluntary work is providing informal assistance to family members, to friends and neighbours and more formally to others through an organisation or group. 19 percent of the total Australian population aged 15 years and older were engaged in some form of voluntary work in the 1995 Australian Bureau of Statistics Survey of Voluntary Work for the previous year (Australian Bureau of Statistics, 1995b). Of these people, 24 percent were aged 55 years or over. Twenty percent of those were aged 55-64 years and 17 percent were aged

over 65 years. The main reason given for voluntary work in this survey was to help others or the community which was cited by 48 percent of respondents. Meanwhile, 29 percent of respondents stated that they wanted to do something worthwhile through their work as a volunteer and a further 26 percent stated personal satisfaction was gained through their voluntary work. Personal or family involvement and to enhance social contact accounted for other major reasons that people undertake voluntary work (Australian Bureau of Statistics, 1995b).

### **Factors Influencing Health**

Older men and women with lower levels of family income and/or education are more likely to report their health is fair or poor. Marital status also seems to influence health. Death rates for unmarried older men and women are about 40 percent higher than those who are married. People in older age groups rate their own health as poorer than those at younger ages. In the 1995 National Health Survey (Kendig et al, 1996) preliminary findings illustrated that only 9 percent of the 65-69 age group rated their health as 'poor' compared with 17 percent of the 85-89 aged group. Self ratings of health are an important predictor of mortality. Furthermore, there are differences between men and women in the relationship between self-rated health and mortality. For men, only self ratings of 'poor health' were significant in predicting lower survival rates. However, for women, self ratings of 'good' and 'fair' health were significant in predicting survival. It has been suggested that self-rated health is an economic indicator of health status and is mainly defined by severe illness and disability. Self-rated health may reflect physical and psychological well being as well as aspects of health behaviour, social support and self-efficacy. However, these findings are not conclusive and past research has suggested that the nature of the questions asked in surveys may be constructed with connotations in order to elicit expected results (Ruler and Lack, 1988). A qualitative study by Walker-Birckhead in 1996, where older peoples' meaning of health was linked to their self-

rated health, revealed that older people appear to adapt to these limitations or perhaps adjust their expectations accordingly (Walker-Birckhead, 1996).

## **Disability And Handicap**

The 1993 survey of Disability, Ageing and Carers (Australian Bureau of Statistics, 1995a) provides the most recent data available on the dependency levels of the Australian population. Impairment, disability and handicap provide the indices of dependency and the definitions were based on those in the 1980 International Classification of Impairments, Disabilities and Handicaps. This survey suggests that most older Australians are neither frail nor in need of long-term care and assistance.

In 1993, 18 percent, or 3.2 million people in Australia had a disability. Of these, 36 percent were aged 65 years or over. 48 percent of all older people had a handicap. Of these, 21 percent reported a mild or not determined handicap, 10 percent a moderate handicap and 17 percent a profound or severe handicap. As people grow older, these proportions increase, with 71 percent of people aged 80 or over reporting a handicap and 41 percent having a profound or severe handicap. The rates of profound and severe handicap doubled between those aged 75-79 years and those aged 80-84. Women are more likely than men to have a profound or severe handicap across all age groups, particularly between the ages of 70 and 84. Need for assistance is established by assessing those with profound and severe handicaps and this category identifies three areas where assistance is most frequently required. These areas are self-care, mobility and verbal communication. It was concluded that disability and handicap rates amongst the older population have remained relatively stable in the preceding decade particularly in the profound or severe handicap category (Australian Bureau of Statistics, 1995a).

Arthritis was the most prevalent severe, profound or moderate handicap reported by 25 percent of the frail elderly. Next most common were circulatory diseases, followed by musculoskeletal conditions other than arthritis (9 percent), diseases of the nervous system (7 percent) and respiratory diseases (7 percent). Almost one-third of all older people with a profound, severe or moderate handicap did not know the cause of their condition. 17 percent of 65-79 year olds were identified as being in care provided by health establishments compared to 42% for people aged 80 and over. Ninety four percent of older people with a profound or severe handicap who need help with self care, mobility or communication receive assistance from the informal care network of family, friends and neighbours. About one-third received help from both informal carers and formal services such as a community organisation or a health professional. However, people with a moderate handicap were more likely to seek help from formal agencies and community organisations as well.

### **Government Policy And Community Care**

There have been substantial increases in the proportion of frail and disabled older people living in the community over the last decade (Australian Institute of Health and Welfare, 1995 & 1997). For example, between 1988 and 1993, the proportion of people aged 80 and over living in the community increased from 50 to 59 percent and for the 65-79 year age group, the increase was from 79 percent to 84 percent. These trends reflect government policy over the last decade which emphasises the need to reduce reliance on residential care in favour of an expanded community care sector. The reduction of reliance on health establishments has occurred most markedly in acute care facilities, although chronic care facilities have also been affected. Greater demands on both formal and informal support have resulted from the increased proportion of highly dependent older people living in the community (Australian Institute of Health and Welfare, 1997).

## **Health Expenditure**

Health expenditure per person for older persons is much greater than for younger persons. For people aged 65 and over in 1993-1994 it was four times greater than those less than 65 years. During the same period the population aged 65 and over constituted 12 percent of the total population and they used 35 percent of the total expenditure on health services. The greatest increases of expenditure were in nursing homes and pharmaceuticals. Expenditure on pharmaceuticals was 2.5 percent higher for 65 year olds than for those aged under 65. Similarly, expenditure for acute hospitals was 2.3 times higher for older people than for those aged less than 65 years (Goss et al, 1994).

A large proportion of costs associated with nursing home care are not true health costs but rather costs of food and accommodation. Therefore, this finding may be misleading (Goss, 1992; Goss, et al, 1994). Between 1982-83 and 1994-1995 Australian real health expenditure per person grew by 2.8 percent per year. However only one-fifth of this increase or 0.6 percent per year was a result of the costs associated with an ageing population (Goss, 1992; Goss et al, 1994).

## **Residential Care**

Two levels of care are available in the Australian system of residential care. Nursing Homes are available for residents with high dependency needs, and hostels are available for residents with lower dependency needs. These two streams of care were combined into one uniform system on October 1, 1997, so that each facility provides care for residents who may have a range of disabilities.

Aged Care Facilities (encompassing Nursing Homes and Hostels) provide accommodation and other support services for the frail older person. Support services include domestic



services, help with performing daily tasks, and medical care. Highly dependent older people with physical, medical or psychological care needs who require ongoing access to nursing care that cannot be met in the community are eligible for nursing home care. Hostels offer a similar range of services, however the client is usually relatively well and would not normally require ongoing access to nursing care unless significant changes occur in their health status.

The report of the Nursing Homes and Hostels Review in 1986 (Department of Community Services, 1986) argued strongly for the restructuring of Australia's aged care system. Problems identified include an excessive emphasis on institutional care, the lack of co-ordination of services, the inefficiency of funding mechanisms and the failure to develop adequate assessment procedures (Australian Institute of Health and Welfare, 1993 and 1995). In 1984 people who wished to gain entry to Australian nursing homes were assessed by geriatric assessment teams and subsequently this became the preferred assessment strategy for nursing home entry. By 1991-92 they were called Aged Care Assessment Teams (ACATs) and they were responsible for approving over half of the admissions to nursing homes (Australian Institute of Health and Welfare, 1995). Currently, 121 regionally based multidisciplinary Aged Care Assessment Teams provide services across Australia. These teams are responsible for determining eligibility for admission to nursing homes, hostels and community aged care packages. They can also recommend a range of Home and Community Care services, but do not determine eligibility for them. For the 1994-1995 financial year, 156 assessments were undertaken, equivalent to 110 assessments per 1,000 people aged 70 and over in the Australian population. Long-term residential care was recommended for 45 percent of clients assessed, with 24 percent being for nursing home care and 22 percent for hostel care. Where clients were assessed as suffering from disabilities relating to mobility, continence or orientation, they were more likely to be recommended for nursing home care (Lincoln Gerontology Centre Aged Care Group, 1995).

There were 75,008 nursing home beds in Australia at June, 1996. This figure is the equivalent of 49.5 beds per 1,000 people aged 70 years and over and is a reduction from 66.5 beds for the same population in 1985. During this same period, the supply of home-based services and hostel places has been increased as part of a deliberate plan to reduce reliance on the intensive level of care in nursing homes. This reduction in the number of available nursing home beds by 17 per 1,000 people aged 70 and over and the introduction of a national assessment program to control eligibility for admission to nursing homes has led to an increase in the dependency levels of nursing home residents. Financial incentives were also offered to nursing home proprietors to admit more dependent residents. Additionally, these changes have also led to a dramatic increase in the number and proportion of admissions for respite, rather than permanent care. In 1991-92 respite admissions accounted for 8 percent of all admissions and this increased to 27 percent in 1995-1996. In any one financial year, respite admissions have a maximum length of stay of 62 days (Australian Institute of Health and Welfare and the Office for the Aged, 1997).

As a result of the greater influx of more dependent residents to nursing homes, it was expected that length of stay would become shorter and that there would be an increase in turnover rates. However, this has not transpired. In 1991-1992 the turnover rate was 0.54 percent and 0.55 percent in 1995-96. In 1995-96 over one-third of people admitted to a nursing home remained for less than two months and 13 percent stayed for between 2 and 6 months. About a half stayed for six months or more. The median length of stay for this group was calculated to be 356 days. 72 percent of the nursing home residents were women and over half the residents in nursing homes were women aged 80 and over. Very few younger people with disabilities were accommodated in nursing homes. The majority of residents were aged 80 and over with only 5 percent aged under 65 years (Australian Institute of Health and Welfare and Department of Health and Family Services, 1997).

Forty seven percent of nursing home beds and 2 percent of hostel places are provided by private (for profit) organisations. 37 percent of nursing home beds and 92 percent of hostel places are provided by non profit organisations. 16 percent of nursing home beds and 6 percent of hostel places are also provided by State Governments (Australian Institute of Health and Welfare and Department of Health and Family Services, 1997).

### **Older People With Cognitive Impairments**

Estimates of the number of people with dementia have varied according to the definition used. However, in 1996 it was estimated to be about 134,800 or 6 percent of the population aged 65 years and older (Rosewarne et al, 1997). These statistics showed that about half of those with dementia live in the community however, they are likely to be placed in residential care. About 19 percent of clients of Home and Community Care Services (of all ages) exhibited confusion or disorientation in their behaviours. About 20,000 people or 30 percent of those with dementia living in the community are receiving some level of ongoing formal support services. A variety of types of care are available for people with dementia. In hostel care 4.8 percent of all beds are specifically allocated to residents with dementia. 5.9 percent of beds in nursing homes are specifically allocated to dementia care. The level of cognitive impairment varies for residents according to whether they live in a hostel or nursing home. In 1996, of hostel residents, the cognitive impairment levels were 46 percent with none, 35 percent mild, 17 percent moderate and 3 percent severe. For nursing home residents, 10 percent had none, 22 percent mild, 27 percent moderate and 41 percent severe (Rosewarne et al, 1997).

### **Summary**

In summary , the major issues that seem to affect the care of older people appear to be that the numbers of older people are increasing rapidly, both internationally and specifically in Australia. Women make up the majority of older people. Family income, education and

marital status are major influences of health for older people. A large number of Australian older people report having a disability including cognitive impairment, resulting in increased health expenditure and the provision of residential care for some of these people. This chapter has introduced briefly the situation of older people to the time during which the study was conducted.

## Chapter Two

### **The History Of The Social And Cultural Constructs Of Ageing**

Historical evidence about the cultural and social structural factors that have tended to affect the relative power and influence of older people's current situation is now presented. This section draws heavily on the work of Williamson, Evans, and Powell (1982), Jones (1990) and Victor (1994) because these authors provide the most suitable descriptive backdrops to most closely support the specific aims of the study. Normal social practices tend to differ from one society to the next and likewise from one epoch of history to another. This account starts with hunter gatherer societies, who were primarily concerned with mainly meeting the basic necessities of life.

#### ***Hunter-Gatherer Societies***

In hunter-gatherer societies there is evidence that suggests that the distribution of food was of central importance (Williamson et al, 1982). Physical capacity was a prerequisite for participation. Consequently, older people tended to fare best as fishers and collectors and not as well among hunters and herders. Some hunter gatherer societies such as the Aleuts, treated their old well and even viewed long life as a reward (de Beauvoir, 1972). Hottentot hunters of Africa also cared for many of their elderly except for those who were poor or suspected of witchcraft and therefore were left behind to die (Murdoch, 1934). In some cases, tolerance for and support of decrepitude tended to be low and conditions were often so harsh that old persons did not survive. By western standards, they were often middle aged as opposed to aged. Under some conditions, the feeble elderly were abandoned to starvation. For example, among the Tasmanian island hunters, the sick and infirm were given a little food and left behind to die. Within certain Eskimo families, the aged could be left in a hut or out in the open to freeze to death (Freuchen, 1931). Among some geographically mobile populations

property was confined to temporarily used pastures. The elderly had few if any resources that they could accumulate or control. Consequently, these groups, which were often egalitarian and youth-orientated, provided no particular status to the elderly on the basis of age (Sheehan,1976; Dowd, 1975).

### ***Early Agricultural Society***

The fate of the elderly has tended to improve as societies have moved from primitive hunter-gatherer economies to more advanced economies based on agriculture. In agricultural societies the elderly were often able to increase their status and power by obtaining control over important new social roles. Belief systems and rituals became more complex as societies became more stable and less nomadic. The elderly came to control major legal, religious, medical and political roles. An individual's position improved with control of these key roles, with respect to tangible assets. For example, once old persons came to monopolise the secrets and ceremony of initiation rites, they were in a position to extend the associated taboos for their own benefit. Uninitiated boys could be denied access to young girls who were by custom otherwise available to elderly men and the best food could be reserved for socially powerful adults as opposed to their younger counterparts (Dowd,1980).

Older people gradually became the guardians and enforcers of traditions as physical strength was replaced as a major factor in determining status and power. Cultural resources of one kind could be converted into personal material resources, allowing further empowerment of the elderly. For example, tribal chieftains might trade on their authority or knowledge to gain increased food allocations. Any resource that could be transmitted at will from generation to generation, such as information about food sources, knowledge of gods, and secret rites, resulted in favour and communal power for the elderly (Dowd, 1980).

Old age has been consistently associated with death. This has allowed old age to be envied within some societies in terms of age-related resource control and yet to be dreaded and loathed as an experience. This association was symbolised within both the ancient world and the middle ages by blindness. Here, it was considered possible that blindness allowed spiritual insights which assisted in preparation for death. Blindness or its symbolic representation was a deviation associated with old age that placed them at the outer limits of what was considered to be human and represented a rite of transition into the devalued role of the near dead (Durkheim, 1958; Erikson, 1964).

### ***The Institution of Private Property***

As agricultural societies became more complex it became possible to accumulate assets and the institution of private property emerged, resulting in the systems that we have today. This greatly increased the influence of those elderly who were able to acquire substantial assets, but many did not benefit. For example, elderly women tended to be excluded from these benefits in patriarchal and patrilineal societies in which property was controlled and passed on through males. The matrilineal alternative was more common among the primitive hunting and gathering societies.

The onset of settled agriculture promoted the interests of older men but weakened the power of old women. Thus the process that gave rise to the great agrarian civilisations of ancient Greece, Rome and China also launched major class differences and the subjugation of women. Even within primitive societies, the more secure the food supply and elaborate the social structure, the less well-off were women in terms of status and power. Their standard of living may have risen absolutely, but the resources and social deference they could command fell. This is possibly because of the labor required in the performance of farming tasks and an associated decreasing contribution made by women. The prevalence of the institution of private property was made possible by the accumulation of a financial surplus

due to farming techniques providing surplus produce. Women became property themselves, and while elderly men who owned property shared the prerogatives of their gender and class, elderly women experienced the subordinated status of all women. As the circumstances of elderly males improved, conditions for the elderly women and elderly poor deteriorated (O'Kelly, 1980; Reid, 1981).

The main source of power and control conferred on the elderly was through the economic constraints that they held over the younger people in their families and society. However, this came at significant costs such as growing intergenerational tensions and ambivalence toward the aged. Intergenerational tension over resources that are valued in different cultures has existed throughout history. Intergenerational relations have been and remain tinged with various mixtures of fear, affection, influence, respect, guilt and coercion and these commodities have flowed in both intergenerational directions (Matthews, 1978; Seelbach, 1978).

### **Charity**

Traditional, pre-industrial notions of social protection for the aged, handicapped and indigent had been evolving in Europe since medieval times. The care of disadvantaged social groups in medieval Europe was left to private charity. Relief efforts for the elderly were administered by the clergy, through local parishes and monasteries. By the sixteenth century, political elites in England, France and other emerging nation-states began to pay serious attention to growing numbers of disadvantaged people. As the disadvantaged and unfortunate were the majority it became necessary to make at least token efforts to ameliorate their harsh lot as this population posed a potential threat to regime maintenance. These old regime traditions of protectionism involved a sense of social provision for the aged and other dependent groups, more for the sake of society than the disadvantaged themselves. Charity was not regarded as a right and the assumption prevailed that if sources of support were kept minimal, uncertain



and unreliable, this would discourage idle dependency. Many of the Old World protectionist ideas and practices that had accompanied the late mercantilist period in Europe were brought to established colonies (Rimlinger, 1971).

### ***Advanced Agrarian Societies***

The relative power and influence of the elderly peaked in advanced agrarian societies such as ancient Rome and colonial America. In the latter, surviving to an old age was interpreted in the Calvinist tradition as a sign of God's favour. Retirement was relatively unknown, as clergy, schoolmasters and judges typically held their positions until death. However, not all elderly people were revered during this time. The elderly poor without supportive and willing families to provide support could be treated with callous disregard. Some were driven out of the community for fear that they would become too dependent on the community for support. Most pre-industrial societies did not have sufficient resources to satisfy the needs of all, and this generated conflict. The wealthy elderly, while commanding respect, also generated resentment because of their wealth and power. In pre-industrial societies the status and power of the elderly was relatively low. Individual attributes and economic resources that were relevant for both young and old dictated individual prestige and authority in the traditional community. However, a minor element of ritual deference to the elderly was accorded to the aged as a group (Lipman, 1970).

### ***Modernisation***

Modernisation, or the transition of western society from an economy based on agriculture to one mainly based on industry, resulted in a decline in the power and influence of the elderly. This was due to the high value placed on newness, youth, vigour, productivity and technical skills of the individual in the modernised world and these values were in direct competition to the inclinations of the aged. Advances in economic technology and new occupations accompanied a demand for highly educated workers with up-to-date skills. The older persons' skills and education may have become obsolete. The traditional knowledge and role

of the older person as a transmitter of information became devalued as knowledge became increasingly specialised, especially with advances in technology. Although modern society still acknowledges the knowledge and experience of older people accumulated over time, there is also the belief that these attributes become obsolete because of rapid technological developments. This results in a diminution of the importance and usefulness of the older persons knowledge and experience (Achenbaum and Sterns, 1978).

### ***Urbanisation***

Urbanisation has contributed to the diminished status of the elderly by producing age segregation. Workers often move to where the jobs are, and this is most often in urban settings. This results in geographical separation of families and a weakening of emotional ties. Previously, kinship ties prevailed in rural neighbourhoods, and older people had clearly defined roles and enjoyed relative power and authority. No new realm of influence has emerged to foster a continued sense of importance in the lives of older family members to replace their devalued position in family and work relations (Cowgill, 1974). This process of modernisation however, did not always lead to a reduction in the power and status of the elderly. In some instances, the decline of the power and influence of the aged may have occurred prior to the onset of modernisation (Laslett, 1976 & 1979).

### ***Capitalism***

During the nineteenth century, capitalism was dependent upon abundant unskilled labor which required discipline and industriousness within the work force. This need for discipline along with an emphasis upon increased productivity led to a situation where the state helped subsidise the costs of production. Country poor farms, mental institutions and municipal old-age homes were established where non-productive members could be segregated from the rest of society. Although the reformers claimed that this change was humane, the segregation process served to advantage the industrialists. Able workers gained work by the removal of

unproductive dependents. Because of this, the poor family's discontent about the cost of caring for their unproductive members was diffused without altering their wages. Those who were tempted to feign illness or poverty to avoid work were deterred from doing so by making residence in these institutions stigmatising and unpleasant. This also allowed those who were not contributing to the system to be punished. Thus social participation within the community was negatively sanctioned in the absence of economic participation. As the costs of labor increased with rises in the requisite skill and education levels for many jobs, industrialists became interested in maintaining the capacity and willingness to work of these more expensive employees. Governments became more deeply committed to subsidising production costs as the passage of social insurance programs constituted an investment in human productivity and capital. In order to attract an ambitious, proficient and fit workforce, industrialists ensured public commitment by providing some continuity in income if the workers became less fit. It was also presumed that by removing 'less efficient' old people from the labor force that morale would be boosted and attractive employment opportunities for younger workers would emerge. Retirement was introduced and became a more subtle form of segregation and social control for older people (Achenbaum, 1978).

The ideology of liberty and equality in the latter half of the 19th century began to undercut the status and influence of age until well into the 20th century. Industrial capitalism and urbanisation accompanied this decline. As adult children moved from their rural settings to the cities for factory work, they became less dependent on their ageing parents and consequently, parents came to have less control over their children. Mandatory retirement started to be introduced. At the same time advances in health technology resulted in substantial increases in the life span. This expansion of life span has coincided with a lowered demand for older workers, placing the older and younger workers in competition for fewer employment positions. Retirement practices were instituted to reduce unemployment, and the workers who retired lost status and identity along with the job (Achenbaum, 1978).

In the nineteenth century those who were confined to institutions were presumed to be lazy or have some sort of character deficit. This rationale was consistent with emerging political and individual values of individual self reliance, the Protestant work ethic and a fear of government intervention in private affairs. These beliefs resulted in low levels of funding that in turn produced conditions for elderly inmates in city and country institutions. These were marked by severe overcrowding, insufficient provisions and frequent physical abuse of inmates by staff. However, because of the stigma and reputation of these institutions, only the very needy ever occupied them and usually only after they had generally exhausted familial and financial resources. Because these early residents was popularly assumed to have deficiencies in moral character, personal indiscretion and lack of motivation, the public were generally indifferent to their plight (Tratner, 1974).

For some elderly however, modernisation was accompanied by an improvement in status and power. This was because their skills did not become immediately obsolete as some people remained in agriculture or traditional crafts and many had a large interest in property ownership. The percentage of the elderly in the labor force before 1890 declined very slowly. It has been mainly in the 20th century that there has been a withdrawal of elderly males from the labor force. Also, new retirement plans and alternative sources of income may have freed some of the elderly from forced retirement (Achenbaum, 1978).

### ***Pension Schemes***

The necessity for some form of social legislation to provide security in old age grew more urgent as a function of rapid industrialisation, urbanisation and modernisation from the late nineteenth century on into the early twentieth century. This decline in the power and status of the elderly began to reverse with the rise of the pension movements and the availability of Social Security. By 1913, Germany, Denmark, Belgium, New Zealand, Australia, France,

Britain and Sweden had all enacted progressive old-age pension schemes. By the time that the United States had enacted its Social Security Act in 1935, twenty-seven other nations had already passed legislation establishing national retirement systems. This suggests that the United States, unlike European cities, has never embraced the transcendence of nineteenth century liberalism and its associated rationales of self-reliance and individualism. This culture did not value social welfare. Instead, the hegemonic ideology of individualism has persisted, with only those concessions to the principle of social welfare which have proven necessary to insure the continued functioning of the social order (Williamson et al, 1982; Jones, 1990).

From the mid 1930s to the 1950s, the influence of the elderly remained relatively unchanged. However, the contemporary senior movement began during the 1950s and by the early 1960s it was clear that the power and influence of the elderly in national politics in Australia was starting to emerge. Passage of the national health scheme in the 1970s by the labour federal government headed by Gough Whitlam benefited the interests of the elderly. While the power and influence of the elderly were increasing during the 1960s and 1970s in the political realm, there was a similar trend in the context of the interpersonal relations of everyday living. A trend developed whereby the more elderly were living alone due to improved economic status, resulting in an increase in autonomy, influence and freedom from control by one's children. However, the elderly at the same time suffered a loss of control over their children, changing the nature of intergenerational relationships. Once again, urbanisation has been influential in creating social isolation for the aged, along with a decline in their status in the family unit. However, many still enjoy frequent interaction with their family and friends although they may not share the same household ( Harris, 1975).

The United States has historically embraced a political ideology of liberal-individualism that in times of perceived economic scarcity, suggests a reversion to earlier 'self reliance' rationales. These may be invoked to justify cutbacks in social programs that are perceived as

burdens to the economy. These 'user pays' principles are underpinned by a philosophy of economic rationalism. These 'self reliance' strategies have influenced Australia's policies as seen in the growing use of the 'user pays' and economic rationalist principles, in all areas of government expenditure and particularly influencing services provided to the elderly. Such services include health and related residential centres for older people.

### ***The Impact Of Modernisation***

Although they may not be the only influences, large scale changes such as urbanisation, industrialisation, and mass education have influenced the Elderslie's power and status. The exact nature of modernisation's impact on the status of the elderly continues to be debatable but clearly it does have some influence. With appropriate modification and qualification, modernisation can be used to analyse the impact of changes associated in third world nations today and in the future. It is possible that technological breakthroughs in communication, mass media, transportation and health technology may lead to greater influence and autonomy for the elderly. Alternatively, political changes may subject them to greater government control, depending on choices made now and in the future by the political process, including older people themselves (Williamson, 1982; Victor, 1994).

### ***Influence And Social Control***

Power can be viewed as a subcategory of influence. Intended and unintended influence have different relationships to power. Unintended influence cannot be considered an instance of a power relationship whereas intended influence is. There is an intended influence if there is a clearly defined person or group that is the influence holder, such as in some nursing institutions. Social control is also a subcategory of influence. Direct social control exists where there is a clearly defined person or group as power holder. Social control tends to be restricted to instances of influence that involve constraint of the influenced subject. Indirect social control occurs where there is no clearly defined person or group as control holder. An example may be the social control of behaviour due to internalised social and institutional

norms (Williamson et al, 1982). For example, mandatory retirement is a social situation that is strongly influenced by institutionalised rules and regulations. Established norms of behaviour expected of older people are also instances of social control (Neugarten et al, 1965).

### ***Politics And Autonomy***

Politics is not only concerned with the struggle to obtain power and influence. Equally relevant is the struggle by many to free themselves from the constraints imposed by the power of others and for the equitable distribution of resources. The issue here is autonomy. Many older people are more concerned with maintaining their autonomy and independence than they are with the issues of power and influence. However, those who have more power tend to have greater autonomy and to be less vulnerable to the demands of others. Also, one may have relatively little power and influence over others and still maintain considerable autonomy. The value the elderly place on autonomy is commonly reflected in the strong preference shown for living independently rather than with their children or in an institution. The desire for economic independence and autonomy amongst the elderly has been present through history. The control of economic assets has shown to be particularly useful in achieving this aim, enabling the elderly to reach further power and autonomy (Verba and Nie, 1972)

### ***Constraints***

While the elderly as a group have made a great deal of progress over the past fifty years with respect to economic status as well as availability of health care and social service programs, these gains have had associated costs. The availability of Social Security to pensioners has resulted in economic independence for the elderly on one hand but increased dependence on and control by the state on the other. With each new government-initiated advance on behalf of the elderly has come an increase in control by federal and state planners and policy makers over the lives of those who have come to depend on these programs and agencies. To become

eligible for many of the benefits offered by the government, the elderly are means tested and they may go through their life savings in a few short years in the process of 'spending down' to the point at which they become eligible for the benefits. If a government system were to decide to put a further cap on spending that affects the aged, such as nursing home benefits, the patients may be trapped and their quality of life decline markedly (Williamson et al, 1982; Jones, 1990).

### **Summary**

In summary, social practices for caring and supporting older people have varied throughout history and cultures. It appears that life for the older people in hunter gatherer societies was a battle for basic survival, although those communities that incorporated fishers, collectors and communal food practices tended to support older people best. The transition of Western society from an economy based on agriculture to one mainly based on industry resulted in a decline in the power and influence of the elderly due to a higher value being placed on newness, youth, vigour, productivity and technical skills. Urbanisation has reinforced this negative trend as it has produced aged segregation, however for some elderly, modernisation has been accompanied by an improvement in status and power. Older people seem to have done better with the evolution of more advanced economies particularly as the institution of private property emerged. A trend has developed whereby more elderly live alone due to improved economic status. However, at the same time, they suffer a loss of control over their children, changing the nature of intergenerational relationships. 'User pays' and other economic rationalist principles now tend to dictate the government expenditure on services provided to the elderly. Older people as a group are very tightly controlled directly and indirectly through government bureaucracy with a great deal of influence from other groups such as the mass media. However, older people as a progressively more active and educated group, continually struggle to obtain power and influence despite these constraints. The control of economic assets is particularly helpful in achieving these ends.



## Chapter Three

### **Social Control Of The Elderly**

Older people are controlled by various means. It could be suggested that as a person ages, their likelihood of achieving financial independence is higher. However, this independence comes at a considerable personal price. Yet to be dependent on government funding also imposes considerable bureaucratic controls. Social control mechanisms need also to be considered as a salient force. There have been a number of social theories of old age emerge. A brief description of some of the more influential now follows, however these theories presented are limited by their immediate relevance to the thesis and there are a number of other theories available elsewhere that may further contribute to the debate about the social structure of old age.

#### ***Theoretical Considerations***

Philosophers have been concerned with the tension between the desire for freedom and autonomy on the one hand and the need for order and security on the other. Thus, the extent to which individuals forego some liberties and exercise of free will in order to gain from order and predictability within their environment has been a long standing debate. Jean Jacques Rousseau (1728-1778) and John Locke (1638-1704) emphasised a greater disposition to freedom; others such as Thomas Hobbes (1588-1679) emphasised social order (Stumpf,1994). Social Darwinists such as Herbert Spencer (1820-1903) drew a Hobbesian picture of humankind as naturally animalistic and competitive (Spencer,1896). In this context, social theorists became interested in the specific mechanics inherent in social control whereby society constrains and controls individual behaviour. Such controls vary from the use of the police force to the subtle transmission of values and norms through the socialisation process (Williamson et al, 1982).

A pressing question that has been asked regarding social control and constraints is 'whose interests are best served by a society's organisational arrangements and how do those not well-served come to accept boundaries or controls on their options?' (Williamson et al, 1982: 215). The evidence suggests that the interests being served are those of adults under 70 years of age to the detriment of those who are older, even when their standard of living has improved. It is possible that all of the resources developed to support older people are implicated in this tightening of controls by being directly influenced by government policy. The improved economic independence of the elderly from their families has resulted in an accompanying increase in dependence on and control by the state and its representatives in various government bureaucracies (Verba and Nie, 1972; Estes, 1979).

### **Functionalism**

Emile Durkheim (1958) advances the idea that the total community is greater than the sum of its parts or members. This suggests that the balance of control is held by the group. He identifies public opinion, law, belief systems, education, custom, religion, ceremonial rites of passage and values as means by which groups could exert pressure on individuals to confine their behaviours within acceptable public boundaries. Both Durkheim (1958) and Marx (Miller, 1984) identify social stratification and the ensuing unequal distribution of resources and power as the major mechanisms by which individuals' options are differentially limited and controlled. Durkheim (1958) assumes a certain normative consensus among community members about what constitutes appropriate behaviour.

In contrast, American social scientists depict society as an organism whose equilibrium is constantly being maintained. In this structure, deviants should change, rather than existing economic and social arrangements. The concept that society is an organism whose parts or

institutions are in balance is known as functionalism (Spencer, 1896; Durkheim, 1958; Parsons, 1937, 1951).

It was considered that there was a loss of the 'natural order' inherent in small rural communities that has been displaced by industrialisation. Social selection of the most productive required adjustment to this new order. Assimilation of immigrants and amelioration of emerging social problems through correction of individual pathology became part of industrialisation. An order based on shared values and outlooks was to be replaced with a legally based order. Those behaviours that were socially conducive to the new order were mandated through law. Early concern about presumed animal drives within individuals and the desirability of social order has led to a dual approach in studying social control. On one hand, efforts have been made to study and 'rehabilitate' maladjusted individuals and on the other hand, some acknowledgment of structural strains within the social order has occurred. Theorists such as Merton (1957) have suggested that deviance is an adjustment (not a maladjustment) to contradictions within the social system. Here, behaviour is adjusted as some roles, values and goals that people are socialised to aspire to are structurally frustrated, for example by socioeconomic status. Functionalists assume that the more effective the socialisation processes resulting in informal control, then the less need for legal or formal means of social control (Roucek, 1947).

Functionalism and neo-functionalism have been identified by Estes, Binney and Culbertson (1992) as a dominant paradigm in social gerontology. Functionalism and neo-functionalism have been described as basic to American traditions of individualism, self-reliance, and independence and posits that cohesion and social harmony are natural products. These definitions may greatly influence the way that ageing is defined and research is undertaken in gerontology (Brown, 1990).

## **Labelling Theorists**

Labelling theorists are interested in how people define one another and how these definitions constrain behaviour. They reflect the symbolic interactionist ideology and stress the importance of symbols in creating a social reality perspective (Mead, 1934; Blumer, 1969). These theorists view social control as the successful manipulation of labels and accordingly, elites, ruling classes, and other dominant groups exercise power through controlling how people define the world and what is possible. Labelling theorists contend that through this process, a non-costly and apparently non-coercive type of oppression can be implemented and eventually taken for granted. Accordingly, labelling or social control may play a part in creating deviant or disempowered pathways that individuals may take during the course of their life. (Erikson, 1964; Davis, 1975).

## **Reconstruction Theory**

Reconstruction theory was proposed by Kuypers and Bengston (1973) to explain the situation of the aged in modern society. It elaborates on the negative aspects of old age even more than did the theories emphasising socially disruptive events and the loss of major life roles. Here, it is proposed that the elderly are labelled as incompetent by both social and self-labelling processes. Lack of reference groups and ambiguous normative guidance were both suggested as primary sources of this very negative labelling. Kuypers and Bengston (1973) suggested that extensive societal intervention and restructuring would be necessary to reverse this negative labelling process. Specifically, interventions could include: (1) Substantial improvement of social services offered to the aged (2) teaching older people better coping mechanisms of greater internal control and self confidence and (3) re-defining the importance of work in society.

The negative aspects of old age began to be challenged towards the end of the 1970's. For example, emphasis on role change rather than role loss became evident (George, 1980).

Here, the author criticised the labelling perspective for not recognising the personal skills or coping mechanisms of individuals.

One major source of more positive labels for older people has been through the formation of age-peer groups in more recent years. The increasing number of these groups formation are evidence that increasing numbers of older people are grouping together and interacting more with each other. It also suggests that those who choose not to participate in these groups may be less likely to maintain or reformulate positive self images ( Brown, 1990).

### ***Conflict Theorists***

Conflict theorists attempt to locate the conditions under which official labelling occurs and to identify high-level agents of social control. Rather than studying how labelling can lead to a loss of autonomy and personal power, conflict theorists argue that the act of being labelled reflects prior powerlessness. According to conflict theorists, the study of deviance is in itself an instrument of social control because system victims are targeted for analysis, rather than the system or those benefiting from present arrangements. Social control is thus an active control involving the regulation of powerless groups and economic stratification serves as the principal determinant of where power lies and what form laws will take (Davis, 1975). This emphasis upon structural inequalities underpinning social control stems from early European social scientists (Durkheim, 1958 and Marx, 1964) rather than Americans who that stressed individual pathologies were responsible for social differences (Williamson et al, 1982).

### ***Political Consensus***

Functionalists assume a political consensus is communally based whereas conflict theorists tend to believe that this is reached as a manipulated consensus. Conflict theorists believe the state is seen as using its legitimated authority to rationalise and supplement the exploitation of some groups by others. Market and political goals of elites determine the direction and scope of social changes and the only reform proposals that are ever found acceptable to these elites involve improvements which benefit themselves, such as the creation of new bureaucracies,

not redistributive ones. Similarly, conflict theorists assert that 'reforms' enhance state power over controlled groups and invariably secure the interests of the elites. This solidification of power to the elites occurs through the appearance that something is being done to redress a problem. Any challenge to existing economic arrangements is rapidly diffused (Davis, 1975).

### ***Social Security—Social Control?***

So how do these theories inform the changes in the status of the elderly? Has the introduction of social security tended to increase or decrease the power and autonomy of the elderly? It is likely that it has increased autonomy in certain spheres, but also increased the extent of social control in others. For example, the pension benefits that the older person may receive may assist them in achieving increased autonomy. However, social security legislation has also created jobs for a wide variety of caretakers who have come to play an increasing role in the management and control of the lives of the elderly. In this way, social security legislation has been very successful in controlling the lives of the elderly (Verba and Nie, 1972).

Although Western governments were involved in the subsidised segregation of the elderly to a limited degree at the turn of the century, their role was further expanded with the passage of social security legislation. Social security was first passed in order to diffuse growing dissatisfaction amongst the elderly without making any serious distributive changes in the system and to regulate the labor market by removing older members. Although social security can be compared with public assistance in that its stated purpose is humanitarian, it actually helps to stabilise the social order and thereby sustain the dominance of elites (Piven & Cloward, 1971). Mandatory retirement is an example of this where public assistance was accepted but also meant that older people became an official target group for government policies.

## ***Social Security Legislation***

Social security legislation has operated as a constraint upon the well-being of the elderly. Deinstitutionalisation of many state inmates has recently taken place. A huge network of caretakers and gerontologists has flowered to deal with the 'problem' group identified by social security. Although old people's economic resources have been increased with social security, there has also been an accompanying growth of network bureaucracies and what conflict theorists call 'regimes of experts' to assess, regulate, advise and ultimately control the elderly. Whether social control is viewed as the exercise of legitimised authority in the form of laws (functionalism), constraint of personal autonomy (labelling theory), or dominance of one group by another (conflict theory), the elderly are a heavily controlled segment of the population. This control evolved into the dependency system created through legislation. In contrast to this, independence supports the user pays system and the individualism that accompanies it, but does not support people who are not economically able to meet their own needs. Social security not only assisted to stabilise the social order by meeting these needs and ensuring the positions of elites, it also created the conditions whereby legions of 'experts' would come to speak on behalf of the elderly. In these ways, technocratic rather than redistributive policies were developed (Piven and Cloward, 1971; Verba and Nie, 1972).

Increases in spending on programs for the aged can be interpreted as gains for the elderly, but these gains have not been without their costs. They have made it possible for a greater proportion of the elderly to avoid dependency on their children. This increase in autonomy and reduction in social control by one's children has been welcomed and has contributed to an improvement in the quality of life for many who are elderly. It is now becoming evident that for many of the elderly the cost of independence from one's children has been an increased dependence on personal public bureaucratic structures and functionaries. The administrators and professional service providers associated with various programs become

agents of social control. The elderly have government subsidies for nursing care in nursing home and community care arrangements but the financial limits of these subsidies has implications for the quality of care such institutions can provide. As a result, life in these institutions is organised more around the goal of cost efficiency than patient autonomy (Vladeck, 1980; Percy, 1974).

### ***Labelling The Elderly***

The formal labelling of people as 'old' along with the increased social distance between them and the rest of the community were key issues to be considered by the theorists of the labelling school. The labelling school asked how the elderly came to become stigmatised. It was noted by Cohen (1966) that all deviant roles are devalued and that they are usually low-status and undesirable roles. It does not mean however, that all devalued roles such as being an old person are deviant. While in the broadest sense, the deviant is assumed to choose to violate a norm, those occupants of a devalued role are seen as 'unfortunate' and not 'reprehensible'. Nevertheless, once they are labelled in the same kind of segregating and stigmatising way, their attempts to manoeuvre around the label or their failure to do so are similar to those of deviants. The question of whether fear lead to the dispensing of stigma or vice-versa is relevant to the elderly. At about the same time that being 'old' was being categorised as a legislative issue, the elderly were becoming more numerous as were anxieties about their employment prospects. Thus, being 'old', especially in increasing numbers, led to growing fear in the broader community. Concurrent reports of the physical hardships of ageing and negative descriptions of the ageing process contributed to this fear and to the devaluing of the older person role. The growth of this fear has continued in contemporary western society. The older population are feared as their numbers are growing and the process of ageing is presumed to involve loss of highly valued attributes such as activity, productivity and independence. Whereas earlier generations may have feared the physical



consequences of ageing, a situation has now been created where the social aspects are feared also (Becker, 1973).

The social process of ageing has therefore led to the labelling of older people as a deviant group resulting in them becoming incarcerated or driven into relatively isolated and less powerful centres such as nursing homes, the focus of this study. Older people, seen as deviants by way of their age, limitations, behaviour, loss of economic and familial supports are subject to bureaucratic controls that intensely regulate their activities.

### ***The Political Economic Theory of Aging***

This theory was proposed to explain the conflict over economic and political power that affects older people. On one hand, the policies of providing older retired people with financial resources are analysed in terms of how they actually improve the economy and benefit the economically powerful. On the other hand, how those policies then become the basis for blaming the relatively powerless elderly people for economic crises is also suggested. It also offers a framework to explain how the resources allocated to implement age-related social and health service policies have been used to fund self-serving special interest networks more than to serve older people themselves. Political economic theorists point out that part of the consequences of this approach may be that it could serve to encourage unnecessary dependency of the elderly (Hendricks and Hendricks, 1986). Political economic analysts report that intergenerational conflict is emerging in younger adults who judge that expenditures to older people are unfair due to the perception that people have developed a welfare state to benefit themselves in advancing age. However, Passuth and Bengston (1988) identify political economic theory with Marxism and suggest that political economic theory tends to overstate the extent that older people are impoverished and disenfranchised. Estes and her colleagues (1992) have urged for the development of a positive "gerontological

imagination” on the part of gerontologists, that would move us away from the crisis mentality into which political economic debates tend to lock us (Estes, Binney and Culbertson, 1992)

### **Summary**

In summary, older people are greatly influenced by the broader social structure in which they live. Theories of functionalism, labelling and conflict provide perspectives by which social processes of control may influence older people as a group. Furthermore, social security legislation is seen as a very successful means of controlling the lives of the elderly. Other forms of bureaucratic control include the network of ‘experts’ that has flourished to deal with the ‘problems’ of older people. Although financial independence may become more common within the older population, social and personal freedoms are very restricted. It appears that the negative stereotypes of ageing have resulted in self fulfilling prophecies, and are reflected in the development of a society where the very natural process of ageing is itself feared because of the negative social consequences. Development of a positive “gerontological imagination” of ageing in research , analysis and information dissemination is needed to help overcome these obstacles.

## Chapter Four

### The Process Of Ageing As A Career

This chapter examines the fulfillment of negative social expectations that affect older people. It continues on from the previous chapter in identifying self fulfilling prophecies and relevant theoretical perspectives. These perspectives range from disengagement theory, to the processes of stereotyping, ageism, medicalisation and frequently institutionalisation. These social processes are instrumental in understanding the evolution of the culture of nursing older people, as they all contribute to the social web that older people find themselves in. As nursing homes are usually predominantly occupied by older people, it is important to understand how these expectations are concentrated in these institutions and how these social processes may apply to the residents.

A career may refer to a sequence of movements from one position to another within the world of work. It may also refer, as Becker (1973) has argued, to a sequence of events which can follow the act of being labelled deviant or devalued. In this approach an interaction exists between the labelled person and society. This suggests that from the moment a person is seen by the community as being old, his or her career as an older person has begun. Perceived indicators to this labelling are varied. For example, there may be signs of wrinkles, a physical limitation, or simply a statement of one's chronological age. Reaching the age of eligibility for a service such as housing or Social Security payments or being retired can trigger this public labelling. The older person now may experience difficulties and restricted options in carrying out the routines of every day life. Gaining or keeping employment is one sanction and the requirement that wages not exceed a certain amount for those collecting Social Security pension benefits is a more indirect but potent exercise of social control. Social contacts become more limited after retirement and a sizeable drop in income is experienced.

New health problems may eventuate also. Socially expected signs of ageing may be exhibited. At the point where the social labelling and ensuing limitation of options lead approximation to the old-age stereotype, society fulfils its preset prophecies and expectations of older people (Williamson et al., 1982).

### ***Disengagement Theory***

Disengagement theory is critical of activity theory. The latter suggests that continuing involvements in middle age may dictate success and happiness in older age. Disengagement theory proposes that the individual and society operate to achieve equilibrium. Progressive loss of social roles and partnerships affect this social equilibrium. As the old are replaced by the young, disruption to the social system is kept to a minimum. Factors such as the finality of death, presumed declining abilities that accompany old age, high values put on youth and the need to maintain social and particularly productive roles all support disengagement theory. It acts to relieve the older person of normative social roles over time and allows younger people into the system. Thus, according to this model a reduction of activity and effectiveness represents 'successful' ageing. It is a two way system in that not only does the ageing person withdraw from society, but society also withdraws from the individual. Social stability is enhanced as the exit of older people from the system is predictable and causes minimal disruption (Aroni & Minichiello, 1992).

### ***Negative Stereotypes***

Chronological age serves as a triggering mechanism for negative stereotyping at any stage in the older person's career and it is not surprising that people try to avoid being 'caught' and labelled in this way. The gerontophobia that accompanies structural controls may originate as a prejudice against others but often ends up in self hatred. Thus the career of an old person is strongly coloured with subjective dimensions as well (Goffman, 1961).

Even if the elderly person manages to avoid succumbing to expected aged-related behaviours, various familial and media-enforced weapons of social control will encroach on the individual and forward their career as an older person. Here, the older person frequently attracts a negative stereotype and is treated with disrespect and portrayed as stubborn, eccentric or foolish. The elderly person's options may be constrained to the extent that an older person's social group subscribe to age norms and try to elicit 'age appropriate' behaviour from others. For example, there is a form of social control which underscores the television stereotype that older women have romantic adult roles less often than do older men. The stereotype both reflects reality and helps to sustain it (Goffman, 1961; Lookinland & Anson, 1995; Greipp, 1996).

If an older person chooses to depend on relatives, the costs may be very high in terms of physical, emotional and financial abuse (Brown, 1990). The elderly may have such low self-esteem that they either think they deserve such abuse or fear the unknown outside the family, more than their current predicament. The existence of nursing homes and their negative public reputations can exert pressure on fearful old persons to put up with the alternatives, regardless of the personal cost.

### ***Ageism And Death***

Notions of ageism are accentuated by the popular media, along with fear of nursing homes and an untimely and traumatic death. Death is difficult for many people and this difficulty is a contributing factor to the very presence of nursing homes. Here, nursing homes may serve the purpose of caring for the dying who can no longer operate within the broader community. Kübler-Ross (1997) has suggested that the reason for an individual's difficulty in accepting death is that the subconscious cannot allow itself to contemplate life without its living presence. The death of another also tends to remind ourselves of our own mortality, a confrontation which may not be adequately resolved amongst many. Because death is so

unpalatable in the general society, it is institutionalised and hidden. Nursing homes, other aged care facilities and more recently, funeral service providers, advertise their market interests to provide a service to assist with death.

The association of age with death has resulted in negative images and stereotypes of ageing. These have influenced the way that society treats older people as a whole. The positive aspects of growth and development across the lifespan need to be developed and incorporated into the care of older people. A study by Ruler (1996) of the influence of a man's swimming throughout his lifespan and into his latter years portrays his experiences in positive terms. The study concludes with a positive image of the influence of exercise on lifespan development. This study shows how learning from the most difficult situation, such as separation and divorce, can be associated with the positive and used constructively during the next stages of life. Learning to take the positive out of any situation is a life skill in itself, but achievable for willing learners. Kübler-Ross's final book is a fine portrayal of this skill, that seemed to be developed in the formative years of her life and still flourishes as she dies. Even during her final transition to death, she still focuses and experiences the positive, basing her life as that of a 'learning experience' (Kübler-Ross, 1997).

### ***The Last Step—Loss Of Autonomy***

Some of the most coercive structural control mechanisms encountered by old persons relate to labels that suggest incompetence, mental illness, or incontinence. These labels make it possible for the elderly to lose the legal right to oversee their own affairs and to be assigned to the protective custody of a social worker or other. This alternative can be used as a threat and increase the power of some family members over their elderly members. This situation also clearly elevates the caretaker role of the state. Institutionalisation in either a nursing home or psychiatric facility may result in the older person losing the last vestiges of personal autonomy or power (Williamson et al., 1982).

## ***Medicalisation And Institutionalisation***

Functionalists, labelling theorists and conflict proponents have all perceived medicalisation as a primary source of formal social control in modern western society and all argue that while such control is rationalised as humane, it results in the political castration of the deviant or devalued person. As Goffman (1961) has pointed out, when medicalization ends in confinement to a 'total institution' the patient is exposed to a closed and rigidly administered life-style that reduces the individual to the symbolic antithesis of what is presumed to constitute 'adulthood.' Self determination and freedom of action disappear as options.

An older person being treated as a child facilitates a complete degradation of self. Forced communal living, regimentation, infantilism, segregation from the outside world, staff impersonalism and task orientation all result in the stigmatism of the identity of the older person to the point of non-personhood (Goffman, 1961; 1963).

If the resident does not submit to this institutional routine he or she may end up becoming physically or chemically restrained. Drugs can be used as a means of deterring potentially 'disruptive behaviour' within total institutions such as nursing homes and psychiatric institutions. Drugs are also used on an outpatient basis with the elderly so as to help them 'adjust' or cope with any isolation, hostility or alienation that they are feeling. This is problematic as firstly, they focus 'corrective' measures on the victim rather than the system and secondly he or she is being managed or controlled by the use of the drugs for what are social, not medical problems (Goffman, 1961).

## ***Current Conditions***

The connections between the changing needs of capital and passage of social security legislation are having repercussions today. The state has absorbed more and more of the costs of production through subsidising the employed and unemployed work forces. Changing the

economic structures of social control has become politically desirable. Here, the aim of social control of deviant or devalued populations at lower costs is the goal. The elderly in particular have become adversely affected by these changes. Reform that could potentially lead to more integrated life-styles and quality community care for 'deviant' or devalued populations such as the elderly has resulted in a number of serious problems. Many elderly have been discharged from state mental health facilities into communities where resources have never been adequately allocated for their care. Some have suggested that this 'dumping' of stigmatised populations into the community is a new type of social control rationalised on the basis of costing less than institutionalisation. This recently decarcerated population lack adequate incomes, work and in many cases basic coping mechanisms and comprises a relatively powerless social group in the hearts of cities (Scull, 1977).

### ***The Subculture Of Older People***

Another subjective component in the career of an old person can be withdrawal into an aged subculture. This may have positive outcomes for eventual political activity among the elderly but the concept of subculture connotes several negative dynamics. After labelling the person as old, setting a series of structural changes in motion (ie retirement, reduced income) and thereby limiting the older person's options within the community, the social control network has manoeuvred the older person into a situation where he or she only feels free to be 'old' among other old persons. Within the elderly subculture, the devalued role of being old can be carried out with less trouble than in the broader culture. In addition, fear of criminal victimisation or familial abandonment could contribute to participation in an aged subculture to the extent that it takes the form of a retirement community. Thus, the label and associated social expectations of being old become a self - fulfilling prophecy. People, not abstract institutions, are the principal agents of social control and labelling theorists implicate all social levels in the stigmatising process. Degrees of segregation from the economic mainstream and



social isolation reflect degrees of stigma directed by the community toward the labelled group, in this case, older people (Goffman, 1961, Scull, 1977).

### ***The Politics Of Older People***

Evidence suggests that most people become more stable in their political orientations as they age, and they do not necessarily become more conservative (Foner, 1974). On some issues and in certain circumstances, people may move to the left or right as they age. When circumstances suggest the need, older persons may also ignore ideological predispositions they may have for the sake of pragmatic benefits that they perceive as in their interest as aged persons. Political alienation among the elderly may be related to their position in productivity-orientated societies. As education levels have risen among the population, the active voices of older people with already high levels of political awareness may expand and could increase the potential for political mobilisation around ageing issues. New technological developments in mass communications provide opportunities to exploit these interests (Comstock et al, 1978; Hwang, 1974).

Since industrialisation Western society has depended on women to bear most of the financial, time and emotional costs of raising children and caring for the sick and aged. More equality between men and women is inevitable and evolving. Social changes that have accompanied such equality have created new incentives to raise the birthrate and created new ways of caring for the sick and aged. The costs of caring are spread more equitably, even though moving care from the family to an institution is usually a great deal more costly and may often result in a lowering of quality care standards. For a population that is rapidly ageing, this spreading of the load has dramatic implications for social policy. The welfare state now provides most of the services formerly provided within families. Such programs operate from the cradle to the grave. The aged are still by far the most important beneficiaries of government programs, even when other forms of social dependence, such as single

parenthood and unemployment have been taken into account. The state is expected to bear most of the costs of caring for the aged. The extension of the life span is still a comparatively recent development in human history (Jones, 1990).

### ***The Exploitation Of Women In Community Care Arrangements***

Dalley (1988) comments that women have internalised altruism, and in this way society is provided with a ready labour force that is cheap and accessible to care for the sick and ageing. Wage earning men are assumed to be the support for these women as they go about their caring activities. Dalley (1988) asserts that the women who are willing to take on this caring role have been being increasingly activated to provide the community care over the recent years. This caring role is taken for granted and the cost of this care is not measured by officials.

A problem with the community care movement is that the significant and increasing number of aged persons living alone may be a serious social problem. The administrative apparatus of the modern welfare state is so overwhelmed by the increase in demand for state services that any need that is not concentrated and visible is likely to be neglected. It has also been argued that the community care movement may inadvertently support a low-cost fragmented system that is only a weak replacement for family care (Jones, 1990).

The history of nursing illustrates that men have had a pivotal role in caring for the sick, poor and infirm (Webb, 1982; Chisholm, 1985; Gomez, 1994; Squires, 1995). It remains to be seen whether these male caring roles can be translated into family and community caring roles in a similar capacity. For example, a 'house husband' role is evolving for men who would prefer a more domestic role in housekeeping and child rearing. A similar role is possible for men who wish to care for older people (Dalley, 1996).

## ***The Future***

The elderly will in the future most likely have more political resources than they have had in the past. This will increase the potential for political influence, but the realisation of this potential is by no means inevitable. The major reason for this uncertainty is the dialectical relationship between these increasing resources and the efforts of those groups who oppose further increases in the power, influence and autonomy of the older population.

There are a variety of social, economic, technological and political changes that may take place over the next fifty years that could increase the probability of increased political influence of the elderly. These include substantial alterations in the age structure of the electorate, technical innovations in mass communications, continuing declines in party identification, a corresponding upsurge in independent voting and an increase in education level amongst the elderly. The development of a sense of group solidarity among the aged may develop further in response to political opposition to their needs and a sense of relative deprivation as a group.

With the increasing numbers in the elderly population there is a growing reluctance of the general public to supply services and meet the needs and demands of the elderly population. This arena of conflict between the elderly and non-elderly coalitions may result in polarisation that may lead to the emergence of a stronger age-based consciousness. Political opposition may provide a shared focus for the elderly as a group and enable them to establish solidarity against a common foe. This shared interest may even cut across social class, ethnic and educational backgrounds which have in the past tended to restrict the formation of coalitions among the aged. Therefore, in the future, powerful influences could be exerted by the growth in the ageing population especially if the aged are united by common interests and solidarity. This sets the scene for an examination of the political history of older people in Australia to provide the context for scrutiny of local influences.

## **Summary**

Theoretical perspectives and processes of social expectations and their fulfilment that affect older people have been outlined. They include disengagement theory, stereotyping, ageism, loss of autonomy, medicalisation and institutionalisation. All of these inform processes involved in making up the social web that older people find themselves in. Old age stereotypes can be fulfilled as society labels and limits older people's options.

Women are often held responsible for the care of people generally, particularly those who are very young, sick or old. The extension of the life span that allows people to live longer has been a more recent development and the state also bears a large proportion of the costs of caring for the aged. Also social change may encourage more men to take up caring roles in the community.

Older people tend to be better informed and educated than ever before and therefore potentially have more political resources to draw upon now and in the future. However, this shift is counteracted by other social groups who oppose further empowerment of older people. This opposition may be overcome by older people as a group becoming united by common interests and goals.

## Chapter Five

### **The Political History Of Ageing People In Australia**

Changing social patterns and constraints frequently require political intervention. The previous chapter has identified various negative patterns and constraints that currently affect older people and may be amenable to political intervention. Politics and its processes may reflect the ways in which things are done in a particular society or group. Therefore, the political history of ageing people in Australia can be understood in terms of government and community practices that affect older people. This chapter offers an explanation of how care for older people has evolved into the current framework. The development of the care of older people in Australia is linked to current standards of residential care. In order to suggest future directions it is necessary to identify and explain relevant historical forces.

“The Welfare State”, by Jones (1990) offers a critical analysis of bureaucracy and government intervention systems in Australia. It has been drawn on extensively in this work because of its relevance to the study which aims, in part, to identify how older people, while striving to become more independent, are conversely more dependent on government intervention than other age groups.

#### ***Traditional Aboriginal Australia***

Old age in an aboriginal society, has been suggested to imply added experience and to show that a person, man or woman, is in a position to advise others less well equipped. The authority of the elders is paramount generally in Aboriginal Australia. However, their authority is based on whether they have something to offer rather than on the grounds of age alone. Most elders, not all, are viewed as the final repositories of custom and religious belief. However, middle - aged men are far more powerful in both the religious and secular or mundane spheres. A man on reaching middle age, may become a camp boss or head man.

He may also become a native doctor if he is the right kind of person and goes through a special initiation. His status as a native doctor allows him to work healing or beneficial magic as well as sorcery. Traditional healers were often known as *maban*, *kadaicha*, *ngangkayi*, *mekigar*, *wirrnum* or *birraark*. Psychic ability - such as telepathy and clairvoyance- have been suggested to be common in Aboriginal cultures but traditional doctors have been associated with special powers and abilities. Later, at perhaps fifty-five to sixty years old he may not be capable of much in the way of hunting and food-gathering and may come to rely on his sons and daughter's husbands. This is considered to be the major benefit of having children, who are expected to care for aging parents in return for their upbringing. Members of the extended family are also frequently involved in the care of their older relatives (Berndt and Berndt, 1999).

Elderly women seem to forage and collect bush tucker for many more years than the men hunt , and are often very supportive of each other. Small groups of senior women tend to live by themselves in single women's camps at larger campsites. Single women's camps currently tend to house separated and divorced women, visiting women and older powerful women and these camps continue to wield considerable influence in any settlement (Voigt and Drury, 1997).

While the family were often the main caregivers to Australian aborigines cases of neglect have also been reported. For example, in desert regions during bad seasons the tribe may be forced to leave its old people behind to starve or die of thirst. Generally speaking though, old men derive their authority and prestige through their knowledge of tribal beliefs and customs. The gradual acquiring of sacred and ritual knowledge with the ultimate secrets in the hands of the older men and to a certain extent to older women is the basis of their authority system and therefore close care is applied to their needs. In the early days before formal care systems were established, certain procedures were generally followed. Food was mashed and ground

by young women and included wild yam, kangaroo and emu meat, emu eggs, witchetty grubs and water (Utopia Health Workers, 1995). The main components of caring for their older relatives was through the provision of shelter, water and fire. Bush medicines played an important role in caring for older Aboriginal people. For example, kurrajong roots were filled and the juice was sucked out by the older people. Goanna fat was used as a medicinal emollient on skin and sores (Utopia Health Workers, 1995).

Older, less mobile people were carried on young men's backs, especially in times of scarce resources. If an elder was close to dying, they would be carried back to their grandfathers' country or homeland. These trips could be extensive but the tribe tried to stay with the dying person where possible. The Australian aborigines have continued this tradition to the present day (Utopia Health Workers, 1995).

At the end of the life cycle, some mortuary rite takes place. Commonly in aboriginal society there is belief in the survival of the dead person's spirit. The dead person's physical body is always regarded as a temporary manifestation. The life of the spirit is thought to come to the fore at birth, initiation, death and other crises, and is considered to be fundamental and in some ways, eternal (Berndt and Berndt, 1999). For example, the Pukamiani ceremony of the Tiwi aboriginies is an assurance of life after death and ensures that the spirit will find its way to the spirit world, where it will live forever. According to this culture, when a person dies, a spirit called a *mobadidi* is released and wanders about near the camp and ceremony ground to see whether the ceremony is performed correctly and with due honour. If it is pleased, the *mobadidi* will still go to its home country and join the spirits there. If a person dies away from the Tiwi islands, the spirit will return to its home. Sometimes it appears to close relatives in dreams to inquire about their welfare or to warn them of imminent danger (Le Brun Holmes, 1995).

## ***Organised Aged Care In Colonial Australia***

Traditional approaches view the Australian welfare system as selectivist, relying on harsh, flat-rate, means tested benefits targeted to the needy. Dependency figures that reached nearly 50 percent in the 1983 recession suggest that such an approach is no longer true. Other explanations have suggested that social dependency may have little to do with poverty in its true sense. Rather, the Australian welfare state is better seen as part of a circular causation process integral to deep seated social, economic and political changes. In other ways, the development of the welfare state is also an indicator of other social changes, particularly in the role of women.

The current public policy uses definitions of retirement age whereby dependency on the aged pension averages at over 20 years for women and for men, over 10 years. These retirement ages are 60-65 years and were originally chosen in the latter half of the nineteenth century as ages when the aged were either already dead or approaching it. It now appears that Australia in the 21st century will be a society where children will be a rare sight and the aged will dominated the economic, social and political system. Many of the post-retirement aged can expect to live for several decades. The welfare state was established partly because of tragic early deaths, however death is now something that is more common over 60 years of age. The medical care industry extracts about 8 percent of the gross domestic product and this is mainly spent on the very old in what are often futile health-care expenditures (Jones, 1990).

The 1980s was marked by a rediscovery of capitalism and the virtues of the private market rather than dependence on government benefits. All of the major political parties have attempted to support the old values of family, thrift and work. Historically, even until 1945 in Australia, capitalism provided harsh incentives to rely on the family and one's own efforts in the event of social distress. Political philosophers, including Marx himself, have generally not been able to predict or understand the eventual domination of the welfare state in western



capitalism. Both Marxists and conservative writers now argue that the welfare state over-emphasises consumption and leisure and by neglecting investment, may be a significant cause of the decline of western economies. Marx underestimated the capacity of capitalist economies, while they were expanding, to support a major proportion of their population on welfare benefits (Marx, 1964; Howe, 1990; Jones, 1990).

The welfare state is now so dominant that it is very difficult to alter programs to encourage self-reliance. The means-tested Australian welfare system may discourage private savings; for example, retirement may result in the individual becoming ineligible for government retirement benefits that may be equal to or more generous than substantial levels of lifetime private savings. Means-tested benefits mean that some households face massive disincentives to work, because they would lose so many benefits and would have to pay taxes while they engaged in relatively undesirable work (Jones, 1990).

The regulation of wages, especially the basic wage judgment of 1907, established one of the main ingredients in Australian social policy. The search for a minimum wage raised the whole question of how to measure poverty. The regulation of wages also affects the way social services are regarded. Wage regulation implies that market forces are tempered by human needs, a precondition of the welfare state. A future conflict was to be that wages were taxed to support non-workers dependent on social security. Higher wages based on productivity requirements can make it very difficult for the aged to continue working because they had to compete with younger, more productive workers (Achenbaum, 1978).

There was to be a distinction between the 'pauper' and the 'poor'. The pauper class, deserving because they were not able bodied and had not directly caused their condition, included the aged, the sick, children and orphans and lunatics. This group was eligible for indoor relief in workhouses, while the able-bodied poor were supposed to be restricted to

less attractive workhouses, where families were separated. In Britain as in Australia, the pauper class and some of the able-bodied poor drifted to public hospitals, which often became quasi-work houses for the indigent. It seemed that Australia could not match the 7 percent of people receiving poor law assistance in Britain in the 1840s. For inmates in Victorian state charitable institutions for the years 1888/89, the total over the year was about 3 percent while the daily average was about 1 percent of the total population. Furthermore, these figures overstate those who were most in need as they included all hospital patients, not all of whom were poor (Dickey, 1986; Jones, 1990).

Many poor Australians suffered because the welfare state was limited in its scope until the 1970s. The Victorian government introduced the first age pension in January 1901, two years after the benefit was introduced in New Zealand. New South Wales followed in August 1901 and Queensland in 1908. A national scheme was created in 1909 and the Commonwealth government initiated age and invalid pensions in 1909-1910 and a maternity allowance in 1912. Early aged care pensions were strictly means - tested and strong incentives were offered for families to take care of their elderly. The initial age pension schemes in Australia were of great long-term importance. The flat-rate, means-tested, non-contributory plan was the long term model, partly because it was too difficult to alter social welfare schemes once they were started. Expectations and entitlements were created. Initially, the pension age was 65 for all the State schemes and the federal plan in 1909, but the age was lowered to 60 for women in December 1910. This concession to women, along with longer female life expectancies and low female workforce participation, meant that the age pension would become a benefit biased towards women. By 1913 there were only 76 males for every 100 females on the aged pension. The pension, which would become mainly a female pension, was also a way of relieving the problem of very low female workforce participation that condemned many older women to a bleak, old age. In 1988, despite higher female workforce participation, 70 percent of aged pensioners were women. The pension became a

self fulfilling prophecy, creating the incentive to retire even though an average lifespan meant literally decades on the pension, especially for women. In 1911, before the pension altered work patterns, 85.8 percent of Australian males aged 60-64, 72 percent aged 65-70 and 44 percent aged 70 and above were in full time work. Groups such as the Aboriginal peoples of Australia, ex-prisoners and people from Asia and other groups were declared undesirable and were made ineligible for the pension (Dickey, 1986; Jones, 1990). The first wave of Australian federal and state old-age pension legislation did try to limit the benefit to the 'deserving'.

Most welfare state historians see the old age pension as a great victory for human rights, because the poor aged could exist, or subsist, on the pension and avoid institutionalisation. However, the cash benefit system that came to dominate the social welfare system created several social problems. The aged were removed from the workforce and the expensive asylums to barely subsist on a low pension, removed from the general trends of the broader community (Achenbaum, 1978).

The old age and invalid pensions of the early twentieth century were viewed by the government as a minimum standard below which vulnerable groups should not fall. Central government generosity to the needy then stalled until family allowances were introduced in 1941. Benefits for unemployment, widowhood and sickness were not in place until 1945. Most other modern countries had a basic social safety net in place well before this late date (Rimlinger, 1971).

### ***Voluntary Agencies***

Voluntary agencies, often based on British systems, played a major role in the provision of welfare services before state intervention in the late nineteenth and early twentieth centuries. The voluntary system performed reasonably well in the period of rapid economic growth

from 1860 to 1890 but was incapable of dealing with the social problems emerging during the depression of the 1890s, when the slow economy caused an increase in the number of the poor, especially the aged poor. Opposition to institutionalisation was a constant theme in governmental inquiries both in Australia and overseas in the latter part of the nineteenth century. It was expensive and was seen as an important causal element in pauperisation; cash social services seemed better and cheaper. The voluntary agencies were very important in the social welfare system, they provided the safety net for the destitute before the provision of State age pensions (Dickey, 1986; Jones, 1990).

### ***The Nineteenth Century***

The Australian population grew very slowly during the nineteenth century, but the proportion of aged people grew significantly during this time. The Australian Aborigines may have accounted for most of the aged in the nineteenth century as their population declined from an estimated 750,000 in 1788 to about 94,000 by 1901. The 1861 census showed that aged whites accounted for only 1 percent of the population. Australian society at this time was dominated by children, 36 percent of the population aged 14 or less. The percentage of the aged gradually increased to 4 percent by 1901. Although this was small by today's standards, it was a fourfold increase since 1861. Australians were experiencing an ageing crisis around 1900. The population had increased by only 3.28 times between 1861 and 1900, but the aged had increased by a factor of thirteen times (Jones, 1990).

### ***The 1970s***

Welfare spending and the proportion of the population on benefits expanded greatly in the 1970s, especially after the Whitlam government came to power in late 1972. Demographic changes, such as an ageing population, only help to explain a small part of this increase. Means tests were liberalised, real benefit rates increased and new programs such as the supporting parent's benefit were established. The rapid growth in welfare state spending in Australia was part of a worldwide pattern as western societies struggled with the new

problems caused by the end of the 'golden age' from 1945 to 1974. During this period, there was low inflation, high growth, high birthrates, unemployment that rarely rose above 2 percent, low levels of social dependency and correspondingly low levels of welfare state spending (Jones, 1990; Gibson, 1998).

From 1973, unemployment soared, reaching almost 10 percent and rarely falling below 7 percent of the workforce. Inflation rose by 170 percent in the decade 1970-1980. Family structures weakened, sending the costs of single parent support soaring. The growing number of aged needed expensive hospital care and pensions. Benefits were increased generously as a reaction against the harsh attitude towards poverty in the 1960s. The selective mean-tested system rapidly became semi-universal, with the abolition of the means test on age pensions for those aged 70 and over by the Whitlam government. The new Australian welfare state created in the 1970s was particularly disturbing because it consisted of long-term dependent groups such as the unemployed. However the most predominant long term dependent were the pensioners (Jones, 1990; Gibson, 1998).

### ***Current***

The welfare state now provides most of the services formerly provided within families from the cradle to the grave. Before the creation of state age pensions early this century, parents would usually negotiate complex contracts with their children. Most children in western societies now expect the state to provide support for their parents if those parents have been unable to provide for their own retirement. The western birthrate has fallen partly because the intergenerational contract now often has little meaning in affluent western countries. The resource flow is very much from parents towards children, not from children towards aged parents, although there can be important 'emotional flows' from children to their aged parents. The state has had to provide a wide range of benefits to the aged because widespread deprivation testifies to the failure of families to support their aged parents. A transaction cost

approach to the family suggests that intergenerational contracts would now be too complicated and too uncertain and would probably create a substantial proportion of poor aged, unable to gain assistance from their children. The lower birthrate since 1970, and the growth of childlessness amongst some women, means that the aged this century will have fewer children to care for them, financially or emotionally. The current aged are receiving benefits paid for by those currently working, and the current workforce will expect to obtain similar benefits when they retire. However, there is no guarantee that the current workforce will be able to obtain benefits as generous as those that existed in 1989. An ageing population and a slow growing economy may limit future benefits (Jones, 1990; Gibson, 1998). With the introduction of economic rationalism, the welfare state has also been gradually dismantled and eroded, depending instead on 'user pay' principles, reducing the availability of benefits. No society in human history has ever had to cope with the proportion of the aged now facing Australia and other affluent countries (Jones, 1990; Gibson, 1998). Male life expectancy at birth in 1984 was 72.5 years and 75 years in 1994. Female life expectancy at birth in 1984 was 79 years and 80.9 years in 1994. Thus, life expectancy is extending as public health measures, technology and knowledge have grown. The total health expenditure as a proportion of gross domestic product in Australia in 1984 was 7.5 percent and 8.2 percent in 1994, representing a considerable growth of expenditure over time. In the five years to 1991, Australia's total population grew by 8 percent while the aged population grew by 16 percent. Here, the term aged is used to refer to the population aged 65 years and over. Australia's population is expected to grow by 41 percent between 1993 and 2041 and to age rapidly. In the year 2024 it is projected that the number of older people in the population will exceed the number of children for the first time. By 2041, there are projected to be 5.5 million older people (22 percent of the population). To 2011, the total population is projected to grow by 19 percent and the largest percentage growth (55 percent) is projected to be among those aged 45-64. For the next 30 years, it has been predicted that the 65 years and over age group will grow at the fastest rate (Australian Bureau of Statistics, 1995c).

Old age would not be a social problem if the aged were financially independent. The Australian aged are surprisingly heavily dependent on the aged pension despite rising real living standards for the past 30 years. In the future, a high proportion of aged households in an affluent society like Australia should be able to provide for their own income support in retirement. Many Australians already do this by owning their own homes outright on retirement. The high level of home ownership among the current aged is a major influence moderating government pension expenditures. This was not possible for many in the past, because high birthrates and single income households left little room for substantial saving for retirement (Jones, 1990).

### ***Community And Residential Care***

Linking health and community services is a realistic policy because of the domination of the aged in the Australian welfare state. There is a strong economic element in the link between health and community care. Health costs are difficult to control especially with an ageing population. In the past there was a strong suspicion that hospitals and nursing homes were used as high-cost dumping grounds for the handicapped and the aged because of a lack of alternatives. While attempts have been made to improve the quality of nursing homes, the major emphasis has been on providing services so that most of the aged do not need expensive nursing home care. The first age pensions in Australia around the turn of the century were justified mainly on the grounds that it was already costing so much to maintain the poor in institutions. The bias against institutionalisation has continued to the present time, usually supported by economists and those who fear control over individual freedom in an institution. Cohen (1966) views the anti-institutional movement dating from the 1960s as a distinct change in the forms of social control in western society. The attack on institutions was part of a general suspicion of the expert, especially the professional, and contributed to major 'deinstitutionalisation programs', as patients were released into the community. Much

of the push towards deinstitutionalisation also came from conflicting professional opinion and clients were rarely consulted. There is now a realisation that many deinstitutionalised persons, particularly from psychiatric institutions, form part of the 'new homeless' who wander through major cities. There is a greater need for balance: some people do need institutionalisation, and the real questions concern the design of effective institutions and the selection of those who need these facilities. There is remarkably little evidence on comparative costs between the effectiveness of private and public alternative care systems. Keeping the aged in their own homes may well be more expensive than other options. Home care services may require the poorly funded services of many staff and quite frequently may simply mean that little help is given. Service delivery adjusted for quality may be very expensive for home care services, if all of the direct and indirect costs are included. Rising levels of female workforce participation, female wage levels and increasing demands for professionally qualified staff in community care services also increase costs. The suburban dream of independent living, usually in a separate house with a garden, continues to be a powerful force in Australia, but it may become more often a nightmare in an ageing society with a higher proportion of handicapped and lonely people. Australian social security policies are strongly biased towards home ownership and rental allowances for private renters are well below rent levels in most areas. Generally, it would disadvantage pensioners to sell their properties and rent or move into an institutional environment. Community care may be a harsh way of enforcing the Australian obsession of home ownership if it serves to prevent older people from moving into an institutional environment when needed, particularly if the client is disabled and/or isolated (Jones, 1990; Gibson, 1998).

### ***The Current Ageing Population***

Those currently aged 60 and over are a product of a particular period in history and their attitude to retirement is influenced by this. Most people in this group have raised families and engaged in considerable self sacrifice and may therefore look forward to a leisured time in



retirement. Men now over 60 have frequently experienced very long working lives, and many of the women have been housewives in a time when labour-saving devices were less common than now and families were larger (Jones, 1990).

Future cohorts may well have very different attitudes to retirement as they reach it. Those reaching 60 after 2010 will have experienced far more lifetime leisure than the current aged. They may regard the prospect of decades on the age pension with no employment as a terrible denial of their rights to a job and further self-development. The desire to work amongst the aged cohort of 2010 may be motivated partly by pressures from women who have enjoyed many years of employment. Both men and women may find it difficult to cope with the meagre pension and want the money, recognition and better health that come from some workforce participation.

Many future aged people will not have married or have had as many children, a key role for many of the current aged. The economy next century will be more knowledge based, and fewer jobs will require the physical strength that has forced some of the current aged into retirement and premature death (Australian Bureau of Statistics, 1995c).

### ***Workable Self-Reliance***

The dependency of the aged on the welfare state is partly a result of the unintended consequences of government policy. There is overwhelming evidence that social security benefits influence life-cycle consumption and saving behaviour (Achenbaum, 1978).

A funding system has been suggested by Jones (1990) that would require compulsory earmarked contributions to a government approved fund, probably managed by competitive private firms. Like the present superannuation schemes, there would be a tight legal contract between the individual and the government. The funds are paid into an account accompanied

by a social security tax built into the existing tax system, creating a personalised fund for the individual. Modern computers and tax file numbers allow the government to keep track of individual's funds throughout their lifetime. High real interest rates mean that the funds increase in value over time and most individuals would be able to provide for their own retirement. The benefits from the fund are not subject to a means test but could be taxable. A separate means-tested scheme, probably similar to the existing age pension, could assist those unable to create a viable sum in the fund. As in Sweden and other welfare states, the basic 'welfare' component has to be kept at a minimum level to encourage people to provide for their own retirements. The funds in the scheme are available on retirement and cannot not be taken as a lump sum (Jones, 1990).

### **Summary**

The political history of older people in Australia is characterised by a gradual move from family to government responsibility. Care provided in traditional aboriginal Australia was quite different to that organised in colonial Australia. Wage regulation in the early 20th century resulted in a specific measurement of poverty and shortly after its introduction provided a means to justify financial assistance to be given to the needy, including the aged. Voluntary agencies continue to provide relief for needy older people. The welfare system flourished in the 1970's evolving into the current welfare system that provides many services that were formerly provided by family structures and demand will continue to increase as the population continues to age. The long held dream of independent home ownership in Australia coupled with the tendency towards discouraging institutionalisation may result in a great deal of loneliness and restriction for handicapped and older people. It has been identified that a balance needs to be achieved between institutionalisation and deinstitutionalisation; dependency and self reliance.

## Chapter Six

### Nursing Home Care Policy In Australia

The history of nursing homes and their policies in Australia presented next will lead into the specific arena of the study of the culture of nursing homes. The previous chapter showed that for older people there needs to be a balance between institutionalisation and deinstitutionalisation, dependence and self reliance. These issues have all lent to the evolution of nursing home policies which follow.

It has been estimated that about 25 percent of people over sixty-five years will experience admission to a residential care facility where skilled nursing care is provided (Howe, 1990; Rowland, 1991). The majority of aged people live outside institutional care. In June 1996, there was equivalent to 49.5 nursing home beds per 1,000 people aged 70 and over. This is a marked reduction from the provision of 66.5 beds per 1,000 people aged 70 years and older in 1985. This reduction is due to stricter admission criteria being imposed and was accompanied by a large increase in the number of respite places and community care packages being utilised during the same period (Australian Institute for Health and Welfare and Department of Health and Family Services, 1997). Therefore, although institutionalised care may apply to only a small proportion of older people, the recurrent expenditure on services for frail older people has increased significantly. Because of increases in public expenditure in this arena, public policy has been continually modified since the 1960s to accommodate these changes. Some widely held prevailing negative attitudes towards older people are coupled with the problem of higher projected costs for their care.

## **1980s-1990s**

The rights of service consumers, concerns about inappropriate institutionalisation, inequities in existing arrangements and the implications of a growing aged population and its costs were the main foci of public policy development in relation to older people in Australia from the 1960s through to the 1990s.

In the late 1980s reforms were introduced in a number of stages. These included expanded geriatric assessment and increased funding for hostel and home and community care. Outcome standards and new infrastructure funding arrangements for nursing homes were also instituted. These consisted of new nursing and personal care funding arrangements in nursing homes followed by the introduction and implementation of strategies to protect the rights of the users of residential care services (Pearson, 1998).

As part of consultation with individuals and groups involved in aged care, resident outcome standards were developed by the Commonwealth government and are reflected in the *National Health Act, 1953* (Cwlth) after being introduced in 1988. Seven major objectives of nursing home care were identified. They were: health care, social independence, freedom of choice, home-like environment, privacy and dignity, variety of experience and safety. Thirty one specific outcome standards were detailed in relation to these objectives and achievement of outcome standards was necessary in order to attract full funding for resident care (*National Health Act 1953*, Cwlth). This was monitored by officers employed by the Commonwealth Government (Pearson, 1998).

The resident classification instrument (RCI) was introduced to identify factors that would predict the level of care needed for the residents. It ascertained relative need, not total need, in terms of actual nursing or personal care hours. Residents were allocated to one of five

categories of need that ranged from Category 5—very low need; to Category 3—medium need and Category 1—very high need.

The care aggregate module encompassed the categories, hours and mix of nursing and personal care staff to be allocated to each category. This funding covered the costs of employing nursing and personal care staff, enrolled nurses and nurses aides, therapists and assistants providing therapy services. An hourly rate of pay was allocated which varied from state to state and the category of staff employed. Also, the homes were able to vary their staffing mix with the allocation generated from their eligible hours and standard hourly rates of pay. Funding was structured to allow one hour of Director of Nursing administration per week and the remaining funding was shared between Registered nurses (32.5 percent), Enrolled Nurses/Personal Care Assistants (59.5 percent) and therapy staff (8 percent). Twenty-four hour a day registered nursing cover was ensured, as the standard hourly rate was topped up to enable the employment of a greater number of Registered nurses (Pearson, 1998; Gibson, 1998).

### **1996-1997**

The reform strategy targeted at aged care that commenced in 1985 was followed by a new wave of changes in 1996-1997 with the election of a new federal government. This government introduced reforms to counteract criticisms of the previous system where it was argued that there were unnecessarily high degrees of bureaucracy and levels of monitoring imposed by the Commonwealth government. (Pearson, 1998). There was a crisis whereby increasing numbers of long established facilities were required to upgrade their buildings. Also, the economic problems that would result from the increase in the proportion of the population requiring the services of an aged care facility perpetuated fears (Pearson, 1998). The new reform agenda was intended to assist with funding the improvements of facilities, to assist provision of care of people with dementia, to avoid intrusive regulation by the

Government and to improve flexibility for consumers (Pearson, 1998). Following the passing of the *Aged Care Act, 1997* (Commonwealth) in April, 1997, several principles of change were established. A single, unified, residential aged care system was to be established from the pre-existing system where nursing homes and hostel care were operating separately. This new system was to have a single relative funding instrument, the Resident Classification Scale, (RCS). This instrument is still in use in a modified form and is discussed further in this Chapter under the heading 'Resident Classification Scale Review'. Accreditation was initially suggested to involve industry and government and has recently been actively implemented in the system. Accommodation bonds were introduced for incoming residents and these are discussed under the heading 'Funding' appearing later in this Chapter.

The quality assurance programmes of the 1997 reforms detail specific standards that reflect the quality management and services expected of aged care facilities and a structured approach to the management of quality. The four major groups for focus include: management system, staffing and organisation development, health and personal care, residential lifestyle and physical environment and safe systems. Within this programme, buildings are maintained and allow inspection for certification.

### ***Certification***

According to the *Aged Care Act, 1997* (Cwlth), facilities that were certified in early 1998 would not require inspection again until after January 1, 2001. The priority for improvement in the medium term is fire safety. The new certification requirements contain a separate standard on fire safety, which must be passed by all aged care services that receive Commonwealth funding. The improvement of privacy and space for residents is another major long term goal. Existing buildings have until 2008 for investment and rebuilding although higher requirements are set for new buildings. No minimum sleeping space requirement is applied to existing buildings. However, the Standards Agency is allocated the

task of examining the functioning of spaces in terms of both occupational health and safety for staff, and safety and access for residents. This issue is being referred to a group undertaking the review of the Building Code of Australia as it relates to aged care. If a new requirement is proposed during this review, then it will apply to new buildings only (Commonwealth Department of Health and Family Services, June, 1998).

Overall, proposed Residential Care Standards for the physical environment and safe systems of the reforms cover: continuous improvement, regulatory compliance, education and staff development, living environment, occupational health and safety, fire, security and other emergencies, infection control and finally catering, cleaning and laundry services (Commonwealth Department of Health and Family Services, June, 1998).

### **Funding**

The system of payment of bonds was initiated when the accommodation charge was created under the *User Rights Principles Act, 1997 (Cwlth) S.23.83A*. This has since been incorporated into the *Aged Care Act, 1997 (Cwlth)* through the *Aged Care Amendment (Omnibus) Act, 1999 (Cwlth) Div 57A (Cwlth)*. The system of payment of bonds to secure nursing home beds was modified in 1998. The rule became that if a person entered a certified residential care service as a permanent resident, then they may be asked to pay an accommodation bond or charge if they could afford to do so. If the resident is approved for high level (nursing home) care, they can agree with the provider either to pay an accommodation charge or an accommodation bond. If they choose an accommodation charge, they may pay the charge for up to five years. If they choose an accommodation bond, the same limits on the maximum bond and retention would apply as for residents entering hostel level care.

Income tested fees are payable after entering care as of March 1, 1998. They may apply 28 days after a resident enters care. Income tested care fees are paid by part pensioners and non-pensioners, depending on the cost of their care. Costs are calculated at 25 c for each dollar of private or non-pension income over \$50 a week for singles. Fees for each member of a couple is based on half their combined private income over \$88 a week. Those who do not pay income tested fees are full rate pensioners, residents who receive respite care, residents who are classified as Category 8 on the RCS, residents with dependent children, those who are ex-prisoners of war and those who were already in permanent residential care by March 1, 1998. Two circumstances were introduced where by a resident may be charged fees prior to entering a residential aged care service. They are under the condition of pre-entry leave covered in Sections 58-1(c) and 42-3(3) of the *Aged Care Act*, 1997 (Cwlth) and respite care booking fees (Section 56-1(c) of the *Aged Care Act* and Section 23.18 of the *User Rights Principles Act*, 1997 (Cwlth). However the *Aged Care Act* in these sections also states that residents may not be charged fees for any period prior to their entry into a residential care service and that residents are prohibited from being required to pay fees for more than one month in advance.

The Government committed itself to equity of access to aged care services, based on need (Commonwealth Department of Health and Family Services, May and June, 1998). The aged care industry in the first half of 1998 met and exceeded concessional resident targets, which averaged 27 percent across Australia. The aged care industry by comparison was achieving a 38 percent ratio, where 43 percent of facilities had more than 40 percent of new residents as concessional. Concessional residents were described as full or part pensioners who have not owned their own home in the last two years and who have assets of less than \$23,000. The home was not counted as an asset if, when the resident enters care, the resident's spouse or dependent child was living there or a carer eligible for a pension or benefit has lived there for at least two years. Otherwise a close relative who is eligible for a pension or benefit who has



been living there for at least five years may be included. For a married resident, half the couple's combined assets is counted. The maximum rates for the basic daily care fee increased from April 2, 1998 in line with the age pension. The maximum rate for a full or part pensioner was \$21.52 a day and the maximum rate for a self-funded retiree (non-pensioner was \$26.91 per day). Similar rates were offered to hostel residents (Commonwealth Department of Health and Family Services, May and June, 1998).

### ***Staffing in the New System***

The current policies have allowed a broad interpretation for the implementation of an appropriate skills mix of staff. The *Aged Care Act 1997* (Cwlth) defined 'residential care' in a way that made nursing and personal care an essential element of the kind of care that must be provided to all care recipients. By this definition 'residential care' provides nursing or personal care or both, depending on what an individual care recipient requires. The prescribed services set out in the *Quality of Care Principles (Aged Care Act Principles, Aged Care Act, 1997)* (Cwlth) provided for minimum level of staffing to ensure resident safety and supervision. This included the provision of on call staff and registered nursing staff for residents with high care needs.

Pearson (1998), has argued that 'skills mix' may tend to describe and allocate staff in terms of their qualifications. However, he has suggested that 'skills mix' may also include the numbers of staff, their life and educational experiences, methods of deployment and leadership skills of staff. Pearson et al. (1992 b) showed that a skills mix of about 30 percent registered nurses; 6 percent allied health and 64 percent generic carers were significantly related to quality outcomes. In this study, the skills of the Director of Nursing and the quality of ongoing educational in-service training were found to be the most powerful predictors of quality aged care. Under the new Aged Care Reforms, management systems, staffing and organisational development standards require: continuous improvement, regulatory

compliance, education and staff development, mechanisms to receive comments and complaints, planning and leadership strategies, human recourse management, inventory and equipment records, information systems and the provision of external services (Pearson, 1998).

Subsidiary legislation, *The Aged Care Act, Quality of Care Principles, 1997* (Cwlth) were introduced in September and October of 1997. It included references to the services which must be provided to nursing home residents. This section sets down a requirement for nursing care to be provided by trained nurses and specifies the hours of care to be provided, based on the dependency levels of residents.

### ***National Training For Dementia Care***

The National Residential Dementia Training Initiative (NRDTI) was developed to provide training for staff in Commonwealth funded nursing homes to improve dementia care practice. Eight professional training providers developed and delivered training courses throughout Australia from July 1996 to December 1997. An evaluation report of this process indicated that over 70 percent of all Commonwealth funded aged care services received dementia care training through the initiative with a total of 17,764 staff participating. 72 percent of attendees at Management Information Sessions were facility managers, Board of Management members or proprietors. More than 90 percent of participants felt that they gained a better understanding of dementia and that the information they received would help them in caring for people with dementia (Commonwealth Department of Health and Family Services; June, 1998).

### ***Resident Classification Scale Review***

The Resident Classification Scale (RCS) determines a resident's relative care needs by responses made to its 22 questions. This scale is used by all residential care facilities. One of

four possible answers to each question is identified and the responses are then summed and made into a general score. There are eight RCS categories that relate to a specific range of scores, ranging from category 1, a very high need, to category 8, which is unfunded, and applies to individuals who require little care. Health and Personal Care Categories include: continuous improvement, regulatory compliance, education and staff development, clinical care, Specialised Nursing Care needs, other health and related services, medication management, pain management, palliative care, nutrition and hydration, skin care, continence management, behavioural management, mobility and dexterity, oral and dental care, sensory loss and sleep. In addition to these, 'Resident Lifestyle' categories of care include: emotional support, independence, privacy and dignity, leisure interests and activities, cultural and spiritual life and choice and decision making (Pearson, 1998).

A review of the newly introduced resident classification scale was made available in 1998 and involved a detailed analysis of resident records and other relevant data covering the first three months operation of the RCS (Cuthbertson, Rosewarne and Smith, 1998). The data represented 26,675 hostel and 20,276 nursing home residents, being about a third of the resident population. It enabled the funding outcomes to be assessed as well as RCS funding allocations to be compared with allocations under the previous classification instruments. The preliminary findings note there was higher funding on average, for both nursing home and hostel residents; there was a large increase in funding for more dependent hostel residents especially for residents with dementia and behavioural care needs; and there was slightly less funding for residents who were relatively independent of nursing and personal care. Results also show an overall increase in funding for every state and these levels were slightly higher than expected. Amendments are proposed for the RCS and guidelines to address industrial concerns. These include disincentives for the use of medication administration aids, a weighting for continence and appropriate acknowledgment of the role of continence management programs and the capacity of facilities to deliver therapy programs. The review

also acknowledges concerns about the impact of the specified care and services requirement to provide 24 hour, on site, nursing care where there are 8 or more high level care residents, for certain facilities, particularly dementia specific hostels. Several concerns over documentation are raised in the review however it observed that over-documentation may be a response to uncertainty about change and this is expected to be more accepted as the new system becomes more established (Cuthbertson, Rosewarne and Smith, 1998).

### ***Summary***

It has been identified that a balance needs to be struck in issues that affect older people, particularly those that address self reliance and dependence, institutionalisation and deinstitutionalisation. Nursing homes are frequently most affected by such policies, as they are predominantly occupied by older people. The growing influence of bureaucratic control in nursing homes has been identified and is coupled with the increased government expenditure in maintaining them. Elaborate control systems such as the resident classification scale, accreditation, certification, training and fee payment controls have specifically been discussed bringing the reader up to the current day requirements and standards of aged care. Because nursing and aged care have mutually contributed to each other's development, it is now timely to examine the historical background to aged care nursing.

## Chapter Seven

### A Historical Background To Aged Care Nursing

After settlement of Australia by the English in 1778, the first nursing personnel were selected from convicts in the new colony in New South Wales. Therefore, in order to understand the current position of nursing in Australia, it is necessary to review the historical foundations of nursing in the United Kingdom. Many of the practices in today's Australian nursing arena have arguably evolved from the early days of aged care nursing. A history of aged care nursing in Australia is therefore necessary to illustrate local influences on its evolution.

Aged care has, at least for the twentieth century been associated with social welfare, and the social welfare system in South Australia has evolved quite differently from other Australian states. A primary source for this section is the book *Rations, Residence, Resources- A History of Social Welfare in South Australia since 1836* by B.Dickey (1986) as it focuses specifically on the welfare issues to be studied. Norton's (1990) *The Age of Old Age* and Durdin's (1991) *They Became Nurses. A History of Nursing in South Australia 1836-1980*, are also cited extensively as they specifically focus on the background issues identified during the course of this research.

#### **Why Study Nursing?**

The definition of nursing as a discipline is a culmination of a long line of descriptions, many of which are still being debated: a vocation, a practice, an occupation, an industry, an art, a science, a craft, a profession or a practice discipline . Given the emergence of Nursing Science in the 1950s, the rapid expansion of nursing theory over the last three decades has added weight to nursing's claim for recognition as a practice discipline in its own right (Choi,

1989). The joining of the practice and theory of nursing can be fragmented but researchers have suggested several strategies that may strengthen the links. Benner and Wrubel (1989) have suggested that practice and theory set up a dialogue that creates new possibilities for exploration and research and Moccia, (in Speedy, 1986) takes the position that there is a dialectical relationship between nursing theory and nursing practice. She suggests that the ongoing development of nursing theory and nursing practice depend on each other. By nurturing the dialectical relationship between theory and practice, nurses are instrumental in assisting those in their care to reach a state of health.

### **Background**

Norton (1990) has documented the first real evidence of organised aged care found in a community of monks in Egypt in AD 390. A historian of early monasticism, Palladius, lived in this community and he describes several Brothers who took it upon themselves to care for their own aged and thereafter to assist the poor and aged outside the sanctuary. The early commitment to nursing by the Christian church in the early medieval period resulted in the development of *xendochium*, which was a residence where an individual who could not be cared for in their own home could go. This group of people included the traveller or pilgrim, the poor and the destitute, the orphaned and abandoned children, the elderly and the plague-stricken. The physical, emotional and spiritual aspects of care of the inmates were nursed by both women and men attendants. At this time, religion started to pressure nurses to make a commitment that required money, family and personal freedom to be sacrificed, distinguishing it from the history of medicine, where such sacrifices were not required (Bullough & Bullough, 1984). The notion of caring for those who were old, infirm or poor spread throughout Christendom initially in the form of doles of food or money given at the gate of monasteries by the monk-almoner. Later, when monastic institutions were more established they provided accommodation for the aged and sick poor, in what were called 'infirmaries'. Norton (1990) describes these nurses who cared for the poor and aged as

'infirmarers' and suggests from this history that nursing had its origins in aged care. At this time there were disparaging attitudes towards people in their old age for the old were coupled with the poor, who were often rejected from general society. To be a recipient of charity implied diminished social status and loss of prestige. The earliest charitable institutions were houses of hospitality for travellers, hospitality being considered a most important obligation. These establishments became the earliest hospitals. Pilgrim House in England was one of the earliest recorded examples and was established in 1076 and became the hospital of St Thomas in 1345. One of the earliest long stay hospitals that specifically catered for the poor, who, because of age or disease, could not earn a living was St John's at Canterbury founded in about 1084. It exists today as an almshouse.

About 560 hospitals were founded in England between the twelfth and fourteenth centuries along with the actual monasteries and friaries that gave shelter and care. The hospitals were in centres of pilgrimage and were most often named after saints. Because of the crudeness of medical knowledge much reliance was placed on divine providence after cleansing of the soul and much prayer for healing. The emphasis in hospitals at this time was on care rather than cure and they tended to be ecclesiastical and not medical institutions. Participation in religious services was a very important part of the resident's treatment. St. Mary's at Chichester still accommodates old people and is divided into compartments in the form of almshouses. Here, older people have been sheltered for almost 700 years (Norton, 1990).

### ***The Middle Ages***

Much private and corporate benevolence prevailed in the middle ages, centred around providing accommodation, often in the form of almshouses. Use of the term 'almshouse' however, was interchangeable with that of 'hospital' which was sometimes little more than a cottage, hence the origins of the cottage hospital in England. Almshouses featured prominently in the story of the care and welfare of old people. However, by the latter half of

the eighteenth century many charities were trusts and guilds of trades and professions, and their benevolence was restricted to workers in the particular field that they represented.

By the beginning of the fifteenth century the peak of the pilgrimage movement had passed and vagrancy became a social problem. Accompanying vagrancy was the abuse of benevolence and hospitals intended for the sick poor and aged. The statute of labourers (1350) attempted to curb misuses by recognising that a man should be capable of working until the age of sixty. This was the first official recognition of there being a time for retirement. This system was subject to abuse however as there were no accurate records kept of age. Although this statute also recognised that disablement could cause unemployment, with resultant poverty, it also recognised that rogues were adept in faking disability. As medical knowledge was too meagre at this time to show otherwise, some genuine cases may have been victimised by the harsh vagrancy laws that followed. For example, the Act of 1530-1 ruled that beggars be whipped and driven from towns (Norton, 1990).

The majority of hospitals of the fifteenth century remained for the care of the infirm poor and aged. However, during his reign, Henry VIII dissolved the monasteries, nunneries and priories and most of the establishments with ecclesiastical patronage. This left an enormous vacuum for the destitute, leaving the most vulnerable including some of the aged, to suffer in misery (Norton, 1990).

### ***The Elizabethan Age***

Elizabethan statutes of the late sixteenth century were intended to rectify the problems brought about during Henry VIII's reign and to control the persistent vagrancy. The English Poor Law system began with the Act of 1601. It lasted for over three hundred years and influenced care provision in other parts of the British Isles and established colonies, including Australia.



This Act made each parish responsible for its impoverished old and others incapable of work with a tax levied on its inhabitants and administered by an appointed overseer. Subsistence was provided as either money or goods and could include payment of a physician to attend a sick person at home. However, there remained some degree of shame or resentment in association with sick payments, however.

Other alternatives were the 'parish poorhouses' that tended to be quite small and homelike. There, the inmates had to earn their keep by domestic work and attending the sick and infirm. Increasing economic unease at faults of this system by able-bodied people led to the establishment of 'houses of industry' which were workhouses, the first being built in 1697 and privately funded. The workhouse system was favoured and by 1723 and were widely established. They were intended to have room set aside for sick and infirm inmates, but this was not generally implemented (Norton, 1990).

An attempt at reform accompanied The Gilbert Act of 1782 which encouraged parishes to combine to form unions and construct a 'Union Workhouse' with an infirmary where the sick and old might receive more humane care and attention. Yet few 'Gilbert Unions' were built and the intended 'reform' neither provided for the care of the occupants of an infirmary or sick ward nor addressed the problem of discerning the 'deserving' from the 'undeserving.' The majority of the workhouses were not well administered and there were gross indulgences. It is likely that the vulnerable inmates, such as the old and cognitively impaired, could not compete for the meagre resources offered.

The poorhouses, workhouses and private madhouses were the main repositories for those classed as lunatics and idiots, depending on the social status of the person afflicted, whether they were a pauper, or a person with means. The principle in these institutions was absolute custody with person restriction, often by ingenious and barbaric devices. The keepers were

persons of lowly status with little or no interest in the welfare of the inmates and the system of confinement, lacking statutory supervision until the latter half of the century, made it conducive to abuse and brutality (Norton, 1990).

### ***The Nineteenth Century.***

The Napoleonic wars led to economic hardship by the beginning of the nineteenth century. This was accompanied by an influx of immigrants and high unemployment. The burden of the Poor Law became intolerable and a Royal Commission was conducted to enquire into the working of the existing law. The Commission reported that outdoor relief afforded to the able-bodied was a great source of abuse. Institutional care provision for the old and infirm had deteriorated extensively and most of the voluntary hospitals limited admission of the impoverished sick to curable or clinically interesting cases.

The following Poor Law amendment Act of 1834 and the orders that followed were intended to correct widespread pauperism, which had resulted from abuse of outdoor relief. A form of means test identified those who were not eligible and forced the destitute to accept the workhouse where conditions were deliberately very grim. This was to discourage their use as a refuge. Here, impoverished old people were unintentionally caught in the trap of the workhouse and spent their last days stigmatised and dying as paupers in unmarked graves. The new Poor Law became associated with the organisational structure of more than 600 workhouses built in England and Wales in the seventy years following the Act. The Commissioners had originally wanted separate accommodation for the elderly with sleeping compartments for couples, the sick, children and pregnant women, but this was considered too costly. A revised plan for a more 'general mix' where there was strict segregation of the sexes was adopted. Here, families were split up and old couples forced to part. Still, had an elderly, sick person chosen to enter the workhouse, it is unlikely she or he would have been better off in their own home. Each 'Union' (the common name for workhouse) had sick

wards in the men's and women's sections and although there were doctors appointed to the institutions, they had little authority. Infirm inmates were still 'nursed' by able-bodied paupers earning their keep, either in Unions or in the community. Although some may have been kind and helpful, the pauper nurses had a reputation for cruelty, stealing and drunkenness, captured in the character of *Sairey Gamp* the nurse from Charles Dickens's (1896) novel, *Martin Chuzzlewit*. No allowances were made for the changing dietary needs of the aged and the aged were made to wear house uniform. They were not allowed to have personal belongings. No lockers or chairs were provided. There was no form of occupation for those too old or frail to work.

Visiting had been actively discouraged, but after a visiting society was established in 1858, it became more widely known how harshly treated and deprived the old and sick were. Social and medical concern about the treatment of old and infirm inmates prevailed from the outset of the 1834 Act, however fears of exploitation hampered their enlightenment. The principal was set that the workhouse was a deterrent to pauperism. The Master and Matron of most institutions (often a married couple) frequently saw the inmates as being there for correction, as if their infirmity was self inflicted and gave them no moral right to exist (Norton, 1990).

### ***Reform In The Nineteenth Century***

William Rathbone, a Liverpool merchant initiated changes to care provision for maintaining the sick and elderly frail in their own homes. This was a type of domiciliary service provided by nurses. Together, with a number of other influential reformers of the time including Florence Nightingale, humanitarian principles began to influence further reform.

At this time the workhouses were becoming infirmaries. In earlier times building additions to workhouses had been sick wards that were used by able bodied paupers. Now they were fast filling with the sick and the old and infirm, estimated to be about 40 percent of total inmates

in 1861. Public debate and a series of public scandals initiated reform. The poor Law infirmaries were established, otherwise known as the 'Hospitals for the Sick Poor'.

The old have traditionally been coupled with the poor. Likewise from the late nineteenth to the early twentieth century the welfare of old people has become inseparable from social reforms and the emergence of the health professions.

During the Victorian Era, local government Boards were made responsible for poor relief and public health in 1871. Medical officers for health were appointed two years later and several domiciliary nursing associations were founded. Some Poor Law Unions preferred to employ their own district nurses but generally this care provision was totally inadequate to maintain sick and infirm old people in their own homes, especially in rural areas. These problems largely resulted from the development of an industrial society, since the great migration of younger people to the towns and cities had diminished the family support structures. The breakdown of the family structure also led many old people to become 'aged inmates' of Unions.

A Charities Organisation Society came into being in 1869, and these societies benefited the destitute, especially children, the elderly, single women and widows. Men were outnumbered by women in the population and women in traditional female trades such as drapery and domestic service generally worked for very small wages and needed these services to maintain them as they became too old to work.

Gradually, in the forty years leading up to the cessation of the Poor Law in 1929, long advocated concessions in Unions to aged inmates were granted. The strict separation of the sexes came to an end and some married couples were provided with share bedrooms. Reliable residents were allowed to venture out of the building precincts. Residents were

allowed access to food and drink privileges and became entitled to decide when they wished to go to bed, which personal possessions they wanted to keep and a free choice of clothing.

Unions were divided into several parts that included accommodation for the 'undeserving pauper' where austerity, labouring and harsh discipline still prevailed; and an infirmary or sick ward and an old people's section, with some resemblance of the home comforts of the impoverished class of that era. Unions had become increasingly filled by people in need of some form of nursing care from the middle of the nineteenth century. Old age and all manner of sickness and disability were now the chief reasons that people became 'indoor paupers'. The building of the Poor Law Infirmaries 'Hospitals for the Sick Poor' commenced in the London area as a result of the Metropolitan Poor Bill of 1867. This legislation also established asylums for the mentally ill and for the mentally handicapped, isolation hospitals and dispensaries (Norton, 1990).

Florence Nightingale was influential in establishing the Poor Law infirmaries and played an active part in their design. She sent some of the first nurses from her training school at St Thomas' Hospital to take charge of the care of infirmary patients. One of the pioneers was Agnes Jones, who was appointed 'Lady Superintendent' of three male wards of over 500 inmates at Brownlow Hill Infirmary, Liverpool, in 1865. Previously, this establishment had been managed by a lay 'matron' and the sick wards were staffed by paupers. The attendants were given instruction by Agnes Jones and her small band of trained nurses, along with a small wage. Agnes Jones died (of typhus) after only three years in this position, but during this period she established the first training school for nurses in a Poor Law institution. Other training schools became attached to infirmaries such as Highgate Infirmary in 1870 and St Marylebone Infirmary London, 1881 (Norton, 1990).

By 1896, every London Union had a modern purpose-built infirmary, with most eventually establishing schools of nursing. Nightingale's grand plan to stimulate and continually develop the training of nurses largely materialised through the poor law infirmaries, highlighting further the close association between the nursing of the old and infirm and the foundation of professional nursing (Norton, 1990).

## ***Care In Colonial Australia***

### **Early Settlement**

Although Captain James Cook landed in Australia in 1770 and buried a sailor who had died from pulmonary tuberculosis, there was no European settlement until January 26, 1788, when the first fleet arrived. This expedition had been decided upon by Lord Sydney, Secretary of State for Colonies of Britain, who gave instructions regarding the transport of 750 convicts with the necessary staff and guards, to Botany Bay. This expedition consisted of six transport ships, three store ships and two ships of the Navy. The fleet sailed from Portsmouth on May 13, 1787 and arrived in Botany Bay individually between January 18 and 20, 1788. The ships subsequently moved to Port Jackson, where, on January 26, the Colony of New South Wales was founded. The settlement was established in a cove, into the head of which flowed a small stream that became known as the Tank Stream. This tank stream was for the first years of the settlement, the sole source of water supply.

In the beginning the food supply presented difficulties. The first colonists did not consider asking the native inhabitants of the land for advice regarding available food. Therefore, the main source of food was that brought by store ships from England. Consequently, scurvy was common during the first years due to the lack of fresh vegetables and fruit. Later, cattle were introduced and grain grown, providing abundance of fresh food (Cumpston, 1972).

The total initial population was 1,024, consisting of 529 male and 188 female convicts, 233 male and 34 female civil and military personnel and 40 children (Cumpston, 1972). The criminal code in England at this time was stringent and it was almost impossible for a hardened criminal to escape the death penalty. It is probable that 83 percent of the first transportees were guilty of offences against the law which in later times would be dealt with by the summary jurisdiction of a police court or possibly pardoned under a First offenders' Act (Watson, 1913; Watson, 1914-1925).

### ***The First Hospital***

The First Fleet sick tents were pitched on the west-side of Sydney cove at the beginning of February, 1788 and it was here that Sydney Hospital has been considered to originate. The first hospital was a rough structure of bark and canvas on the western side of Sydney Cove. It was usually crowded, lacked sanitation and patients frequently did not survive. Governor Arthur Phillip was himself a patient after being speared in the shoulder by a native at Manly Cove. Although '... medicines, drugs, surgeon's instruments and necessaries to the value of 1,429 pounds' (Watson, 1913:3) were brought in the First Fleet, there were no blankets or sheets for the hospital and some of the drugs perished during the voyage. By November 16, 1788, Captain Phillip reported that except for the old and those who brought incurable complaints with them, the people were very healthy. Scurvy, which was initially common, disappeared on the first approach of spring, but affected other passengers on later voyages (Cumpston, 1972).

The first doctors to live in Australia were the eight surgeons and two surgeon's mates who arrived with the First Fleet in Port Jackson on January, 26, 1788. The Chief Surgeon was John White. All of the first nurses were selected from convicts. Francis (1998) reports that the more able bodied convicts were generally used for heavy labour such as agricultural and

building pursuits but the convicts who were assigned to nursing positions tended to lack the physical strength required for other occupations.

During the first two years the hospital had enlarged to accommodate 60 patients and when stressed 80, but sickness was rife and the hospital resources were inadequate. The whole colonial population was on half rations and malnutrition was very common. In July 1790 the second fleet arrived and full rations were issued. However, the number of sick rose to 486. One of the ships of this fleet, The Justinian, brought with it a portable hospital made from wood and copper. This hospital, along with between 90 and 100 tents were used, with each tent accommodating four patients. The surgeons attended the sick along with a small number of convicts as nurses. The mortality was very high, being a little under 10 percent.

The diseases which affected the settlement during the first 42 years are of special interest. When the first fleet left England the general living conditions were very insanitary. Typhus fever was prevalent both in the English gaols and upon the overcrowded and insanitary ships. Typhus fever was also common amongst the marines of the early fleets. Also common in the whole population were fever, dysentery and cholera morbus (Cumpston, 1972; Watson 1913). There was a serious outbreak of smallpox amongst the aboriginal people in 1790 and many died on the New South Wales foreshores. None of the Europeans were affected, possibly because they had already had the disease or had been inoculated in England (Cumpston, 1972).

### ***The Rum Hospital***

With the second fleet came a special regiment that was a detachment of the New South Wales Corps. The officers in this regiment initiated a traffic in rum which was to play a vital part in the eventual building of the main Sydney Hospital. Between the departure of Governor Phillip and the arrival of Governor Hunter, 1792-1795, the government was in the hands of



the two senior officers of the corps, Major Grose and Captain Paterson. Between the two, very little discipline was exercised. The King's store was the sole provider of rations and since rum was most highly sought after, the supply of rum became a means of barter from which the officers made an enormous profit.

In 1796 medical conditions remained deplorable. Governor Hunter had the original hospital pulled down and re-erected on a stone foundation near the site of the present Argyle Court. A hospital store and a dispensary were also built and the hospital was allocated grounds of about 2 acres. The rum traffic progressively increased and Captain P. G. King was appointed Governor in 1800 with instructions to suppress the traffic, but met with a great deal of opposition from within the colony (Cumpston, 1972; Watson, 1913).

### ***The First Nurses Of The Hospital***

In 1803, there were a staff of 20 convicts at the hospital in the capacity of overseers, dressers, wardsmen, gardeners, boatmen and nurses selected from the convicts. These staff received no pay, but were maintained at public expense. This system, with slight modifications, remained throughout the convict era.

The Musters of New South Wales and Norfolk Island dated 1805-1806 (Baxter, 1989) indicate that there were eleven convicts specifically employed as nurses in the new colony. Records however, were poorly kept, and it is possible that more were employed but were simply listed as Government employees. Additionally, many early censuses were destroyed to maintain privacy, so very early records are rare, especially those where the occupation of the convicts are listed.

The nurses of the new colony listed in the Muster of 1805-1806 (Baxter, 1989) included the following women: Sarah Brown, Martha Barnet, Margaret Catchpole, Elizabeth Curtin,

Sarah Davis, Ann Jones, Rachel Matthews, Catherine Malone, Jane Tewes, Mary Smith (off the ship 'Experiment') and another Mary Smith (off the Ship 'Minerva'). All were listed as hospital nurses, and all were prisoners except for Martha Barnet, Catherine Malone, and Mary Smith (of the Ship Minerva) who were '... free by servitude' (Baxter, 1989).

A number of midwives were also listed for this period. They included Ann Burke and Hannah Leeson both of whom were free by servitude. Jane Rose was also a midwife at the time, but she came to the colony as a free settler on the ship 'Bellona'. No nurses were listed as being on Norfolk Island (Baxter, 1989).

### ***The Influence Of Governor Macquarie***

In August 1806, Governor King was superseded by Captain William Bligh as Governor. Bligh attempted to contain the monopoly, sale and barter of spirits but failed. After the insurrection of 1808, the rum traffic was still rampant and it was stated that 40,000 gallons were given away by authorities at this time to their favourites and supporters.

Major General L. Macquarie arrived in December 1809 to take charge as Governor. He had brought out instructions for the return of the New South Wales Corps to England whose officers were thought to play a large part in the unrest in the colony. Also, regulations were framed to control the liquor traffic and this objective was attained by imposing an import duty and by licensing vendors.

After his arrival, Macquarie sought to improve the health of the colony. He appointed new medical staff and initiated the infrastructure that led to a new hospital being built. In his first dispatch of March 8, 1810, 10 weeks after his arrival, he wrote:

there will be an absolute necessity for building a new general hospital as soon as possible, the present one being in a most ruinous state, and

very unfit for the reception of the sick that must necessarily be sent to it, of which there are on an average seldom less in it than between seventy and eighty men, women and children (Watson, 1913:14).

The hospital's construction was financed by profits made from the rum trade by the contractors and tenders of the building. They made a large profit and this way allowed the government to erect the building virtually free of charge. The foundation stone was laid on October 30, 1811.

The hospital commenced operation with 40 patients accommodated in three wards at the southern end of the main building, two on the ground floor for male patients and one above for the female patients. These were the only wards in occupation until 1819. No regular record of patient numbers were kept but it was said to be frequently overcrowded and fluctuated between 70 and 80. During the early days of the hospital, the unqualified staff consisted of an overseer, an attendant who acted as a clerk, a gatekeeper, a matron and a number of male and female nurses. The female nurses were described to be of a dissolute class and it was noted that they often came on duty intoxicated in spite of frequent punishments for such an offence (Watson, 1913).

Some of the case books of the Sydney Hospital have been preserved. These cover portions of the years 1808-1809 and 1817-1818. From these records it has been deduced that the most prevalent conditions were dysentery and venereal diseases. Speaking of the period 1816-1819, Watson (1913:33) suggests, '... dysentery was the most prevalent disease, and recurred at regular seasons. It was ascribed to diet, water, and the conditions of life, but many cases were probably enteric fever ...'.

### ***Daily Routine At The Rum Hospital***

Medicines were dispensed by a convict assistant and the bottles handed to the convict nurses and wardsmen, but it was well known that the medicines ordered were often administered to the wrong people. All classes of diseases were admitted, as well as midwifery 'cases', but no effort at classification was made.

All of the food was cooked by the patients themselves in the wards and rations were issued to every patient individually 3 times a week. Because of this arrangement, each ward was virtually a scullery with a kitchen and larder combined. The patients were mustered every evening by the overseer who locked them in their wards in the hospital from sundown until the next morning at 6 am. Overnight, they were locked in without an overseer, nurse or attendant. No lavatories had been provided in the hospital itself and patients were often allowed to lie in bed without clothing. Dressings were often thrown under the bed and remained on the floor. The bed linen was changed once a week and replaced by an often poorly kept and equally dirty 'new' supply (Watson, 1913).

In the 1820s a crisis arose when 40 newcomers landed sick with scurvy. All cooking or linen washing on the wards was forbidden. Clean linen was issued as required and all bedding was aired thoroughly once a week. Commodes were provided and the sexes were completely segregated. The wards were thoroughly washed between 6-8 am every morning. Order was maintained at night time when the nurses and wardsmen were instructed to sleep on the premises and were locked in with the patients. These changes quashed the drunkenness and dissolute living which was said to be very common amongst the nurses of this period (Watson, 1913).

In the 1830s, the personal staff at the Sydney Hospital were augmented and then consisted of an overseer, a clerk, an assistant clerk, a cook, an assistant cook, a messenger and two

gatekeepers. Nurses and wardsmen were maintained at the level of one to every seven patients. All staff consisted of convicts who were selected by the principal Superintendent of Convicts. One wardsmen and one nurse were made seniors and were made responsible for the personal administration of the medicines to the patients in order to reduce chances of error. The senior nurse was afterwards officially called the matron, and the first one given this title was a Mrs. Baxter, who remained in charge from 1845 to 1852. All subsequent Matrons and Directors of Nursing at Sydney Hospital that followed, were women (Watson, 1913; Sydney Hospital, 1978).

### ***The Cessation Of Convict Labour***

The transport of convicts ceased entirely in 1841 and the necessity for maintaining a convict hospital also declined. The government accepted a degree of responsibility for pauper patients who were not convicts, however, as convict numbers declined and the emancipated and free population grew, the Government disengaged itself from direct responsibility for the 'respectable poor'. Meanwhile, the Sydney Dispensary had been created in 1826 to provide out-patient care for those persons who were free but unable to pay for medical attention. It was conducted on traditional charitable lines and operated from several city premises before acquiring the South Wing of the Rum Hospital. At the same time, the institution expanded to serve in-patients and changed its name to the Sydney Infirmary and Dispensary, a title officially approved in 1844. Convict in-patients continued to be treated in the separately managed hospital next door. The General Hospital at Sydney was the last to survive, but on March 28, 1848 it was reported that all convict patients under treatment had been transferred to the Parramatta factory. With the dissolution of the convict hospital system, the Sydney Infirmary and Dispensary gave up the South Wing in 1848 in return for approved occupancy of the entire middle section of the Rum Hospital complex. With minor variations, it has retained the site to the present day. The institution changed its name for the last time to Sydney Hospital in 1881 (Watson, 1913, Sydney Hospital, 1978).

In subsequent trips to the new colony, many relatives of the convicts were listed as 'nursemaids' or 'nurses.' Some free settlers, such as Louisa Duke, were also attracted to the colony. Louisa travelled to the new country at the age of 22 in 1849 and listed herself as a 'nursemaid'.

### ***The Aged In Early Australia***

It has been reported that the Australian aborigines may have accounted for most of the aged in the nineteenth century as they declined from an estimated 750,000 in 1788 to about 94,000 by 1901. However, the aged as applied to these figures was not defined and records of the aborigine population and their corresponding ages were rarely kept. No provisions were made for their care by the colonists and later they were to be excluded from receiving welfare benefits, introduced in the early 20th century, even when they reached old age. The aborigines treated with fear and often hatred as an outcast group with less status than that of the undeserving poor.

The 1861 census showed that aged whites accounted for only one percent of the population. Therefore, at this stage, the population of colonial Australia was very young by current standards. At the Sydney Hospital, records of diagnoses for admission were kept from the 1820s. No separate figures for the aged were given, but it was said that in July, August and September 'simple continued fever' used to attack chiefly older people and children (Watson, 1913:65).

### ***The Administration Of 'Lunacy and Idiocy'***

The disposal of convict or pauper lunatics in the early years of white settlement was not defined in the official papers. The disposal of convict lunatics was merely a matter of the Governor's discretion, and custody was usually in the gaol or hospital depending on the

danger to the community by the likely actions of the lunatic or their circumstances. For pauper lunatics, a similar procedure may have applied, probably with a preference for hospitalisation rather than confinement in a gaol (Cummins, 1967).

In 1811 a lunatic asylum was established at Castle Hill. The administration of the asylum rested with the Governor, starting with Captain Phillip. He delegated these responsibilities until the establishment of the Supreme Court in 1823 which was based absolutely on the constitution and the Governor's authority. The management of the asylum was predetermined by existing English law and procedure, any differences or modifications resulting from the special circumstances of the Colony. The emphasis of the Governor's authority was on custodial confinement and restraint, less for the protection of the individual than to conserve his personal estate and preserve the harmony of society. This approach was repeated in the commissions of successive Governors up to 1825 when the jurisdiction of the Supreme court came into being. The establishment of the Supreme Court in 1823 paralleled developments of such a system in other colonies and England. The governor's authority was extended to cover issues of personal insanity and idiocy. The colony was not ready for the form of local government with the delegated powers known in Britain or the other Colonies. In the absence of any system of governmental control of the care of the poor, the afflicted or the chronically ill, there was no alternative to the Governor's authority or jurisdiction for idiots or lunatics who threatened the peace or harmony of the community. The extent and convenience of the Governor's authority are well illustrated by its survival as a mechanism of the administration of lunacy long after Self- Government.

The allocation of a resident medical staff of at least one surgeon, sometimes with an assistant to Castle Hill Asylum, was established in advance of its time when compared with many of the asylums in Great Britain. The rules and regulations drawn up by Governor Macquarie for the conduct of the Asylum were equally enlightened with insistence on cleanliness, comfort,

humane treatment, recreation, medical attention and records (Cummins, 1967). The building of Liverpool (1825), Tarban Creek (1838) and Parramatta (1848) asylums were to follow in due course, some also providing services for the free population.

### ***The Asylum Nurses***

Eighteen convicts listed as nurses, midwives, medical attendants and wardsmen were listed in the General Muster of New South Wales in 1822 (Baxter, 1988). Of these, the following were listed specifically as nurses: Ruth Clashman, Ann Donnelly, John London, John Miles, Ester Sweetman, and Sarah Sweetman. Notably, this list includes two male nurses: John London who was serving a life term and worked at Windsor as a Nurse; and John Miles, who was serving a seven-year term and working as a Nurse at Parramatta. Esther Sweetman and Sarah Sweetman were both Nurses employed at the Lunatic Asylum. In addition, Peter McGrath, Thomas Martin, James Mooney, Peter Morgan, Ann Parker, Christiana Simpson, Dennis Sullivan and William Webster were included in the 1822 Muster as being at the lunatic asylum but whether they were patients or staff is unclear, as occupation and residence were classified in the same way during this muster (Baxter, 1988).

The Lunatic Asylum at Parramatta was occupied by 26 convicts in this muster of 1822 and once again it is difficult to distinguish whether they were the staff or inmates of this institution. Only four of these convicts were women. William Bennett was the superintendent. William Campbell was the keeper of this institution at this time and he carried a seven-year convict sentence (Baxter, 1988).

### ***Male Nurses In Colonial Australia***

Barber (1996) and Pearson, Taylor and Coleborne (1997) have emphasised that men played a very important role in nursing in the early colonies and that it was not until the arrival of Lucy Osborne and her party of Nightingale nurses in 1868 that nursing became engendered as a female occupation. During this time the number of men undertaking nursing duties declined



dramatically, partly attributed to the controlled ambience of nursing and its subservient relationship to medicine over this period. Various titles of employment were given to men who were broadly considered to be contributing to nursing. Male nurses were variously recorded in the records as nurses, wardsmen, house stewards, attendants, medical assistants and orderlies before and after the influence of Nightingale. The listing of men working at the hospitals and lunatic asylums in the early convict records tends to support this argument. For example, see the muster of 1822 (Baxter, 1988).

Nursing practices that evolved in the earlier settlements influenced those that developed in South Australia. The focus of this study now turns to understanding the history of aged care specifically in South Australia.

### ***The Beginnings Of Supported Aged Care In South Australia***

Government involvement in the provision of aid for the destitute in New South Wales, Van Diemen's Land, Queensland (when established) and Western Australia, had grown directly and rapidly out of the presence of convicts who had been transported there from Britain. By contrast the colony of South Australia had explicitly refused the British government access entry to transported convicts. The systematic plans for colonisation enunciated by Wakefield were designed to create a prosperous, balanced society and one in which government interference would be minimal (Dickey, 1986).

### ***The Emigration Agent And The Rejection Of The Poor Law***

During the period 1836 to 1848 the emigration agent decided that the Poor Law in its English form was to be avoided. The work of the Emigration Agent was to supervise the arriving shiploads of migrants, to ascertain that their welfare on the journey had been properly maintained and to see to their immediate welfare on arrival. As a result the Emigration Agent was soon providing shelter in 'Emigration Square', 'Coromandel row' and 'Buffalo row' in the parklands just west of the city square. These attracted a great deal of public criticism. The

agent also had a clear directive in 1838 that he should exercise '... a superintendence over the laboring emigrants in affording them gratuitous advice and assistance as regards obtaining employment' (Dickey, 1986: 4). In addition, if they could find no other employment he was to engage them himself at reduced wages to work on colonial government projects such as road-making (Dickey, 1986).

The workforce brought to the colony officially excluded paupers from British or Irish parishes except in a few controversial cases. The notion of ridding the paupers was rejected by the new colony's theorists. Yet the arrival of labourers in South Australia was nevertheless part of a contrived, rational approach to the questions of political economy which were agitating reformers in England in the 1820s. The necessity for a poor law was avoided by attempts to implement a balance between the three elements in the classical, Ricardian economic equation : land, labour and capital. It was argued that there would be no marginal inefficiency and therefore no social dependents and therefore no need for poor law. The delicate balance of labour and capital was further manipulated when the Colonisation Commissioners agreed that all assisted emigrants should be able to find work in the colony on the open market. If not, they were to be employed, at reduced wages, on government works. This admission of final responsibility for employment and hence maintenance, by the planners of the colony was to become the cornerstone of South Australia's welfare system and to make it unique in Australia. The concept of an obligation to provide relief to all who were destitute was never accepted in the colony. Instead a geographically comprehensive, if still largely government-based, system of poor relief emerged, very much the product of local pragmatism. Its principle of action, in direct opposition to the Poor Law, was to be selective, not universal (Dickey, 1986).

### ***The Developing Problem Of Poverty***

The reality of welfare in South Australia contrasted sharply with the original plans. Within a year or two of the foundation of the colony, the Emigration Agent, charged with supervising the welfare of assisted migrants, was providing very large expenditures to provide work and rations for destitute people after they landed. A generation later, there was a large general poor-house in Adelaide, a Government Board with a salaried chairman and numerous staff, an annual parliamentary vote and a system of relief for the poor, covering the whole colony. It was by far the most complete and centralised form of government engagement in the administration of social welfare in colonial Australia (Dickey, 1986).

The Agent reported to Governor Grey on 20 May 1841 that in 1840 his department had afforded relief to 904 persons who, on strict enquiry, had been found to be in destitute circumstances. Among the cases he dealt with in that year, the Emigration Agent had to provide nursing aid for the sick, burials for others and rations for widows and seven orphaned children. Not only had the Emigration Agent been providing rations and medical comforts to dependent destitute at Governor Gawler's instructions; he was also organising work on the public account for the able-bodied but destitute males. In his covering dispatch to that report from the Emigration Agent, Governor Grey reported his struggles during the autumn of 1841 to cope with a financial crisis which had confronted the colony as the governor's bills were refused. Without further funds to expend on public works and without the prospect of further assisted emigration, there was little likelihood of continuing economic growth in the colony. Confidence collapsed and the new Governor set about economising on government expenses and encouraging the colonists to do the same (Dickey, 1986).

In an attempted solution, Grey appointed a Board of Emigration in November 1841, alongside the emigration Agent, instructing them to produce a more systematic arrangement to deal with the evil of what he called a 'pauper population'. The board was to review all cases

receiving relief and present recommendations to the Governor, who would authorise each in turn. When reviewing some of these weekly figures in January 1842 the Register urged that the government should not interfere with the labour market and should only act to prevent destitution. Here, the legitimisation of action derived from the character of capitalism. The Colonial Secretary reiterated that the applicants of welfare must accept work in return for rations. In response to another dispatch from Grey in 1841, Lord Stanley, the Secretary of State, explicitly rejected the notion of an imperial responsibility for the poor, deriving from the Poor Law, to the able-bodied poor. Unemployed labourers were not to be employed if it could be shown that they had refused private employment, whatever the wage. Instead, as a last resort, let them be offered passages to other Australian colonies. If they refused, said Stanley, that would discharge the so-called obligation the government had towards them, arising out of the Colonisation commissioners' promise. Stanley ordered that the '... sick and impotent poor ... widows and deserted women with their families, and ... orphans and deserted children be thrown upon their own resources and those of their nearest relatives, as soon as possible' (Dickey, 1986; 21).

### ***Partial Introduction Of The Poor Law***

Governor Grey was able, in late 1842, to cease government relief works of employment altogether because the labour market had improved. The Emigration Board was also disbanded because its work was done. He introduced a Maintenance Bill to the Executive Council in late 1842. This was the imposition on direct relatives such as wives, husbands, parents, children and grandchildren, of legal responsibility for maintenance of dependents. The bill included the requirement to support illegitimate children and the power to bind poor children in indentures. It was based on the amended English Poor law of 1834 and therefore imported a small element of the English Poor law to Australia. It omitted any formal statement of state responsibility and it did not address the questions of 'settlement' or financial burden.

Although it was difficult to enforce, it became the legal foundation for the social welfare action undertaken by the government in the colony for the next twenty-five years. In the last resort this was because the Maintenance Act, occasionally called the Destitute Relief Act, meant that where it could be shown that there were no relatives who could support people in destitute circumstances, then the government must act by providing support. Like the Poor Law, Grey's Act laid the responsibility on an extended family of three generations, from which could be derived a definition of the 'deserving poor', worthy of public assistance. These people were dependents without natural protectors, unable to support themselves and not responsible for their destitution. These deserving poor were assisted from public funds and the able-bodied poor (able to work) both male and female, were excluded, for the market would take care of them. The colony continued to prosper economically and in early 1845 emigration to the colony was recommenced. By late 1846 the worst of the depression was over and in 1847 Governor Robe urged the use of all available money to support emigration, for labour was badly needed. The duties of the Emigration Agent were changed so that he was not helping the labouring immigrants to find work, but instead be employed in caring for the destitute poor, inquiring into their claims for assistance, preventing imposition and acting as their guardian and friend (Dickey, 1986).

### ***Establishment Of The Destitute Board***

It was being recognised that the Emigration Agent could supervise incoming vessels and supervise the reception of assisted migrants from Port Adelaide, where he had been directed to reside. However, this arrangement tended to preclude him from his duties with the destitute. In early 1849 the Colonial Secretary wrote to several church representatives and William Giles, a well known Congregationalist and manager of the South Australian company, inviting them to become members of a Destitute Board. The responsibility for the destitute was now passed to the Board which consisted of a group of clergymen and a

number of government officials who, apart from the emigration Agent, did not attend the meetings. However, at no point were the duties of the Board to go further than recommendation to the government that rations be given. Those decisions remained in the hands of the executive. The distribution of rations would have to be carried out by public officers under the general direction of the Emigration Agent.

For just over ten years until 1860, the Emigration Agent, plus Giles and nominated clergy men were the active members of the board. The board supervised applications for assistance for the destitute of South Australia and also the Destitute Asylum when it was established in 1852 (Dickey, 1986).

### ***The Destitute Asylum***

The term 'destitute asylum' was used in the early nineteenth century, in England, the United States and in the Australian colonies. Children, lunatics, aged, destitute, inebriates, women, Aborigines, lepers, were among the many categories for whom institutional care and control were provided within a building or group of buildings called an 'asylum'. This was the application of the concept of a factory to problems of managing social dependence. Like a factory, the asylum would permit regularity, supervision, economies of scale, the division of labour and the creation of a new social order. Only indoor residence would satisfy these demands for regularity and efficiency. Like outwork, outdoor relief was of the past, so powerfully condemned by the Poor Law Report of 1833 in England. Indoor relief in an asylum had become widely accepted and applied. The Destitute Asylum in Adelaide was no exception (Dickey, 1986; Norton, 1990).

When the board reported on its first year to the governor in 1850, it identified two general problems in coping with people who required assistance. One was that many of these people needed medical aid. The Board was given power to recommend such help at the Colonial



Hospital after consultation with the Colonial Surgeon. The second need was for proper accommodation as the Board reported that it was housing about twenty-five people in various huts.

The Destitute Board tried to fulfil the duty of providing residual aid to the dependent destitute on behalf of the colonial community of South Australia. However, the policy of rigorous selectivity among the poor was made impossible as had been the experience in other welfare agencies of last resort at mid-century (Dickey, 1986).

Housing the destitute and the question of discipline plagued the board. Initially, the destitute were housed in scattered huts in Emigration Square but were difficult to control. Rules were drawn up in March 1850 requiring presence at night, obedience to the matron and forbidding indecent language, other misconduct or unannounced visitors with the threat of eviction. By early 1851 there were five 'blind' people, five 'paralytics', five chronically ill men, two pregnant women, one 'imbecile' girl and eleven deserted children, 29 in all, in whatever accommodation was available (Dickey, 1986; 25). In April 1851 the government granted the Board access to part of the barracks complex next to Government House on North Terrace. Destitute people moved into their new quarters on 10 May 1851. These buildings were regarded by the government as only a temporary home for the destitute and discussion continued on other alternatives. However, space became crowded and the practical outcome was characteristic of the administration of difficult, low-priority social problems in the Australian colonies. The Lunatic Asylum provided some space for a short time. A small building was erected to the west of the soldiers barracks in 1852 and the Board was granted expanded facilities at that site, some purpose built, as demand grew higher. In due course the Asylum spread back into the soldiers' barracks area, housing a growing number of people through the late 1850s and 1860s. The asylum eventually spread over three quadrangles. Some buildings were two-storeyed with verandahs, others only single-storeyed. Normally

several officials, including relieving officers and later superintendents, matrons and attendants, lived on the site. The resident population of adults and children peaked at over 600 during the First World War. The 'Destitute Asylum' was therefore for sixty-five years the venue for the admission to dependent status of thousands of colonists and for the provision of what aid the community thought they deserved (Dickey, 1986).

At the end of 1859 the following people resided in the Asylum:

*Table One : Residents of the Destitute Asylum, 1859*

Condition	Females	Males	Total
Aged and frail	6	14	20
Blind	2	2	4
Rheumatics	1	4	5
Epileptics	2	1	3
Paralytics	1	9	10
Chronically Ill	8	2	10
Imbeciles	13	2	15
Convalescent (after childbirth)	2	-	2
Convalescing (after illness)	4	-	4
Single women	5	-	5
Children	-	-	76

Source: ( Dickey, 1986:29)



## ***Increasing Government Control And The Destitute***

A new Act in place in 1863 provided rules about misbehaviour on the part of applicants and inmates in the asylum. It permitted the imposition of fines or gaol sentences on inmates through the police magistrate's Court. In addition the rules dealt with the imposition of penalties. 'False pretences' if proved, carried a penalty of up to six months' gaol, as did fraudulent conversion. Moreover, there was also the power to recover the cost of the goods involved.

The 1863 Act passed to regulate the Asylum proved to be inadequate. It was also clear from exchanges between the officers of the Destitute Board and the government, that the acts of 1842 and 1863 gave little explicit basis for the existence and operation of the Board and the Asylum. These had been inaugurated by administrative action and were sustained only by annual appropriations and the continued supervision of the Chief Secretary. A new Bill introduced in 1866 provided for the continued management of destitute and neglected children but also provided a statutory basis for the Board and its executive Chairman. It functioned to gather up the provisions of the two previous Acts and to combine them into the new Act. The Board was given power to draw up rules, which would require the approval of the Governor-In-Council and which would define those who were to receive the benefits of the Asylum as well as prescribe the proper behaviour for the inmates of the Asylum. Now, salaried positions on the Board were advertised and filled. By June 1867 the Board had prepared its regulations and published them with the approval of the Executive Council. The new rules did include provision for admitting wayfarers or casual poor and they also regulated in twenty-three clauses, the behaviour of Asylum inmates, emphasising routine and the exclusion of bad characters. The necessity for all inmates to work was explicitly laid down. The duties of each officer were prescribed in hierarchical order. The operations of the Industrial School were set out. The procedures by which requests for aid in country districts

would be dealt with and the necessary forms of indenture for apprenticeship were appended (Dickey, 1986).

In this way, South Australia took another forward step in the process of bureaucratisation of government social welfare. The dependent poor were to be assessed selectively, personally and without recourse to appeal. Comprehensive control was to be exerted on those admitted to the Asylum. Supervision would be strictly adhered to in the dispensing of rations. The reciprocal obligations on the part of the board were left imprecise and discretionary thus allowing selective charity to be given a permanent and state controlled, form (Dickey, 1986).

By the 1860s, the Destitute Asylum became a fixture on North Terrace and money was being spent to extend the facilities provided. The roster of indoor cases was even more clearly dominated by aged, chronically ill people - those who were bed ridden, crippled, blind, paralysed and diseased. Some of the cripples were young or middle aged and had a miserable future. The Asylum also continued to provide shelter for deserted women and children and also for pregnant destitute women while they gave birth and nursed their infants. At the end of June 1864 there were seventy six males and sixty nine females (including children) spanning all of these categories.

### ***The Daily Routine At The Asylum***

The daily routine in the 1860s was roughly as follows :

The day began at 7 am, breakfast was at 8 am and reading was permitted between 9 and 10 am. Daily duties were then carried out for 2 hours and again for 3 hours after dinner. These duties included washing on Mondays, Wednesdays and Fridays with folding on the alternate days. Some women did needle work. The men might clean

the yard and do other miscellaneous tasks, but it was often pointed out that the men were too helpless to do the tasks. A few might act as messengers, doorkeepers or even make mattresses. Visitors were permitted twice weekly, but absence required a pass. Intoxication, possession of liquor, or obscenity would lead to eviction as would conversation between the sexes or refusal to work. Divine Services were conducted for the Protestants twice on Sundays and on Wednesdays at 4 pm.

Source: Dickey (1986:38)

### ***The 1880s***

By the mid 1880s indoor cases had trebled. By the early 1880s the colony's economy was gradually retracting. That recession led to increases in the number of applications to the Destitute Board for assistance. Also the colony's population was growing. 126,830 people were listed in South Australia in 1861 compared to 275,244 in 1881. The population was also ageing. 1.7 percent of the population was reported to be over the age of sixty in 1861 compared with 4.2 percent in 1881. More inmates at the Asylum would have been aged and more likely to remain there. On the other hand, the very existence of the facilities helped to create the increase in numbers. Each time a crisis occurred, the asylum filled to capacity and a small extension of space and facilities was provided which also quickly filled up. If the space not been extended, the numbers of destitute in both categories would have been fewer in South Australia. In New South Wales there were small, government-subsidised benevolent societies in a few centres, perhaps twelve and consequently fewer recipients of outdoor relief. However, the Government Asylums for the Aged and Destitute could utilise four major sites in new South Wales, including an old mill in Parramatta that had been inherited from convict days. Thus there were proportionally more indoor cases in New South Wales than in South

Australia, resulting from a different structure and background of available services (Dickey, 1986).

### ***The Destitute Asylum: For The Poor And Aged***

The Asylum continued to accumulate destitute and dependent people and in the 1860's it took on the character of a hospital for aged, chronically ill people. In 1865 the staff at the Asylum included a matron and a nurse. In June 1867, of the 167 adults living there, 152 people were suffering from a physical disability which ensured their permanent residence in the Asylum. Conditions at the Asylum remained crowded despite the opening of the Children's Industrial School at Magill and the Reformatory at Semaphore together with the practice of boarding out children to families. Applicants continued to arrive, increasingly referred by the Adelaide Hospital. The Destitute Asylum became a nursing home and chronic care facility where patients were sent when they were unlikely to recover in hospital and would occupy expensive beds. The Destitute Board was forced to press for improved facilities and extra nurses to care for these people as numbers continued to increase as there was no other facility for them, public or private. The Board pressed for a separate hospital for chronically ill patients to be established but this demand remained unfulfilled for a decade. The Adelaide Hospital sent its house surgeon to visit the asylum each day, to see inmates and those in need of medical aid who had been referred by the Hospital. In 1882 the government recognised the need for professional full-time medical care at the Asylum and supported the appointment of a full time medical officer. His duties included the medical supervision of the Asylum, aid for all the other inmates in the care of the Board at the Magill and the Boys Reformatory and also medical visits to outdoor cases in Adelaide and its near suburbs (Dickey, 1986; Durdin, 1991).

In 1888 the population of South Australia was 317,000, about 100,000 of whom lived in Adelaide and its suburbs. The Destitute Asylum and the State Children's Council were parts

of a stable, free enterprise economy of merchants and businessmen and their employees in the city and country. 359 people resided in the Destitute Asylum in June 1888, of whom 102 male and 50 female residents were described as 'aged and infirm'. For the years 1887-1888, 44 hospital patients, 21 medical patients, 9 'blind or partially blind', 51 'aged or infirm', 7 partly 'imbecile', 59 pregnant women and a further miscellaneous 32 people were admitted to the Asylum. Four-fifths of the admissions in 1888 were migrants, described as aged and frail. (Dickey, 1986 : 79).

The single primary experience shared by every client of the Board was complete poverty. The inmates lacked saleable skills and resources. At best they had been previously employed as labourers, domestic servants, shepherds and sailors. The results of age and poverty were usually described in medical terms, for example, of 'senile decay', or 'locomotor ataxia'. They also completely lacked the ability to care for themselves and were State dependents. The Asylum therefore effectively became a hospital for incurably sick people who were also destitute.

### ***Establishment Of The Home For Incurables***

Plans promoted by Dean Alexander Russell in 1878 were for the creation of a hospital for the incurable. This scheme was thought to have considerable long-term potential. The Home for Incurables was established and gained considerable government and public support, earning a stable and valued role in the community. Mrs Julia Farr was among the leading organisers who helped to raise an initial sum of 2,000 pounds. This money was spent on establishing a house in Fullarton where the Home was initially based. Admission required some kind of incurable condition. A payment of 1,000 pounds per annum was received from the government which gained the right to fill six beds. This payment formed the basis from which the Home was transformed to government sponsorship in the 1960s. Until then it had survived on subscriptions and donations (Kerr, 1978).

In the first year, thirty four patients were admitted, of whom two or three returned by their own choice to the Destitute Asylum. In that same first year there were eleven deaths. By 1888, there were forty four patients and a staff of nine. Nursing duties were undertaken by the matron, a head nurse and three others. The Home provided care for those who were terminally ill but the criteria for admission changed gradually to emphasise those who were suffering long term disabilities. Evidence was required that the patient was mentally sound but suffered a long term illness that was not infectious or contagious (Kerr, 1978; Durdin, 1991; Dickey, 1886).

### ***Other Caring Bodies For The Aged***

By the late 1860s there were a few charities run by non government bodies such as the Anglican Orphan Home, (since 1860) and the Adelaide Benevolent and Strangers' Friend Society (since 1849). In 1868 the sisters of St Joseph also established a 'Providence', another general relief agency though very modest in size. They offered residence as well as resources from a house in West Terrace, but moved several times in following years. The Sisters of St Joseph opened a residence for aged women and some 750 people, including unemployed servants, children, old and infirm ladies were admitted. It provided indoor and outdoor assistance and gained high repute in Adelaide and beyond (Dickey, 1986; Durdin, 1991).

There was a movement in late 1871 to fund the purchase of cottages for destitute, aged people. A group of men and women canvassed potential supporters in September of that year. During this time the Reverend James Jefferis of Brougham Place congregational Church pointed out that his church was already letting twenty cottages to the poor at low rentals in connection with the City Mission. A management committee was appointed with representatives of the Methodist, Anglican, 'Independent' and Baptist congregations. Soon

they had 28 old ladies in residence in purpose-built cottages in Stanley Street, North Adelaide. In subsequent years, cottages were bought or built at Brompton, Glenelg, Mitcham and Prospect, so that by 1900 the organisation disposed of over 70 places (Dickey, 1986, Durdin, 1991). Further efforts by benevolent groups at building cottages were tried but failed, because of difficulties in buying and selling them and non-payment of the rents.

Other agencies also entered the field in the twentieth century. In 1915, the Roman Catholic Little Sisters of the Poor began with accommodation for 13 which grew to 150 in 1925. The Salvation Army established an Aged Men's Home in 1910. The 'Resthaven' group for aged care was resolved to be set up in 1935. These services were to be transformed by the intervention of the Commonwealth government in the 1950s (Dickey, 1986; Durdin, 1991).

The introduction of the aged pension in 1909 met the most pressing need as it provided the aged poor with cash with which they could rent accommodation in a style beyond the means initially supplied by the charities of Adelaide. The relatively limited range of non-government welfare agencies up to the mid-1930s in South Australia were characterised by a commitment to selective policies towards their applicants, a focus on a series of residual categories of problem people and a preference for institutional solutions. The most significant relief for the poor and destitute was funded and controlled by the government (Dickey, 1986).

### ***The Old Folks Home At Magill***

Of the 359 people in the Asylum in 1888, 41 died within the buildings and 13 were sent to the Adelaide Hospital in the hope of treatment. Another seven inmates were set to the Lunatic Asylum and two were admitted to the Home for Incurables. Three people were sent to gaol, three were expelled and three children were set to the care of the State Children's Council (Dickey, 1986).

The Asylum on Kintore Avenue was overcrowded with over 600 inmates during the 1890's. However, it was not until 1911 that the Verran Government and the Destitute Board confronted to problem of costs and arrangements for the building of an 'Old Folks Home'. A three-day review of the Asylum was carried out and then a report compiled that highlighted lack of adequate staff and resources. A new single level Asylum was proposed, with an infirmary, infectious ward and bathing facilities to house sixty female and seventy male residents. It was to be staffed by a matron, five nurses, four wardsmen, two laundresses and three cooks.

Magill Old Folks Home was opened on 27 February, 1917. The inmates were referred to by politicians as the 'rugged pioneers' for whom the government argued, could never be repaid for their work as pioneers. Thus Magill Old Folks Home became the first institution specialising in the care of older people funded by the Government in South Australia. It continued to offer places for those people who were most dependent. Federal subsidies for building aged accommodation were introduced by Sir Robert Menzies in the 1950s. These services though largely conducted by what had originally been welfare agencies, steadily became services for the aged community at large. A broader set of criteria that took into account physical and family capacity was introduced and replaced the sense of serving the special needs of economically dependent aged people. This permanent and substantial subsidy system allowed the development of a tightly community controlled and rigorously scrutinised range of aged care institutions. From a handful of agencies for the aged in 1969 there were over a hundred by 1980. A third were based on religious affiliations. Aged care had become a service available to most South Australians. The buildings and patient maintenance were paid for by the state and Commonwealth governments: the former through direct, strictly regulated grants and the latter through the requirement that a fixed portion of the aged pension be paid to the agencies (Dickey, 1986; Durdin, 1991).



### ***The 1980s - Severing The Links With The Poor Law***

The Community Welfare Act of 1981 transformed the maintenance requirements which had survived for so long as evidence of the links with the English Poor Law. For the first time since 1843 there was no legal requirement for family members to support adult near relatives. The obligation was now applied only to children and was essentially focused on the parents. This Act made specific reference to individual dignity and the welfare of the family as the bases of the welfare of the community. The activities of the Department of Community Welfare became broader. They now extended to giving assistance to individual or groups to help overcome their problems and family support. These groups of people included ethnic communities, aboriginals, children, youth, aged persons, unemployed persons, women, mentally or handicapped persons, single parents and persons living in isolated areas. The presence of these groups suggested a large statement of potential dependence and set the philosophical and operational objectives that signalled the character of social welfare for the 1980s and 1990s (Dickey, 1986).

### ***Nursing In Colonial South Australia***

According to the Register of Emigrant Labourers applying for a free passage to South Australia, 1836-1841, the first person who described themselves as a 'nurse' was Mary Oakley, from Northampton. At age 15, she was single and engaged by a Dr. Fisher who had arrived earlier on the ship, 'Buffalo'. During this time, when the wealthier in Britain were sick, doctors attended them at home and members of the family or a personal attendant, male or female, provided the necessary nursing care. This system was adopted by the free settlers in South Australia. It was expected that the early colonists of South Australia would be relatively healthy and be relatively young. Land was to be sold at a relatively high price and the proceeds of these sales were to be used to fund the emigration of the labouring class to the new colony. However, like other colonies, the long voyage in restricted living quarters created health problems, with the highest death rate being among mothers and infants.

Also according to the Register of Emigrant Labourers, Ann Hatton was registered in 1836 as a 'nursemaid'. However, it was recorded that she 'quitted the ship' and did not arrive. In 1837 Eliza Staniford was registered on the vessel, describing herself as a 'nurse'. She was single and 21 years of age. She was followed by Eliza Charman, a 'nursery maid' in 1838 and Julia Follett, a 'nursemaid' in 1839. On her voyage in 1839 Bridget McCullough registered on the log as a nurse. It was noted that she was 39 years of age and engaged to Captain Brewer. Several domestic servants, housemaids and general servants are listed throughout the registry. For example, Eliza Crow was registered in 1837 as a 'servant of all work' and it was recorded that she was also single and 17 years of age (South Australian Register of Emigrant Labourers Applying For a Free Passage to South Australia, 1836-1841).

As the immigrants settled into the new colony, women most frequently attended to the care of neighbours and families in times of sickness and childbirth. Mothers taught their daughters and domestic servants to nurse. In the early nineteenth century, a women's sense of relationship and caring for family and friends was an integral part of her self identity. An example of this activity was in the early colony in New South Wales, where typhoid fever was prevalent and was associated with infected water supplies (Durdin, 1991; Watson, 1913).

The colonial infirmary was established in 1837 following an urgent need to provide services to those who were destitute or could not care for themselves. Following representations to the Governor, the Colonial Secretary and the Storekeeper, the problem was referred to the finance committee. A hut was made available on North Terrace to provide care for these people and within a few months the government set up a dispensary and an infirmary. There were no beds, earthenware nor any sanitary provisions. The first nursing services at the

infirmary were provided by Mrs. Wickham, who cared for and cooked for the inmates. Following her were attendants including several men named Chadwick, John Wigden and Sergeant Jolly (Durdin, 1991).

### ***The First Hospital***

The first Hospital was built in 1840 near Hackney Road and accommodated thirty patients. By 1857, it had been replaced by a larger hospital built on the site where the present Royal Adelaide Hospital stands. It housed an average of eighty patients per day and it was reported that the most common afflictions were abscesses, ulcers, wounds, rheumatic afflictions and diseases of the eye, stomach, bowels and lungs. A staff of eight or nine nurses cared for the patients in 1857 but by 1864 the nursing staff comprised a matron, 8 female and 2 male nurses and the average number of patients was ninety. The matron was Mrs Joanna Briggs, wife of the dispenser, and her role was mainly concerned with housekeeping and supervising the nurses. At that time the female nurses were expected to sleep at the entrances of the wards at night time and provide care to patients who were seriously ill. They were chosen according to their family backgrounds without specific qualification. Their duties included: scrubbing, carrying coal, feeding the patients, administering medications, regulation of rest and sleeping times and activities, regulation of visitors, sewing, attending to the hygiene of patients and to maintain a quiet environment. At this time, nurses were also employed at the Destitute Asylum, the Lunatic Asylum, St. Margaret's Convalescent Hospital, The Home for Incurables and private and country hospitals (Dickey, 1986; Durdin, 1991).

On recovery, the patients at the Adelaide Hospital were expected to help the nurses in their duties including the nursing of other patients, an arrangement which benefited the economy of the hospital. In 1888, there arose several disagreements between the nurses and officers employed by the government. After the subsequent resignation of the head nurse, the Board

considered engaging supervisory nurses from Britain. They advertised overseas and from the applicants selected four trained nurses who arrived from London in 1889 (Durdin, 1991).

### ***Colonial Care Of The Mentally III***

Male nurses were predominant at the lunatic asylum, later to become Glenside Hospital. As in New South Wales and Britain, lunatics were kept in custody in order to protect the public rather than to effect a cure. Total restraint was commonly used. Initially, the government was not prepared to outlay funds for their care despite lunatics being identified in the early years of colonisation. Those who posed a threat to the public and had nobody to care for them were housed in the gaol. On the site where Glenside hospital is now located an eight roomed house was rented by the government in 1846 to accommodate the mentally ill. It was not adequate for the needs of the colony. In 1849 a lunatic asylum was built and by 1851 accommodated fourteen male and twelve female patients. The head keeper of the asylum was not enlightened in the treatment of the mentally ill. He supervised 9 male attendants. His wife was the matron and she, along with six nurses, cared for the female patients. All of the attendants lived at the asylum and married male attendants were permitted to sleep out twice a week. The environmental conditions were very poor and the asylum and its patients were transferred to Parkside in 1870 with a new Matron, Miss Lucy Harriet. She took an interest in the education of the nurses and arranged for them to attend lectures and use handbooks. The nurses did not wear uniforms but instead wore red armbands so that they could be identified readily. Little distinction was made between the treatment of differing mental illness's in the nineteenth century. 'Imbecile' children were also cared for in the lunatic asylum until a house was purchased in Fullarton to accommodate them and became the forerunner of Minda Home (Dickey, 1986; Durdin, 1991).

These early establishments became the sites at which modern nursing practices were established and evolved. Modern nursing care of the aged in South Australia is now examined in this context.

### ***Modern Nursing Care Of The Aged In South Australia***

As previously stated, most nursing care in the early days of South Australia was carried out by usually well meaning but often poorly educated and ill prepared people, including domestic servants and relatives. Mostly women were called to care for sick relatives and friends partly because the men were often required to be the sole providers especially at the time of industrialisation. Women were largely relegated to domestic duties and caring for others often reflected their self identity within the community (Dickey, 1986; Durdin, 1991).

However, those who were aged with no means, relatives or friends to care for them were frequently placed in the Destitute Asylum and after the turn of the 20th century, Magill Old Folks Home. Limited relief could also be sought from charities and religious organisations (Dickey, 1986, Durdin, 1991). The introduction of the aged pension in 1909, gave the aged more choice of accommodation and care in their latter years. Some chose to be cared for in small private hospitals and these largely met the demand for nursing services.

### ***Hospital Trained Nurses***

With income donated in recognition of Florence Nightingale's work during the Crimean War, a nurse training school had been set up in 1860 at St. Thomas's Hospital in London. There was an annual recruitment of fifteen young 'probationers' or trainee nurses. Florence Nightingale outlined their training programme in detail and kept a close interest in its progress. It was expected that those who successfully graduated from the training school would carry their skills and abilities to other hospitals as Nightingale had intended in her original plans (Nightingale, 1970).

Henry Parkes, the Colonial Secretary of New South Wales, secured the services of six such nurses in 1868 to work at Sydney Hospital under the leadership of Miss Lucy Osborne (Watson, 1913; Durdin, 1991). Likewise, South Australia followed the example of New South Wales in securing the services of these nurses. Miss E. J. McKenzie was appointed as Lady Superintendent of Nurses and among her early duties she constructed a one year training programme for nurses. The probationers worked in the wards of the Children's Hospital and the lying - in ward at the Destitute Asylum. Weekly lectures and quarterly examinations were given. The academic qualification for potential probationers was their ability to read instructions and to be able to write (Durdin, 1991).

Alice Tibbits and Louisa Holthouse successfully finished the required one year of training and received the first Nurses' Certificates, both from the Children's Hospital. In 1889, training at the children's hospital was extended to two years. Here South Australia followed similar trends in Britain and relied heavily on English models of practice. In the 1890s the course was extended to three years (Durdin, 1991).

Following conflict between the then largely domestic nurses and the doctors, the hospital board was prompted to employ a qualified nurse to oversee the nursing service. They subsequently employed Miss Maud Thackthwaite of London who arrived with three other trained nurses in February, 1889. The Adelaide Hospital introduced a training course for nurses in 1889 under her supervision. Despite considerable expenditure made on raising the nursing standards at the hospital she resigned in 1891. Her successor, Miss Rosa Banks, also came out from England in 1891. After her resignation in 1894, largely local nurses were employed in the senior positions. Despite a great deal of internal turmoil involving the nurses in the 1890s the number of nursing trainees grew steadily until it reached twenty at about the turn of the century (Durdin, 1991)..

## ***The Beginnings Of A Career In Nursing***

Both the domestic nurses and the first trained nurses were engaged in very demanding work that concentrated on caring for sick people. They were poorly paid, yet worked extensive taxing hours often in excess of twelve hours a day. They were accommodated in difficult environments that often restricted their activities outside of work hours. But, as Durdin (1991) has noted, the domestic nurses may not have been able to foresee a change in their circumstances whereas the trained nurses did. They seemed able to associate the discipline imposed in their lives as a necessary part of preparation for a career. A culture of collegial sharing and helping each other was established both within and between the institutions (Durdin, 1991:35)

## ***The 1950s & 1960s***

There was a considerable demand for hospital or nursing home accommodation for the aged by the 1950s. Concurrent with this was a demand for nurses working in the area. Many of the owners of the small private nursing homes were women with a background in nursing. They were often involved in the day to day nursing work of the home. A small Commonwealth Benefit was made in the 1960s for patients in approved nursing homes regardless of their means. This was accompanied by formal administrative procedures required of the nursing homes although the financial burdens of many of the residents were relieved. The Intensive Care Nursing Home Benefit was introduced in 1968 and enabled fees for those receiving intensive nursing care to be raised without financially disadvantaging the residents. However, once again, these changes were accompanied by further bureaucratic responsibilities of the managers or matrons who became more distant from the actual nursing work. Further legislative changes in the 1960s were followed by upgrades of the physical environments of nursing homes. These changes were amended to Section 4 of the *National Health Act , 1953* (Cwlth). In this act however, 'nursing home care' meant 'accommodation and nursing care of a kind provided in an nursing home, and included 'any prescribed service

of a kind provided in a nursing home.' Nursing care itself, although mentioned, was not defined.

### ***Nursing Home Care In The 1970s***

It was not until the *Nursing Homes Assistance Act 1974—Section 3* of the *National Health Act, 1953* (Cwlth) that Registered Nurses were acknowledged in their role of implementing and supervising nursing care. Here, the Act reads: '... **nursing care** means nursing care given by or under the supervision of a registered nurse' and was included in the definition of 'nursing home care'. Here, nursing home care meant '... accommodation, personal care and **nursing care** of a kind provided in a nursing home' and included '... any prescribed service of a kind provided in a nursing home'. The inclusion of 'nursing care' and its definition in this Act guaranteed the involvement of Registered Nurses in the delivery of nursing care to clients in aged care facilities from this time up until October 1, 1997, when the *Aged Care Act 1997* (Cwlth) was introduced. Other legislative changes in the 1970s encouraged new purpose built nursing homes to be established, and their appropriateness in caring for the aged was enhanced.

All nursing homes were required to have at least 1 Registered nurse on duty up until October 1, 1997. After this time, according to the *Aged Care Act, 1997* (Cwlth) the requirement was changed so that it did not apply in all circumstances. The requirement for all nursing homes to have qualified staff available 24 hours a day was abolished in August 1998 by the Federal Government, instead relying on guidelines that had recently been introduced.

### ***The Transfer Of Education To The Tertiary Sector***

The South Australian transfer of basic general nursing education from hospital school into the tertiary education system began in the mid 1970s. While the idea of tertiary education was supported, South Australia tended to follow the example of all the other states in its curriculum. In these states, nursing colleges had already established post - basic courses.



Sturt College became an college of advanced education in 1973 and was approved for a basic nursing course in 1974. By 1975, the course was ready to begin. The facilitators of the nursing course liaised with the Nurses Board of South Australia, Flinders Medical Centre, The Repatriation General Hospital and the Masonic Nursing Home. By 1976, A 'conversion course' became available to Nurses who had hospital qualifications and also wished to possess tertiary qualifications (Durdin, 1991).

### ***Post Graduate Qualifications In Gerontic Nursing***

Geriatric Nursing was expanding and attracting an increasing number of people. At the end of the 1970s the Health Commission introduced a course in Geriatric and Rehabilitation Nursing, allowing and encourageing further specialisation in this field. It was introduced at Glenside Hospital in 1977 and continued to attract nurses through the 1980s. This was followed by the Post Registration Certificate Course in Gerontic Nursing by distance education at the Julia Farr Centre, the post-basic enrolled nurse course in Rehabilitation, Gerontic and Long Term Care course and a Post Basic Certificate Course in Gerontic Nursing For Registered Nurses conducted by the Repatriation General Hospital (South Australian Health Commission, 1989). Since the early 1990s, specialist education in aged care has been available to nurses in South Australia, by distance and local education offered through several university courses.

### ***Ageism Amongst Present And Future Health Care Personnel***

A study by Lookinland and Anson (1995) described and compared the attitudes of registered nurses and health career work study students (HCS) who work with elderly people in institutionalised clinical settings. Demographic data were taken and an analysis was conducted to ascertain whether these variables influenced attitudes to the elderly. The results illustrated that the students held significantly less favourable attitudes toward elderly people. Demographic variables and attitudes scores revealed that gender and ethnicity were significantly related to registered nurse attitudes where people who were male, black and

Asian were less favourably viewed. Although both groups held attitudes that were more favourable than unfavourable, Registered Nurses and HCSs expressed stereotypical views about old people in general. The authors recommended that nursing education and service target these findings and in future ensure a more positive impact of the approach to care elderly people receive. Thus there is a great need to promote positive images of ageing and life development across the lifespan. Examples of these can be found in Ruler's (1996) analysis of the impact of exercise over a man's life span, where exercise was found to positively influence virtually all aspects of his identity and role in society. Another example is Ruler's (1998b) narrative analysis of the meaning of work for older people, both paid and voluntary, and for the very positive effects it has for the community as a whole and the individuals concerned.

### **Summary**

Nursing theory can be in a dialectical relationship with nursing practice. Therefore the study of nursing practice can help to contribute to nursing knowledge and theory, and the study of nursing as a discipline evolves.

Nursing has a strong background in aged care dating back to before the birth of Christ. Later, aged care developed further in western society through the christian churches. Almhouses evolved in English history for the care and welfare of older people and a workhouse system developed by the eighteenth century. The Poor Law amendment Act of 1834 in England was intended to correct widespread pauperism, identify people who were ineligible and force the destitute to work in the workhouses. The workhouse became a deterrent to pauperism. Poor Law Infirmaries were established and Florence Nightingale played a very influential role in their design and role. Training schools for nurses became attached to infirmaries in the late twentieth century. Meanwhile charitable institutions continued to support the needs of the older, poorer people until the present day. The Poor Law was abolished in England in the

first half of the twentieth century but before its abolition played an important role in influencing health care systems in Australia.

European settlement occurred in Sydney, Australia on January 26, 1788 with limited food supplies and medicines, contributing to early health problems in the colony. A prolific traffic in rum helped to finance the building and establishment of the early health facilities, which were mainly staffed by convicts, both male and female. Convict transportation ceased in 1841 and facilities at Sydney Dispensary were made available to free citizens. The aged in early Australia appeared to consist mainly of Australian Aborigines, who declined rapidly in number. 'Lunatics' were sent to hospital rather than gaol.

In South Australia, there were no convict or pauper settlers planned, rather free settlers. It was planned that there would be no social dependents. The Destitute Asylum was used in the early nineteenth century in England, the United States and in the Australian Colonies including South Australia. By the mid 1880's the number of residents at the asylum in Adelaide had increased dramatically and the population was ageing. The destitute asylum became a nursing home and chronic care facility. Its functions spread to other institutions in the late nineteenth century, specifically to care for those who were chronically ill, disabled or handicapped. They were staffed by people who had arrived in South Australia since the first disembarkment, listing themselves as nurses and skilled workers but without a specific qualification. The first hospital was built in South Australia in 1840 and was replaced by a larger hospital by 1857. The first hospital for the mentally ill was established in 1846. South Australia followed the other Australian states in securing the services of trained nurses by the end of the nineteenth century, and established a training programme for nurses. Nurse education was transferred to the tertiary education system in the mid 1970's. Specific post graduate qualifications in aged care became available after 1977 and since the early 1990s

specialist education in aged care has been available through tertiary courses to nurses in South Australia.

## Part Two

### An Old Woman's Prayer

(Naomi Poston)

*Dear God  
My hands are old and wrinkled  
my hair is thin and white  
my legs are thin , tired and weak  
But  
My eyes still see  
my smile still charms  
my mind is alive and  
my heart still loves  
Today  
I soared above the earth  
looked down and saw my course  
smooth turns, rugged turns,  
pain , mist and sunshine.  
Yesterday  
was not in vain  
I was, I gave  
I lived , I loved  
I still am*

## Chapter Eight

### Power And Change

In order to be effectively recognised, nursing needs to assert itself in the community. The history of nursing, the bureaucratic structures in which it operates and its subservience to medicine has resulted in a need for nurses to understand and utilise power if they are to play a growing role in the health needs of consumers. For nursing to be empowered as the result of any research, it is necessary to identify those processes that may be involved in such a direction.

#### ***Definitions And Parameters Of Power***

Power is a concept that may encompass both authority and influence. Bottomore (1979) describes power as the ability of an individual or a social group to pursue a course of action (to make and implement decisions and more broadly to determine the agenda for decision making) if necessary against the interests and even against the opposition, of other individuals or groups. Leftwich (1983) effectively defines power as the ability to control resources that are increasingly boundless such as time, status and knowledge. The most frequently cited definition of power is that proposed by Max Weber (1968:926):

In general, we understand by 'power' the chance of a man or a number of men to realise their own will in a social action even against the resistance of others who are participating in the action.

The reference to action even against resistance implies that the power holder has the capacity to bring negative sanctions to bear if needed. Additionally, Wrong (1980) has described power as the capacity of some persons to produce intended and foreseen effects on others. It

has been argued that the concept of power itself is open ended and therefore it is always possible to contest whether or not it is being exercised. A variety of models of power can therefore be used to reveal different aspects of power (Muetzelfeldt, 1994; Cox, Furlong & Page, 1985).

Two broad approaches have been taken to elaborate on the definition of power in society. Liberal political science is the dominant approach and it initially identified power as being either centralised in a ruling elite or distributed throughout a network of interlocking interest groups (Kotter, 1977; Maraldo, 1978). The basic assumption is that the individual is the basic unit of social life. Power is therefore seen as being exercised either by individuals interacting with one another, or by groups which are formed out of groups of individuals. Here, power is present in all human relationships. People with power know that it is mythical and often created by impressions, perceptions and illusion. Power has been described as an art of impression management and this can be seen in political circles. In order to influence others, a high level of skill in strategic manipulation of impressions towards others is required. The seasoned power wielder will often draw on several forms of power to influence somebody (Kotter, 1977; Maraldo, 1978).

The Marxist approach emphasises the structural characteristics in the society. These are viewed as having the effect of giving power to the ruling group (Miller, 1984). In Lukes' structural notion of power, power is an extension of the liberal position as power is still exercised by individuals or groups of individuals. The relevant groups of people may be called social classes but these people are still central to the analysis, in contrast to the Marxist structural notion of class (Lukes, 1974).

A fully structural notion of power starts from the assumption that social groups and power relations are formed simultaneously by the structure of society. Therefore the analysis starts

with an examination of social structure and only subsequently, if at all, moves on to place individuals within groups and power relations. In this model, conceptualising power goes hand in hand with identifying the major structural features of the society. This approach to power has been developed within Marxist and feminist literature (Bunting and Campbell, 1990; Muetzelfeldt, 1994).

To successfully label something as not involving power, is to free it from the close and possible critical scrutiny which is applied to exposed power. A situation in which power is being exercised can only be changed if people firstly consider that power is being exercised and secondly disapprove of it. Therefore one way in which powerful people can protect their position is to conceal their use of power and/or to win approval for what they are doing, especially from those whose interests are not served by their actions. The first step in challenging authority is to reduce its legitimacy so that it becomes obvious that power is being misused. In practical terms, a major aim of politics is to attack the legitimacy of the power one wants to challenge (Muetzelfeldt, 1994).

### ***Types Of Power***

According to Weber, authority is a form of power where legitimacy is recognised by those to whom it is applied. Coercion is a form of power whose legitimacy is denied by those to whom it is applied (Robertson, 1987). Power, based on authority is most commonly accepted by those to whom it is applied and obedience to it is a social norm. Power, based on coercion, tends to be unstable, because people obey only out of fear and will disobey if possible. Max Weber identified three basic types of legitimate authority: traditional authority, legal-rational authority and charismatic authority. Each may be legitimate as it rests on the consent of those who are governed. Traditional authority is generally bestowed by ancient custom and may be inherited; for example, through monarchies. The competence or policies of the ruler are of secondary importance in deciding whether he or she has a legitimate claim



to rule. Claims to traditional authority are generally based on birthright. The power of the ruler over the subjects may seem in some cases to be unlimited however in practice it is generally limited by norms and rules that set the boundaries in which the power can be practised. Exceeding these limits may result in those being ruled regarding the use of such power as illegitimate and coercive and the ruler may be deposed (Robertson, 1987).

Legal-rational authority refers to power legitimated by clear rules and procedures that define the rights and obligations of the rulers. The rules and procedures may be reflected in a societally agreed upon constitution and laws. Most modern societies attempt to use this type of authority in their political systems. It emphasises government through laws rather than by specific rulers. The power of an official in this system reflects the position the person holds and they can exercise power only within legally defined limits that have been formally set down in advance (Robertson, 1987).

Charismatic authority is where power is legitimated by the unique qualities that are attributed to a specific leader. The charismatic leader is seen as a person of destiny who is inspired as their charisma is sufficient to make their authority seem legitimate to their followers. However, charismatic authority is unstable as it has no traditions or rules to guide conduct and it rests on the unique characteristics of a particular individual who may leave or die. Because of this, systems based on charismatic authority are usually short lived and may become traditional or legal-rational authority systems.

Other types of power that have been described in the literature are the power of expertise, the power of association, the power of position and personal power. All types of power are subject to the changing nature of human relationships (Maraldo, 1985).

## **Critical Theory**

According to Carr and Kemmis (1986) critical theory examines the relationship between theory and practice by applying constructive criticism to the positivist and interpretive approaches to social science. Positivist science regards human and social life as inanimate and open to objective and constituted investigation. Social values and contexts are neglected and the investigators try to solve problems of nature, truth and existence. In response to the limitations positivist science has in social situations and human life, critical theory has emerged to promote practical philosophy and to reorganise social science. Consequently, critical theory unifies social science and philosophy to include social science under a critical paradigm. The outcome of criticism of the application of the positivist approach to social science has resulted in critical paradigm research. A critical theory can be either the outcome of a process of critique of existing literature or a result of the processes in which social actions of individuals and groups are exposed to critique. Critical theory may be limited to changing the way of viewing instances and does not necessarily result in changing practices (Carr and Kemmis, 1986).

## **Habermas's Critical Social Science**

Carr and Kemmis (1986) refer to Habermas's critical social science as being a critical examination of the positivist understanding of knowledge legitimation. Three fundamental *a priori* knowledge interests are constructed by Habermas (1990): technical interest concerned with instrumental knowledge, practical interest concerned with practical knowledge and communication and emancipatory interest concerned with emancipatory knowledge and change. Instrumental knowledge results from technology and is applied to natural science. Practical knowledge is concerned with understanding others and meaningful communication and can be sought in an interpretative paradigm. Emancipatory interests serve to critique social circumstances and outcomes of freedom and rationality are sought.

Habermas (1990) has described critical social science as a social process that combines collaboration in the process of critique with the political determination to overcome contradictions in the rationality and justice of social action and social institutions. A critical social science is a form of practice in which such social actions are transformed through the enlightenment of actors who lead practice changes in the world. Integration of theory and practice in terms of reflective and practical movements is necessary in such transformations which include dialectical methods of reflection, enlightenment and political struggle in order to achieve emancipation (Carr and Kemmis, 1986).

A critical social science aims at enlightening practice and practitioners and it consists of three functions: formation and extension of critical theorems, the organisation of enlightenment and the selection of appropriate strategies. The process of self reflection is applied as a key function of cyclical processes of action research that undertakes to close the gap between theory and practice.

### ***Nurses And Power***

The political position of nursing today is closely linked with the status of women and the dominance of the masculine world view. It has been argued that because nursing is a female dominated occupation and is seen as legitimately 'women's work' and because the health care system in itself is paternalistic, suppressing the development of nursing, that nursing has not reached a strong power base in health care (Greenleaf, 1990; Pearson, 1994). Because of the prevalence of patriarchy and the overwhelming dominance of a masculine world view, human caring and its association with womanhood have persistently and consistently been publicly devalued, yet privately desired. Women's work, including nursing, is devalued because it does not fit in with the masculine view of work as it is predominantly carried out in the private or domestic sphere (Pearson, 1994). Ashley, (1980) has written about the extent to which patriarchal ideas, institutions and practice affect nursing's ability to effectively exercise

politics of care. She argues that the structure of patriarchy is a misogynous one and that it keeps women in a subordinate role to men. Ultimately, she believes that patriarchal ideals and misogyny will contribute to the destruction of the earth as we know it and that this is shown in the environmental devastation that has already occurred. Mathews (1984) suggests that an integration of social and radical feminism and a movement away from polarisation between the sexes may resolve this dilemma.

According to McFarlane, (1980), the prevailing cure oriented medical model with its routinisation and rigid hierarchical structures are inappropriate and they prevent the needs of individuals from being met. The major causes of feelings of powerlessness are frequently said to be combined with the subordination of nursing to medicine and sexism as applied to the subordination of what is a predominantly female occupation, to the prevailing masculine ideology (Campbell, 1984). In para-medical occupations there is pressure to value more highly activities labelled 'curing' and to devalue those which are 'caring' such as those that are associated with nursing (Hahn & Kleinman, 1983).

Society continues to view medicine as supreme and other groups opinions are viewed favourably only when they are legitimised by medicine. Gender relates to the likelihood to be powerful and this impacts on the political dimensions of nursing. Thus, the bureaucratic settings and the historical development of nursing all serve to restrict nursing's potential contribution to decision making in the health arena. These pressures may have resulted in the oppression of the consumer and has limited the ability of nurses to effect healing and promote growth in individuals (Pearson, 1983). Questioning the apparently powerless position of nursing could be accomplished by drawing on the knowledge and articulation of the role of nursing and its effects on client outcomes. This current situation could also be rebalanced through political action (Pearson, 1994).

Autonomy of practice for nurses still seems to be out of reach for the majority. It has been suggested that when an occupation has created a dependency on its service that autonomy can occur and that nursing has failed to demonstrate its uniqueness and value to society (Davis, 1986). Stein (1978) suggests that the present subservience of nurses, particularly in aged care, may give rise to ritualistic behaviour and excessive role portrayal. Personal accountability for individual actions is also necessary for a practitioner to be autonomous. However, in nursing, accountability has become dissipated under the bureaucratic settings in which it has functioned. Here, individuals and their actions are subsumed under the organisation and no single nurse is ever visibly accountable to the community at large. Accountability is defined here as being able and willing to justify and explain actions when called to give an account. Pearson (1994) has argued that accountability to clients is very difficult to ascertain when health care agencies impose mandatory rules and regulations in their structure. Additionally, much nursing work is generated from decisions made by other members of the health care teams such as medicine, paramedical worker and managers resulting in poor client autonomy and accountability by nurses.

The willingness of employing authorities to accept vicarious liability for the actions of the nurses who they employ implies that nurses themselves may not want to accept personal liability for their own actions. The developing nurse practitioner role where the practitioner is self insured and licensed to offer and carry out a broad range of services for their clients is currently being evaluated in Australia and has proven very successful overseas (Ruler, 1998a). Ongoing development of this model may assist nursing to attain higher degrees of autonomy in practice.

However, since the majority of nurses presently work under hierarchal structures within nursing itself, the power base of such clinicians is limited. Accountability and autonomy for nurses actions are thwarted and nurses are excluded from decision making roles. Freedom of

choice for the consumer of services is restricted and the consumer in turn seeks assistance from those with decision making and autonomous power, reinforcing the weak power structures that nurses find themselves positioned in (Pearson, 1994).

Wolf (1985) suggests four requirements to be met in order for professional growth to occur.

They are:

1. An Open System - where the range, diversity and effectiveness of nursing's information channelling and capacity to extended roles and responsibilities are increased. Also, a system whereby the capacity to change and accommodate new information and clientele is expanded.
2. Goal Attainment - alternative methods and capacity for flexibility in goal attainment are created.
3. Integration - where the collective identity is maintained despite there being a capacity to differentiate into sub-parts.
4. Pattern and Organisation - a capacity to formulate and convey the professional uniqueness of the group and to receive new members, exposing them to the roles, responsibilities and capacities of the profession.

It can be seen that nursing is only partly meeting some of these criteria at present, but nurses are working hard at improving their conditions. Innovations such as Evidence Based Practice, tertiary and post graduate education, improved communication channels, preceptorship and mentoring programmes and the development of the nurse practitioner model all aid nursing's development as a profession.

### ***The Way Ahead***

Bailey and Claus (1975) have argued for a positive concept of power that can operate at a group or individual level. They have identified three underlying factors, being:

- Strength - an awareness of ones own ability and skills.
- Energy - the will to act and a positive use of energy.
- Action -the powerful person will actually act in order to solve problems and make decisions.

A combination of all three of these attributes is viewed as individually and collectively empowering.

Wheeler and Chinn (1991) have also suggested a process based on feminist principles that is empowering for individuals and groups and aims to have peaceful, united outcomes. As a group individuals are empowered by delegating them to the chair position when communicating. The chair position is rotated for each individual. United consensus is sought after discussions and alternative points of view are considered. Diversity and unity are the principles of the group and conflict is transformed to reflect this. To convince policy makers that nursing must have a greater input to decision making, nursing must use the art of impression management as well as power plays. Conveying a sense of unity and consensus within the profession is a very important aspect of this.

Change can only be effected by the attitudes, skills, education and awareness of individuals to collectively assert themselves in today's social setting and the political arena. Nurses have the ability not only to empower others but to empower themselves. A process of critical reflection that links thought with action, as described in the critical social sciences, is essential for nurses to meet the challenges of the future. Growing dissatisfaction with conventional medicine and healing has set the stage for change. Can nurses take advantage of the opportunities that are being presented?

## **Summary**

Nursing needs to identify those power related processes that may assist it to play a growing role in the health needs of consumers. Concealing the use of power and winning approval are two ways that powerful people can protect their interests. Therefore, to reveal that power is being used in a situation can effectively reduce its legitimacy. Critical theory helps to reveal the power being used and applies constructive criticism to the positivist and interpretive approaches to social science. Critical theory unifies social science and philosophy and may help to change the way of viewing situations and at times, practices.

The political position of nursing today is closely linked with the status of women and the dominance of the masculine world view. It appears that occupations related to curing (such as medicine) rather than caring (such as nursing) tend to be more highly valued.

Professional growth in nursing is required if nurses are to gain autonomy of practice. The developing nurse practitioner role helps to lead nurses into higher levels of practical autonomy. The use of strength, energy and action and processes that aim for peaceful, united and powerful outcomes in nursing can help nursing as a profession gain its autonomy.



## Chapter Nine

### **Methodology**

Nursing needs to be based on a sound background of practice, research and education in order to be understood and accepted in the wider community. It is hoped that the research undertaken during this study will contribute to that knowledge base and community respect. It has already been argued that nursing theory and practice are in a dialectical relationship, informing each other as they evolve. However, there is a scarcity of nursing theories that account for the contribution of nursing practices in aged care. The background to this study has already examined the sociological, political and historical influences that have contributed to shaping nursing. It has already been suggested that nursing homes are viewed negatively by the larger community and such negative sanctioning could be explained and understood through use of the framework of ethnomethodology, which in part seeks to explain social reactions to individuals who are seen to deviate from norms (Garfinkel, 1967). Exposition of this philosophy is now presented as follows.

### ***Ethnomethodology***

Ethnomethodology was described in the mid 1950s as a label to capture ‘... a range of phenomena associated with the use of mundane knowledge and reasoning procedures by ordinary members of society’ (Heritage, 1984:4). The term was originally coined by Harold Garfinkel during this time. Ethnomethodology has since come to refer to the study of a particular subject matter: ‘the body of common sense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in and act on the circumstances in which they find themselves’ (Heritage, 1984:4). Ethnomethodology has shown that social reality is basically a set of interpretations.

A fundamental premise is the belief that theorising is a self-expressive activity (Sharrock & Anderson, 1991).

Prior to Garfinkel's studies (1967), a weakness within sociology was that the construction and recognition of social activities by the actors themselves had not been included in the prevailing theoretical considerations. Garfinkel (1967) developed theories of the sociology of mundane knowledge and proceeded to a grounded analysis of institutionalised conduct. Garfinkel also focused on the social constitution of knowledge based on his understanding that an analysis of action must take into account the actor's use of 'common sense knowledge'. 'Common sense knowledge' is the social constitution of knowledge and Garfinkel argued that it could not be analysed independently of the contexts of the institutional activity in which it is generated and maintained. Garfinkel asserted that there was a profoundly reflexive relationship between knowledge and action (Garfinkel, 1967).

### ***The Work Of Talcot Parsons***

Talcot Parsons was Garfinkel's philosophical predecessor. As suggested previously, Garfinkel was in search of a theoretical framework which would directly capture the procedures by which actors analyse their circumstances and devise and carry out courses of action. The main difference between Parsons and Garfinkel was whether the actors point of view should be analysed and treated by means which are intrinsic or external to the structure of the actors experience. Parsons' main point was that social actors would come to adopt external value standards which then limited the range of ends they could aspire to and the means they could employ to achieve them. He depicted how the actors internalise these value standards that integrate institutional activity and contended that:

- the actors share complementary role expectations
- these expectations are themselves integrated with a more general value system that is also shared

- both the specific role expectations and the wider values are internalised by the actors (Parsons, 1937).

The working of the theory of institutionalised action effectively provided that the actor would become positively motivated to co-operate with others and in turn, the theorem underwrites the likelihood that actors would want to act in accordance with institutional necessities. On this basis, Parsons arrived at an entirely external analysis of the norms and values which he treated as constraining and determining conduct. Here, the actor was increasingly seen as 'the bearer' of internalised value patterns: the facts of social structure evolved in response to the functional imperatives. Parsons treated action in terms of concepts that were almost wholly external to the point of view of the actor. Action was analysed as the product of causal processes which, although operating 'in the minds' of actors, were largely inaccessible to them and uncontrollable by them (Parsons, 1937).

One of Parson's problems was how to account for the fact that rather than passively adapting to their external circumstances as they were originally encountered, human beings act positively (and sometimes at great cost) to transform recalcitrant environments in accordance with the dictates of normative ideals that were held by the actors (Heritage, 1984). He did not consider the actors' knowledge of their circumstances or the role of actors cognitions in actions—considering circumstances and selecting an action. From this position, there also evolved a problem of rationality that asks to what extent actors could justify and be accountable for their actions. Also, there was a problem of intersubjectivity, otherwise known as how to account for shared or mutual knowledge and understanding among actors. Yet another consideration was that of reflexivity, which was the extent to which the theorist of action would allow that the actors have 'insight' into the normative background of their own actions. From Parson's theory, a concept known as a 'judgmental dope' developed and

this was meant to typify a person who 'acts out' the institutionalised directives of the culture without judgement, as Parsons suggested (Heritage, 1984 : 27).

Garfinkel sought to remedy the problems that Parson's theorising posed. He rejected the view that normative rules, no matter how detailed, specific or deeply 'internalised,' could in anyway be determinative of conduct. Garfinkel argued that the reflexive aspects of actors orientations were critical to the maintenance of social organisation. He contended that the ordinary judgements of mundane social actors were always important in the analysis of social action and organisation. It was the Parsonian disregard for the entire commonsense world in which ordinary actors choose courses of action on the basis of detailed practical considerations and judgements which are intelligible and accountable to others, which ultimately constitutes the central focus and point of departure for Garfinkel's analysis of the theory of action from that of Parsons (Garfinkel, 1967; Heritage, 1984).

Garfinkel proposed that in vast areas of social life, the theoretical choice is not between rational and normatively determined actions . He argued that the mundane world was constituted, produced and reproduced in the texture of reasonable actions. Garfinkel attempted to build a theory of approximate judgements and reasonable grounds that constituted the common sense world. These were based on 'experience structures' (Garfinkel, 1967; Heritage, 1984: 36).

### ***The Phenomenological Input***

Husserl is reputed to be the founder of phenomenology (Stumpf, 1994). He rejected psychological reductionism in all of its forms and proceeded on the assumption that there exists a correlation between the object of an act of cognition on one hand and any dissociated subjective structure pertaining to the act on the other. Husserl insisted that these subjective structures are active in the make-up or constitution of the objects of experience. From the

beginning, Husserl was not limited to simply how we experience the objects of the external world, but rather with giving an account of *how we encounter* any object of experience; whether it is concrete or ideal and whether perceived, remembered, imagined, theorised, dreamed or otherwise experienced (Husserl, 1970).

In approaching these modes of experience, he advocated a purely descriptive orientation. The objects of experience and subjective structures through which they are given consciousness were to be described as faithfully as possible and not explained away by reference to psychological forces. Husserl then adopted a view of the constitutive role of consciousness and its operations as foundational in relation to psychological and epistemological reflection. With respect to the constitutive subjective realm, Husserl made a fundamental distinction between the natural attitude and the radical 'Cartesian doubt'. Here 'natural attitude' characterised the framework in which people mundanely perceive, interpret and act on. It involved the suspension of doubt that things might not be as they appear or that past experience may not be a valid guide to present and future experience. The perceiver sees things as they are. The actor assumes that actions which were successful in previous similar conditions will be successful in the present situation. Husserl's notion contrasted with Cartesian doubt which sceptically denies the objectivity of perception, the adequacy of knowledge or the utility of past experience. In sum, the phenomenologist made a strong distinction between a sensory representation and an intended object which constituted the sensory representation. The phenomenologist distinguished between the 'inner' and 'outer' horizons of the object. Husserl's aim was to establish a foundation for all human knowledge through a consideration of its make-up in subjective acts of consciousness. Husserl looks to consciousness itself as the foundation of knowledge and sought, in the transcendental operations of pure consciousness, the foundations of intersubjectivity (Husserl, 1970).

## ***Schutz And A Typified World***

Schutz followed Husserl in arguing that experiencing consciousness is inherently a typifying one. For Schutz, an 'object' constituted a set of sensory presentations that were themselves the 'sedimented' products of past activities of comparing and contrasting out of which mundane typifications occur (Schutz, 1967).

A major consequence of this process of typification was that every experience of the actor occurs within a horizon of familiarity and pre-acquaintance which was furnished through a stock of knowledge at hand. Even the totally novel and unfamiliar was understood as such against this pre established background of normality and typicality (Schutz, 1967; Heritage, 1984).

The stock of knowledge that the actor has ready to use contains both type constructs of objects and typified 'recipe knowledge' concerning the 'how to do it' of all kinds of courses of action. Most of this was treated as contingently valid or 'valid until counter evidence appears'. Type constructs are thus abstractions from the concrete uniqueness of objects and events and they therefore bear an inherently approximate and adjustable relation to the objects they typify. Type constructs bear a relationship to concrete particulars which is variable. Type constructs have to be 'applied' and in their application the unique specificity of objects and events is lost. The type constructs that actors may use to navigate the natural and social worlds and with which they communicate through natural language are inherently approximate, open ended and reviewable. They may undergo change, elaboration or qualification at any moment subject to local contingencies. Their development and use is shaped by the practical experiences and relevances which arise in the course of the actor's engagement with the world around them. Schutz (1967) noted that few of the type constructs constituting the actor's knowledge of the world originate with personal experience. It has been suggested that certain basic constructs arise prior to the acquisition of language and

serve as the foundation for its acquisition. These constructs were rapidly and greatly 'socialised' through the development of increasingly complex communication skills. All of these 'socialised acquisitions' involve and require intersubjectivity and Schutz develops an understanding of intersubjectivity that is applicable to Garfinkel's work in ethnomethodology (Schutz, 1967; Heritage, 1984).

### ***Intersubjectivity***

Intersubjectivity was treated by Schutz as an everyday occurrence and its achievement and maintenance are practical problems that are routinely 'solved' by social actors in the course of their dealings with one another. The problem of intersubjectivity is posed by the following question: how can two or more actors share common experiences of the natural and social world and relatedly, how can they communicate about them? Schutz's answer to this was that humans can *never* have identical experiences of anything, but that this was irrelevant because they continuously *assume* that their experiences of the world are similar and act as if their experiences were identical for all practical purposes. Schutz (1967) insisted that the full impact of the subjective experience of the other was essentially inaccessible to every other individual.

Despite this, mundane actors know that the same objects are encountered differently by each of them because:

1. They are located in physically different places and thus see different aspects and configurations of objects. Some objects can be seen, heard and manipulated by one person and not the other and vice versa.
2. Each actor comes to the domain of the objects with different motivation. They subsequently have different practical purposes in mind and they may be viewing the domain of objects in differently 'interested' ways.

However, despite these problems of intersubjectivity, actors still take it for granted that their view - point may be the same as another's even though it is not. They assume that they have selected and interpreted the common objects and their features in an identical manner even though, as stated previously, they have not, because their motivations and viewpoints may differ so much (Schutz, 1967; Heritage, 1984).

It is as though, through the operation of these two assumptions, a 'common world' which transcends the actors private experience, can be established. Here, on the one hand, the actors assume from the outset that they share a common world. On the other, they know that the world displays a perspective and appearance as previously described. It is through a continuous process of adjustment expressed in the two idealisations that the actors succeed in resolving the discrepancies in their perspectives which could otherwise throw doubt on the shared nature of their perceptions and cognitions (Schutz, 1967; Heritage, 1984).

The problem for others is the question of how the actors undertake the subjective meanings of one another's action. Included in this category of 'subjective meanings' are the other's goals, intentions and motivations together with their affective colourings—for example, desires, hopes, fears and anxieties with which these goals and motivations are vested.

Intersubjectivity was a notion at the threshold of ethnomethodology as it investigated whatever and however intersubjective knowledge and understanding were achieved. It sought to uncover what it was that secured the actor's compliance with the prescriptions and conventions of the common sense world.

It was Garfinkel's task to demonstrate both the research ability and the constraining power of a world organised according to Schutzian principles, since only in this way could 'a generalised social system built solely from the analysis of experience structures' become a



credible possibility. Garfinkel's achievement was accomplished by capturing the nature of social action in life and examining the properties of its elements (Heritage, 1984: 74).

### ***Morality As A Force In Cognition***

Parsons treated the organisation of action as maintained largely through the operation of externally and internally constraining 'moral' rules while taking little or no interest in the properties of the actors common-sense judgements. Schutz was interested in common sense judgements but not in the moral force with which common sense judgements were made. Garfinkel attempted to integrate the moral choices people made with cognitions. Actions became accountable moral choices (Schutz, 1967; Garfinkel, 1967; Heritage, 1984).

The actor's framework of knowledge was analysed, rendering it clearly and distinctively as possible as 'second order constructs' of experience structures for the analysis of action. Actors were found to rely on this knowledge and question it only when they had to. Actors' knowledge would be held in typified form and contain much of which was indeterminate and indistinct. The concept of activity is a step-by-step process after which the actors viewpoints undergo clarification during the actual temporal course of action. Actors engage in coordinated actions with others, assume the socially standardised and shared nature of their knowledge and actively seek to sustain it. This is accomplished by the 'reciprocity of perspectives' meaning that their self knowledge is available only to a limited extent to others (Garfinkel, 1967; Heritage, 1984).

### ***The Tic Tac Toe Experiment***

A series of experiments was devised by Garfinkel (1967) to elucidate the common sense world of mundane, ordinary social experience and those processes that served to maintain it.

Results of this series of experiments investigated by Garfinkel and his students showed that the active maintenance of a 'world in common' was sustained only in the absence of counter evidence. Behaviours which were at variance with the basic rules immediately motivated attempts by the participants to normalise the discrepancies. (Garfinkel, 1967).

During this series of experiments, the experimenters were instructed to ask participants to make the first move in a game similarly known as 'noughts and crosses'. The experimenters then erased the participants mark, moved it to another cell and made their own mark. They did this without acknowledging that it was unusual.

The participants tried to normalise deviations from the rules of the game. They attempted to offer alternate explanations of why the experimenters behaved in the manner they did. Disturbance arose if the subject attempted to normalise the discrepancy while the experimenter returned an unaltered view of their unorthodox 'rules of the game'. Garfinkel was wary of attempting to extrapolate these results to general society, however he suggested *that participants will generally attempt to normalise behaviour which deviates from social rules or norms*. The basic rules of a game were found to be independent of the strategies of the players. The basic rules defined rational, realistic and understandable game activities (Garfinkel, 1967; Heritage, 1984).

### **Conversation Experiments**

Another test that Garfinkel devised for his students was to engage them and an acquaintance in an ordinary conversation and without indicating that what the experimenter was saying was in anyway out of the ordinary, to insist that the participant clarify the sense of their commonplace remarks. For example, an experiment subject, after asking the experimenter how they were, was replied to with " How am I in regard to what? My health, my finance, my school work, my peace of mind, my...." The subject, then red in the face and suddenly

out of control said “ Look! I was just trying to be polite. Frankly, I don’t give a damn how you are” (Heritage, 1984:80). During this series of experiments, the students breached one of the fundamental idealisations that underpinned Schutz’s general thesis of reciprocal perspectives. In this thesis, the actors assume that the differences arising from their circumstances are irrelevant for the purposes of the conversations. Schutz’s thesis suggests that the actors assume that they have selected and interpreted the actually or potentially common objects and their features in an identical manner for all practical purposes (Schutz, 1967; Heritage, 1984). In each case, the participants had expected that the experimenters would, by drawing on background knowledge of what everybody knew, supply a sense to their remarks that was empirically identical with the sense intended by the participants. The participants assumed in each case, that the experimenters knew what they were talking about without any requirement to check this. The participants took for granted that the experimenters would supply whatever unstated understandings would be required in order to make recognisable sense of what was said. Garfinkel showed that in any two party conversation that much is being talked about that is not mentioned, although each expects that an adequate sense of the matter being talked about is settled (Garfinkel, 1967; Heritage, 1984).

The experimenter’s breaching of this requirement was done by asking the participants to clarify their commonplace remarks. This resulted in rapid and complete interactional breakdowns. A stance of ‘righteous hostility’ was assumed by the participants, as their interactions were breached. The participants made intense efforts to restore the situation of reciprocity but ended up proposing or demanding explanations of the experimenters’ conduct.

In each case, the participant treated their own talk as something to which they were entitled and treated the breaching move as illegitimate, deserving of negative sanction and requiring explanation. This series of experiments illustrated that the reciprocity of perspectives was one

in which each participant trusted that the other would accomplish it as a matter of moral necessity (Garfinkel, 1967; Heritage, 1984).

In both experiments, for example noughts and crosses and the breaching of the reciprocity of perspectives, the perceived normality of events was impugned or disturbed. From the results of these experiments, Garfinkel conjectured that all actions as perceived events may have a constitutive structure. He concluded that *it was the threat to the normative order of events* that was the critical variable in invoking indignation and not the breach of the sacredness of rules. The basic relationship between normative rules and socially organised events appears to be a strongly cognitive one in which 'rules' are constitutive of 'what the events are' or of 'what is going on here' (Garfinkel, 1967). If conduct cannot be interpreted in accordance with the rules, the social organisation of a set of 'real circumstances' disintegrates. Rules, where they are used to mark out 'proper' or 'desirable' conduct were of a more secondary nature. The experiments suggest that there is an order of normative organisation at the level of action and interaction and this finding contrasts with Parsons' (1937) view of externally based but internalised action. During the experiments, the participants hold themselves and one another morally accountable for the 'accommodative work' through which they make sense of their circumstances (Garfinkel, 1967; Heritage, 1984).

### ***The Documentary Method Of Interpretation***

The documentary method of interpretation involves the search for an identical pattern underlying a vast variety of totally different realisations of meaning. Phenomenologists had developed an analysis of perceptual and cognitive activity which treats all acts of consciousness as involving a 'documentary' process. Garfinkel endorsed the phenomenological treatment of acts of cognition and proposed the documentary method as an invariant and unavoidable feature of all acts of mundane perception and cognition (Garfinkel, 1967; Heritage, 1984).

Any intended object, a phenomenologist may argue, is constructed as a unity from a succession of appearances which wax and wane in the course of 'inner time' or 'duree'. Time is thus a constitutive feature of objects and the significance of an object is therefore permeated with temporal considerations. The role of time as an integral feature of the constitution of objects and events will become particularly significant in the treatment of action. Garfinkel was very critical of Parson's neglect of this. Thus social objects such as the 'cheerful person' are the products of complicated judgements in which an underlying pattern is built up from a temporally qualified succession of events (Garfinkel, 1967; Heritage, 1984).

The second aspect of the documentary method is where individual judgements are based on 'what is known' about the underlying pattern. The power of 'what is known' about an underlying pattern may be so great as to override all subsequent experiences or intellectual knowledge of the object (Garfinkel, 1967; Heritage, 1984).

### ***The Counsellor Experiments***

This experiment was devised by Garfinkel who was assisted in its implementation by his students. Here, in an established counselling environment, the counsellor, (who was an experimenter), responded to the student with pre-set 'yes' or 'no' responses. The students who sought advice, perceived the experimenter's answers to have been motivated by their questions. They reported that they were 'able to see what the adviser had in mind' in producing the answers to their questions, even though they were pre-set. In this way, the sense of the problems were progressively accommodated to each present answer, while the answer motivated fresh aspects of the underlying problem. This elaboration and accommodation of the problem was done to maintain the course of the advice. The students managed their interpretations so that the 'advice' they had been given was eventually perceived as coherent and the trustworthy product of properly motivated advisers. The

student's pursuit of a consistent underlying pattern in the 'advice' they were receiving involved use of a large and unpredictable range of considerations. These considerations were consulted in a haphazard manner 'as the situation required'. Responses were not taken as literal or at face value, but were assumed to have unspoken assumptions and presuppositions that each party attributed to each other. These 'common understandings' could only be achieved by the parties to the conversation doing whatever is necessary at the time to 'fill-in' a background of 'seen but unnoticed' interpretation for whatever is said as it is said. Together the studies demonstrate a huge range of assumptions and contextual features which may be mobilised ad hoc to sustain a particular 'documentary version' of a sequence of events. The participants in the experiments were very willing to give the underlying pattern the benefit of the doubt. In accordance with the 'natural attitude' the participants disattended or suspended any emerging doubts about discrepancies between appearances and realities for as long as possible (Garfinkel, 1967; Heritage, 1984).

### ***The Suspension Of Doubt And Morality***

The participants treated their use of interpretive resources for the contextual 'filling in' of 'what anyone can see' and their suspension of doubt in a deeply moral manner. The participants in the previously mentioned breaching experiments sought an explanation from the researcher for the breaches and when this was not forthcoming expressed great hostility.

Therefore there was a great array of possible contextualizations for any statement and possible interpretations of it. The producers of statements could never literally say what they meant. The producers of statements could only make themselves understandable by assuming that the recipients are accomplishing the relevant contextual judgements for what was being said. Interpretative 'trust' was involved and was relied upon in the proposed documentary pattern over the course of the emergence of information. If a socially organised and

intersubjective world stands or falls with the maintenance of this interpretative trust then it is acceptable that it is attended to as a deeply moral matter (Garfinkel, 1967; Heritage, 1984).

### ***The Moral Enforcement Of Trust***

Where breaches of the reciprocity of perspectives occurred, although the participants were not fully aware of what was going on, their conduct did not reveal that they found the interchanges senseless. They finally interpreted the experimenter's behaviours as involving active (ie. chosen or motivated) departures from the norms which they viewed as offensive and illegitimate. They saw these departures as unco-operative and somehow directed at them. The conclusion was that the experimenters behaviours were intelligibly motivated. Such behaviours were accompanied by a sense of mistrust between the participants and experimenters and can be likened to similar occurrences in everyday life. While the procedures for 'making sense' are normally relied upon in a 'seen but unnoticed' fashion, deviations from these procedures were instantly interpreted as motivated departures on the part of experimenters who were treated as acting from undisclosed motives. The experimenters were seen as behaving in a way that was somehow hostile as they deviated from the norms (Garfinkel, 1967; Heritage, 1984).

The subject's choices in interpreting the experimenter's conduct were not simply between 'normal, acceptable' behaviour and 'senseless' behaviour. It was between 'normal' behaviour and behaviour for which a sense has yet to be found and 'when it is it won't be pleasant'. Deviations from a norm are always analysable as departures from it and may be responded to as such. Departures from the norm are visible as meaningful and 'wilful'. The subjects reacted with hostility to breaches of the norm to an unaccountable breach of 'trust' which they perceived as somehow directed 'at themselves'. This notion persisted even after the experimental nature of the situations had been revealed (Garfinkel, 1967; Heritage, 1984).

Therefore, Garfinkel (1967) argued that individuals accountably treat their own and one another's actions as the products of 'motivated choices' and as such, are believed to be designed with respect to the specifics of settings and their constituent participants. In conclusion, Garfinkel's discovery was that the constitutive expectancies of the attitude of everyday life are treated by mundane actors as profoundly normative and morally sanctionable matters (Garfinkel, 1967; Heritage, 1984). Associated with this discovery is Garfinkel's view that 'norms' of all kinds are most productively regarded as a constitutive feature of 'perceivably normal' environments. Therefore, common sense knowledge is invested with moral force (Heritage, 1984).

### ***Reflexivity***

Myerhoff and Ruby (1982:2) define reflexivity as '... the capacity of any system of signification to turn back upon itself, to make itself its own object by referring to itself: subject and object fuse'. Reflexivity describes people thinking about themselves in their situation, but does not require awareness of the implications of their concern.

In order to allow for a stable organisation of some set of social activities, detailed consideration must be given to the participant's understandings of their empirical circumstances. The located organisation of a scene of conduct is both 'trusted' and acted upon and as the breaching experiments demonstrated, treated as a morally sanctionable 'matter of fact' (Garfinkel, 1967).

An action is an element of central importance because the actions are no longer perceived as passive but instead as engaged in activity within the circumstances. The actors find that their actions reflexively contribute to the sense of the scene which is undergoing development as a temporal sequence of events.



Within Garfinkel's viewpoint, the common norms, rather than regulating conduct in predefined scenes of action, are instead reflexively constitutive of the activities and unfolding circumstances to which they are applied. What the activities are, with all the subsequent interpretative elaboration of motive and circumstance, is only visible and available in the first place through the reflexive application of norms and maxims of conduct to temporally extended sequences of actions. The cognitive and the moral codes are deeply entwined in human behaviour (Garfinkel, 1967; Heritage, 1984).

Reflexive phenomena as applied to actors is a new departure from the traditionally phenomenological views of reflexivity. Phenomenologists can be preoccupied with the reflexive aspects of the hermeneutic circle. Annells (1996, p 707) describes the concept of the hermeneutic circle '....as a metaphor to explain the dynamic movement between the parts and the whole of the text within the seeking of understanding'. In keeping with this, phenomenologists have characteristically treated these phenomena from the perspective of an observer who stands *outside* the events they describe. Therefore the phenomena of reflexivity have traditionally emerged in discussions concerning the interpretation of texts. Garfinkel's introduction of these issues of action transforms the theory of action. It is through the reflexive accountability of action that ordinary actors' actions have the property by which their behaviour will be intelligible and accountable in the maintenance of the surrounding activities of others. Likewise, surrounding activities influence the actors individual actions. It is through the reflexive properties of actions that participants find themselves in a world that they are visibly producing and reproducing (Garfinkel, 1967; Heritage, 1984).

Parsons (1937) theorised that norms of conduct are internalised as need dispositions of personality. Parsons' actors are therefore broadly unreflexive to norms they have identified. The result is that his actors can neither adopt a manipulative or game-like stance towards the

norms, nor are they capable of the reflection necessary to make a moral choice. They evolve to become 'judgemental dopes' as a consequence of this (Heritage, 1984).

Garfinkel has argued that models of action become based on entirely retrospective considerations. He theorised that the outcome of a series of actions is the privileged standing point from which to work back to the 'necessary causes' which are presented as responsible for the actions turning out as they did. For Garfinkel, conduct is seen as a possible product of practical choice or 'reasoned' decision making (Garfinkel, 1967).

A theory of co-ordinated interaction depends on acceptance of the idea that the actors are trained in such a way that not only do they share substantive norms of conduct but they share common identification of the situations for which the norms are appropriate. The actors use accommodative work through which they treat specifically differentiated situations as 'identical for all practical purposes' and exhibit these treatments in their actions. It is the reflexive characteristics of ordinary actors which play a central role in the creation and maintenance of the sense of a sequence of events and the contexts in which they occur. The perceived normality of ordinary conduct is provided for even though this provision is 'seen but unnoticed' and often becomes visible only when it is breached.

Garfinkel repeatedly stresses the routine nature of the implementation of 'seen but unnoticed' procedures for accomplishing, producing and reproducing 'perceivably normal' courses of action. Participants in such actions are typically interested in getting their ordinary tasks done and the reflexive features of their activities are uninteresting. Only in cases of breach or anticipated breach may the reflexive features of conduct come to be considered. This is due to the fact that where there is a breach of behaviour, actors may anticipate being held to account for their actions. They may anticipate that they could have known and done it differently and therefore should have done so. Therefore, the treatment of the actor as a 'judgemental dope',

whose common-sense rationalities of judgment are ignored, misses both the analytical foundations and the empirical grounding of normatively organised conduct (Garfinkel, 1967; Heritage, 1984).

Garfinkel's theory does not deny the phenomena of normative internalization, introjection or identification as empirical phenomena. Many of the 'breaching' experiments indeed can be viewed as revealing the extent to which ordinary actors are prepared to proclaim and act on the basis of such identifications. His perspective was fundamentally both 'cognitive' and 'moral.' He argued that if cognitive shifts occur the moral arena will under go corresponding alternatives (Garfinkel, 1967).

### ***Rules As Insufficient To Depict Everyday Conduct***

Garfinkel argued that rules are very insufficient as explanations or directives to human action. He found that rules are always relative to contingent application and it follows that rules per se cannot determine specifics of actual conduct no matter how deeply internalised they are. Rules can never completely define the character or legally possible range of conduct of an activity. Rules do not exhaustively describe even a game. For vast areas of social conduct the rules of action are formulated or enforced by the participants (Garfinkel, 1967; Heritage, 1984).

### ***Intuition***

Intuition is a term commonly used to refer to matters which are not explicitly formulated or codified within the culture but which are none the less taken for granted and known in common. Likewise, social action cannot be analysed as 'governed' or 'determined' by rules in any straightforward sense. Many classes of actions are not analysable by reference to clear cut rules which either delimit them as a class or, still less, could be held to constrain or determine their empirical occurrence. These actions are produced and recognised by reference

to the actors' reasoning procedures which draw upon complex tacit and inductively based arrays of considerations and awareness. These reasoning procedures may include intuition . Social actors are, through their own actions, unavoidably engaged in producing and reproducing the intelligible characterisations of their own circumstances (Heritage, 1984).

### ***Accounts And Accountings***

Garfinkel was compelled to build almost from the beginning a case for the role of language in the constitution of social relations and social reality. He described how, during a substantial proportion of their daily lives, ordinary members of society are engaged in descriptive accountings of states of affairs to one another. Discussions of the weather, depictions of goods and services, assessments of character and reports of the day's doings are the routine stock in trade of mundane talk. Such talk is somehow done seriously and as a feature of real practical tasks with significant outcomes for the parties concerned (Garfinkel, 1967; Heritage, 1984).

The 'mastery of natural language' including the capacity to recognise and produce adequate descriptive representations of ordinary everyday affairs was seen as the defining feature of an actor's membership of a society or collectivity. Garfinkel's approach to the phenomena of mundane description was consistent with his overall focus on the accountable nature of social action.

Descriptions make reference to the status of affairs and occur in particular interactional and situational contexts. They will unavoidably be understood as actions which are chosen and consequential. Descriptions are indexical and are to be understood by reference to where and when they occur. Descriptions are also 'reflexive' in maintaining or altering the sense of the activities and unfolding circumstances in which they occur (Heritage, 1984).

### ***Ethnomethodological Indifference***

Ethnomethodological indifference is a variant of phenomenological 'bracketing' transferred to the study of social process. Phenomenologists systematically suspended judgement on the ontological states of the objects intended in acts of perception, cognition and so on, so as to investigate how these acts are constituted in consciousness. Thus, Garfinkel 'brackets' all external judgements or consequentiality of descriptive accountings. Instead, he treats the later as purely and simply practical 'actions' and suspends judgement on their adequacy in order to focus on how they are used as facets of the organisation and management of social settings (Garfinkel, 1967; Heritage, 1984).

For Garfinkel, the important thing about descriptions is how they are used to affect social activities. The question of how mundane conversations and descriptions are used is therefore an empirical one. Accounts 'fit' to the circumstances in a loose way and are subject to adjustment by ad hoc devices. Accounts like actions, are understood by reference to a mass of unstated assumptions and the sense of an account is heavily dependent on the context of its production (Garfinkel, 1967).

Garfinkel argued that no description is strictly compelled by the situation that it describes. Any description is thus inherently selective in relation to the situation it depicts. An account can never exhaust all of the options that may be used to describe a given situation. Thus any description 'lifts out' certain aspects of a referenced state of affairs into prominence, while discarding other aspects. The description will also be found to reference those aspects in a particular way. A description is offered when the speaker might not have spoken. Part of the process of understanding it will involve grasping the purpose or motive for it being produced at a particular moment (Garfinkel, 1967; Heritage, 1984).

There is a network of background assumptions which speakers trust one another to put in place and in terms of which they hold one another accountable as competent users of natural language. Various aspects of the physical context need to be considered and include the referenced and the conversational or wider social background in which the conversation occurs. The actor knows that no description is ever non-consequential, non-methodological or non-alternatively produced. Descriptions, like other actions, reconstitute the circumstances in which they occur (Heritage, 1984).

The interpretative process is an essential feature even of such a low-level activity such as the coding of data. The accomplishment of coding requires some closure of the interpretative gap between the 'words on a page' and what they mean. It is the same gap we find between saying and meaning. The gap between the data and 'what the data means' which is closed by reasonable interpretation given 'what is usually the case' and 'what is a defensible conclusion under the circumstances'. There is an element of erring on the side of caution with respect to social implications of judgements made (Garfinkel, 1967; Heritage, 1984).

In conclusion, there is an inherent looseness of fit between a state of affairs and the language used to describe it. This looseness of fit permits and motivates the circumstantial elaboration of any natural language incident. These circumstantial elaborations are both indexical and reflexive. In these elaborations social actors determine every aspect of an account's sense and how to treat it. For example, how to treat it, act on it, reject it, laugh at it etc. It is necessary to take into account the circumstantial indexical and reflexive nature of all accords. Therefore, no matter how firmly scientific accounts are proposed as reporting independently existing facts and no matter how fully they are supported by firm evidence and reasoned argument scientific accounts need to be analysed within the socially organised worlds in which they appear (Garfinkel, 1967; Heritage, 1984).

### ***Institutional Realities***

Societies members encounter and know the moral order as 'normal' courses of action. Here, familiar scenes of everyday affairs and the world of daily life known in common with others are taken for granted. Social action is fundamentally organised with respect to its reflexivity and accountability. The intersubjective intelligibility of actions ultimately rests on a symmetry between the production of actions on one hand and their recognition on the other. The production and recognition of actions is dependent on the parties supplying and trusting one another to supply, an array of unstated assumptions so as to establish the recognisable sense of an action. The production of an action will always reflexively redetermine, maintain, expand or alter the circumstances in which it occurs.

### ***Social Institutions - The Social Institution Of Gender***

In maintaining, elaborating or transforming their circumstances by their actions, the actors are also simultaneously reproducing, developing or modifying the institutional realities that surround those actions. Garfinkel used the case of 'Agnes' as an example of focussing on the ways in which sexual identity is produced and managed as a 'seen but unnoticed' but nonetheless institutionalised feature of ordinary social interactions and institutional workings. This resulted in an analysis of gender as a profound institutional and socially produced fact. Garfinkel was able to illustrate it as socially produced and reproduced. The gender differentiation of culturally specific 'males' and 'females' was the end point of the analysis.

'Agnes' was the pseudonym of an individual who was born with male genitalia but by the age of 19 had developed all of the other characteristics attributable to a woman. She had applied to have a sex change operation so that the male genitalia would be removed and an artificial vagina be built from this tissue to complement her otherwise 'female' identity and appearance. Agnes had to deal both with people who did not know about her problems and

those who did. She had to convince her inner circle that she was 'all along and essentially' a female. This helped her secure the sex change operation as a 'moral right.' Agnes showed that she was a sensitive ethnographer of gender. She had become acutely aware of the ways in which sexual status can have implications for the conduct of ordinary social activities. She had lived as a male until two years prior to Garfinkel seeing her. During these two years, she concentrated heavily on female activities that furnished for her a fascinating input of new experiences which she used as resources to construct and reconstruct her own biography (Garfinkel, 1967).

For those who were ignorant of her problems, Agnes was preoccupied with maintaining their ignorance. To aid this, she maintained a modesty-at-all-costs rule and avoided nudity at all times. She played a passive role amongst women to facilitate knowledge on learning 'proper conduct'. Not only did she adopt the pose of passive acceptance of instructions, but she learned as well the value of passive acceptance as a desirable female trait. Agnes did not talk about her background to others openly, as she had had a male identity for 16-17 years and nondisclosure of this period was important. The nature of Agnes's task in managing, constructing and reconstructing her new social identity as a female is thus perhaps well described by the metaphor of being compelled 'to build the boat while already being out in the ocean'.

Agnes rarely encountered any situations which could be treated as 'time out' from the work of 'passing' as a female. She found that she was always 'on parade' and compelled at all times to secure her female identity by the acquisition and use of skills and capacities, the efficacious display of female appearances and performances and the mobilisation of appropriate feelings and purposes. The work and socially structured occasions of sexual passing were resistant to her attempts to routinize the grounds of daily activities. This



resistance points to the omni-relevance of sexual status to affairs of daily life as an invariant but unnoticed background in the texture of relevance.

The right to the sex change operation was treated by Agnes as a moral right on the basis of what she said was the 'natural facts' of her femininity. She rigorously suppressed her history of male upbringing. Agnes associated her physical and psychological development as a female in a natural feminine way. Sexual status became a 'natural-moral' institution (Garfinkel, 1967; Heritage, 1984).

As individuals come to know the moral order as a perceivably normal course of action, the real world features of a society are treated by its members as 'objective, institutionalised facts' (ie: moral facts). The everyday world becomes an institutionalised and institutionally provided-for domain of accountably real objects, events and activities that are, from the society's point of view, a natural moral world. Garfinkel argued that the 'natural' distribution of sexual status is simultaneously a 'moral distribution' and is revealed by ordinary reactions to persons who are seen to deviate from the norm. These reactions commonly take the form of moral retribution. For example, Agnes's natural family displayed 'open hostility' and 'consternation' and 'severe disapproval,' of her plans to have a sex change operation. After the operation the family exhibited relieved acceptance and treated her as a 'real female after all'. The surgeon who performed the sex change surgery suggested that Agnes was not a transsexual and expressed his belief that Agnes was fundamentally female not simply desiring to be female. The medical staff revealed in their decision the same natural-moral grounds which were invoked by all significant others (Garfinkel, 1967; Heritage, 1984).

In summary, Agnes subscribed to the natural, moral order of sexual status within which normal sexual status is treated as a natural fact while aberrations from the norm are treated as morally accountable. Agnes subscribed to the objective reality of normal sexual status,

despite her knowledge of its intricate management in everyday life, both as a condition of maintaining her own identity and also to secure the sex change operation. She sought to conform with and reproduce the 'natural moral' institutional order in which she so clearly wished to participate as a 'normal, natural' female.

Because of Agnes's management strategies and because almost every occasion could somehow take on the features of an 'character and fitness' test, Garfinkel suggested that in almost any occasion of social life, institutionalised features of sexual status are being produced and reproduced by 'normally sexed' males and females (Garfinkel, 1967). Agnes's case further suggests that while institutionalised sexuality is being produced and reproduced as a supremely natural 'matter of fact', its reproduction is simultaneously supported by a massive repair machinery of moral accountability which is brought to bear in cases of discrepancy or deviance . Normal people routinize their management and detection of displays of 'normally sexed' conduct so that it is seen and unnoticed in the background of commonplace events (Heritage, 1984).

Agnes's secrets were such that she could not lose sight of what, for normal people is so massively invisible. For Agnes the commonplace recognition of normal sexuality as a 'case of the real thing' consisted of a serious, situated and prevailing accomplishment. Her anguish and triumphs resided in the observability, which was particular to her and uncommunicable, of the steps whereby the society organises the activities that dictate gender. For Agnes, construction of a observably normally sexed person consisted of repeated, organisationally located work (Heritage, 1984).

The 'judgemental dope' theory suggested by Parsons failed to recognise the continual and problematic work of managing sexual status. Agnes knew that ascribed sexual status is achieved as the product of unnoticed, yet unremitting, work. Thus, gender differentiation

includes a filigree of small scale, socially organised behaviours that one repeats. These individually insignificant behaviours interlock to constitute the public institution of gender as a morally organised 'natural fact' of life. Garfinkel treated the institution of gender as a densely woven fabric of morally accountable cultural practices which are accountable and 'natural.' He found that sexual status is maintained as a 'natural fact' through a variety of institutionalised procedures and practices (Garfinkel, 1967; Heritage, 1984).

### **Summary**

Garfinkel's social experiments as described here, all point to the institutionalisation of everyday action and the reflexive nature of action in society. The breeching experiments and case study of 'Agnes' illustrate that these actions have a deeply moral nature, based to a certain extent on 'good faith' or trust that is shared between participants. These studies highlight the moral nature of ordinarily seen but unnoticed actions in that breaches of actions resulted in the perpetrator being exposed to 'righteous indignation' or hostility from observers and other participants. Thus, cognition of social action is deeply entwined with social morality. The norms of social action are reinforced by and maintained by the society in which they are carried out. Deviant action, or actions that are perceived to deviate from norms meet with hostility and indignation.

However, it has also been argued that actors know that the same objects are encountered differently as they are located in physically different places. Therefore, different aspects and configurations of objects are perceived by them and the motivations and purposes the actors differ in respect to the object. Despite these problems of intersubjectivity, actors still take it for granted that their view point may be the same. It is as though the operation of these two assumptions that a 'common world,' which transcends the actors private experience can be established. It is through a continuous process of adjustment that the actors succeed in

resolving the discrepancies in their perspectives which could otherwise throw doubt on the shared nature of their perceptions and cognitions.

The methodology or philosophy of this study has been described as ethnomethodology. The method was participant observation in an ethnographic framework. The description of the method now follows so that the results and analysis can be understood within its framework.

## Chapter Ten

### Method

#### *Method And Methodology*

This study attempts to compare cultural norms and behaviours with those that prevail in institutions that purport to look after persons with neurological impairments and changes associated with ageing. It seeks to identify those behaviours, practices and systems that result in the culture of the nursing homes studied and to understand how these cultures have evolved through examination of historical, sociological and political frameworks.

The results may show the many 'seen but unnoticed ways' that people with impairments are treated. People with impairments may not be able to uphold all of the social norms that our society has come to expect. As discussed previously, Garfinkel (1967) shows that when people break social norms, the result can be 'moral retribution' for their 'breaking of trust relations', especially when no other explanation for the behaviour can be sustained or offered. Is it our society's retribution for neurologically and otherwise impaired individuals to be institutionalised in a culture that defies the immediate environmental and general culture of the broader society? The nursing home cultures studied are dictated by the shared behaviours and attitudes of the people visiting, living and employed there as well as the environment within which they are situated.

For cognitively impaired individuals, maintaining ordinary social relations may be an ongoing task similar to Agnes's 'building the boat whilst out at sea', that Garfinkel describes in his studies (Garfinkel, 1967). In this way, Agnes actively tried to build her identity as a female while being immersed in society. Similarly, while nurses, carers and involved others may

seek an explanation from the resident for the deviant behaviour, it may not always be suitably forthcoming, especially if the individual is cognitively impaired.

### ***Qualitative And Quantitative Research***

Science cannot claim such things as truth, rigour or explanation solely for itself and art cannot claim such things as beauty, imagination and poetic license solely for itself. Furthermore, qualitative research is described as being found where art and science meet and is concerned with finding truths and representations that are true to its subject matter. People who are engaged in qualitative research at these crossroads must decide whether to celebrate it or deny its artistic merit (Sandelowski, 1994).

The goals of qualitative research are generally the development of theory, description, explanation and understanding. These are contrasted with the general goals of quantitative research which include the precise testing of hypotheses (Morse, 1994). Tacit or practitioner knowledge is distinct from scientific knowledge. May (1994) argues that the implementation and explication of method alone never explains the process of abstract knowing regardless of which paradigm a scientist espouses and which method is used. This is because the product of knowledge is shaped but not completely defined by the process through which it was created. She claims that in all realms of science and most specifically in qualitative research there is a point past which knowing cannot be explained. She attributes insight past this point to immeasurable and unobservable activities such as intuition and creativity.

There is growing acknowledgment in the general scientific community that 'method is not enough'. The observer and the observed are now more often thought to be in mutual and irreducible interaction. Thus the work of science is increasingly shifting to be seen not as the accumulation of knowledge from which the scientist is distanced, but rather as the creation of

cognitive maps that shape and are shaped by the scientist's perceptions and actions (Bohm, 1987). Science writers have been describing the collective nature of knowledge and how dialogue allows individuals to observe their own thinking, thus taking a more creative, less reactive stance toward their own thought (Singe, 1990). Thus intuition and creativity are increasingly acknowledged as important if not essential ingredients for scientific discovery. Intuition and creativity are as much a part of scientific work as are careful observation and description. May (1994) argues that an attribute of expert practice in qualitative research is an exquisitely tuned capacity for pattern acquisition and recognition.

Four cognitive processes appear integral to all qualitative methods: comprehending, synthesising, theorising and recontextualizing which are weighted, targeted and sequenced. When entering the setting, to attain good quality research, the researcher relies on the ability to view the experience from the participants perspective. To do this, the researcher must enter the setting as a stranger, earn the trust of the participants and establish a level of intimacy with the participants so that they will be willing to share information freely with the researcher. Comprehension is reached when the researcher has enough data to be analysed as part of a complete, detailed, coherent and rich description. The investigator must act like a sponge, absorbing and drawing information, maintaining a spirit of inquisitiveness, rather than that of a judgmental, evaluative manner. Notes are made as frequently and completely as possible. These notes should be descriptive of any reflection or conjecture and should be recorded elsewhere, separate from the example (Morse, 1994:25-26).

Synthesis in ethnography is facilitated by the processes of coding and content analysis. By pooling data from all transcriptions and notes, categories are constructed and data are linked both from transcripts and from one participant and between participants. Synthesis has occurred when data are saturated or when no new categories occur.

In this kind of qualitative investigation, theory is developed from comprehending and synthesising data, not as a structure or frame within which to sort data. Theory gives qualitative data structure. Theory gives qualitative findings application. Without theory qualitative results would be disconnected from the greater body of knowledge. Theorising is the systematic selection and fitting of alternative models to the data. The goal of research is to be able to place the results in the context of established knowledge and to identify clearly findings that support established knowledge and theory and to claim original contributions (Morse, 1994).

### ***Ethnography As A Method***

This qualitative study has used an ethnomethodological approach. An ethnography is always informed by a concept of culture. Ethnography is based on the assumption that culture is learned and shared among members of a group and as such, can be described and understood. Culture here is viewed as a force that categorises, encodes and defines the world in which people live. Thus the cultures in the nursing homes are captured in such a way that their effects on residents, as they are being admitted to the nursing homes and as they resided in the nursing homes, are described through the use of field notes and by the researcher joining in with the activities of the nursing home. In this approach, details of transactions are kept to discover the shared systems of meanings at the nursing homes. An ethnography is holistic and contextualizing the data involves placing observations and interview data into a larger perspective. This helps us to understand human behaviour from its relevant contexts of meaning and purpose and allows the ethnographer to understand why the behaviour takes place and under what circumstances.

Marcus (1986) notes that in ethnography, theorising is often embedded in the data synthesis as reflections within a given context. The analysis phase of theorising is rarely separated off into a discrete section as a level of discourse with a distinct purpose, such as embedding the



analysis in critical theory, political discourse and so forth. New explanatory models and theories may be derived in the course of analysis.

‘Retextualisation is the development of the emerging theory so that the theory is applicable to other settings and to other populations to whom the research may be applied’ (Morse, 1994:34). The work of other researchers and established theory plays a critical role, as these provide the context in which the researcher’s model links the new findings with established knowledge. The new findings can be placed in context with established theory as this allows the demonstration of the usefulness and implications of the new findings as well as a clear identification of new contributions. The new findings may be used to support or reject previous research and offer new directions for the future. Retextualisation is achieved by forcing the theory to a higher level of abstraction. The degree of abstraction attained in turn, determines the generalizability of the theory (Morse, 1994).

Ethnographic analysis and all scientific analysis is the search for patterns in data and for ideas that help explain the existence of those patterns. Descriptive analysis occurs when complicated things are made understandable by reducing them to their component parts. Theory results when complicated things are made understandable by showing how their component parts fit together according to some principles (Morse, 1994).

### ***Participant Observation***

The central method in this ethnography is participant observation, whereby the researcher becomes part of the culture. Participant observation combines participation in the lives of the people under study while maintaining some professional distance that allows for adequate observation and recording of data. Participant observation sets the stage for other techniques such as interviews, life histories and other data collection procedures. This stage provides the baseline of meaning and the contextual data for the ethnography. A good ethnography

attempts to describe as much as possible about a cultural or social group. The description might include the groups history, religion, politics, economy, environment and how the group relates to the social units under study (Boyle, 1994). Spradley (1979) believes that the emphasis during an ethnographic interview should be put on learning from people rather than collecting data from people and he asserted that it is this process of 'learning from people' process that primarily distinguishes ethnographic studies from empirical scientific analysis. At the core of ethnography is a concern with the cultural meaning of actions and events to the people who are being studied.

Ethnographers ask questions that are first of all broadly descriptive and they then may narrow their focus to specific details of the situation. Spradley (1980) suggests studying a few isolated domains in-depth, while still attempting to gain a surface understanding of the cultural scene as a whole. For example, the participant observer might firstly engage in activities that are appropriate to the nursing home and also observes the activities, people and physical aspects of the situation. The researcher needs to become explicitly aware of things usually blocked out to avoid overload. In a sense the researcher needs to use themselves as a research tool by increasing their introspectiveness. The ethnographer experiences being an insider and an outsider to the situation simultaneously.

Ethnography is chosen as a method that will lead to a discovery of the knowledge that people use socially and culturally to understand their experience and organise their behaviour (Germain, 1993). The ethnographer starts with discovering the empirical reality. Then, through long-term participant observation, the ethnographer learns and analyses its local meanings (Spradley, 1980). Descriptions from the ethnographer includes their thoughts and feelings as well as entities of space, object, acts, activity, events, time, other people and their goals and feelings. There may be a wide variety of types of information, including written texts such as poetry, media, verbal transcriptions, maps, film, drawings, or other visual

representations, oral recitations and music. The ethnographer gathers a variety of data types that go beyond the visible facts and that identify the experiential connections that link those facts in people's lives. The ethnographer lives a process of analysing data while collecting them, engaging in an interactive process of gathering and verifying information. In ethnographic work much information is arrived at intuitively and informally. The ethnography should trace the people's ways of living with each other and continuing their society. The ultimate purpose of an ethnography is to make the social action of a society understandable to an audience of another society or to the rest of the same society.

### ***Particularistic Ethnography***

Morse (1991) suggests that focused ethnography be used to describe the topic-orientated, small group ethnographies found in the nursing literature. Thus, as Morse observes, the unit of ethnography in nursing can be a hospital unit or a support group of patients, or more recently, a nursing home (Golander, 1992). These particularistic ethnographies focused on a social unit or process within a small group and generally identified and helped to understand the cultural rules, norms and values and how they are relate to health and illness behaviour. Such ethnographies have generated descriptive theories about phenomena of interest and concern to health professionals. Thorne (1991) suggests that nurse ethnographers rarely conduct whole ethnographies. Most nurse ethnographers draw on ethnographies from other anthropological research to contextualize their discrete findings within the larger picture. Muecke (1994) believes that in this way, details of specialised inquiries into such questions as health behaviours or healing rituals can be interpreted in the context of linguistic patterns, kinship rules or seasonal nutritional variations understood from the composite picture of the cultural whole.

The greatest risk of focused ethnographies is that the boundaries of their focus unknowingly exclude what may be relevant. Ethnographies of all varieties should correct the common problem associated with deductive research of excluding the unrecognised but potentially powerful interpretation. Muecke (1994) argues that the researcher should aim for as complete a participation in the life space of the people being studied as possible as this gives the researchers greater exposure to a variety of situations and the value of the study is enhanced.

### ***The Process Of Selection***

Initially two nursing home sites were sought for the study so that procedures, processes, cultures and other findings could be compared and contrasted with each other. It was considered that a private and public enterprise be chosen, to highlight potential contrasts. An exempt nursing home was originally approached but was not inclined to participate in the study because of the likelihood of the identity of the nursing home becoming known. Finally, a nursing home unit situated within a large state government organisation was chosen, along with a nursing home that was attached to a hostel and larger aged care and management structure. Before being approached, records of their outcome standards of care were checked to ensure that from the outset, the standards of care were acceptable and met with government criteria. This enabled a degree of uniformity of standards to be met in the first instance and ensured that conflicting standards were not a major contributor to the research findings. Letters outlining the study were sent to the management of each establishment (Appendices A & B), along with a copy of the research proposal (Appendix C).

### ***Informed Consent***

Written consent to do the study was obtained from each nursing home (Appendices E & F). Consent for the field work part of the investigation was institutional; that is, all people present in the nursing home setting at the time of field work were observed and therefore included in the study. This type of consent allowed the researcher to move about the environment, opportunistically gathering data as the research question demanded (Germain, 1993). The

researcher visited the nursing home staff to explain the nature of the research prior to its commencement. At the first nursing home studied, referred to as Maple Nursing Home, a meeting was arranged for the relatives, residents and other interested parties to meet the researcher and have the research explained. A date and time was set, however, circumstances were such that the meeting was cancelled and the management of the nursing home considered that the research could proceed regardless. A large poster depicting the researcher and nature of the research was drawn up and placed in central position in each nursing home about 3 months preceding the commencement of the study in each home (Appendix G). This was undertaken to allow staff, residents and families to refer to the researcher and the aims and objectives of the research. They were also informed of the activities of the researcher on the premises. Further explanations about the research were offered each time the researcher entered the setting and in an ongoing and as needed basis. Verbal consent was solicited each time the researcher approached a new person in the setting. Any person could refuse to engage in the research or cease to participate at any time but all relevant observations were included. Only those who were not cognitively impaired were interviewed so that a deeper meaning for their experiences can be gained and consent for participation in this way was fully understood.

### ***Getting Started***

At the Cedar Nursing Home, the researcher was viewed initially with suspicion. A time and place was advertised for the staff and residents to meet with the researcher during working hours before the commencement of the study. None of the staff or residents at the Cedar Nursing Home attended this meeting. The nurses and carers later explained that a previous study had recently been done where a researcher was sent to the unit and they had cooperated with her. They associated the resulting research findings with a further reduction of their working hours. This suspicion was not helped by the management's omission to distribute information brochures (Appendix D) to the staff that told them of the research and who to

contact if they wished to discuss any concerns. When the brochures were made available to the staff, they became more accepting of the researcher on the unit. Management had in the past offered redundancy packages to those staff who would resign and were now looking at reducing the hours individual staff members worked, adding to the nursing staff's insecurity.

At Maple Nursing Home, the researcher was accepted by the staff and she was personally introduced to them by the Director of Nursing who described her as 'a registered nurse, one of us.' Management informed the families of the study through a newsletter that was regularly distributed. Like Cedar Nursing Home, a large poster was placed for general display to inform residents and interested others of the nature, aims and objectives and about the presence of the nurse researcher on the premises (Appendix G). Information sheets were made available to staff, residents and relatives for their perusal and the researcher was available to assist with any enquiries.

Research at the Maple Nursing Home commenced in the first week of February, 1997 and continued for 7 weeks, with an interruption of one week. After this time, the researcher visited the premises at prearranged times to follow up with staff, residents or relatives who felt that they had a further contribution to make. After a short break, research work at the Cedar Nursing Home commenced in mid-April, 1997 and continued until July of the same year. The research was broken to allow the researcher time to recover from an illness. Total time at the Cedar Nursing Home was approximately 7 weeks, about the same as at the Maple Nursing Home.

During the first weeks of the study the researcher was present at the nursing home mainly during the day time to introduce herself to the participants and allow them to adjust to her presence and ask any questions about issues that concerned them. The researcher then became more involved with the general nursing care at the nursing home and participated in

pressure area and toileting rounds, feeding the residents and socialising with the staff, residents and their families. A special roster was drawn up for each nursing home, so that each shift for each day of the week was attended by the researcher over the period of seven weeks, including weekends, public holidays and day, evening and night shifts. The researcher on average spent three hours each day in the nursing homes, although this was extended or reduced depending on the circumstances.

### ***Interviews***

In this study the researcher invited a selection of the nurses and carers, who had been observed during field work, to be interviewed in an effort to uncover deeper meanings and enhance the understanding of the inside view of nursing home nursing care. Data from these interviews were based on a sample of nurses, who could validate, refute and/or expand the researcher's observations. The exact nature of the questions were ascertained as the study evolved. The interviews ranged from unstructured to semi-structured, so that a comprehensive view of the nursing care of patients could be established. These interviews were audio-taped and transcribed for analysis. Written consent was obtained from these nurses on a form that further explained the details of the study in 'plain language' (Appendix H). It was understood that the interviews could be terminated at any time by any participant, without any consequences to them. Likewise written consent could have been withdrawn at any time (Appendix I).

Some demographic data about observed residents were included as a means of describing the participants. Demographic data about nurses and carers was not sought because of the transient and casual employment of many of the nurses and to avoid exacerbating suspicion within some groups. Further supplementary data that was also used in this study included patient records of those people in the nursing homes at the time of field work and written

procedures and policies relating to the nursing units. Attention was also paid to the environment and locations of the nursing units.

The case studies concentrated on each unit as a whole without paying specific attention to any particular area. This broad approach to each case study minimised the possibility of the field researcher becoming overly focussed on any particular area. This approach contextualised the experiences and identified patterns of practice. Data was collected in the form of field notes of nursing actions and nursing units, interviews with informants from within the groups and the reflective accounts of the participant observer's own experiences in the setting (Spradley, 1979).

### ***Ethical Issues***

All participants in this research have remained anonymous through the use of identification codes and pseudonyms. Inconsequential detail of the general nursing home used for the study was altered in a further effort to assure anonymity. It was anticipated that Nurses and residents may feel uncomfortable about being observed and their discomfort was reduced by the researcher making herself known, and familiar to them. The researcher maintained a non-judgmental stance as otherwise participants behaviour and responses may become affected. It was the researchers' responsibility to form relationships that allow the inside of the culture of the nursing home to be revealed. Time spent in the unit early in the course of fieldwork enabled the researcher to build familiarity and trust and to establish healthy working relationships with the staff in an effort to build confidence and trust. All data including field notes, personal field journals, audio-tapes of interviews and their transcriptions were stored in a locked office and were accessible to the researcher only.

### ***Reliability And Validity Provisions***

An aim of this study is to capture the everyday practices in the nursing homes and how sense-making occurs. The perspective from the inside, the emic data, such as those meanings



elicited from informants, were compared to the etic data, observations and theoretical speculation of the researcher. The validity of this research was dependent on the extent to which the captured descriptions and observations match those who know the culture. Through the use of key informants and through continuous analysis, the researcher of this study checked her information with key informants. The comparison of what key informants said and how it related to others viewpoints added reliability to the study as did the investigation of discrepancies.

### ***Summary***

This chapter distinguishes and identifies the method and methodologies used during this study. The research has been identified as qualitative and a comparison has been made with quantitative research methods. Particularistic ethnography, using participant observation has been identified as the method used and the processes of selection, gaining informed consent, interviewing, ethical issues and getting started have been described. Reliability and validity provisions have also been presented. The general routine and environment at the nursing homes studied following the implementation of these methods is presented next.

## Chapter Eleven

### The Daily Lives Of Residents At The Cedar Nursing Home

#### *The Environment*

This nursing home was first established as a major centre for disabled people in the late nineteenth century and accepted nursing home residents in the mid 1990's. The facilities were purpose built for disabled people and this in turn affected the admission criteria for older people in that they needed to have a disability that was not remedial by long term treatment. The funding mechanism is a mixture of Commonwealth and State funding. Although Commonwealth funding criteria were incorporated into the care of the residents, the funding was under review at the time of the research and not strictly allocated by the usual method of individual and relative need. When most of the residents were first admitted to the nursing home, 6 hours of nursing staff time was allocated for their care in the budget. However, because of policy changes, they now are allocated an average of 4 hours of nursing staff time each per day and this is to further decrease to 3 hours of nursing staff time each per day in the future. The community average is 2.78 hours of nursing staff time allocated per day. On any given shift in the unit, there was always a Registered Nurse allocated to the unit supported by one or two each of enrolled nurses and personal care staff. The educational qualifications of the staff were not formally noted as the staff were very sensitive to the researcher being on the unit, however information gathered informally through interviews revealed that there were about an equal mixture of hospital trained and tertiary educated registered nursing staff with few having obtained post graduate qualifications and none having being identified as having obtained gerontological qualifications. The model of care being used in the facility was a medical model, where all things considered important were identified by medical terminology and diagnoses. Medical systems were tightly organised to support these and their treatment and are discussed later in this chapter. There were twenty three residents in the unit studied

56 percent (N=13) male and 44 percent (N=10) female. The mean age of the male residents was 68 years and for the females, 71 years. The mean length of stay for the men was 12 years and for the women, 16 years. The most common medical condition diagnosed amongst residents at Cedar Nursing Home was cerebrovascular accident (39 percent) followed by multiple sclerosis (22 percent).

'Open space' is the first impression noted by visitors to the Cedar Nursing Home as they step out of the elevators and start to walk towards the entrance. The entrance is marked by a wall and two corridors leading off it, one to the right and left. There is a large sign on the wall that explains that the nursing home has met accreditation standards and a clock that is set in the centre. A resident may pass in their wheelchair, eyeing visitors curiously, sometimes accompanying them. Two cushioned seats and a large glass container filled with evergreen plants are stationed to the right of the entrance. Daytime lighting is fluorescent, with the assistance of natural light that streams through the windows and doors in all of the residents rooms, dining room and sun room.

Down the corridor to the right, there is a drinking fountain to the right of this the nursing home's 'Emergency Plan' hangs on the cupboard marked 'Fire Equipment'. To the far right of the entrance is a small kitchenette with cupboards and shelves and a green public phone on the wall with an 'Out of order, Don't use' sign on it. This particular telephone has a volume control with 'Push on' and 'Push off' buttons on the side. Above the telephone is a taxi directory notice with telephone numbers of taxi companies listed. Five oxygen cylinders sit in the far corner. There is also an 'Odourgas Pressure Bulk Deodorant Pack' sitting in the corner and a 'Jordan Frame' hanging next to it on the wall. Opposite these is the laundry area, where a small washing machine and dryer is installed. Sitting next to it is a shower chair. At the far end of the area are two linen chutes and an empty trolley. A small pile of 5 empty cardboard boxes lie in a corner.

The corridor is lined with lamps, some of which have pictures and posters below them. Most of the pictures and prints are of nature scenes such as flowing rivers, forests, birds and dwellings. Several are of animals and flowers. Occasionally, there are pictures of residents, their families and staff.

Further down this corridor, there are shared rooms where sliding doors are left invitingly open. The first two or three are double rooms, each bed separated by a partition down the centre and usually empty of residents during the day. As the nurses' station, situated at the lower end of the corridor, is approached, there are sounds of residents' voices and more activity. Here, there are two rooms shared by four residents. Generally there are at least one or two residents in them at any time during the day. The rooms have four beds, two facing the other two on opposite sides of the room. Each bed has a small metal locker which contains the residents' personal belongings and toileting effects. Behind the beds are large spaces on the walls for pictures or photographs that may be used by the residents. By the farthest walls are glass windows and a sliding door which leads out to a patio. The patio runs along the circumference of the building. Occasionally, crocheted rugs or stuffed toys, which may belong to an individual resident, are situated on the beds. Many residents have a television and radio/cassette on the bed tables and lockers. In the entrance of the four bed rooms is a small alcove with cupboards that store the residents clothing. A ceramic sink sits just inside the entrance to the rooms. Commode chairs are located alongside the resident's beds or lockers.

In the first four-bed room a very frail lady lies curled up, carefully cushioned with pillows. She is barely able to speak, except in very hushed tones. Her only movement is to push the call bell which is especially designed for her and pinned on her nightgown. The call bell can be activated by the resident simply nodding her head slightly, putting pressure on the bell.

In the next share room of four beds, is a man in a bed by the window. He sits immobile, propped up in bed with pillows but leaning to the right hand side. He is constantly moaning. Saliva dribbles continually from his mouth and he seems unable to recognise visitors. Next to him is a trolley with suction equipment on the top of it with material for dressings on the lower shelf.

In the centre of the corridor are the wheelchair and accessory rooms, followed by sluice rooms, toilets and showers. At the end of the corridor is the nurses' station. Here, there is a cassette player and radio plugged in from the corridor. A poster of an ancient tree, surrounded by scrubland and a river is fixed to the back wall. This station consists of an elongated desk behind which the nurses often sit and chat. Directly in front of the nurses' station is a clock and a small board which is often lit up with the room numbers of residents who ring their call bells wanting attention. Just above the call bell board is a sign 'Gimme a break' positioned so that it is immediately obvious when observing the bell board. Under the bell board is a 'Counter Disaster Plan'. There is also a plan of the floor showing where the fire equipment is kept. Further alongside on the wall is a red phone with a sign 'For Fire Wardens Only' and a red box that has a small sign which reads 'Fire Alarm, Break Glass'. A sign on a door leading off the wall reads 'Fire Equipment' and inside is a fire hose, water extinguisher and carbon dioxide extinguisher. Outside this door there is a yellow helmet with 'Warden' printed across it in red letters and a beacon, both hanging from a hook on the wall.

The station for the registered nurses is located next to the nurses station in a closed room with glass panelling. In here, there are residents' current nursing and medical records, accompanying paperwork and policy and procedure manuals for the nursing home. Just behind the registered nurses' station is the treatment room where current dressings, gastrostomy equipment and medications are stored. The staff have a tendency to collect

around the nurses stations at this end of the building. In the morning, one registered nurse and at least six other nurses gather to hear handover. Both the male and female registered nurses are usually all dressed in white uniforms, except for one female registered nurse who wears navy blue slacks and a white polo blouse. The accompanying six enrolled nurses and nurse assistants are distinguishable in their blue and white pinstriped uniform. Otherwise, male enrolled nurses and nurse assistants wear white trousers and shirts. Generally, some nurses go home at 1:30 pm and at 11 am so that during the busiest times of the day, when showering, washing, dressing and feeding residents are attended, there is a greater concentration of staff. A helper, known as a WA2, could also be on the unit in the morning or afternoon to supervise dependent residents and attend to bed making and transporting the residents to appointments. The WA2 generally wears a white uniform. Usually, two enrolled nurses or nurse assistants work until 2:30 pm. One registered nurse and three other nurses who are enrolled nurses or nurse assistants, work through the evening shift. On the night shift, there is one registered nurse and one other enrolled nurse or nurse assistant. The pantry maids and cleaners wear brightly coloured uniforms that distinguish them from nurses. All ward clerks, management and allied health personnel wear casual clothes.

To the right of the nurses station is a large dining room where several residents sit in their wheel chairs watching the colour television. The television is positioned over a VCR on a tall television trolley. The room is partially surrounded by glass windows and sliding doors, through which one may view the hills and surrounding neighbourhood. The vast expanse of the green lawns and trees of the nursing home can also be seen from here and the outside patio, which runs from the dining room. There is a kitchen cabinet that contains a single row of books, some in large print. Towards the back of the room is a table on which a pile of women's magazines are stacked. Some have their covers and other pages missing and they date back over the last decade.

Down the left hand corridor from the entrance is a series of seven single rooms. Most of these reflect the character of the resident and have more of the resident's personal property exposed in them. The room at the end of the left corridor is shared but has no partition in the centre of it to separate the beds. From here, the corridor leads to the sun room, where a large dining room table with chairs is placed in the centre. The handover between the morning and the afternoon staff is generally held in here. Other upholstered chairs line the borders of the room. There is a large fish tank with fish swimming in it in the far end. Long, finely decorated blue curtains with vases of flowers of flowers printed on them conceal some of the glass windows and sliding doors that lead into the sun room. In the centre wall here, there is a very large poster of extended cliffs, coastline and the sea with footprints along the sand. Other posters of birds are on the walls and face the door. Close to the sun room, hanging from the corridor wall, is a large notice board on which there are eighteen photos of residents and four photos of staff. A notice of memoriam regarding a deceased resident is pinned to the notice board.

### ***The Residents And Staff***

Many of the residents have impaired mobility and they are reliant on other forms of transport such as wheelchairs, walking frames, lifters and assistance of one to two nurses to mobilise around the nursing home. Some have supportive families, but many are dependent on staff and the volunteer service which provides people to visit them. Many of the residents are dependent on the staff to cut up and assist with feeding them their meals. They also regularly require assistance with toileting, pressure area care, cleaning their teeth and dentures, hygiene care, dressing and undressing, communication and other aspects of general nursing care. Many of the more able residents tend to group together and communicate with each other. For example, Mary, Lynette and Alice regularly gather together and exchange news and views with each other. Mary is the only resident who ventures out of the complex

independently and regularly during the week, to attend to one of the many charities she collects money for outside a busy shop in a main street in the city.

There is a mixture of staff. The nurses include agency staff as well as permanent and casual staff that are working in the home temporarily having been transferred from other areas. There are several groups of nurses present on the unit. They include the manager of the area, the unit manager, the registered, enrolled nurses and the nurse assistants. Both male and female nurse assistants and registered nurses are present but there are only female enrolled nurses. All working age groups are represented. There is an enrolled nurse who is also a nursing union representative. Other staff members who come to the unit but who are involved in allied health include the occupational therapist, physiotherapist, volunteers, pharmacist, ward clerk, doctor, social worker and speech pathologist. A dental service attends from outside of the nursing home and most of the doctors who attend the residents are also not employed by the nursing home. There is also a contingency of pantry maids, cleaners and maintenance men who regularly make their way through the unit.

### ***The Routine***

At 7 am, there is often an informal handover at the nurses station between the night nursing staff who are going home and the day nursing staff who have just come on duty. This handover finishes shortly after 7 am. Call bells are answered and the nurses generally organise themselves into working in either the resident's rooms leading off the central ward area or the corridors. The linen trolleys are stacked with fresh linen from the nearby linen room and the non-nursing attendant then comes on duty. The cleaning lady collects the water jugs and is ready to sweep the corridors. The pantry maid starts in the kitchen to wash up some dishes. The more able and ambulant residents begin to get up of their own accord. A total of eleven residents often remain in bed at 7:30 am. The registered nurse helps with making beds and assisting with resident care, including the assessment of new residents



when she has spare time between gastrostomy feed administration and attending to dressings. The Clinical Nurse Consultant (CNC) appears and greets the staff and residents at about 8 am and then leaves the unit. Just after 8:00am the medication round is commenced by the registered nurse. There are usually about nine residents already in the dining room for breakfast. Residents are assessed and documentation done by the registered nurse after the medication round is finished at about 9:30 am. The remaining residents who are in bed are successively woken, toiletted, given breakfast and showered or washed until at 10 am, when only about five residents are still in bed. A further pressure area care and toileting round is commenced at 10:30am. The non-nursing attendant remains in the dining room to supervise a dependent resident. A nasogastric feed is commenced at about mid-morning for two residents.

At 11 am typically six residents remain in bed. The first staff lunch is taken by two nurses at 11:15am and they return at about 11:45am when the remaining nurses and registered nurses go to lunch. All of the staff are back by 12:15pm. The registered nurse, along with other nurses, help sit residents up at a quarter to twelve. The registered nurse then attends to other duties such as documentation, filling doctor's requests and assessing residents. The resident's meals arrive on a large trolley from the kitchen at about 12:15pm.

Eight or nine residents are usually present in the dining room at a typical sitting for a meal. The registered nurse dispenses the medications and a pantry maid is in the dining room giving out the drinks. The nurses mix the resident's foods for them and feed many of them. A non-nursing assistant supervises a dependent but restless resident in the dining room. At the end of the meal, the pantry maid attends to stacking plates on the trolley and cleaning down the tables.

Call bells ringing from the resident's rooms are answered by nurses. In between and after lunch the nurses attend to the residents pressure area care and toileting needs. At 2 pm the bowel book is filled out by the nurses. At least seven residents remain out of bed in the early afternoon and the remaining residents go back to bed. Any documentation is then written up by the registered nurse. Some residents can have a cigarette after lunch. The afternoon staff begin to come on duty at 2:15pm and handover between the morning and afternoon shifts usually starts.

Most of the day and evening staff attend handover and about once a month the unit program manager also attends. At the end of handover the afternoon staff return to the ward where often residents are waiting for their return. A gastrostomy feed is commenced for two residents by mid afternoon. Residents are checked for incontinence and pressure area care is attended. Residents sit up for tea at about 4:30pm and then some of the staff go to tea. On their return the food trolley arrives from the kitchen. The nurses take small bundles of spoons and serviettes and place them on the trays before taking them to the residents. The residents slowly prepare for their meal and those who eat in the dining room move there, some with the assistance of staff. Staff give out the meals in the dining room and feed some of the residents both in the dining room and in their rooms. After tea, the staff have about five minutes to socialise with the residents. Some residents are returned to their rooms and the nurses conduct a pressure area and toileting round. At 5:30pm staff who are allocated go to second tea. Residents who smoke may be given a cigarette after tea. The pantry maid washes up dishes in the kitchen. Between 5:45pm and 6 pm the registered nurse begins to administer the early evening medications and commences a further gastrostomy feed for a resident, depending on whether she goes to the early or later tea break.

Between 6 pm and 8 pm about eight residents are put to bed by the enrolled nurses and nurse assistants, often with the assistance of the registered nurse. Occasionally, telephone calls by

staff are made at this time. At about 6:45pm, a round of all the residents could be undertaken. The residents' pressure area care is attended, their incontinence is checked and pads changed as necessary. At about 7:45pm the nurses begin to give out supper drinks from a trolley to the residents, answering bells as they continue on with their work. As the nurses do the supper round, each takes time out to give the residents drinks when assistance is needed.

At 8:00pm six beds are regularly unoccupied. The nurses supper break occurs at about 8:00pm and the registered nurse usually sits at the nurses' station. In between answering callbells, rosters may be discussed. The registered nurse may organise the benzodiazepine tablets for the residents by asking an enrolled nurse to check them before she administers them to the residents. Just after 8 pm, the unit's white board may be changed, with the names of the next day's staff on it, distinguishing between nurse assistants, enrolled nurses and registered nurses. A pressure area round is usually commenced at half past eight, with the nurses working in pairs, often using lifters to handle the residents. At least eight residents are attended to on this round as well as others being checked for incontinence and their general well being. The nurse attending to the residents cleans their teeth, empties urinals and bedpans and empties drainage catheters.

The registered nurse also attempts to assist some residents with or without the assistance of enrolled nurses or nurse assistants. She commences the evening medication round at about 8:30pm. She helps out with the work of settling the residents for their sleep as she continues with the medication round and commences an evening gastrostomy feed for a resident. Meanwhile, as she completes her medication round, two nurses may sit at the nurse's station discussing work related issues and other topics of common interest, in between answering bells. Just after 9 pm the nurses regularly put one resident to bed followed by another resident at approximately 9:30pm. They then join up with the third nurse and check on the more dependent residents who may be restless. After 9:30pm it is time for the registered

nurse to do the paperwork and assist in answering any bells. Monthly summaries about the residents are also usually completed at this time. The nurses may sit and chat after 9:45pm and continue to answer the occasional bells. The registered nurse continues with her documentation until 10 pm. By 10:30pm the nurse manager arrives and shares information with the staff.

Handover for the nightstaff is held at the nurses' station at 10:30pm, with the one night duty nurse and the two registered nurses from both shifts. The residents status is discussed in order of their rooms and those who have been given analgesia or currently experiencing problems are discussed. The registered nurses then count the drugs, including the benzodiazepines. The evening registered nurse leaves to go home and the night registered nurse checks that all the medications are given and signed for during the previous day. The nurse assistant wanders up and down the corridor checking the residents. Bells are answered. The registered nurse further assists the nurse to settle some of the residents. The 'Milton' container in the treatment room is emptied and cleaned. Water is added followed by a measured amount of 'Milton', a sterilising solution.

The nurse sets up the linen trolley for the night and urinals and pans are put out for several of the residents. The nurse assistant requests help from time to time from the registered nurse to re-position the residents. The registered nurse completes the day's documentation between 10:30pm and midnight, so that all residents have something written about them. The first pressure area round for the night generally commences at midnight and the single rooms are attended to first. Residents' toileting needs, as well as their pressure area care, are attended. One resident is routinely put to bed after midnight, at the resident's request. The round finishes at 1:10am and bells are answered after that. The nurses sit down for coffee at the end of the round after 1:45am. The bowel book is checked to see who will have suppositories or a disposable enema in the morning.

On Tuesdays and Sundays the medication stock is reordered for the impress system. The oxygen cylinders in the dining room and behind the nurses desk are checked, as well as those in the treatment room. The suction is also checked and this is positioned on a trolley near the entrance to the dining room. Medication charts are checked at the beginning of night shift, the need for new ones identified and notes left for the doctors to this effect. The times that the medications are due are written on the new medication charts. The treatment room is restocked. The gastrostomy feeds for the next day are made up at about 2 am.

The next official round is at 5 am. One resident is always turned at 3am and another is given medication via their gastrostomy tube at 3 am. Some residents ring frequently throughout the night, often for a chat or nourishment, or to have their toileting needs attended.

On an average night, at least six people are attended according to their demands, as well as regular care being given for pressure area and toileting needs. Some residents are attended individually six times on an ordinary night. The nurses complete their work by showering two residents and washing another and preparing them for the day ahead.

The registered nurse gives the 6am medications, eyedrops and commences a gastrostomy feed for a resident. Also, drugs dispersed via inhalers precede handover. The drugs are again counted with the registered nurse who arrives to commence day duty at 7 am.

## **Summary**

A section of Cedar Nursing Home is set aside for the care of older residents most of whom had originally been admitted when funded by the State government as part of receiving rehabilitation treatment and being part of a rehabilitation program. Allocation of funding is in a state of transition from being fully funded by the State government to being largely funded by the Commonwealth government. The aged care unit did not receive funding for active rehabilitation and policies discourage new residents who seek rehabilitation from applying for entrance.

Staff at the Cedar Nursing Home are very sensitive to the researcher being present as they had assisted a previous researcher within the nursing home and they associate this with their working hours being reduced. Therefore information about staff is largely limited to that which could be obtained by informal means. The management structure of the nursing home is formalised and hierarchal. The registered nurse is a relatively isolated figure on the unit. An enrolled nurse is also allocated to most shifts and the remaining direct care staff tend to be untrained. The model of care in use is a medical model, where information obtained and shared about the residents reflects a medicalised process. Many facets of the environment suggest that the living arrangements are very institutionalised, however there are also occasional elements that are more open and homelike. There are both share and single accommodation rooms available and these are allocated on a predetermined basis of need by the management. Uniforms are worn by unit staff and are coloured to distinguish one department from another. Ward Clerks, management and allied health personnel wear casual clothes. Staff have very set routines which are adhered to with minimal flexibility. Residents

are perceived as preferring a high degree of routine in their daily lives and several also insist on their own preset routines being rigidly adhered to by staff.

## Chapter Twelve

### The Daily Lives Of Residents At The Maple Nursing Home

#### *The Environment*

The second nursing home was, for the purposes of this study, given the fictitious name of Maple Nursing Home. This nursing home was part of a larger private, not for profit organisation. It was purpose built in the mid 1970's and at the time of the research had available 38 beds. It had been originally built to accommodate 70 residents in shared facilities, however as the result of research done within the larger organisation the number of available beds were to be reduced to 35 to more fully accommodate the identified needs of the residents.

The nursing home is difficult to see from the main road. It is accessible from a side street called Maple St which intersects the main road. The building is of cream brick. It is partly obscured by a very high brush fence leaving only the corner of the top floor visible. The building is surrounded by large old native trees, well kept lawns and gardens. After turning right into Maple Street, a sign, 'Maple Nursing Home' becomes visible on the left. This sign is followed by a car park that is usually full of cars. The entrance is not clearly identifiable. From the position from the car park at Maple Street, three floors of the nursing home building are visible and these appear to be connected to the main building at the front. There is a gate with a small hand painted sign that reads, 'Please shut the gate'. After walking through the gate there is a courtyard with a pergola in the far corner. A bird bath sits in the centre of the lawns. There are large pot plants grown in old, open barrels.

The initial impression of Maple Nursing Home is of elegant comfort. At the entrance of the nursing home is a verandah that houses two iron garden settings, more pot plants and a glass



door surrounded by windows with timber frames. Through the door, there are two antique upholstered chairs on either side of a polished, antique table on which rests a vase of dried flowers and a mauve, cut glass lantern. Immediately above this table are windows covered with elegant, lacy curtains that allow the outside light to shine through. The carpet is lavender and pink checks and this spreads throughout the nursing home. To the right there is a wooden sign saying 'Office' that points to the reception. To the right of the reception desk is a series of recently upholstered antique styled polished chairs and a writing cabinet. The elevator to other floors of the building is adjacent to the reception area. Next to the elevator is a plaque commemorating the opening of the nursing home. Directly ahead from reception are two entrances to the nursing home, both leading off to the right. Leading off to the left is another entrance.

### ***The Main Nursing Home Section***

At the first entrance to the nursing home is a door with glass panels, timber surrounds and lacy curtains. It has a sign on it 'Please be sure that the door has closed properly behind you'. Through this door is a long corridor that houses the residents' personal bedrooms to the right and the facilities of the nursing home down the centre. There are four single rooms, then two double rooms. The double rooms have writing desks and bedside tables. All of the residents' rooms have flowing drapes that are colour coordinated with their rooms. A light coloured linoleum reflects the light from the windows for all of the rooms except two that are carpeted. The corridor is lined with fancy lamps but there are very few pictures on the walls. The wall paper is cream coloured with a blue background and mauve flowers. The carpet on the corridor is mauve checked.

At the back section of the nursing home are double fire doors. Down the centre of the building are shower rooms, a treatment room, linen room, sluice room, toilets and showers. At the end of the building there are racks of clothing that appeared to be airing.

Before moving through the second, northerly entrance there is a large television room that is distinguished by its slate floor. In this room are upholstered sofas with lace antimacassars, polished wood tables and upholstered chairs. A polished wood drinks trolley sits in the corner. A wooden bookcase and cabinet are also present and hold porcelain ornaments and vases. The television cabinet in the far corner houses a large colour television. A upholstered recliner chair sits in another corner. A compact disk player rests on a cabinet. On the walls are framed pictures of the Australian outback, social gatherings and flowers.

After going through the second northerly door to the nursing home, residents' facilities are positioned down the centre of the building, adjoining the first corridor. To the left is a large kitchen area and adjoining lounge. The furniture is largely antique and polished wood. It comprises cabinets, bookcases and upholstered chairs. Lamps are fitted with colour coordinated shades. Pictures on the walls depict country scenes and cherubs. Several residents move to this area at mealtimes. Some might sit in their especially shaped foam chairs to prevent them from falling out. Occasionally, residents can be seen up and wandering independently, sometimes talking to themselves. Other residents sit at the main circular table, some clap their hands, others sit quietly or occasionally speak out.

Down to the left of this corridor are six single rooms. At the end of the corridor is a laundry. A room that stores soiled linen is also positioned at the back of the nursing home. In the corridor there are scattered linen trolleys, handwash basins, fire extinguishers, a water cooler and occasional pot plants. The corridors of the nursing home all have polished timber railings.

Most of the residents' rooms have several framed paintings, an upholstered chair, several vases of flowers and an upholstered commode chair. The beds are framed and covered with printed quilt covers. Bed tables are positioned by the bed and may have had the residents' nursing care plan on it. There is often an upholstered recliner in the room. A table next to the bed may have had a drink and perhaps a cassette radio on it. Opposite the entrances to the rooms are double glass windows with lace curtains. Double wardrobes with four doors and ten drawers usually contain the resident's clothing. A divider frequently runs down the centre of the room and it separates the sitting area from the bed when the curtain is drawn.

The nursing home residents are divided into two sections. Section 2A is the main part of the nursing home, and section 2B is the smaller section of the building.

### ***The Smaller Section Of The Nursing Home***

On one of the walls leading to the smaller section of the nursing home is a memorable picture of a smiling elderly man skipping with a rope on a fine day at the sea shore. Pot plants are scattered throughout the building. The cream brick corridors are lined with framed glass pictures mainly of flowers, birds and country scenes. Lacy, fine curtains cover the windows in the corridor. The hand rails here are also wooden and completely follow the circumference of the corridors. There are several polished wooden frame mirrors and long curtains that form a graceful archway along the corridors. In the corners sit upholstered polished cane furniture and tall lamps with matching lampshades. There are two dining rooms in this smaller section. The dining room for residents is lined with pink carpet. It contains a polished cabinet with fine china, glass wear, polished silver ware and a bowl of fresh fruit. The tables were prepared for the next meal. The table clothes are covered with lace and there are placemats with colourful fruit pictures on the borders.

Five residents are located in the larger dining room for nursing home residents. For example, Mrs Granite sits in her elegant chair. She is only able to speak single words but enjoys her meal and eats all of the food provided. An elderly couple also often share the room, where a woman assists feeding her frail husband who is unable to verbally respond. A very slight, frail lady usually sits in the corner of the room with a table placed in front of her to hold her plate of food.

The timber in the room is polished and the chairs have vinyl upholstery that match the colour of the carpets. Crafted mirrors are situated at the entrance and inside of the dining room. Lace, off-white coloured curtains line the window. Individually selected lights hang from the ceilings of the dining rooms, but fluorescent lights are placed along the corridors. The corridors lead around the full circumference of the building. From the corridor a stairway leads downstairs and is blocked by a 3 feet high metal gate.

### ***The Residents And Staff***

The nursing home has 38 beds. Of these 38 beds, 4 are occupied by male and 34 are occupied by female residents. Of these 38 residents, 87 percent are cognitively impaired and dementia is recorded as one of the main causes of cognitive impairment. 59 percent of residents have medically identified disease processes which result in difficulties in mobility. These diseases include osteoarthritis and osteoporosis. A total of 45 percent of residents suffer cardiovascular accidents and associated pathology. Most residents have a mixture of medical diagnoses that have resulted in the resident's admission to the nursing home. 49 percent of residents have RCS (Residential Classification Scale) classifications of level 2 of care, 46 percent level 3 and 5 percent level 4. Levels or categories of care range from level 8 (the lowest category of care), to level 1 (the highest and therefore the most highly funded) category of care. 17 doctors service the needs of the residents from local medical clinics,

however one particular doctor gives medical care to approximately one third of the residents. A local pharmacist also services the pharmaceutical needs of the institution. A physiotherapist is available to assess the needs of residents as required.

The staff are of mixed working age and both male and female, although female staff easily outnumber the male. Staff wear very neat casual clothing and safety shoes which cover the toes of the foot. The nurses include agency staff amongst the permanent part time staff. The senior staff are all registered nurses. A Director of Nursing is on duty at the nursing home most often from after 7am until 4 or 5pm. The Clinical Nurse Consultant is present from 8am until 4 or 5pm. The Director of Nursing is currently studying for post graduate qualifications in business management and the Clinical Nurse Consultant has tertiary qualifications in nursing. Several of the registered nurses are studying courses outside of nursing and none hold formal post graduate qualifications in nursing or aged care. The registered nurses work on the floor between 7 and 10am in the morning and for the most part of the afternoon and night shifts. Enrolled nurses and personal carers give most of the immediate nursing care to the residents. The enrolled nurses and personal carers are required to work shift work and their hours of work are scheduled to meet the residents' needs. Personal carers are required to mix their skills and also help to clean the residents rooms, assist with the preparation and serving of food and attend to laundry needs as well as the usual nursing tasks. They are required to be "multi skilled" in all of their work routines. Routine nursing tasks include attention and assistance with pressure area care, toileting, feeding and drinking, personal hygiene, dressing and undressing, assistance with mobility, communication and comprehension. A small number of residents require specialised palliative care.

There is an active group of volunteers who consist mainly of relatives and friends of the residents. There are also kitchen staff and maintenance men. Some of the maintenance men

are contracted for specific work on the building and others are permanent employees. The mean length of stay for the residents in the nursing home is approximately 4.5 years.

### **Background Research**

One of the organisation's managers (Hall, 1994) conducted a survey at the Maple nursing home in 1992. This survey was initiated after both staff and residents had stated that the physical aspects of the building worked against them being able to meet people's needs in an acceptable way. The organisation had considered this problem for some time and then initiated the survey which found the following:

Residents responded that

- 1 -75 percent of residents were lonely
- 2 -75 percent said they were bored
- 3 -50 percent said that they wished to be living in their own home
- 4 -most wanted more space
- 5 -all wanted more privacy
- 6 -no one thought they had any roles any more
- 7 -only 3 people said they had someone they were close to
- 8 -no one felt they contributed anything useful
- 9 -all said they received good nourishing food
- 10 -nearly all thought staff were very caring and committed
- 11 -all said standards of hygiene were high
- 12 -most said that they would like to spend more time with their grandchildren but could not.

As a result of this study it was decided to provide community nursing packages for people who wished to stay at home. These packages were operated from the premises after government approval was sought and granted. Staff were trained in a social role valorisation model, so that the residents could be more fully supported. This social role valorisation

model was a model for human services that had been proposed by Wolfensberger (1991). Within this model devalued people such as the aged are assumed to usually have initially negative roles and attributes. These negative roles are addressed by replacing them with more positive and socially acceptable ones. Such replacement roles are those of volunteer worker, spouse, parents, grandparents, teacher, church member, shopper, customer, usher, minister and choir member, friend, neighbour or confidante.

Large changes to the structure of the buildings were made so that the residents could be given more space and privacy. These changes resulted in many job losses for the staff and much uncertainty for their future as resident numbers declined from its original 70 to 38 being present at the time of this research. During the changes there was much consultation with residents, their families, staff, unions and resident committees to ensure that all were familiar with the change process. This ethnographic study was undertaken during the final phase of these changes.

Initially there were two floors to the nursing home. The management wished to shut down the upper floor because of the fire risk it posed and because the residents there were relatively isolated. This meant moving seven residents who occupied the top floor to the lower floor. Three were then to share three rooms which would normally be shared by two additional residents. With one additional resident in each, the rooms would then be occupied by three residents. As other rooms became available residents were to move out if they and their relatives were agreeable, then leaving these rooms with two residents each. The remaining four were to live in the smaller area of the nursing home. The families of the residents and the residents themselves were told about the move. Prior to moving, the residents had been taken downstairs and shown their new areas. Familiar objects were taken from the residents' rooms on the third floor and placed into the new rooms. For example, one female reallocate recognised her curtains as she was transferred to the next room. During the move, the

registered nurse who was normally rostered from 7-10am was rostered from 7am till 3:30pm to provide additional assistance.

There was no model of nursing stated to be in use, however the processes of nursing strongly reflected elements of Roy's (1976) adaptation model. Consistent with Roy's (1976) theory, people are seen as individuals who are in constant interaction with the environment and are assisted as necessary to respond or adapt to any changes that occur. Physiological, self-concept, role function and interdependence needs are recognised and facilitated in conjunction with the resident and where possible, their family.

### ***The Routine***

The day staff generally start to arrive at about 6:50am. Their arrival is announced by the ringing of a buzzer attached to the door. After entering, the registered nurse proceeds to the office area and takes an electronic device from a small box and notes it in the book. The device is an electronic buzzer that the residents can sound from their rooms when they are in need of assistance.

A short, informal handover takes place between the registered nurses at 7am. The registered nurse going off duty reports the main points for the last evening and night. Elevated temperatures, dressings, skin tears of individual residents and falls are commonly discussed. Any dangerous drugs of addiction are then checked in the treatment room where they are stored in a locked cupboard within a locked cupboard.

Medications are given out at 7am by the registered nurse who is rostered on the 7-10am shift. She draws up insulin in syringes. The bowel book is checked for information regarding the regularity of the resident's bowel motions and suppositories are prepared for residents who



need them. If a doctor is expected, the progress notes for the doctor's patients are taken out of the filing cabinet and opened. Between 7am and 7:30am the suppositories are given out, insulin injections given, progress notes reviewed and early morning (before breakfast) tablets distributed. Normally, the medications are ordered by the registered nurse on a Monday, Wednesday and Friday. The dressings are likewise reviewed by the registered nurse on a Monday, Wednesday and Friday.

This first drug round could last for up to three full hours as the registered nurse is also expected to attend to residents and Doctors as required. The registered nurse has the buzzer attached to her waist and it rings continuously. After taking over at 10am during the weekdays, the clinical nurse consultant might try to do some dressings and assessments as well as attend to other administrative tasks.

The carers arrive at staggered times. For example, some arrive at 7am, another at 7:30am, still another at 8am and more at 8:30am. They also finish at different times and this staggering of times is meant to complement the differing needs of the residents, rather than forcing them all into an inflexible routine. For example, in the main nursing home 5 nurses and carers are available to help with the lunchtime feeding, but they leave to go home at 12:30pm, 1pm, and 1:30pm, leaving two nurses or carers to toilet the residents in the early afternoon. By 8:45am generally at least three residents are out of bed in the main nursing home. By 9:15am generally four nursing home residents in the smaller nursing home section are out of bed. The remaining residents are generally out by 10:30am. Back in the main nursing home 5 residents are still in bed by 10:30am.

The registered nurses' weekend day shift is extended from 7am to 3pm as the clinical nurse consultant is not available to take over from 10 am as is the case during the week. Weekends

are more relaxed as the residents rarely have to be prepared for other appointments but extra time is often spent by the nurses to prepare them for their visitors.

Registered nurses are permitted to attend the nursing home at any time during unscheduled working hours to catch up on their paper work. The staff are reimbursed financially for this extra work. This work practice enables staff to control their own hours. It amounts to the organisation having to pay for an extra 3-4 hours per fortnight for documentation.

At midday in section 2B, food arrives from the kitchen in plastic bags and is served onto plates by a nurse. A personal care attendant prepares the trays containing a main course and desert. A drink is added to the tray then the tray is taken to the resident. After the meal, a carer collects the serviettes and takes them to the laundry to be washed. There are three afternoon nursing staff in 2B and two of them go to tea together for half an hour after the residents have eaten leaving one staff member to attend the residents. There are 14 residents that need attention from the three staff.

After lunch, the registered nurse assesses the residents. The carers conduct a pressure area round and toilets the residents. Some residents, especially those who are tired, are repositioned or returned to bed for a siesta after lunch. A plate of biscuits or cake and drinks may be taken around to the residents and their guests for afternoon tea.

At 3pm the afternoon registered nurse arrives for duty. The Schedule 8 "dangerous drugs of dependence" are checked and during this time the registered nurses engages in an informal handover, discussing the residents that they are currently most concerned about. The evening registered nurse then checks on those residents who are sick or dying. The other afternoon nursing staff arrives for duty at 3:30pm. They inform the registered nurse of their presence and listen to any important information that the registered nurse needs to impart. The

registered nurse reads through the nursing progress notes and informs individual nurses of special observations for particular residents. Medications that are due before meals are dispensed at about 4pm followed by the tea-time medications.

The registered nurse commences her tea-time medication round at about 5pm which generally takes a couple of hours to complete. The mobile phone she carries has to be regularly answered and the residents need other types of attention. The dressings are attended after the medication round. Nursing care plans regarding the dressings have to be updated. The dressing and medication trolleys and teaspoons are cleared and cleaned.

The resident's tea time usually occurs at about 5pm and the evening duty nurses go to tea generally after 5:30pm. Those staff rostered on a short shift have a break of about 10 minutes, whereas those working the longer shifts take a half an hour break. The breaks are staggered and dependent on the residents needs. The dishwasher is set by a nurse to clean the dishes. The eating area and kitchen is cleared and cleaned. After tea, there is a toileting and pressure area round.

The registered nurse has her tea break by about 6:30-7pm. The front door is locked at 7:30pm. The registered nurse double checks any outstanding medication orders. The catheter tray is also located in the treatment room and she checks it to ensure that all of the necessary equipment is ready for use. The smaller nursing home section medications are organised and they are often dispensed without the assistance of the medication trolley. The effects of any analgesia that has previously been given out is assessed and noted. The latest incoming drugs from the pharmacy are recorded. Staff who telephone in their unavailability for work the next day are replaced. Up to half an hour can be spent finding suitable replacement staff. More dressings are attended and concerns of the current staff addressed. Usually, at about 8pm the Schedule 8 drugs are dispensed, followed by the sedations. As the sedations are dispensed,

the residents are assessed and given drinks when appropriate. Temperatures or other observations are taken as indicated. Creams are applied and eyedrops instilled. The nurses and carers may be asked again by the registered staff if they have any concerns about the residents and these are duly addressed.

Before 8pm the nurses and carers attend a further pressure area and toileting round. They have their supper break generally between 9pm and 9:30pm. After this, there is another pressure area and toileting round. Nursing care plans and charts are filled out after care for each resident is attended. The used linen and clothing are separated in the sluice room into different containers. The sluice room smells very strongly of personal waste at this time so the door is opened to aide ventilation. A cover is placed over the container with personal linen and this is transferred to the laundry for attention by the laundry staff the next day. The container with the general linen is closed and placed in a collection room which can be accessed by the commercial laundry organisation. The sluice room is deodorised using a spray deodorant and then cleaned with a spray commercial product and dried with a cloth. The nurses and carers finish their shift at 10pm or thereabouts.

During the medication round it is not unusual for the registered nurse to attend to the needs of residents. After 10pm she tidies up for the next shift and the documentation is undertaken. Agency staffs' forms are signed by the registered nurse. At the main nursing home three carers leave at 10pm. There is then one nurse in each of the main and smaller nursing home units plus the registered nurse. The registered nurse leaves the building at about 11pm.

The night staff check that the windows and doors are locked and the carers check that the residents have taken their sedation. Afterwards, a pressure area and assessment round is undertaken. On night shift, there is one registered nurse for the entire building and one nurse for each of the two nursing home sections. During the night shift, the registered nurse is

responsible for the care of all of the nursing home residents. Only two residents use the intercom and the rest have vital call electronic monitors which, when sounded, alert the nurse to the resident by a buzzer clipped to a belt around their waist.

The registered nurse examines the progress notes and estimates when analgesia was last given to the relevant residents and other relevant information. After checking the analgesia and progress notes, she reads the medication books thoroughly to ensure that the evening drugs have been given. If they have not been given or the drugs not signed for in the medication book, the names of the resident and registered nurse responsible, plus the drug details, are recorded on a paper sticker and affixed to a cupboard door where they can be clearly seen. Drugs packed in the system can be marked off on the photocopied order sheet. This is undertaken when the registered nurse does not have time on a previous shift to complete such work. Each new medication chart is then reviewed and the next days' date filled in ready for the next day.

The staff undertake a second pressure area and toileting round at about 1-1:30am, and a third round at 5am. The registered nurse assists with pressure area care for the residents and works on the nursing home floor. She attends to the more independent residents by herself and leaves the heavier residents for the nurses who worked as a pair. Sometimes the pressure area round takes 2 hours to complete. The registered nurse tries to remain present on the nursing home floor so that the residents can contact her easily and she can observe them. When the nurses finish the pressure area round in the smaller nursing home section they help in the main nursing home by attending to the heavier residents.

During the night shift the carers iron some of the residents' clothes in the dining room and routinely set up the dining rooms in anticipation of breakfast and lunch the next day. All of the reports are read and the carers assist with rounds and answer any call bells.

Other duties for the carers during the night include: tidying the linen room; emptying the dishwasher and setting it up for breakfast; attending filing; compiling a stationary list; cleaning the sluice room; turning the hoses on in the garden on Monday, Wednesday and Friday mornings; picking flowers for some of the residents and running the carpet sweeper over the carpets.

Between 5am and 6am the carers attend all of the nursing home residents together and at 6am one carer moves to the main nursing home and the other to the smaller nursing home section. Finally, the carers write the reports for the smaller nursing home section and the registered nurse mainly writes the reports for the main nursing home. At about 6am two or three residents are showered as requested by them. Blood sugar level readings for diabetic residents are also taken. At 6am the cleaning lady arrives at the front door ready for duty.

At 6am the registered nurse unlocks the front door and proceeds to the treatment room to check through the medication chart. The residents in their 5th week of the 6 week medication charts are noted for when the Doctor visits. A blank medication page is placed behind the used sheet. Pharmacy orders are prepared on sheets of paper with the prescriptions loosely piled up on top of them. The drugs of dependence register is prepared for the next shift. The drugs are organised using a card system where the drugs are prepacked by the pharmacist according to the times that they are due. Documentation is written by the registered nurse before leaving to go home. The registered nurse dispenses a few early morning medications after 6am, before going off duty at 7am.

## **Summary**

Maple Nursing Home was the second nursing home studied during the research and is a private (not for profit) establishment within a larger organisation. Purpose built in the 1970's, it was undergoing change to accommodate needs of residents that resulted from research undertaken within the institution. Physical building changes included changing multi-shared rooms to double or single accommodation. Care based changes were based on resident's assessed needs and included offering more flexible services in all aspects of daily living and promoting the identity and role of the residents within the institution. The management structure is relatively flat and members of the management are seen by residents, their relatives and staff as actively involved in the day to day decision making of the nursing home. Many elements of Roy's (1976) adaptation model in nursing were observed to be in use at the nursing home, facilitating the resident's adaptation to their environment. Although having to conform to safety standards, the environment of the nursing home reflects highly personalised influences of the residents and their concerned others.

## Part Three

### The Caring Sense

(Patricia Dittman)

*You see me blossom in your care  
The loving caring action that speaks  
in all languages.  
Our eyes meet and we are on in spirit and soul...*

*You hear my cry, whether silent or loud.  
And you are there to lift spirits, courage  
and to be proud,  
For we have shared our interconnecting hands...*

*You smell the many fragrances  
of our mixed bouquet.  
The hours , the days, the weeks and still you stay  
For we have soldered our relationship  
forever and a day...*

*You feel many moods,  
some soft , some hard,  
You feel my skin, my bones, my soul  
As we share the secrets never to be told...*



## Chapter Thirteen

### **An Ethnomethodological Interpretation.**

The negative impressions of nursing homes conveyed in the media are commonly held. Some relatives have been shown to be very reluctant to send their loved ones to nursing homes, believing that care at home may be more appropriate (Pearson et al, 1996, 1998). The question remains- What are those practices and behaviours that result in nursing homes receiving such negative reactions from the rest of the community and how are they reinforced and allowed to continue within the culture of the nursing homes? It has been argued that aged care and nursing are closely related. Could nursing practices also serve to perpetuate nursing home cultures ?

Ethnomethodology offers explanations for socially negative reactions to behaviour and individuals who are seen to deviate from socially held norms. The term "Ethnomethodology" has been coined by Harold Garfinkel during the course of his studies and has come to refer to 'the body of common sense knowledge and the range of procedures and considerations by means of which ordinary people make sense of, find their way about in and act on the circumstances in which they find themselves' (Heritage, 1984; 4). Harold Garfinkel developed theories of the sociology of everyday knowledge and then cultivated an analysis of institutionalised conduct (Garfinkel, 1967).

Common sense knowledge is the social constitution of knowledge and Garfinkel (1967) argues that it cannot be analysed independently of the contexts of institutional activity in which it is generated and maintained. Therefore, a study of nursing home culture must be conducted within a nursing home. Participant observation is a most appropriate method of

ethnography for this study as it allows observation of the institutional activity as it is being generated and maintained.

### ***Social Institutions: The Social Institution Of Impairment***

Garfinkel (1967) is able to show that in maintaining, elaborating or transforming their circumstances by their actions, the actors simultaneously reproduce, develop or modify the institutional realities that surround these actions. Garfinkel uses the case of 'Agnes' as an example of focussing on the ways in which sexual identity is produced and managed as a 'seen but unnoticed' but nonetheless institutionalised feature of ordinary social interactions and institutional working. Garfinkel (1967) treats sexual status as a socially produced and reproduced fact.

From his description, it is arguable that those with a mental and/or physical impairment also engage in unremitting 'seen but unnoticed' work to maintain as high a degree of normality as possible to fit in with the 'common world'. This work may be similar to 'building the boat whilst out at sea' that Agnes knowingly engaged in to maintain her sexual identity. Ongoing work to make sense of and to participate in one's world is required of cognitively and physically impaired people. Much effort is also required to maintain the 'normality' of their environment. Despite the unremitting work (which frequently goes unnoticed), residents may not be fully assisted to build up independence and self care. To illustrate the difficulties that impaired people have in adapting to what are usually seen but unnoticed events such as meal times and their living environment, a number of situational case studies were generated from the data.

## ***Tea Time For People With A Cognitive Impairment***

Daphne, Sylvia and Bessie were sitting in the dining area in three chairs around a table where there was a vacant fourth chair.

Sylvia said, "That was very nice" to the carer attending her.

"Alright" responded the carer, "I'll put your serviette up there".

The resident's serviette was then shifted from the resident's lap to under her chin.

The carer attending Sylvia then spoke to another carer in the adjacent kitchen. "What's this resident's first name? Sue? Sylvia?"

The carer in the kitchen responded that it was Sylvia.

"Here you are" said Sylvia, putting a piece of sausage on the table, "That's the best I can do."

"Have you had enough of your sausage?" asked the carer.

"I'm alright up till now" said Sylvia, "I don't know when she's going to give me mine."

"Here we go, have some more," offered the carer.

"Very nice, very nice indeed," said Sylvia, chewing her food thoughtfully.

"I'll go and get you some dessert," said the carer.

"Alright, thankyou dear," said Sylvia.

The nurse then left to go to the kitchen area.

Sylvia burped loudly, then said "Oops, pardon me," to nobody in particular.

Bessie sat to her right with her arms crossed and her main course half finished in front of her, staring at the table.

Daphne, to Sylvia's right, ate bright pink coloured dessert speckled with chocolate pieces and listened attentively to the conversations around her but not saying anything.

Another staff member entered and greeted everybody.

"Someone just said hello to me," said Sylvia. The carer then offered Sylvia a spoonful of dessert that also had chocolate chips on it.

"Okay, Sylvia, another spoonful," she said.

The carer then spoke to another in the kitchen, "Would you please serve up Tippie some dessert? She's not really eating her main course."

"She will have instant pudding," said the carer in the kitchen.

The nurse in the dining room continued to feed Sylvia. "Do you want some more Sylvia? Here we are, would you like a drink?"

Sylvia remained seated with her arms folded. A lively discussion between the carers then followed in the kitchen.

Meanwhile, Daphne finished dessert herself and drank water from a cup with a feeding spout as she watched others.

Sylvia burped loudly again. "Oops, pardon me!" she exclaimed.

Bessie then hesitated with her eating her dessert. She put some of her dessert onto a spoon held with her right hand and touched the food curiously with her left fingers. She licked these fingers and scooped some of her dessert up with her left index finger, putting her finger into her mouth as though to taste the dessert.

The registered nurse entered to dispense some medication, apologising for the interruption.

Bessie pushed the dessert aside and folded her arms and smacked her lips. She then drew her dessert back to her and rubbed her hands vigorously together, staring at the half finished dessert.

Sylvia finished feeding herself her drink. Bessie then continued to look at her dessert with her spoon positioned in it. A radio played softly in the background.

Sylvia said to Bessie, "Here we are love" and offered her empty glass to her.

Bessie responded by saying, "Just sit there and stand there for a minute".

Sylvia continued to offer the glass, saying, "Here we are—do you want this or not?"

Bessie sat staring at her desert and did not respond. A carer walked past and said "Here we are, give it to me" and took the glass from Sylvia as she held it up in the air.

The radio continued to play a Roy Orbison song from the 1960s in the background . Bessie continued to stare at her half finished meal.

Another carer entered and Sylvia greeted her by saying "Hello".

"Hi" responded the carer. She was carrying a tray and put it in the kitchen. "Right, I'll go on a break" she said. "Has everyone been fed? What about Mabel?"

Sylvia and Bessie both stared into space. Bessie then got her dessert plate and moved it over to her so it was directly in front of her. There was a background discussion between the nurses and carers about their meal breaks. The buzzer of the Registered nurse was also heard along with the voice of another resident.

The above series of events illustrates a continual struggle that cognitively impaired residents address during events such as mealtimes that the average person may take for granted. To an outsider, the behaviours of the residents may have seemed disjointed at times but for the residents it was highly appropriate. The behaviour of the residents may fall short of what our culture dictates as 'normal'. Even so, the behaviour of the residents is the best that they can offer in the circumstances and as such, a continual struggle is involved in maintaining these standards. The gaps in the expected and actual behaviour of the residents illustrates the extent to which 'seen but unnoticed' work plays a major role in our culture.

### ***The Living Environment Of A Resident With A Physical Impairment***

Mary's room was very comfortable and had a profound sense of history about it because of all of the photographs and other memorabilia that decorated her walls. There was a large clock, thermometer and a photo of her son by the door. The wall facing her bed was full of more photos of her son. There was also a small fridge and letter desk along side the wall and a stack of tables to the left. Three chests of drawers lined the wall and on these were toys including black coloured dolls and ornaments. There was also a small pile of clothes in the corner on one chest. In all, there were seven chimpanzees and apes, three dolls and one small teddy bear. A cassette player was on the left hand side of the bed locker and four

colourful toy clowns were attached to it in different poses. The bed had a monkey bar attached to it with 'I love you' printed on a cloth heart on the monkey bar. Along the back wall there were pictures of Mary as a child and young woman with her son and grandson. There were also family pictures. In the right corner was a sink with boxes piled underneath it. On the cupboard were pinned a number of sayings such as :

'You are a free person  
I am so happy because in your freedom  
You choose me to be your friend.'

And:

'Faith is the bird that sees the light  
When the dawn is still dark.'

Other poems and statements were pinned to the cupboard, including a very touching poem from her son.

There were six illustrations of different birds on the wall above the door and cupboard and five toy chimpanzees, monkeys and apes hanging from the ceiling. Also hanging from the ceiling were ten mobiles of birds, parrots, butterflies, a moon and an angel.

On the fridge was a large vase of fresh flowers and a flask of sweet sherry. There were also ten rows of cassettes and carved animals on the shelf by the door. Lots of birthday cards were stuck on the sliding door leading to the balcony. On top of a cupboard by the sink was a television and underneath it was a video player. On the top of the television was a basket of soft toys and kookaburras, birds, a koala, rabbit and even a toy snake. A little sign on the right side of just above the bed read, 'Cheer up, the best is yet to come'.

Mary explained that there was a list of nine charities for whom she had collected donations that year and this was read with her permission. She had a standard letter addressed to 'To whom it may concern,' for her application to the groups to be a volunteer fundraiser. After she received a letter of acknowledgment from the organisations for her work, she sent out a letter to them that read:

I would just like to write you a few lines to thank you for letting me work for you. I love doing it as it helps me come out of myself and being with people helps me interact and also helps me to feel more useful.

My biggest handicap is not being able to talk normally, which has made it pretty lonely at times. I have made the most of my life and although being in a wheelchair, I have led a fairly normal life, marrying and having a son.

Being able to do something for others and contributing to the community has given me a reason to live again.

Thanking you once again and looking forward to assisting you in any fundraising efforts.

Yours faithfully,

Mary

She said that she went out every Friday to fundraise in the city but that she had only been doing it since earlier that year.

Mary's environment illustrates that despite her loneliness and need for company, she could enjoy the feelings of company and being valued as a person. Her toys gave her life

amusement and colour that people may otherwise have brought. Her communications with others through her voluntary work were of a standard that many unimpaired people can only aspire to but rarely hope to reach. In doing so, Mary was breaking the boundaries that otherwise may have restricted her to a more isolated and unhappy life. However, to achieve this, Mary had to work very hard, often in seen but unnoticed ways that only she was fully aware of and that others might take for granted if not told otherwise.

### **Summary**

Ethnomethodology refers to the body of common sense knowledge and the ways that ordinary people understand, engage in and behave in their given situations. Ethnomethodology also offers an explanation for how perceived behaviour and deviations from social norms are negatively sanctioned by the immediate social community in which the individual finds themselves. People with cognitive or physical impairments can be seen to engage in behaviours that do not complement social norms and expectations of behaviour. Much seen but unnoticed work can be undertaken by these people with impairments to compensate for their inability to function as socially expected. The end result seems to be an individual best effort to fit in with expectations. When these people are concentrated in an institution such as a nursing home it can be seen that the negative sanctions placed on their behaviours may contribute to the culture of the nursing home as a whole.



## Chapter Fourteen

### **Culture**

This study addresses the culture of nursing homes, but what in fact is meant by culture? Culture can vary from one historical epoch to the next, one place in time to the next, and from different areas. What is meant by the term 'culture' clearly requires closer examination if the culture of nursing homes can be elucidated.

### ***Social Culture***

Barrett (1991: 55) defines culture in anthropological terms as 'the systems of agreed-upon meaning that serve as recipes, or guidelines, for behaviour in any particular society'. He argues that human conduct is largely symbolically based; that is, it is founded on conventional meanings. However, it could be also asserted that what is conventional for the human race does not necessarily equate with the same conventions for animals. The knowledge of animals may be on a level which is completely dissimilar to our 'conventional knowledge' as we know it.

Ethologists refer to a definition of culture that equates it with learned behaviour traits that are socially, as opposed to genetically, transmitted. By employing this definition, they are able to demonstrate that certain animals are able to initiate and then communicate, certain practices to other members of the population. They contend that once such practices become general, that they can also be called 'culture' (Barrett 1991: 56). Freilich (1989: 9) suggests an alternative definition of culture. He argues that culture embodies tradition and more. He describes culture as a set of ideas, plans or a 'guidance system' that allows us to compare humans with other phenomena.

Anthropologists have noted that many customs and rituals are maintained because their users are so attached to them that alternatives are never considered, even though they may not be the best or most efficient. This is because of a number of factors. For example, there is a tendency found everywhere in human society, to conserve and defend established cultural practices. In no society does change occur entirely without opposition, and it is fair to say that resistance to change is just as ubiquitous a feature of human culture as is change itself. Norms and customs are imbued with emotional significance in every society. Once a pattern of behaviour becomes established it takes on a quality of appropriateness: it ceases to be a neutral act and becomes a 'normal one'. People become accustomed to performing the act in a specific way and it appears 'natural' to them; hence deviations may appear unnatural and inappropriate (Barrett, 1991).

It is widely assumed that there must be some degree of fit between the productive, economic enterprises of any society and the customs, attitudes and values that are maintained among the population. Culture is basically a utilitarian instrument and as human beings cope with their surroundings, they create the norms, values and institutions most appropriate to those conditions. Although there is this adaptive, utilitarian dimension to culture, there are many reasons why human societies do not always cope effectively with their circumstances. For example, people can be so committed to previously established ways of doing things that they are unable, or unwilling to initiate changes that would, in the long run, have resulted in enhanced efficiency. Thus, past commitments exert a powerful influence on the way that societies respond to current circumstances. This historical influence and the complex web of interrelationships associated with it may result in societies not fully adapting to new conditions. Adaptation is rarely a matter of choosing the most efficient alternatives. New adjustments, or adaptations, are almost always compromises between the limitations imposed by the preexisting culture and the opportunities offered by new conditions. Because of this,

sudden and revolutionary social transformations are comparatively rare. It is much more common to find cultures making small adjustments that allow them, at one and the same time, to preserve familiar institutions and to take advantage of new opportunities. In all societies, there are always elements that persist from prior conditions that inevitably sets limits to future flexibility. The result is that adaptation is a form of compromise between past history and current realities (Barrett, 1991).

Also vested interests are frequently responsible for perpetuating a system as much as ingrained habits or complacency. It has been suggested that when a social institution comes into being, it frequently serves the interests of one segment of the community more effectively than it serves others. If those most advantaged are aware and able, they will strive to perpetuate it by doing what they can to support the institution and prevent its demise. Thus humans adaptively modify their environments and tend to preserve what ever exists. These factors give reason as to why some rituals develop. The rituals may become unsuitable when change is invoked in the culture, yet remain.

### ***Rituals***

Rituals are common to the animal kingdom. Threat display is a common ritual of many vertebrates that have evolved highly ritualised patterns of behaviour. Threat display is the primary function of ritualised patterns of behaviour and elaborate secondary sex characteristics of many vertebrates. For example, the only known function of the very large proboscis of the male northern elephant seal is associated with the vocal threats used in the aggressive interactions between males. A formal threat can displace another animal, resulting in the animal making the threat having a higher ranking than the more lowly ranked, vanquished animal. Actual fights between animals comprise of behavioural elements that in other circumstances are ritualised in the form of threats. Threat displays may precede and be

interspersed within fights between individuals. These fights are terminated by the retreat and submissive displays of the vanquished animal. Consequently, much of the aggressive behaviour of social animals tends to be formalised and symbolic (Gordon, 1976).

It has been suggested that '... a society is an organisation of individuals that is capable of providing conventionalised competition rather than physical force as a mechanism for maintaining its structure' (Gordon, 1976: 311). For example, most Western human societies condemn physical fighting in peace time except in some sporting events where it is subject to rules and conditions. Much of human behaviour is deeply ritualised providing conventionalised competition as previously suggested. Some rituals have evolved over a long period of time. Other rituals may now be obsolete as the to the original purpose that they were intended for is extinct. For others, the mere engagement in such ritualistic behaviour is harmful.

Monica Wilson (1959: 241), an anthropologist who wrote about outstanding studies of ritual, has stated:

... rituals reveal values at their deepest level ... men express in ritual what moves them most, and since the form of expression is conventionalised and obligatory, it is the values of the group that are revealed. I see in the study of rituals the key to an understanding of the essential constitution of human societies.

It is possible that the pattern of communicating mundane knowledge and practices between people has contributed to how rituals evolve. Schutz's (1967) studies of intersubjectivity show that humans probably never have identical experiences. However, people continuously assume that their experiences of the world are similar and act as if their experiences were identical for all practical purposes. Despite this, ordinary people know that the same objects are encountered differently by each of them because of their differing locations and therefore

differently seen aspects of each situation or object. Additionally, motivation of individuals differ as they approach an object, thus further distorting their experience of it.

Schutz (1967) argues that every experience of the actor occurs within a horizon of familiarity and pre-acquaintance which is furnished through a stock of knowledge at hand. Novel and unfamiliar objects and situations are understood as such against this pre-established background of normality and typicality. He suggests that the stock of knowledge that the actor has ready to use contains 1) type constructs of objects and 2) typified 'recipe knowledge' concerning the 'how to do it' of all kinds of courses of action. Schutz contends that most of the actors knowledge stock at hand is treated as valid until counter evidence appears. Could it be that rituals of behaviour are based on typified recipe knowledge which has not been questioned and counterevidence not been produced to oppose the practices, even when the original circumstances and situations of the practice have changed? In other words, ritualised behaviour may continue even though the events and circumstances that they are contingent upon have changed. The knowledge that they are based on is 'recipe knowledge,' and not independently thought out and considered with each changing situation and circumstance. This problem is made more pronounced by the problems of intersubjectivity where Shultz contends that humans can never have identical experiences of anything although for all practical purposes they assume that they do. This assumption is continued despite humans realising that they may have different motivations and viewpoints of the object or problem. Therefore some objects can be seen, heard and manipulated by one person and not another and vice versa. Likewise, some rituals may be altered by one person, but their meaning and enactment unchanged by another.

## **Summary**

Culture has come to reflect the meanings of behaviour in a given society (Barrett,1991) or a set of ideas, plans or systems that allows us to compare humans with other phenomena. Cultures invariably consist of customs, rituals and behaviours that are resistant to change. New adjustments are frequently compromises between the limitations imposed by the previous culture and opportunities offered by new conditions. Rituals may develop from the tendency to preserve what exists after environmental modification and behaviours that are common throughout the animal kingdom. Typified recipe book type knowledge of events and situations that goes unquestioned may be responsible for the evolution of many rituals and are difficult to change because of intersubjective limitations in perception and motivation.

## Chapter Fifteen

### Nursing Rituals

Rituals have been shown to be very common in nursing and the long history of nursing, particularly in aged care has contributed to the development of these rituals by such mechanisms as discussed in the previous chapter. Here, it has been shown that behaviours do not always change even though the environments in which they are executed change, frequently because of individual differences in perception, motivation and purpose. Thus some behaviours may persist that are relatively unhelpful, others may persist reflecting a long and rich history that helps to prepare individuals for transitions in their lives.

Rosemary Parse has developed theories that allow for a deeper understanding of the development of rituals from a nursing perspective. To link ritualised behaviour with nursing practices, it is therefore timely to review some of her contributions to this area.

### ***Rosemary Parse—Theory Of Human Becoming***

Rosemary Parse is an American nurse theorist who sought to understand the person within the world as a total being who is more than a sum of parts. Her theoretical perspective considers the present, history and the future in the context of the universe. Her theory includes three basic points:

- that the person strives to achieve relatedness to the environment
- that the person strives to achieve constructions of his or her health, in his/her world, including being with others
- that people strive to achieve the understanding of the freedom to be and become in an increasingly complicated world.

She believes that nursing is rooted in the human sciences and postulates an anomaly between medical and nursing theory. She describes a 'lived-world' experience by people and the subject of nursing theory and research (Parse, 1981, 1987, 1990) as contrasting significantly with medicine's primary concern with objective knowledge.

With respect to the principal of helicy, she states that human and environmental change is continuously innovative, probabilistic and characterised with increasing diversity by nature. She denotes a constant interaction between humans and the environment and acknowledges that there is a sympathetic vibration and rhythm of energies between the person and environment. The main point of her theory is that humans and their environment are energy fields which are in simultaneous, continuous and mutual interaction. These field domains are not limited by space or time and the boundaries between them are constantly moving. Within these, patterns form from individual's behaviours, attitudes and characteristics. People may stretch themselves beyond their immediate reality into the transcendental world. In her theory, the human is coexisting along and within rhythmical patterns of the universe. Humans freely choose meaning in situation, and are responsible for decisions (Parse, 1981, 1987).

Her theory is based on the notion of 'human becoming' and for her, people are living unities continuously 'coconstituting' patterns of relating and transcending. Becoming is an open process, associated with the relationship of the human in the universe. Becoming is relating human patterns of situated freedom and openness. Becoming is human unfolding and an intersubjective process of transcending with the possibilities (Parse, 1987).

With respect to the environment or universe, Parse refers to it as an energy field with patterns and organisation that makes it unique but for ever changing. The person and the universe are always together, although at varying distances apart. This fluctuating distance represents



rhythmical pattern of movement. She then enunciates several principles in her theory of health as human becoming (Parse, 1981,1987).

The first principle is that meaning is gathered by the human through experiences in the world. Images are then constructed through reflections and pre-reflections of events and contribute to the person's personal knowledge. The person's values are produced by their world view and this is likewise a product of these values. The reality of the world is constructed by valued images and the meanings found by the person in it (Parse, 1987).

The second principle is that rhythmical patterns are developed through the paradoxes of life. These include motions of showing and hiding, allowing and preventing and meeting and leaving. These are conceptually described as revealing-concealing, enabling-limiting and connecting-separating (Parse, 1981,1987).

The third principle is that of co-transcendence, which means developing an understanding of future possibilities. Here, powering is the force where the person looks beyond the present towards the future, finding original ways of living and being (Parse, 1987).

Theoretical structures have also been developed by Parse to guide both practice and research and to include her ideas of 'human becoming'. The theoretical structures are meant to act as a guide to nursing practice and as a source of questions for research (Parse, 1990; Pearson, Vaughan, and Fitzgerald, 1997). The first theoretical structure is that the process of relating one's goals and pathways to achieving them reflects the person's situation that they are in. Powering is a way of revealing and concealing information, and through this new ideas regarding future possibilities may be attained. The second theoretical structure is that differing perspectives reflect different values, limitations and opportunities. New ways of people being together may be considered through this structure. The third theoretical structure is that

transforming unfolds through the language of connecting and separating (Parse, 1987; Pearson, Vaughan and Fitzgerald, 1997). The relevance of Parse's theory to some aspects of this study is now discussed, with particular attention directed to understanding ritualised behaviour.

### ***Fitting Rituals***

Parse's theories allow for deeper and new understandings of the development of rituals in human behaviour. They support the notion that some rhythms and rituals are necessary parts of human life, drawing one closer to the universe and environment and even being comforted from this. According to Parse's theory, they are a necessary part of transcendence and becoming, if human potential is to be reached. With respect to human behaviour for the purpose of this thesis, 'fitting' rituals are described as behaviours that suit and complement the environment and universe and carry meanings and outcomes. Some examples include the behavioural processes in bathing, feeding, moving, waking, sleeping and dressing.

Rituals are common in many life forms and help us to understand behaviour and its development. By examining the history of nursing, the origins of some rituals can be identified and their context understood. Some could be modified to accommodate advances in current knowledge about nursing and thus retain meaning for the participants. Other rituals require scrutiny and perhaps need to be reconsidered as they are no longer helpful and may even be harmful, in the course of patient care.

### ***Displaced Rituals***

Displaced rituals are, for the purposes of this thesis, those behaviours that no longer complement the environment and no longer serve a constructive, identifiable purpose or outcome. They have evolved and become out of context with their origins in the environment and lack meaning to the participants. They urgently need to be understood and identified in nursing as they may be an impediment to human becoming.

Many displacement activities have been described in the animal kingdom. For example, when one herring gull is confronted by another gull on the attack, the first gull will, initially, vacillate between running away and fighting. It may then display displacement activity by carrying out nest building movements (Braun and Linder, 1979). The word 'displacement' was originally used to suggest that energy was displaced from the conflicting forms of behaviour (vacillating between fight and flight) onto an apparent irrelevant activity, such as nest building. This interpretation based on displaced 'energy' has however, been reviewed and currently 'displacement' is ascribed to that behaviour that seems irrelevant to the situation (Braun & Linder, 1979; Easley, Coelho & Taylor, 1987). Some displacement behaviour is thought to have a biological basis (Robbins & Koob, 1980; Delius, Craig & Chaudoir, 1976) however for the purposes of this thesis, displacement behaviours that occur as human rituals will be examined in terms of their nursing, sociological and cultural implications. However, it is worthwhile noting that displaced behaviours also commonly occur in other species.

### ***Culture And Ritual In Nursing***

Rituals in nursing have been described as stylised routines done in a particular way that carry meaning (Elsbree, 1982). Caring rituals of nursing are thoughtful, purposeful, stylised routines that preserve and enhance the personhood of the other and symbolise the knowing of the connectedness to the other (Barry, 1994). On the other hand, non-caring or displaced rituals of nursing require closer scrutiny and re-evaluation. Walsh and Ford (1992) argue that much clinical nursing lacks a rational basis and frequently ignores research findings which were at times completely contrary to practice. The reasons that they give for this was that there are still nurses who are trained rather than educated; that gender stereotyping still has a strong influence; research and research awareness are still in their early stages; stress defence mechanisms are frequently employed by staff that may circumvent research; and negative

attitudes and beliefs of nurses regarding research. They also add that the employment of large numbers of nursing assistants or carers who often had relatively low levels of educational achievement at school and who had no formal teaching in nursing at all, have exacerbated the situation. As the nurse assistants tended to stay on the same unit, it was from them that other nursing students often learnt during their practical placements. Walsh and Ford (1992), contend that the limited experience and education of these nurses resulted in a very narrow perspective in nursing care, although they may be very well-motivated and caring people.

Furthermore, Ford and Walsh (1994) argue that the absence of research in nursing severely limits the development of key areas of knowledge. Practice is based on tradition with little or no systematic evaluation of the effectiveness of care given. It was not until the mid 1970s that nurses began to take an interest in researching the clinical practice of nursing. However, Ford and Walsh (1994) contend that despite some innovative research findings, nursing research fails to have an impact on nursing in the broader picture of clinical practice. They argue that although research is now becoming integrated to modern, western nursing education programmes, ritualistic and unthinking practices continue because of nursing's reluctance to incorporate research into practice. They suggest that now that research into clinical nursing is finally taking place still many nurses seem unable or unwilling to base their practice upon that research. Many nurses do not have the academic skills to appreciate the significance of research findings or are ignorant of research findings because they do not read research papers. Ford and Walsh (1994) claim that it is the absence of clinical research from the agenda of many nurses that has resulted in ritualistic, unthinking practices and their views are supported by other authors such as Benton and Avery (1993). Benton and Avery have analysed how the monitoring systems now in place offer nurses a unique opportunity to drive for the replacement of ritualised practice by research-based practice. These drives are being witnessed now in the research driven evidence based nursing practice centres that are developing world wide ( Evans et al, 1998). In the future, it is hoped that evidence and

research based practice will take over where unhelpful ritualised practices persist, but as sociological and anthropological studies suggest, change in this way usually tends to be piecemeal and gradual rather than revolutionary (Barrett, 1991).

Ford and Walsh (1994) fail to acknowledge the beneficial aspects of ritualisation and have focussed purely on those rituals that do not meet a high standard of nursing practice as evidenced by research. They suggest that old rituals will be replaced by new, equally inappropriate rituals and that this process is due to uncritical thinking in nursing practice. However, other evidence suggests that some rituals convey meaning, understanding, compassion and support to patients and residents and are of great comfort and benefit to them.

For example, Barry (1994) argues that rituals can be a form of symbolic action over technical. They can be purposeful and the actors or agents can be active participants especially when associated with life's passages. They can create order out of chaos, allow for reflection on the situation and for the laying on of hands. The purer the action the stronger the hold on us as ritual. Rituals are built around common symbols and symbolic actions and can provide us with a sense of personal identity and family connections. They may 'help to heal our losses, express our deepest beliefs and celebrate our existence' (Barry, 1994: 78). Rituals can both announce and create change. For example, bathing is described as a ritual by Wolf (1988). Here it is depicted as a therapeutic nursing ritual and may symbolise the essential character of nursing. Bathing may be looked upon as a healing or purification rite, as well as accomplish its practical functions as maintaining hygiene. For nurses, it may provide a sense of community, connectedness and continuity as they practice in different settings. Barry (1994: 78) writes '... as nurses accompany others through the most intimate, the most beautiful, the most shattering and the most ordinary experiences of their lives, rituals provide comfort in the shared knowing of our connectedness to patients, family members, and the

discipline of nursing'. These rituals are typical of fitting rituals, as previously mentioned and described.

Nursing has undergone many changes with the advent of tertiary education. There has been also a shift from custodial, institutionalised care to primary, holistic and community based care and the rituals and routines involved in these shifts have not always changed to accommodate and compliment the differing directions that nursing has taken. An aim could be to gradually replace those unhelpful rituals that are not upheld by research findings with new rituals that continue to convey meaning and support to the recipients of nursing care but are supported by current research and are found to be therapeutically beneficial in the current climate.

### ***Rituals At The Nursing Homes***

A close scrutiny of observed rituals in nursing from the data now follows and their implications for current practice discussed. Staff and resident-focussed practices were the two types of approaches identified at the nursing homes during the course of this study. Staff-focussed cultures occurred where the needs of the staff tended to come before the residents in the course of the work. Resident-focussed cultures occurred where the needs of the residents tended to come before those of the staff. Staff-focussed cultures tended to be more common at Cedar Nursing Home and resident-focussed cultures at Maple Nursing home.

## ***Rituals Common To Both Resident And Staff Focussed Cultures***

### **Background**

Both nursing homes studied had undergone significant recent changes which had resulted in job loss and insecurity for the staff although Maple Nursing Home was more at the conclusion of changes than the Cedar Nursing Home. Both nursing homes were shifting their focus from institutional to community care and both nursing homes had either expected to or had, in fact, lost about 50 percent of their nursing and carer staff.

At the Cedar nursing home, structural changes were introduced following a report completed by an accountancy and management consultancy firm. These changes had resulted in the replacement of about 65 percent of the management, changing it from a steep, hierarchal structure to a flatter structure. Even so, the structure that remained tended to be hierarchal and this was evidenced by the fact that those who were employed in senior nursing positions had very little day to day contact with the residents and their activities.

The Cedar nursing home section was positioned within the major rehabilitation organisation. Most residents in the nursing home section had originally come as patients to the larger institution. As they fitted the legal criteria for their care to be funded as nursing home residents, they had been moved together to a separate area of the institution. This policy had been introduced over the previous two to three years prior to the study. For this reason, their mean length of stay at the institution was far longer than the national average. The residents at the Cedar Nursing Home had had a mean length of stay in the overall institution of 14 years compared with 4.5 years at the Maple Nursing home. The national median length of stay for nursing home residents generally for Australia in 1996 was 1-2 years (Australian Institute of Health and Welfare and Department of Health and Family Services, 1997). For the same

reasons the mean age of 69 years for residents at the Cedar Nursing Home was much less than that of the residents at Maple Nursing Home, which was about 84 years. The median age for nursing home residents in 1996 for Australia was 85 to 89 years. The other national average figures reflect a predominance of female nursing home residents who occupied 71 percent of the available places (Australian Institute of Health and Welfare and Department of Health and Family Services, 1997). This predominance was partly reflected in the current study where women occupied 90 percent of the available beds at the Maple Nursing Home and 44 percent of the Cedar Nursing Home beds respectively. The difference from the national criteria by the Cedar Nursing home could be accounted for by their unusual criteria for admission. Here, resident's who suffered dementia were excluded but included those who had suffered physical neurological trauma and stroke. Nationally, female residents tend to be older than male residents whereby 52 percent of female residents were 85 years of age or older, compared with 30 percent of male residents (Australian Institute of Health and Welfare and Department of Health and Family Services, 1997). At the Maple Nursing Home, the mean age of residents was 76 years for men and for women, 86 years during the course of this study. During this study, the mean age of men at the Cedar Nursing Home was about 68 years and for women, 70 years. Once again, the larger differences from the national average at Cedar Nursing Home reflected their different client population that were selected from both within and without the larger institution.

At the Maple Nursing Home, changes were introduced following a survey of the residents needs and wishes. Changes were introduced taking these results into account. The end results of such changes at the two institutions contrasted greatly with each other. One nursing home tended to have a predominantly staff-focussed culture and the other tended to be more resident-focussed. However, not all practices within the nursing homes reflected the predominant cultures. There were many examples where groups and individuals did not match the norms of the nursing homes that they were representative of and behaved quite



differently. These two cultural focuses and practices are now examined in more detail to gain a fuller understanding of the nursing practices that were undertaken in these institutions.

### ***Practices Common To Both Nursing Homes***

#### **Transfer To A Nursing Home**

At both nursing homes, a government form that had been authorised by a medical doctor and/or assessment team had to be completed as this was a legal requirement for entry to any nursing home that was funded by the government body. During the time of the study, the situation with nursing home beds generally around the state was that there were not enough to meet demand. A member of the nursing staff management usually assessed the resident for their suitability and estimated the amount of nursing care that would be required to maintain the resident. If acceptable, and after conferring with the relatives and other senior staff at both institutions, an admission date and arrangements were agreed upon. A person responsible for record keeping was notified and instructed to prepare files for the use of storing information about the resident. Several files were prepared, some for medical staff and some for the nursing home unit that included nursing care plans that were at this stage left blank.

Transfer to a nursing home may well be considered a form of community sanction from the outset, as the person's behaviour is no longer able to complement that of the 'commonsense' world of the community at large. Thus, people who are unable to adjust to the social norms of the community are more likely to be institutionalised than those who are not. This is not necessarily detrimental, however, as an individual's ability to survive in the community may be enhanced by the provision of institutional care. However, the process of admission is medicalised from the outset, as the reasons for the individual's inability to fit into the broader community must be stated in medical terms by an authorised medical representative to attract

government funding. Nursing care needs are therefore of a second place nature to medical labelling in the admission process. Custodial and medicalised care models, reminiscent of very early days in Australian nursing history, remained alive and well and frequently to the detriment of the resident's needs, during this study.

Given the history of nursing's importance to aged care, it is of primary concern then that the nursing needs of residents play a clear role in the admission processes and ongoing care of the resident be re-evaluated. Nursing practices that have been found effective in assisting residents to overcome grief, particularly after an admission to a nursing home, following losses and during their stay, have been discussed and outlined by Ruler (1997a).

### **The Admission**

Admission to a nursing home is a rite of passage for many residents to their final living arrangements. Death in our society is a taboo subject and rarely openly discussed. Death is hidden from society in institutions such as nursing homes. For example, for the years 1995-1996, of separations from permanent care in nursing homes, 85 percent were separations due to death, although 6.8 percent returned to the community and 2 percent were discharged to hospitals. Furthermore, of those who died, 43 percent had stayed in the nursing home for less than a year, and 31 percent had stayed for less than six months. 16.3 percent died after a stay of 5 years or more (Australian Institute of Health and Welfare and Department of Health and Family Services, 1997).

Admission to a nursing home is therefore a process that confronts the individual's mortality. The process is suitably ritualised to herald such an occasion, however several of these rituals have lost their constructive meaning in the processes. All residents arrived to the nursing homes by ambulance in a securely strapped stretcher regardless of whether they could also walk or sit. From the ambulance, the stretcher, with the new arrival securely strapped in it,

was taken by two to three ambulance officers to the nursing home where they were either met by expectant staff or directed to the registered nurse's office. Normally, ambulances are used to transfer people who are acutely ill on their way for treatment, but this is not the case for nursing home admissions who are generally stabilised prior to admission to the nursing home. Confinement of the new resident to the ambulance, particularly in being securely strapped to a stretcher, was a reflection of the interests of the staff being served before those of the resident. Here, the resident arrived on a stretcher with wheels so that they could easily be manoeuvred by the staff. The needs of the resident were further ill-considered when their relatives and loved ones were made to travel in their own transport, rather than accompany the resident to the institution. They would arrive at the scene usually shortly after the resident. Frequently they were upset as they had not been given accurate information about the time of the resident's transfer or other details. They were then shown where the new resident's bed was. The ambulance officers and the nurses and carers often helped to lift the resident from the ambulance stretcher to either the bed or a nearby chair. The ambulance officers then gave the information from the transferring institution to a staff member at the scene. After a brief but informal discussion, they then left to return to the ambulance, taking the stretcher with them. Staff other than registered nurses were discouraged from discussing the new resident with the relatives, as this was usually the province of the registered nurse. However, available nursing staff and carers greeted the residents on their arrival and offered them reassurance. The information from the transferring institution was examined by the registered nurse. This information included the general care of the resident in relation to pressure area care, continence, toiling, eating and drinking, dressings, mobility, sensory and cognitive capacities. The presence of prostheses were noted. Current medications were listed and usually included the date and time that they had been last administered. The registered nurse discussed the requirements of care with the relatives and the basic information given on the transfer sheet was transferred to a nursing care plan that the other nurses and carers could

access. As an ongoing process, this information would be altered and updated as new information became available.

The registered nurse in both nursing homes was responsible for recording details of aspects of care from the transfer letters, the resident and the relatives. He or she had to check when the last medications had been given and notify the allocated doctor that the new resident had arrived so that he could assess them and reorder the medications and complete a new medication chart. The pharmacy had to be notified of the arrival and their medications so that they were prepared ready for use. The kitchen was told of the arrival and their diet—whether it was soft, vitamised or ward, and the next meal was generally prepared.

The nurses and the carers introduced themselves to the resident and their relatives where possible. Polite questions and comments were made about the trip from the transferring institution to the new institution and encouragement was given to the new resident. The resident was then confined to their room with their relatives, who normally stayed with them for a short while. Relatives were asked by staff to put names on all of the admissions clothing as they frequently became lost in the process of laundering them.

Normally, when being moved to a new environment, individuals like to see the environment and be shown where the major facilities were. However, new residents were rarely shown around the nursing homes on the day of their arrival. For example, a resident who arrived at a nursing home was not taken to her husband initially, even though he resided in the room next to hers at the nursing home and she had not seen him for several weeks. If at all possible the residents and their relatives were asked to answer questions about their current needs so that a nursing care plan for the attending staff could be devised by the registered nurse. This process of information gathering continued over several days and weeks as the resident became accustomed to their new environment and new information became available.

Information gathering about the new resident was an ongoing process at both nursing homes that commenced prior to the resident's admission. Information was fine tuned on a continual basis. Both nursing homes had procedures where summaries were written about the residents and were meant to highlight changes in the resident's condition and/or nursing care. At the point of admission, the resident was held in close focus so that they could be assessed by the various staff members responsible. However, as time progressed, the staff tended to act more distantly towards the resident and assimilate them in the context of the organisation including them into the routine for their care. This process involved letting go and moving on by the staff and was also a process of normalising the resident into the daily activities and affairs of the units. Assessment for funding purposes followed and could take 21 days to obtain the necessary information required to categorise the new resident. Even after the assessment for funding processes were completed, new information about the residents was gathered and added to the resident's files on an ongoing basis.

## **The Changing Of The Water.**

Each nursing home provided the residents with fluids that were kept in a jug with a lid next to the residents bed. Regardless of whether the fluids were drunk by the residents, the remaining fluids in the jugs were emptied and disposed of at a set time each day, the jug cleaned and then refilled with more fluids. This ritual was done by the pantry maids, or the nurses and carers. Fluids included water, orange and lemon cordial and blackcurrant juice. None of the fluids were required by the manufacturer to be consumed within 24 hours.

The changing of water on a daily basis is an interesting ritual which probably has its roots in history when disease was commonly spread through shared and/or contaminated water supply. In the early days of Australian colonial history, it has been documented that typhus and dysentery were particularly common and much emphasis was placed from the beginning on having access to an unpolluted, fresh source of water. Moreover, it has also been documented that typhus in particular, was very common in the gaols of England prior to departure and its contagious nature noted. Other water borne diseases that have created international epidemics include polio. Thus the changing of the water in the past has served a purpose in that it limited the spread of contagious disease. Currently, a less than significant bacterial growth has been reported in standard tap water (Agriculture and Resource Management Council of Australia and New Zealand and National Health and Medical Research Council, 1996).

## **The Medication Rounds**

The medication round was usually conducted by a registered nurse at both nursing homes. Each had a trolley in which the medications were held for dispensing to the residents. The

metal trolleys were large and shiny and moved on four wheels along the corridors and into each resident's room.

The medication rounds are also an interesting ritual which several authors have already commented upon (Wolf, 1988; Bird & Hassall, 1993 ; Walsh & Ford, 1992). Despite advocacy and even production of a guide to the implementation of self medication (Bird & Hassall, 1993) the nursing homes had only implemented these policies to a very minor extent. At the time of the study there were no guidelines from the statutory bodies such as the Nurses Registration Board regarding the administration of medications as they were being reviewed.

Walsh and Ford (1992: 85) have noted that stable blood levels of drugs are needed to ensure maximum effectiveness, and therefore need to be given in fixed amounts at certain times. However, the drug round rituals identified during the study prevented this from ever occurring as drugs were given out relatively haphazardly within one to three hours sooner or later of the stipulated time. Consequently, a drug that was meant to be given four hourly could be present in the resident in toxic amounts at one time and in untherapeutic quantities the next. Moreover, drugs that were left for the resident to self administer were signed as given by the registered nurse who was genuinely often too pressed for time to properly follow up on their administration or effectiveness. Registered nurses were the only nurses allowed to administer drugs at the Nursing Home sections of the institutions studied.

At both nursing homes, all drugs had to be ordered by a medical doctor. When dispensing drugs, the registered nurse had to sign his or her initials in a space on the medication chart to indicate that the medication had been dispensed and given. The space he or she initialled indicated set times and dates of drug administration.

The signature of the registered nurse as having given the drug helps to identify them and probably has its history in the days of when some 'dissolute' nurses were known to give the wrong drugs to the wrong residents (Watson, 1913). The reputation of the registered nurse is therefore accounted for in the dispensing of the drugs and continues to serve a purpose if the drug administration needs to be checked. However, it may have been far more appropriate to indicate the time that the medication was given on the charts rather than the person who gave it. The identity of the registered nurse could often be more easily and reliably ascertained by checking the roster rather than his or her initials or signature. This was particularly relevant as several of the registered nurses at the nursing homes during the period of research were temporary and/or hired from an agency and their signatures and initials were undecipherable. The nursing homes also used a system of medication incident reports to address errors in drug administration and these were followed up by management. Dependent residents could be encouraged to self medicate if able and educated to do so. The time of some drug administration needs to be clearly documented, especially if given out regularly three or four times a day and this could replace or be added to the nurses initials on the medication chart. Drugs that are self administered by the residents should be documented as such and the registered nurse not held accountable for them once the resident has given their informed consent and been assessed as competent in doing so.

Much has been written about punishments for incorrect drug administration and the futility of drug incident reports. Some nursing homes claim to maintain them for insurance purposes. However, the above points also need consideration. There is a current trend to allow Nurse Practitioners to prescribe some medications for residents and although it has met with opposition from some medical practitioners and pharmacists, it seems that future policies will need to take this further into account (Ruler, 1998a).



## **Dangerous Drugs Of Addiction And The Transfer of Keys**

Both nursing homes had facilities for the recording of dangerous drugs of addiction. They both conformed to the legal requirement that the dangerous drugs of addiction were kept inside a locked cupboard within a locked cupboard and in both nursing homes this location was inside the treatment rooms.

If dangerous drugs of addiction were in store at the nursing homes, the registered nurse coming on duty counted them and checked with the registered nurse coming off duty to ensure that the numbers of these drugs were correct and recorded in a special register. However, this process had lost much of its original meaning. Oral mixtures for palliative care such as morphine were measured during the procedure. The amount of morphine in the bottle was ascertained by measuring the level of the mixture with a measurement marked along the side of the bottle. Unless the bottle was sealed and left unopened, it would have been quite possible for the person with access to this cupboard to take the mixture from the bottle and replace it with another liquid. The measure was usually very approximate and also left the possibility for some of the medication to be removed without being replaced. Likewise, the ampoules of drugs to be given by injection were made of plastic rather than glass. Glass ampoules had been used when the counting of the drugs rules were first introduced. They generally had to be forced open using the fingers or a file. Conceivably, it would not have been difficult to withdraw the drugs from the plastic ampoules using a syringe and fine needle and replacing the contents with water or other clear liquid. The plastic ampoules had many fine bubbles of plastic on their outside and these could have helped to hide the fine penetration of the ampoules with a needle.

Only the registered nurse was meant to have the keys to the dangerous drugs cupboard and these were given to her by the registered nurse completing her shift after she had checked the

drugs with the registered nurse going off duty. These keys were known as the 'red keys' and were usually attached to a red ribbon. Other keys were on a separate key ring that the registered nurse also carried. When the other personnel required the keys to access resources for treatments or creams, keys on the second key ring were given to them. This allowed them access to the residents drugs stored in treatment rooms, along with other stored equipment. The resident's usual drugs were stored in the treatment rooms in both nursing homes, either hanging from the walls or in a drug trolley that was frequently unlocked. Drug addicts and drug addiction in our society are problems associated with personal corruption and crime. Refusal to give the drug keys to other personnel would be an admission of distrust and personally insulting, so in the end the keys were generally handled by quite a number of people who subsequently had access to various types of drugs.

## **Mealtimes**

In Western society, people who are considered to rank highest in terms of social class are those who make the greatest efforts to de-emphasise their animal-like qualities. Manners that emphasise a modulated environment, minimal noise and obtrusiveness in eating, formality in dress, control over immediate impulses and soft understatement of voice are acceptable table behaviours. Table manners that are considered proper in polite society are clearly designed to conceal the more physical aspects of eating, such as slurping, gnawing, chewing and disgorging food from the mouth. There is an effort to de-emphasise the purely physical aspects of the person and to project an image of composure, self-restraint and grace. Table behaviours that fail to do so are associated with animal behaviours, and imagery of the lowest classes are frequently associated with these (Barrett, 1991).

The nurses and carers emphasis was on getting the work done and this was achieved by going from one task to the next and from one resident to the next. Mealtimes were a part of

this routine and consequently mealtimes for the residents lacked the social emphasis that is normally associated with it. Mealtimes in our culture are opportunities for people to interact, and to enjoy the food and drinks amongst the company of others. However, the institutionalised routines of the residents prevented this from happening on a long term basis, depriving many of their cultural social cues.

At mealtimes, several residents were fed vitamised or soft diets as they had been assessed as having chewing or swallowing difficulties. Other residents were given normal diets. The timing of meals and their feeding were generally a reflection of times where the staff, rather than the residents, dictated the terms of caring. This was particularly so for the most dependent and vulnerable of the residents who were confined to bed at this time and were hurriedly fed by nurses in a serial fashion, at times rushing between beds and feeding several residents at a time because some of the residents were slow to eat and swallow.

Some nurses' and carers' frustrations were evident and they sometimes withdrew food from the residents who had difficulty in chewing and swallowing. One resident was told during the study that their diet would be changed to accommodate the time that the nurse had to feed it to them as the resident did not swallow their food quickly enough. While feeding the residents, nurses and carers frequently talked amongst each other, often across the residents and usually about their daily lives and working routines. Feeding was usually a very hurried affair, as usually there were several residents to be fed before the nurse could either go home, go to their own allocated meal break, or move onto the next task. In defiance of this hurried process, food from resident's mouths frequently overflowed, dribbled out or was spat out. This food could then be scooped up by the nurse or carer in a spoon and fed back again to the resident. Thus, the task that had been given to the nurses of identifying the resident's preferred foods and marking them on a menu could be seen as somewhat of a token gesture,

as the real criteria for foods selected, especially for dependent residents, was often how quickly and easily they could consume their meals.

Residents had difficulty in eating in a comfortable style that reflected social values and norms under these circumstances. Some were physically and/or cognitively impaired to the extent that their table manners did not reach the standards of Westernised normality. In many cases, the food was removed from the residents and fed to them by the nurses. It would have been with great difficulty that some of these residents could cope with the most basic of tasks associated with their feeding behaviour.

Many relatives feel frustrated in that they are limited in caring for their loved one once placed in a nursing home. Mealtimes are an important occasion where the resident can more fully enjoy the company of a loved one. This practice of the relatives assisting in the feeding of the residents could have been considered and practiced more extensively in either nursing home.

## **Toileting**

The animal kingdom serves in society as a source of qualities that are considered to be the opposite of human virtues. The moral world of human sympathy has been contrasted with that of the 'unfeeling' world of nature (Barrett, 1991). Therefore, if someone is characterised as a brute, an animal or a beast, they are generally being held in low regard. This contrast can also be seen in the dichotomy of tamed/untamed, so that all that is social is seen as controlled, cultivated and domesticated while all that is thought of in nature is perceived as uncontrolled, unrestrained and wild.

In Western society, biological processes are considered to belong to the 'natural order' and are culturally separated off the usual social relations. The most evident of these biological processes are those that serve as reproductive and of an excretory nature. Both are so hidden

away that they remain very private acts. In our Western Society, public acts of excretion or reproduction are often punishable by law. It is considered offensive in polite company to use expletives that describe these natural processes. The embarrassment expressed when 'creature releases' are expressed highlights our need to camouflage our animal nature. These releases, such as flatulence, belching, digestive rumble, yawns, sneezes and itchiness, are usually taught to be suppressed from early childhood (Barrett, 1991).

Toileting patterns in our society are also gender specific. Women are socialised to expect privacy with all aspects of toileting. Men are conditioned to void together in shared urinals that are private from the outside community and require individual privacy for other acts such as defecation. These cultural norms were shattered in the nursing homes studied. In shared rooms, despite shielding the residents behind curtains, acts of toileting are rarely private affairs. If a resident was unable or unwilling to ambulate to the shared toilets, they were positioned on a commode or with a urinal, usually next to their bed. The commode was like a toilet that the resident could sit upon, with the easily removal pan that the waste was collected in so that it could be emptied and cleaned.

Our society's expectations and cultural norms are such that wastes are eliminated cleanly and hygienically and so our senses do not allow them to be seen or smelt. Systems to do so have evolved so that the spread of disease through incorrectly managed wastes are minimised. The commodes used in the nursing homes usually had a thin paper disposable pan cover which was meant to be placed over the used pan when carrying it to the sluice room to be emptied. However, in both nursing homes, the pan covers were rarely used and the used pans were carried freely and openly from the rooms, down the corridors and into the sluice rooms where they were finally emptied.

The nurses talked across rooms about the state of a resident's ablutions and even when talking in a normal tone, it allowed other residents to hear details of their room mate's activities. Current social norms are that incontinence for both men and women is a very private affair, yet carers and nurses seemed unable to keep details of incontinence private. Details of incontinent episodes were required to be documented and nurses exclaimed out loud the current state of a resident's continence after a mandatory checking under the bed linen to see whether it was soiled. The toilets in the nursing homes were not divided by gender as they are in most public places.

Visits to shower places and the acts of personal hygiene and cleaning also become public rather than private affairs. Shared facilities meant that even if the residents could not see each other, they could hear each other and could also overhear personal conversations directed to other residents by staff and residents. This principle of 'the private becoming public' may also act to prohibit residents from acting in other ways, such as expressing their sexuality. Residents being allocated private rooms did not necessarily provide a trouble free solution to the dilemma. Even when the residents had their own rooms, concerns were raised about the residents becoming too isolated.

The residents were washed after an episode of incontinence, and their faces and hands washed before settling in the evening. At one nursing home each resident had two washers. One was coloured and was meant to be used for washing the lower half of the body and the other was white and was meant for cleaning the face and hands. After each use, either type of facewasher were supposedly discarded and a fresh one put in its place. This displaced ritual was designed to promote hygiene when attending the residents by preventing the transfer of microbes from the bottom half to the top half. However, in practice face washers were used indiscriminately. Sometimes they were replaced by the bedside after use and other times they

were discarded. They were bundled together in a linen bag when discarded, for washing by a contracted laundry.

### **'Dirty Work'**

The wearing of disposable, vinyl gloves had become an important ritual for the nurses and carers in particular when attending the disposal of a resident's wastes or the removal of soiled linen. They acted to provide a barrier between the nurses hands and the resident's body or wastes, and were assumed to somehow protect the gloved person from acquiring any of the resident's 'germs'. However, because the gloves were penetrable, particles of waste products could easily transfer from the linen or resident's body to the wearer's skin, It was therefore important to also wash one's hands after wearing the gloves to prevent cross infection. The nurses and carers seemed unaware of this as they wore the same gloves going from resident to resident, or took the gloves off after attending a resident but did not wash their hands. However, all nurses and carers insisted that gloves were a safety aspect of the care of residents and were reluctant to attend residents without them. Contact of soiled lined on the nurses or carers clothing was also another point of cross infection that was potentially harmful in the course of the nurses and carers practice's, and this risk could not be eliminated by the use of gloves. The wearing of gowns would have been helpful to prevent this source of cross infection but were not worn.

### **Personal Touch**

In Western society, people typically take great care not to intrude on the 'personal space' of others. Personal space can be defined as the immediate space around every person that is thought to be one's own and that should not be transgressed by others. A respectful distance is maintained to allow others their boundaries and personal space. If an accidental intrusion

occurs, such as bumping into another, it is normally acknowledged apologetically (Barrett, 1991).

Furthermore, in our culture, touching another person is a personal act and implies personal closeness and relatedness. If this relationship does not exist then permission to touch another must be sought and granted. A similar rule exists for property. It is understood by our culture that one's personal property is not usually touched or removed without prior permission of the owner. Territoriality has also been noted to occur in nature generally, amongst many species of animals. Territoriality can be shown in many species on a permanent or seasonal basis. It is a term that includes all aspects of the complex patterns of behaviour associated with defence of a specific area. The defence of property against intrusion may be done at the risk of losing life itself (Gordon, 1976).

However, the institutionalised nature of relationships at the nursing homes broke these norms. As nurses and carers accomplished routine tasks, permission was rarely sought or granted in the transactions. Similarly, residents belongings were freely accessed by staff members. Cupboards were opened and contents removed, or objects belonging to one resident were 'lent' by the staff, to another resident. Boundaries of the person and their belongings that are normally upheld were disregarded in these institutions. As current policy discouraged resident's names from appearing on the beds, casual staff who were not familiar with the resident's names felt compelled to search for a name on their belongings for correct identification, adding to the problem. Frequently, the residents could be cognitively impaired and had difficulty in communicating and comprehending, which made the transactions more difficult for them to elicit a response. Opportunities where permission could have been sought and obtained from residents were missed however, as this pattern of boundary crossing became the norm.



For example, two people went to see a man's arm that had been scarred through internment in a concentration camp. The carer entered the room and without acknowledging the resident, simply lifted up his arm and showed the scar to the other, remarking on the ordeals of the resident during the war. No introductions or permission to see the scars were sought.

## **Resident Abuse**

Residents that resisted were called 'difficult', 'demanding' or 'attention seeking' as they required more attention. Sometimes the resistive residents were physically restrained. For example, one nurse routinely put the full weight of her knee on a resident's hand, forcing his hand on the bed, to prevent him from resisting her as she attended him. After she had attended him, she released her knee and the resident grimaced with pain as he tried to reestablish movement in his hand again. At other times the nurses could hold the resident's arms or legs onto the bed as they were being attended. These nursing behaviours were most often witnessed where the resident was reported to be aggressive and were used as a method of avoiding physical aggression from the resident directed to the staff. Staff at the nursing homes expressed strong opinions that opposed resident abuse. However, as has been reported elsewhere, the resident's violation of behaviour expected of institutionalised people temporarily neutralised or suspended the norm prohibiting abuse of residents. It allowed the nurse or carers to use illicit force when attending the resident as it momentarily freed them from the restraining power of the norm (Stannard, 1973). Likewise, Greipp (1996) suggests that discrimination against older people is more likely to occur as a result of perceived unacceptable behaviour rather than as a result of gender or ethnicity issues.

## **Bedtime**

Some residents at both the nursing homes were nursed in bed during the day for extended periods. This was particularly likely if the resident had developed pressure areas and required frequent repositioning. Residents who required palliative care or who were acutely ill were

also likely to be nursed in bed. Also if the resident had had a suppository and were incontinent of faeces they were likely to be confined to bed to avoid soiling of their clothes and furniture upholstery. The resident was easier to move around when in bed so linen and clothing could readily be changed when necessary. Also, when a resident chose to remain in bed their decision was generally respected to promote their comfort.

At least 75 percent of residents were in bed by 8pm at both the nursing homes. Residents who were still up after this time were generally more independent, ambulant or could vocalise their wishes. Residents at the nursing homes had their hands, face and back washed after being undressed and their used incontinence pads removed. This ritual marked the passing of the resident from day time activities to rest in the evening and served to clean and refresh the resident's skin. The men then were generally dressed in a singlet and/or pyjama shirt. Very few men wore pyjama trousers as they prevented the nurses from accessing their incontinence aids if they were used overnight. Also, the pyjama trousers would become frequently soiled due to incontinence when left on and the nurses suggested that removing them frequently created more work for the laundry staff to wash.

Bedrails were frequently used to confine dependent residents to their beds and their use at times illustrated the custodial tradition of institutionalisation that has been described in Chapter 7. These restraints were authorised by appropriate personnel yet sometimes no attempt had been made to reassess and reevaluate the needs for bedrails for dependent residents who were rendered immobile. The use of bedrails as a form of restraint had become a ritualised affair for many of the residents as their practical uses had eroded over time. The use of bedrails frequently highlighted the resident's dependency and helplessness. Alternatives to restraints that were otherwise used were generally not implemented. These could include lowering of the bed or even removal of the bed frame for mobile residents. By

sleeping on a lowered bed or simply a mattress, a mobile resident could be free of restraints and injuries be prevented should they otherwise climb over the bedrails and fall to the floor.

A study by Retsas (1997) examines the use of physical restraints in South Australian nursing homes. In this study which included a total of 3,419 residents, 28.4 percent were physically restrained. Of this number, 74.2 percent were female and 25.8 percent were male and the most common justification for their use was to prevent falls. In these situations, the nurses could not see an alternative to their use. He reports that staff numbers or nursing home size did not influence the use of restraints. He suggests that staff education of the negative consequences of restraints as well as suggestions for alternative management strategies be made available and implemented.

### **The Doctors And Treatment Rituals**

Doctor-Nurse relations were strained at times due to some doctors having large proportions of residents allocated to their care, despite the verbal intentions of the management. This tended to cause difficulty with relations between the nursing staff and visiting medical staff, as the Doctor's perceived power rose with his/her number of patients. Both nursing homes had access to locum doctors for after hours or weekend visits. Generally, the use of these services were regarded as emergency situations and were avoided if possible.

The doctors signed forms for diagnostic tests such as cultures to detect urinary tract infections, as it was necessary for a doctor to authorise this procedure. The remainder of the pathology forms for these tests were left for the registered nurse to complete. She or he was then required to contact the pathologist for collection of the specimen. The tests were generally authorised after urine had been collected by nurses or carers from a commode pan. The urine was originally tested by nursing staff who then suggested that the resident's urine might be infected according to the test results. Urine samples were commonly collected from

a commode pan which was unsterile and then transferred into the sterile container supplied by the pathologist. The specimen was therefore frequently contaminated before it got to the laboratory. Or alternatively, if the pan had been recently sterilised using sterilising chemicals, the residual chemicals tended to kill any micro-organisms in the urine and no infection may have been detected. However, none of these factors prevented the ritual from being carried out. It was generally considered necessary to treat the resident regardless. The growing number of bacteria resistant to antibiotics was not a deterrent. Furthermore, follow up testing following initial administration of the antibiotics were frequently done to determine whether the resident continued to be infected. If results suggested that the specimen remained infected, then treatment with antibiotics was frequently prolonged. The antibiotics for treatment of the infections were ordered by the doctor according to the sensitivity of the micro-organisms as dictated by the laboratory. The pathogens were listed along with the antibiotic concerned on the results sheet that the pathologist sent to the nursing home and the doctor. Few diagnostic skills were employed by the doctor in these rituals and it was considered very important to treat the residents of their urinary tract infections because of the risks that they posed to their health.

Referral to Evidence Based Practice or education guidelines may limit this occurring. Another alternative to this procedure might be a specialist Registered Nurse (for example, a Nurse Practitioner) deciding whether the specimen needed pathology tests, ordering the tests and then prescribing the defined medication to treat the infection, if any. This would reduce the number of medical interventions that are both costly and time consuming for simple urinary tract infections. A Nurse Practitioner could also exert far more influence on how the specimen was collected within the ward, ensuring that it was suitable for testing (Ruler, 1998a).

## ***Handover And Communication***

### **The Problem Of Intersubjectivity-Communication And Relating**

Addressing intersubjectivity for resident-staff relationships could be problematic, as Garfinkel shows that when people are asked to clarify what they perceive to be 'commonplace' remarks, rapid and complete interactional breakdowns may occur. However, what is commonplace to residents may need ongoing clarification from the residents. When staff took considerable time to normalise the behaviour of residents in terms of their needs, ongoing clear verbal communications from the residents would at best be difficult to attain, as many of the residents impairments were of a cognitive and sensory nature. 'Common Understandings' can only be achieved by people doing whatever is necessary at the time to 'fill-in' a background of 'seen but unnoticed' interpretation for whatever is said as it is said. Thus the onus is on the staff to be more involved with the resident's world and engage in resident centred care to avoid further negative sanctioning of the recipients of care.

The problem of intersubjectivity has been stated in that humans can never have identical experiences of anything yet they continuously assume that their experiences of the world are similar and act as if their experiences are identical for all practical purposes. The ordinary person knows this as they are located differently to others in viewing an object or situation, and therefore see different aspects and configurations of it. Some objects and situations can be seen heard and manipulated by one person and not the other and vice versa. Also, motivations amongst actors may differ. Consequently, they may have different practical purposes in mind in viewing the object or situation and therefore view them in differing 'interested' ways.

Despite this, actors still take it for granted that their view point may be the same as another's and a 'common world' evolves which transcends the actors private experience. Intersubjectivity in ethnomethodology investigates the achievement of intersubjective knowledge. This achievement occurs as the actors attempt to grasp the subjective meanings of one another's action. Subjective meanings may be reflected in the other's goals, intentions and motivations together with their associated desires, hopes, fears and anxieties with which these goals and motivations are invested. The problem of intersubjectivity strongly suggests that very clear communication between staff is necessary to maintain a common world with clear goals and objectives. Yet at both nursing homes communication was very limited between staff.

Wolf (1988: 290) reports that at handover 'nurses learnt what it meant to be a nurse'. During this time, nurses learnt the goals and values of nursing through their reiteration. The practices of transferring information from one shift to the next and between staff members varied at each nursing home. However, both nursing homes shared difficulties in transmitting verbal information for different reasons. For example, staff were expected to document each resident's problems or progress in clinical records that were part of the resident's files stored in the registered nurses office each shift. Mainly registered nurses documented this information and then signed their name after each report. Enrolled nurses and carers were allowed access to these notes but were less likely to refer or write in them. They tended to be less educated and less confident with their literacy skills than Registered Nurses.

At Maple Nursing Home there was no time allowed for a formal verbal handover and the registered nurse was expected to read each individual resident's notes to become aware of problems that the resident may have at the beginning of each shift. There was also a handover sheet that summarised resident information at the front of the resident's progress notes. Informally however, the registered nurses transferred information between each other

verbally, most often in the office and when counting the dangerous drugs of addiction and signing the register at the change of shift time. They were not paid for the extra time used in the transfer of this information. After discussion with the registered nurse from the previous shift and intentions to read the progress notes, registered nurses were then expected to instruct staff about the specific needs of individual residents. However, lack of handover time and frequent interruptions severely curtailed staff's ability to check nursing care plans and other documentation. Additionally, there was no formal time allocated for the handing over of information from the registered nurse who worked from 7-10am to the clinical nurse consultant who was in the nursing home after this time. There was no formal opportunity for discussion amongst the personal care and nursing staff between themselves or with other carers or nurses from previous shifts. This severely limited the amount and quality of the information being transferred between staff and tended to impact on the care of the residents and their relatives. For example, the relative of a resident who had been admitted early in the study for palliative care became extremely upset when she discovered that the care and nursing staff that afternoon were not initially made aware of her loved one's specific needs or terminal prognosis. She said that she had expected that the management of the nursing home would be responsible for this, but in the absence of a formal handover, this had become very difficult. The nursing home had a communication book which all staff generally read when coming off duty and to which information and comments were occasionally added. However, this did not always include specific information about resident's needs but tended to address issues that affected the organisation as a whole.

At Maple Nursing Home, because there was no time allowed for formal verbal communication channels between shifts, staff relied heavily on written communication. For example, before attending a resident's toileting or pressure area needs, the nurses and carers checked a chart near their bed in which detailed information had been recorded. This information included the side of the body that the resident had been last turned onto and

details of the residents continence. The time and date that the care was attended was also recorded along with the names of the carers or nurses. New information was also added to the charts after the resident was attended. There were also plenty of written signs about to indicate which residents had their personal laundry done privately or by the nursing home. These signs and the written communications were the major formalised written channels between the nurses and carers regarding the care of the residents. Apart from talking informally between themselves and the instructions that they received from the registered nurses, verbal information about the residents was generally limited. Street (1992), notes that nursing cultures are predominantly verbal and that this poses a complex problem for the recording of pertinent information. During this study, even where policies opposed these practices and emphasised that communications be written, there were still frequent communication breakdowns.

Both nursing homes had very problematic channels of communication. As discussed, one had a heavy emphasis on written communication but important information was frequently missed as oral communication was severely limited, especially since there was no time allowed for handover between the shifts. At the other, there was a certain emphasis placed on written communication but oral communication between shifts was also distorted by the fact that the staff members participating did not properly represent the resident groups.

At the Cedar Nursing Home, where staff were paid and expected to fully participate, handover generally lasted about half an hour between the day and evening shifts and about quarter of an hour between the evening and night shifts. The verbal handover between the day and evening shifts were by far the most detailed, and individual nurses were required to present information about those residents they had been involved with during the day. However, this procedure resembled little more than a displaced ritual to indicate the changing of the shifts. Since the staffing cutbacks, only two nurses from the morning shift were



generally left at the time of this handover to discuss resident care, so a great deal of information was omitted or incorrect as the nurses and carers for specific residents had already left the unit. Discussions about individual residents and their problems arose at handover and staff made suggestions about the resolutions of those problems. The registered nurses from the day and afternoon shifts were both present and occasionally gave opinions or added information during the handover. By contrast, less emphasis was placed on written communications between staff. A book that recorded each residents eliminations was completed at the end of each shift by individual carers or nurses. Pressure area care was not recorded on an ongoing basis. The registered nurses tended to write pertinent notes in the clinical records that were stored in their office for legal and funding requirements. Monthly summaries were written about the residents care needs and progress. However, the registered nurses complained that the written requirements of their work were excessive and detracted from other aspects of care. Handover between the night staff and day staff tended to be verbal and informal. The nurses and carers communicated mainly between themselves details of resident care as did the registered nurses. A similar pattern of communication occurred between the evening and night staff, although both registered nurses and the third nurse or carer was usually available for this time.

### **General Communication**

There was very little opportunity for all staff to participate in sharing information at either nursing home. For example, at Cedar Nursing Home a general 'white' board was the only formal written communication between all of the staff that was used on a regular basis. It conspicuously hung outside the registered nurse's office and on it were written the names of staff who were working on each particular day and shift. At the beginning of each shift, the registered nurses allocated nurses and carers to different areas of the unit and which meal break they were entitled to attend. Messages between staff were often left on the white board.

A notice board that sat adjacent to the white board was rarely read and at the time of research, had information on it that was long since out of date.

Maple Nursing Home had a general communication book and a large notice board in the staff room that shared information. A photocopier was also made freely available to the staff for the use of photocopying information about the processes of care given to the residents. The staff room where the photocopier was kept had many library shelves which was full of information on aged care, policies and procedures. During the course of the study, the nursing home also arranged for a guest overseas speaker to share information that was relevant to the care of the residents and all staff were invited to attend. However, staff meetings between shifts were rare.

As a result of limited and often speculative verbal communications between the staff, the distance of senior staff members from the residents and other staff, limited written documentation of ongoing affairs and events, uncertainty about the future and the cognitively impaired status of many of the residents, some communications were inevitably inaccurate and incongruous with the day to day affairs of the nursing homes.

### **A Typified World-Medical Construct**

Both Schutz (1962) and Husserl (1970) argue that experiencing consciousness is inherently a typifying one. The 'object' or 'event' that is experienced occurs within a 'horizon of familiarity and pre-acquaintance' which is furnished through a stock of knowledge at hand (Shultz, 1962). The novel and unfamiliar are also understood as such against this pre-established background of normality and typicality.

The 'type constructs' of the residents appeared to be based on their medical condition and associated diagnosis at both nursing homes. For example, at Cedar Nursing Home, a

dependent male resident who was nursed only in an incontinence pad with a minimum amount of linen to cover him, barely able to move, yet restrained by bedrails was described by a carer as a 'multiple sclerosis'. This was largely because the way he was being treated seemed to the carer as being 'typical' of a patient who had multiple sclerosis. While the carer was wrong in his 'diagnosis' it remains that the resident's care had been modified to accommodate a 'type construct', or a construct that was perceived as typical of a man with 'multiple sclerosis'. An alternative model to systemise his care would be to construct care around his nursing needs, rather than his medical diagnosis.

Meanwhile, at Maple Nursing Home a resident was described by a carer as 'schizophrenic' because of her unexplained changes in behaviour, moving from placid and content at one time, to irritable, loud and abusive the next. Once again the carer was using a medical description which was also factually incorrect and furthermore, tended to obscure the nursing needs of the resident. By using identifiable nursing needs as descriptors, labelling is diminished and the descriptors are more likely to undergo review and elaboration.

As Shultz (1962) and Husserl (1970) argue, the development and use of type constructs is shaped by the practical experiences and relevances that come about as the actor engages in the world. It could then be extrapolated that the medical model at both nursing homes was extremely influential in the way nurses and carers went about their work, especially as Shultz notes that few of the type constructs constituting the actor's knowledge of the world originate with personal experience. It could be suggested that the medical model of action at both nursing homes frequently subsumed the nursing models of care during the course of this study.

## **Summary**

Rosemary Parse (1981,1987,1990) offers an existential theory that allows for a deeper understanding of rituals from a nursing perspective. Fitting rituals include those behaviours that suit and complement the environment and universe and carries meaning and outcomes. They may include behavioural sequences in bathing, feeding, moving, waking, sleeping and dressing. Displaced rituals are those sets of behaviours that no longer complement the environment or serve a constructive identifiable purpose or outcome. They have evolved and become out of context with their origins and lack meaning to the participants. In nursing, the recognition of displaced rituals is essential to further empower and strengthen nursing and its practices. Many rituals have both displaced and fitting aspects to them. Examples of nursing rituals identified in this study include: admission processes, the changing of the water, medication rounds, storage of dangerous drugs of addiction and the transfer of keys, mealtimes, toileting, hygiene, touch and communication, resident abuse, settling behaviours, doctor's rounds and treatment rituals, handover and general communication. Medical constructs of the nursing home environment were described and this type construct was seen to be extremely influential in the way that nurses and carers went about their work.

## Chapter Sixteen

### Focus Of Practices: Staff-Centred Cultural Focus

Two polarities of nursing orientation and practice were observed during the course of this study. They were staff focussed and resident focussed practices. This chapter identifies those staff focussed practices that together contribute to the manifestation of staff focussed cultures. Staff focussed practices are those that focus primarily on the staff member's needs and choices rather than the residents', although residents may indirectly benefit from these actions.

#### **A Resident Speaks**

Mary was a long term resident at this institution and was one of the original occupants of the nursing home when it first commenced operations. She was very lucid and had quite a lot to say about how the organisation had evolved, as follows:

*"There are some 4 hour people (people working only 4 hour shifts) here leaving less people to feed others. Occasionally the workcover girls (staff receiving insurance benefits for claimed injuries at work) come down. Some residents need people with them all the time. You can't go to the toilet when you want to because there's no-one. And when you get on you can't get off. The hours have been cut so much there's no-one here to do the nursing. Last week I had three different sisters who thought I was 3 different people. How dangerous is that? Two were agency and one hadn't been here before. They could hardly make a mistake with my photo. I noticed that they gave somebody else the wrong pills and lucky they could tell them that they had. Some people can't speak for themselves. We're not old enough to be in a nursing home yet. They want to put us all into one basket. They want us to lie in bed all day or in a cube (foam) chair. One of the managers could have toned it down and been a little more compassionate towards people. She was very unpopular. She was here less than twelve months. There were a lot of letters written about her and a lot of unrest. They're trialing the 3 hours now elsewhere in the building. We get 3 hours (of care) now. We feel guilty because the really old people don't get enough attention. It used to be a home but not any more. At the moment we're cut to the bone and people are working very hard. I hope that things settle down and we don't lose any more staff. There's supposed to be another cut but we don't know whether it will happen.....Patricia was going through a*

*hard time and had to give up her house and her son to move here. Her son was 5 - he's 25 now (cries) .....a big loss..... I had a lot more ego than what I have now. I have still got some freedom. It suits me to be looked after by the staff. All the day staff do is put you on the toilet, that goes with the shower, put me back in the wheelchair and that's it. I have about an hour. That's the most time they spend on you. I shower myself, except for my back and underarms. The night staff get both of us up. We don't know how long that will last. It's been going on for a little while. The day staff shower Patricia in the evening.....We're happy with that so long as it continues.....This is like a community. We're used to arranging parties- we had better craft and physiotherapy. There's little physiotherapy now, and the little bit you get isn't worthwhile. It's all gone downhill. Because we're all RCI we don't matter any more. We should all be lumped in a chair and left all day. That's what the government seem to think anyway."*

### **Organisation Structure**

This staff-focussed culture is characterised by a steeply hierarchal organisation structure. It is headed by a chief executive officer who is answerable to a board of management. Under him are three directors, one of whom incorporates nursing into her larger portfolio. This person is responsible for all extended care services, respite, volunteers, clinical management and the duties of the director of nursing in that she is the professional leader. Under her are two management coordinators. One focuses in another area of the institution and the other is responsible for the programmes that are developed for clients under 65 years and the nursing home clients. Under the control of the two management coordinators, a total of three nurse unit managers are employed to assist in the residents' management. However, they operate at a distance from the resident's daily affairs. Directly under their control are the Registered Nurses, followed by the enrolled nurses, personal care assistants and other ward assistants. Thus the structure is quite hierarchal despite it being flatter than it was prior to the changes that had been introduced.

The staff-focussed culture is characterised by a number of attributes. There appears to be a great deal of tension between the direct care givers and the management. A management representative stated that:

*“Management weren’t communicative three or four years ago but this has been addressed now. The current management is visible and attends meetings including with night staff. The chief executive officer is very approachable and holds a regular forum four weekly but staff choose not to attend. There have been difficulties with the nurse’s unions.”*

However, the management tend to have very little to do with the day to day nursing care of the residents but intervene when a complaint is raised by a nurse, relative or resident. They act in an advisory capacity for residents, significant others and staff who are able to see them at private appointments or at meetings. A management representative stated:

*“ I’m trying to get the nurse educator to talk to the staff about conflict and communication. The nurses get angry because they do so much to help the residents, they do one thing wrong and the resident complains. One relative marked an incontinence pad with a biro mark so that he could see whether the pad was changed and challenge the staff as to whether they had toiletted his father. We got the incontinence person to explain the use of pads to him. The relatives don’t just complain to staff but also the chief executive officer. They’re told to go back to the ward unit manager and if it can’t be resolved to their satisfaction then they take it to the resident’s advocate officer at Cedar, Thomas Knight, who then takes it to the manager of the programme.”*

And later added:

*“.....there’s been so many changes and some people can accept change more than other people. If your working out with a good crew then you have a good day. If you work with whingers then you’ll have a foul day. The residents pick up on it.”*

This management is less able to be directly involved in the commonsense worlds of the other staff and residents as they are far more distanced from their daily activities. They are therefore less able to contribute to the nursing home’s world of ‘reasonable actions’ and very limited in their contribution to the approximate judgements and reasonable grounds that constituted the common sense world of the nursing home.

The Registered Nurse tends to work very independently on the ward, interacting mainly with others who come from outside of the unit such as family members, health professionals, concerned others and management, when they visit the unit. Some Registered Nurses claim that there is little contact or support from those further up in the hierarchy and state that they

are rarely consulted about the residents' welfare or issues regarding nursing care. However, The Registered Nurse on the unit is often the person through whom management give their directives regarding the policies and practices at the nursing home. The Registered Nurse however, is frequently preoccupied with medication administration, documentation and assessment of the residents and has limited involvement in patient care which is more often carried out by the carers and enrolled nurses. One Registered Nurse expressed fear of the nurses and carers and says that they are expected here to do 'hands on work' and that 'they always knew which Registered Nurses did not pull their weight'. In a staff-focussed culture, the Registered Nurses may therefore attend residents 'to help the nurses' and avoid problems with other staff and residents although the residents benefited by their interventions.

For example, one Registered Nurse said:

*"The government is looking at the mighty dollar and not at what the dollar is doing. I'd like to know what they're doing with the money from the health care. I don't know if they are going too far. This is a cynical exercise in cost cutting.... Someone's going to miss out somewhere along the line. The ones who can talk the loudest and ring the most get the attention. The quieter ones will miss out- just get their turns and feeds. For example Estelle, Mary, and Dorothy can talk, they have their own routine and require it to be respected. There's no way that you can change that routine. There's others around that are the same. There's people who will let this happen but others who won't. What time you've got left you give to the others. Management follow up complaints. Estelle's daughter is always whizzing upstairs ( to the management). No one's ever asked to see nursing notes to see where things have gone wrong and no one's bothered to see our version of the story a lot of the time. Management direct what will be done. Management are not consulting staff. I've never been approached about nursing problems and why things have or haven't been done."*

Another Registered Nurse said:

*"I tried to do a palliative care course but had a new nurse manager who couldn't organise shifts. I couldn't do the course because of this. Before Christmas 1996 the management were trying to introduce 24 hour rosters. They didn't seem to realise that people have a life outside of work. Some people work nights because it suits. There's a lot of unrest here. There's uncertainty about what's going on. People have mortgages to pay. The lady in the linen room showed me all of the spare uniforms from people who had left. If people were informed then they would have more choice as you can make an informed decision. People leave uncertain and may find that things are exactly the same in 20 years time as they had been for the*



*last 100 years. Lots of people in administration were given redundancy packages and they were all replaced by other people but under different job titles.....so much uncertainty, lack of information and the information they give you is not always correct anyway. There is definitely a feeling of mistrust. You can walk to the residents and back and feel annoyed but when you are with them you have to switch off because if you show you are annoyed then they feed off it."*

The enrolled nurses generally form work groups when at work and tend to associate with each other and other carers. They share a common experience and background with the carers as frequently they have worked as carers prior to undertaking their enrolled nurse training. These direct care workers work generally in pairs and these pairs are determined more by the nurses associations with each other and the resident's they know than their education or experience.

An enrolled nurse said:

*"There is an element of mistrust due to changes. A lot of things have been done that management said would not be done. This has generated mistrust. There has been staff cutbacks and redundancy and uncertainty about employment future. Will it be here? ..... Mistrust is just not knowing . You hear rumours and go to forums and management try to dispel rumours. But the rumours come true in a month.....A lot of these people are like babies. You know that you spend more than 2.78 hours per day. It's harder that with kids because of their size, age, and disabilities here in particular. It's a larger community than a family and so you have more residents competing for your time. It's insensitive to these people's needs to reduce the time allocated to them by nursing staff to 2.78 hours over 24 hours or whatever is allocated. We have been given 3 hours (for now). A couple of the residents here are all at least 25 minute feeds on a good day. 3 meals a day - so that's an hour and a half taken up. Then you've got your times for activities of daily living, pressure area care, and basic physical needs to consider. Their social needs aren't met. These people here need somebody here who's sensitive, who will talk to them. It's a thankless job. It's very physically and mentally exhausting. You know in this type of nursing .....you know that this may be the resident's last place most of the time and you get little thanks especially from the management. In acute settings you get more satisfaction. Nothing that administration say is acceptable because of the mistrust they've generated. They (the residents) complain to management and management say that they will get the nursing care they need but what the residents are used to and what the management mean by "nursing care" are two different things. Management means total nursing care needs as compared to resident's wants.....Its very painful these changes. It reflects on the residents because they get a lot more wanting and they find that they*

*want more. Some people get upset and frustrated. The mistrust is because of the government and its a government institution. It's a shame that its the elderly copping the brunt of it. After living all of their lives, even fighting wars and working under a lot more trying conditions, they are told that they're only worth about 2.78 hours a day. It is very sad. You can't just blame the staff because they're doing their best to accommodate everybody. Where do you go with deployment . Where do you get extra work? They (the residents) don't know the real world. They've been institutionalised all their lives and had things done for them because they have disabilities. They don't know what its like to come to work in a place like this then go home and continue working in a home environment with insensitive men who ask why they get tired - and say 'You're always tired. What's for tea and where's my shirts?' "*

The direct careworkers spend a great deal of time complaining about the Registered Nurses and senior management indirectly and amongst themselves. All of the staff in the staff focussed culture complain about their lack of work security and it is possible that this contributes to the development of the focus of this culture. The staff members may be so preoccupied with their insecurities that they had less energy to transmit to the care of the residents. Some state they have major financial, personal and social commitments. They direct a lot of their insecurity and negativity about the past, present and future changes towards the management, who they do not feel are being honest about the future or proposed changes. A sense of mistrust prevails and is reinforced further and exacerbated when the management investigates complaints . At times during the study the researcher felt that staff wanted to use her as a channel, through which the care-givers could express their anger and hostility towards the management.

Likewise, in this staff focussed culture, the auxiliary staff tend to associate with each other. For example, the cleaners associate with the pantry maid and the cooks. Except where the staff personally know the residents or their families outside of the nursing home, they tend to limit their interactions with other staff at the same level.

## **Communication And Relating**

Garfinkel (1967) shows that when people are asked to clarify their 'commonplace remarks' rapid and complete interactional breakdowns may occur. However, what is 'commonplace' and commonsense to residents in a staff focussed culture may need ongoing clarification from the residents. As the staff talk across the resident to each other, communications frequently breakdown, especially where a cognitively or sensory impaired resident may misinterpret or misunderstand the information being transmitted. Ongoing clear verbal communications from the residents would be difficult to attain due to the nature of their impairments. This acts to frustrate the caregiver's needs for communications, reinforcing the tendency in a staff focussed culture for the staff to talk mainly to each other and limit their communications with the residents. Distorted items of interest are frequently discussed amongst the residents and transmitted in a further indistinguishable form so that they are frequently entirely foreign to what was originally communicated.

For example, an enrolled nurse relayed the following story:

*"You know, you have to be very careful here what's said in jest. As a joke a senior sister (we called her the SS) came into work in military uniform with a hat, baton and huge keys. It all got blown out of proportion and the press became involved. Some of the residents get traumatised by the title SS sometimes."*

## **The Role Of Language**

The most vulnerable participants in this study are those who are unable to facilitate the use of language to convey their circumstances and the meanings that they ascribe to them. These residents tend to be the most dependent residents requiring the most amount of nursing care. Garfinkel (1967) asserts that mundane talk of everyday affairs is done seriously and has features of real practical tasks with significant outcomes for the parties concerned. He suggests that the mastery of natural language includes the capacity to recognise and produce adequate descriptive representations of ordinary everyday affairs as a defining feature of an

actor's membership of a society or collectivity. Descriptions are indexical and are to be understood by reference to where and when they occur. They are 'reflexive' in maintaining or altering the sense of the activities and unfolding circumstances as they occur. There is an inherent looseness of fit between a state of affairs and the language used to formulate it. This looseness of fit permits and motivates the circumstantial elaboration of any natural language accident. Circumstantial elaborations are both indexical and reflexive. In these elaborations social actors determine every aspect of an account's sense and how to treat it. Thus, the lack of language inputs from the more seriously impaired residents was likely to sustain a situation that was unacceptable to them and fails to identify and maintain situations that were appropriate. Residents in this situation were therefore rendered relatively powerless to exert control over their circumstances or destinies. The production of an action will always reflexively redetermine, maintain, elaborate or alter the circumstances in which it occurs. Thus, in staff-focussed cultures, these residents are relatively powerless and their relative powerlessness is transformed into institutional norms. These institutional norms allow the development of elaborate routines and rituals performed by the staff. These norms become apparent when a resident exerts what little vestige of power they have and rings a bell for nursing attention. The resentment that can follow in the staff focussed culture follows was illustrated by a sign that read 'Gimme a Break' positioned on top of a board (where the bell lights up the room number).

However, some residents enjoy considerably more power than others in the staff focussed culture. They include those residents who are relatively lucid and those with attentive relatives who are not reluctant to take up issues. Here, the residents and concerned others are able to vocalise their displeasures about the unit staff and other residents to the management who are separated from the unit and therefore not subject to direct and personal criticism.. Some lucid residents can assert their needs fairly independently. For example, one resident, 'Cathy' may ring the call bell up to over 20 times in an hour for care, and is able to softly

verbalise her needs when attended. Her relatives are very attentive and despite her requirements apparently being met to her satisfaction, her relatives lodge several complaints about aspects of her care to management during the course of this study. The management act upon these complaints and suggest they have difficulty in understanding why the direct care givers expect gratitude for the care they gave when criticism could be of more use. Another resident, who is not cognitively impaired, has very strict, complicated rituals which she insists be adhered to by all staff attending to her. She is very quick to criticise and condemn staff who fail to understand or participate in her rituals. By establishing strict rituals of behaviour, the resident can exert some control over their otherwise tumultuous life and environment. If the ritual is in any way disturbed, the resident can become extremely upset. This poses particular problems when a nurse or carer assigned to the patient is from an agency or is new to the area. Frequently, they have to tolerate verbal abuse from irate residents who are used to staff knowing them and their particular needs. For example, one particular resident, Dawn, has lived at the Cedar Nursing Home for 13 years. When getting up out of bed to use the commode, she likes to have her slippers on, the lifting straps taken off, pads and pants removed, given her particular cream and also the call bell. Her pillows also have to be fixed, excess pillows removed and the bed folded back. The sheepskin then has to be positioned carefully on the bed along with a linen protector and a small pillow positioned at the foot of the bed under the foot cradle. The pillows have to be in the right order with a satin one on top. The bed linen has to be pulled up to ensure that the bed is warm before she is placed back to bed. When Dawn moves from the commode to the toilet everything had to be done in reverse. For example, when positioning her to go to bed the foot pillow has to be positioned down the bottom of the bed and everything pulled up one by one. The slippers are taken off and the socks pulled down over the toes. Dawn is positioned so that she does not feel any creases of the linen and then the nurses has to ensure that there is no tightness about her shoulders. Dawn's top half is first adjusted then her feet positioned. Her bell is given to her and her television switched off. The commode pan is then cleaned and

the lights were turned off. Additionally, Dawn is toiletted regularly at 1am, between 1am and 5am, 6am, 9:15am, 11:15am, 1:30pm, 3:30pm, 6:30pm and 9:30pm and the nurses say that she can 'be relied on like the clock' to be consistent with her toileting requirements, regardless of whether or not the toileting procedure results in the passing of any waste.

Thus, in a staff-focussed culture, nursing care is often initiated to defend the staff's positions rather than to benefit the resident, although the resident also benefits from some of the care. Also, residents who are not cognitively impaired and are able to assert themselves independently or with the support of relatives enjoy considerably more power than others. In a staff-focussed culture, most often complaints are directed to the management who are not familiar with the day to day ward activities and much to the resentment of the staff, appear to be followed up at a later date. Many of the staff feel that if the complaint had been discussed at the time it could have been more readily dealt with by the staff member. Frequently however, minor complaints are taken to the most senior of the management in an effort to effect punishment, embarrassment and redressing of the nurse or carer. Complaints from relatives are also dealt with in the same manner and ward staff complain that the management never consults them or the documentation about issues that are raised. In particular, staff employment insecurities in a staff-focussed culture are exacerbated and complaints lodged against them, regardless of how trivial, tend to weaken their sense of employment security.

### ***Morals And Cognitions***

Garfinkel (1967) attempts to integrate the moral choices people made with cognitions. Actions, he argues, are accountable moral choices. He shows during his experiments that participants will generally attempt to normalise behaviour which deviates from social rules or norms. Where an individual's behaviour cannot be normalised, then it is negatively sanctioned by others (Garfinkel, 1967; Heritage, 1984).

During the course of this study however, the degree to which the staff attempt to normalise the deviant behaviour of others varies very considerably. The degree to which the behaviour is normalised can more closely reflect the degree to which the resident is accepted in the nursing home, and how much power they wield. Frequently, medical descriptions are used to explain a residents deviation. More infrequently, nursing needs are used to explain the deviations.

Because of the nature of many of the resident's cognitive impairments, they are approached in what Garfinkel describes as a "moral" manner in that moral judgement is cast on them as a result of their relatedness being different from social norms. The care of cognitively impaired residents is consistent with Garfinkel's findings, in that when an explanation for deviant behaviour is not forthcoming from the resident, hostility is expressed. A resident with a cognitive impairment may not be able to make the accommodations necessary to maintain a commonsense world. Furthermore, staff with intersubjective problems who are unable to relate to the perceptions of others may tend to exacerbate the cognitive and communicative problems of the residents and other staff further. Medicalised treatment regimes that do not place residents needs as paramount add to the resident's and staff's burdens. Mistrust can be built up between staff and residents as departures from the norms are seen as 'chosen' or motivated, wilful and meaningful particularly in the absence of ongoing education. In Garfinkel's analysis, these notions of 'chosen' behaviours persist even after the experimental nature of the situations has been revealed. Arguably, then, although an explanation may be provided to account for 'deviant' behaviours of nursing home residents, notions about the motivations of the residents or staff may persist. In a staff-focussed culture, the ultimate negative sanction for these difficulties is the resident being physically and chemically restrained so that their deviant behaviour may no longer exist in a problematic way. Thus cognitions and morals are deeply entwined in the outcomes.

### ***Routines Of Staff-Focussed Cultures***

A strong sense of routine in the staff-focussed culture is enjoyed by all staff. For example, supper is taken usually at the nurse's station that directly faces a board on which the room numbers of residents light up if they require attention. Residents who ring the buzzer for attention while the staff are at their supper break are either ignored or their needs speculated upon for the duration of the break. In a staff-focussed culture, meal breaks for staff are taken at set times regardless of the ward activities. A sense of routine prevails with personal hygiene so that residents who have appointments are showered first at the beginning of the day. Residents are fed, toiletted and have their pressure areas attended at the same time each day, regardless of their changing capacities or needs. In a staff-focussed culture, there is little freedom among staff to implement flexible and varying routines for the residents and they are rigidly tied to their routines. Pressure area care and toileting requirements are rigid affairs. Regarding such activities, residents who are involved tend to be those who are most heavily dependent on the staff and relatively unable to direct their own care, mainly due to cognitive and physical impairments. Many of the staff state firmly that the residents like a sense of routine and that the routine also offers residents a sense of security.

However, at both nursing homes, there are instances where residents attempt to be self directive regarding these aspects of care, but are met with hostility from the nursing and personal care staff. At Cedar nursing home, a condition of entry is that the resident not be suitable for active rehabilitation. Therefore promoting a resident's independence is perceived to be an formidable task as so many of them are cognitively impaired and viewed as incapable of relearning self-help behaviours.

### ***The Admlsion Process***

In the staff-focussed culture, criteria specific to the institution as well as the government funding criteria had to be met before the resident could be considered for admission. The



prospective new resident's names may be placed on a list with their contact details so that if a suitable vacancy became available, they could be contacted and assessed for their suitability. There were several available places for new admissions during the study. One condition was that the resident not be demented even though many of the inmates suffer a neurological impairment.

In the staff focussed culture, there are many specialist staff members employed to assess the new resident. Also a ward clerk is employed to specifically organise the paper work. The physiotherapist assesses mobility, the speech pathologist undertakes assessment of swallowing and the social worker assesses family and social problems. A visiting dental hygienist assesses the resident for their oral hygiene needs. Because it is a condition of admission to the nursing home that the resident should not undertake active rehabilitation, visits from the speech pathologist, physiotherapist and occupational therapist were initial only, and afterwards limited to when the residents require their treatments to be reviewed. There is no diversional therapist available for the more dependent residents but the able residents may attend activities outside of the unit.

### **Uniforms**

In the staff-focussed culture, during the course of this study, the nursing staff were all required to wear regulation uniforms. It was also necessary to allow the nurses to be flexible in their working arrangements in case they were unexpectedly placed elsewhere in the institution. Barrett (1991: 143) asserts that uniforms are perhaps the 'ultimate expression of the harnessed body'. He says that they are the emblems of regimented order and signifies the degree to which the individual who wearing it, is at the service of the organisation. He suggests that Westerners expect a certain, predictable sequence of behaviour from others in uniform. He relates this expectation to the assumption that the body is held in check by a uniform, resulting in the behaviour of the wearer being constrained.

## ***The Medication Rounds***

In a staff focussed culture Registered Nurses are required to dispense the medications directly from containers containing bulk amounts of the same medication. Enrolled nurses and carers are not entitled to dispense medication to residents although they are frequently seen applying creams to residents that are available only on prescription. For example, they are not entitled to dispense paracetamol, even on the residents' request and for which no prescription is needed. The reason that the nurses and carers apply creams is that they are most frequently the carers who attend the resident and this allows them to apply the creams far more readily than the Registered Nurses who are not always available when the carer positions the residents ready for their creams. The Registered Nurse's initials would appear alongside the space that indicate the time and date of medication administration, even though medications are usually administered at any time within approximately two to three hours of the times stipulated on the chart.

The signing of the chart and the dispensing of medications have become at odds with each other. The residents were frequently still asleep when the Registered Nurse went around to give them their medications in the mornings so they were left in a medication cup for the nurses and carers to give, although the Registered Nurse takes responsibility for them and initials that they have been given. The time stated on the chart might be 7am however, the drug round could continue until 10am. Despite this, the Registered Nurses initials appears along the column indicating that at 7am the medication was given regardless of any knowledge of whether or not the medication has been taken by the resident.

Residents who are not cognitively impaired complain when they are given the wrong drugs. Despite their ability to recognise the correct drugs and appropriate times of administration,

they are rarely allowed to self medicate drugs other than those drugs that are freely available without a prescription such as paracetamol and aperients.

In the staff-centred culture, other items such as cigarettes are also 'signed for' by a person who administers them. For example, a resident who requires supervision of her smoking habit, as she has been known to burn herself with cigarettes when smoking unsupervised, is issued with a cigarette each hour on the hour. The person who gives the resident the cigarette is required to sign their initials on the piece of paper to indicate that they have done so.

### ***The Dangerous Drugs Of Addiction And The Transfer Of Keys***

In the staff-focussed culture there are facilities for the storage of dangerous drugs of addiction. The nursing home also had a policy that all benzodiazepines are to be counted between shifts by the Registered Nurses. They are also to be checked by a Registered Nurse and enrolled nurse before administering them to residents, although the enrolled nurse does not have to, and does not, accompany the Registered Nurse while she administers such drugs to the resident. Drugs of addiction normally have to be dispensed by a registered nurse with another as a witness, the quantity of the drugs checked then the drugs' administration also witnessed. This rule has been introduced as it was stated that large amounts of benzodiazepines were missing from another area in the institution. Benzodiazepines are known to create dependency and higher doses of the drugs are required to achieve a therapeutic effect especially if used over a long period of time. They are most commonly prescribed for anxiety and insomnia and used also for their muscle relaxant properties (Badewitz-Dodd, 1997).

Relatively few of the residents take benzodiazepines regularly. At the time of the sedation round the Registered Nurse asks the enrolled nurse to check and count the drugs as she dispenses them into small clear plastic cups for each individual. The Registered Nurse then

takes them independently to the residents and administers them. Although there is no evidence to suggest that the nurses at the staff focussed culture act improperly during the period of the study, it would be possible to do so if an individual was intent on taking the drugs. The administration of the drugs is not witnessed and several residents had them ordered on a 'when necessary' basis.

### ***Mealtimes***

Residents at the dining room in a staff-focussed culture are either able to move themselves there or be wheeled in a wheel chair. Remaining residents are fed separately except at breakfast time, when many residents eat after being positioned in bed.

Residents who are most isolated at meal times are those receiving gastrostomy or Peri Enteric Gastrostomy (PEG) feeds as they are given their diets entirely separately in both time and space. PEG fluids mean that residents are given fluid nutrition through a special tube that conveys fluid nutrition from a bottle through a system of tubes that leads into the resident's abdomen. These are known as gastrostomy 'feeds' and the initial insertion of the tube into the stoma of the residents abdomen follows a surgical procedure. This tube is known as a PEG tube. After this procedure is undertaken and stabilised, the resident may then be fed through the PEG tube by regular intakes of fluid nourishment that is prepared in plastic bottles by the Registered Nurse. This nourishing fluid emanates from a commercial source and has to be carefully measured into the plastic bottle prior to administration. It flows from the plastic bottle that is kept at a height above the resident, through another tube that connects to the PEG tube. After completion of the feed, the tubes have to be flushed with a prescribed quantity of water to prevent them from blocking. These residents are also given medications in a liquid or crushed form through the tube. After drug administration, the tube is flushed again by the Registered Nurse using a quantity of water.

Many residents who cannot feed themselves are fed by nurses or carers and this is frequently done in the isolation of their rooms or beds. Residents who are dependent on PEG feeds for nourishment are fed outside the usual mealtimes and often in isolation.

Cultural patterns of behaviour may be forced on the residents, even in a resident-centred culture. For example, at the nursing homes, all residents have their meals on a tray with a salt and pepper shaker if they are eating their meals in their rooms. As one resident attempts to shake the salt shaker from her tray, her nurse moves the tray with the plate on it so that as the resident shook the shaker, the salt landed on the food. To accomplish this, the nurse has to move the tray backwards and forwards as the resident otherwise shakes the salt onto the tray. After the nurse leaves, the resident continues to shake salt onto the tray into a little pile, and with meticulous care, picks up the food from the plate with a fork and dips it into the pile of salt before eating it. Thus the cultural norms of the nursing home and its staff can be quite different from individual norms of behaviour, and quite unwittingly, be forced onto the residents.

### ***Incontinence***

A characteristic of nursing care in the staff-focussed culture is that changing incontinence aids is made as easy for the staff as possible. For example, one of the most dependent male residents wears nothing more than an incontinence pad when settled into bed. This resident has a severely limited ability to vocalise his needs. The incontinence pad is affixed to the resident by the incorporation of adhesive tapes at the sides of the pad. His body is then covered by a sheet and if the weather is cold, extra blankets are used. Bedrails are placed up and in position. A male nurse explains these actions as being due to the resident having Multiple Sclerosis and that clothing irritates the skin of people with Multiple Sclerosis. However, none of the female residents said to be suffering from Multiple Sclerosis are treated in this way. After checking the male resident's notes I resolved that he was not diagnosed

with Multiple Sclerosis either. It seems that this treatment of these dependent residents has become ritualised and the original reasons for engaging in such actions is no longer apparent. In this way, the resident's role had subtly and slowly come to resemble that of an infant, wearing a 'nappy', being confined to bed, powerless and totally dependent on staff for all aspects of care.

On settling, double use of incontinence aids are frequently used. A 'kylie' bed sheet is designed to absorb urine and prevent skin irritation. Several kylie sheets are used on some residents, and on others they are used in combination with incontinence pads. Other residents have draw sheets, which are white linen sheets spread over a plastic underlay, that prevent the lower sheet from becoming soiled in the case of incontinence. Blue sheets are also used. These are paper-lined plastic sheets that can absorb a limited amount of moisture and prevent the soiling of other bed linen. Double use of incontinence materials could have been ritualised for these residents as they appeared not to serve a practical purpose in either preventing the incontinent episodes or more efficiently absorbing the waste products. They appear to serve as a reminder to the staff that the residents are incontinent and that their incontinence is difficult to control.

Moving the residents around in bed and changing their position is made easier by use of a sheet of material called a 'slippery sam'. The 'slippery sam' is made of a smooth synthetic material that glides the resident across the bed, once positioned under them. Here, one nurse may roll and position the resident. Assistance from a second nurse is required however, when moving a resident with a lifter.

### ***Prescribed Drugs***

About 21 percent of residents at one of the nursing homes are routinely given a drug whose chemical name is 'Temazepam' on settling at one of the nursing homes. For these residents,

Temazepam is given on a long term basis. Temazepam is a benzodiazepine class of drug. According to the manufacturers, it is indicated as adjunctive therapy in the short-term management of insomnia in adults. Precautions include impairment of mental alertness and the possibility of aggravation of depression. Its use has been associated with falls in the older person as it may induce ataxia, giddiness or oversedation. It has been associated with irregularities of blood count, hepatic and renal function tests and the manufacturers have advised that people with impaired renal and hepatic function may have difficulty in metabolising and excreting the drug. Common adverse reactions include headache, vertigo and dizziness. Continuous treatment for more than three months is not recommended by the manufacturers. The manufacturers advise that in general, hypnotics should be prescribed for short periods only (2-4 weeks) except where there is a problem of dependency (Badewitz-Dodd, 1997: 3-205). The residents prescribed this drug during this study have all been taking the drug on a very long term basis so the drug's hypnotic effect is doubtful and the residents may have become dependent on the drugs. Some of the residents already suffer cognitive impairment and confusion and so there is a possibility that this drug can aggravate this and further predispose them to falls. The long term administration of this drug seems to be a part of the bedtime and medication round rituals designed to assist the resident to go to sleep but which in fact risks the well being of the residents and has little, if any, beneficial effects on their sleeping ability.

### ***Medical Models Of Care***

Staff-focussed cultures are characterised by a high level of dependency on a medical model of care. For example, team work is not emphasised as there is a great deal of tension between the personal carers and enrolled nurses who tend to operate on one level and the management, who tend to operate on another. Similar to the older medical model, the Registered Nurses tend to act in a relatively isolated and supervisory capacity rather than as a member of a

coherent team. Additionally, a high proportion of registered and enrolled nurses are agency staff or transitory from other areas of the institution, resulting in poor continuity of care. At times, Registered Nurses are involved in direct patient care accompanied by coercion from the enrolled nurses and nurse assistants to do so. Because of their relative isolation, they are rarely powerful figures in the units. By contrast, Doctors in this model were also 'all powerful'. The available list of residents names are organised around their diagnosis and doctor. Emergency files of patient information is provided for visiting doctors but not visiting nursing staff. These are pre-prepared by the ward clerk so that any doctor could access pertinent information quickly about any resident and are in addition to the usual progress notes. Nursing care documentation is undertaken according to nursing care plans but tends to be second place to medical documentation.

The Doctors who attend the residents at the nursing homes are community based and generally attend the residents if notified. Similarly, they expect rapid attention on arrival to the home and carry out tasks according to a 'Doctor's communication book' that is located in the Registered Nurse's office. The doctor's communication book has suggestions and requests for prescriptions and the renewal of medication charts. Their roles in filling out diagnostic pathology form and medication charts are very similar in both nursing homes.

At one of the nursing homes, when a doctor who sees many residents visits, immediate attention is summoned from the Registered Nurse whom he contacts from the office, regardless of what the Registered Nurse might be doing at the time. Here, it was usually the Registered Nurse who works from 7-10am who has the most involvement with doctors and it frequently results in this person working late or enduring interruption to the drug round. She or he is required to complete the round and is usually paid for extra time worked. Medication charts for his or her residents are prepared before the visit so that he or she may sit down and rewrite the medication orders in minimal time. He or she sees residents who has current



difficulties, such as skin lesions, eye infections and inflammations. As one doctor visits the residents, he hurries from room to room, making comments to the Registered Nurse such as 'watch that one' or 'let me know about it again in two weeks' time.' He occasionally stops to listen to a resident's chest through his stethoscope. The medication orders are generally rewritten as before regardless of whether or not he visits the resident. Antibiotic treatments are added to the charts. The clinical medical records are completed as a legal record of the doctor having attended the resident. Polypharmacy, or the administration of multiple drugs to individual residents, is common despite the resident's increasing age and declining ability to metabolise and excrete the drugs. The possibilities of drug interactions and side effects also exists.

### ***Summary***

The staff centred cultural focus identified during the course of this study was characterised by a steep hierarchal management structure, separation and tension between the workers and management where the registered nurse was relatively isolated and powerless. It was further characterised by poor and distorted communication, a strong and inflexible sense of routine, limitations on admission of new residents, mandatory uniforms, routinised medication delivery, high levels of sedative and drug usage with little consideration of alternatives that all served to primarily serve the staff's needs before the residents. The environment in which this culture seemed to proliferate was seen to be strongly influenced by a medicalised culture.

## Chapter Seventeen

### A Resident-Focussed Culture

The other polarity of cultural focus observed during the course of this study was that of a resident focussed culture. Resident focused practices within this culture relates more to practices that focus on the resident's needs and choices rather than those of the staff. The resident-focussed culture is supported by a strong research and theoretical basis. Furthermore, it tends to be characterised by job security and the rostering of permanent staff.

At the beginning of the study, a permanent roster for staff had been circulated at Maple nursing home. Major changes to staffing and resident care had already been implemented and the study occurred near the end point of these changes. Therefore staff felt relatively secure in their employment.

Management are located in a very flat structure. They do not have a merely overseeing role but are actively involved in the day to day 'hands on' management of the home. The social valorisation model of care of the residents in the resident-focussed culture is the result of a major change introduced following extensive research into the well being of residents at the nursing home. This model of care places a strong emphasis on resident's needs rather than staff needs and is actively reinforced by the management. Even though the emphasis of the social valorisation model that is used focuses more on the psychological and social needs of the resident and is not entirely nursing focussed, it still serves to shift staff's attitude to a resident centred approach to their work and to actively promote it. Other changes, such as flexible working arrangements and a forced departure from standard working hours have been implemented with the result of the resident's interests being primarily served. However, some activities at the mainly resident focussed culture tend to benefit the staff primarily and

they have been mentioned in the previous section that describes practices of a staff focussed culture. Neither nursing home is totally staff or resident focussed and examples of practices of a resident focussed culture have been drawn from both nursing homes.

### ***The Social Valorisation Model***

A Social Role Valorisation is defined as 'the enablement, establishment, enhancement, maintenance, and/or defence of valued social roles for people—particularly for those at value risk- by using, as much as possible, culturally valued means' (Wolfensberger, 1991: 21).

Wolfensberger argues that roles are so powerful that they largely define who clients are, what they do, how they act and with whom and even what they wear. Social role valorisation was devised as a model by Wolfensberger (1991) to improve the lives of devalued people and of human service clients especially. Wolfensberger contends that much of current services are often culture-alien, bizarre and hurtful to the clients who use them. Social role valorisation allows in as many life areas as possible for a devalued person or group to have the opportunity to be personally integrated into the valued life of society. As much as possible, rather than being rejected and treated at a distance, such people would be enabled to live in normative housing within a community of their choice, be with valued people, be educated, work (in a voluntary or paid capacity) and be involved in worship, recreation, shopping and all of the other activities in which members of a given society may engage. To be successful, social valorisation requires that ideological and administrative supports wherever the integration of the model and positive imageing of the clients need to be backed up. The symbols and imagery that have historically been associated with devalued people relentlessly represent negatively valued elements and qualities, such as animality, illness and death, weakness, vice, criminality, worthlessness, incapacity, triviality and ridicule. These image associations may strongly influence people's role expectancies and the social valuation of the devalued person. Social role valorisation aims to enhance the social image of devalued

people. To be successful, the features of the human service that incorporates it into its practice must consistently convey positive image messages about their clientele. If the person is already devalued, valued roles must be found or created for them and then maintained and safeguarded. If a person is at risk of being devalued, then their roles need to be shored up and defended. Past roles need to be re-evaluated and reinforced where possible and new valued roles be created to compensate those that are eroding. Wolfensberger proposes that valued roles may be related to community participation. Such roles include taxpayer, voter, citizen, activist, lobbyist, shopper, customer, church member, usher or choir member. Valued roles may also be related to relationships and may include those of wife, husband, parent, grandparent, aunt or uncle, nephew or niece, sibling, daughter or son, friend, neighbour and confidante. One might also fill several roles and these may also include those of home owner, landlord or tenant. He argues that although paid employment may contribute heavily to a person's image in the minds of others, a great deal of valued status can be achieved through roles that involve unpaid work. A paper by Ruler (1998b) where two people who both worked beyond retirement illustrates this point. Although one is engaged in paid employment and the other in voluntary work, the work itself and the value attributed to it gives the workers much purpose and meaning to their own lives and others.

### ***Direct Resident Care***

A deliberate attempt has been made in the resident-focussed culture to heighten the flexibility of nurses in attending the residents needs and to break down rigidity in doing so. This is evidenced by paying the nurses at the resident-focussed culture to start and finish work at different times, coinciding with the gradual waking of the residents and is most successful in breaking down rigid routines to early morning care. However, the system is not without its problems as mealtimes are rarely individualised but facilities are made available to the residents to prepare their own meals as necessary.

Residents at this nursing home are asked when they want to get out of bed as the morning routine of the staff is flexible. Staff arrive on duty at different times from each other and there is less coercive group pressure to 'get the work done'. One nurse says that coming from a background where confused behaviour is more the norm is of assistance in tolerating and helping cognitively impaired residents. Indeed, several researchers describe nurses who care for ageing relatives themselves as being more adjusted to their role. Some nurses at Maple Nursing Home report that they feel that they are able to gain an insight into cognitively impaired residents by associating some of their language and behaviour together after a long period of time of caring for them.

### ***The Admission Process***

In the resident-focussed culture, the nursing management informs the Registered Nurse on duty that morning of a new arrival. She is asked to work until 3pm on this day rather than finishing her work at 10am. This gives her time to assess the resident and prepare the residents new notes. Thus hours of work are modified and made flexible to meet the resident's needs.

The Registered Nurse takes the required pieces of paper from sections of the filing cabinet in the Registered Nurse's office and organises them so that a resident had two basic information files. One is for general use by the nurses and carers and when complete notes general instructions for the day to day care of the new resident. The other is a clinical record file which stores nurses progress notes, admission and identity details, medical and pathology records and old medication records.

Resident details are upgraded continually and summarised in two nursing care plans, one initially serves as a rough guide and the second one evolves as a more permanent guide as staff become familiar with the resident and their relatives.

### ***The Relatives***

The relatives are encouraged to play a strong role in caring for their loved one in the resident-focussed culture. They are interviewed on the resident's admission to obtain details of their loved one's needs and are frequently consulted thereafter regarding the resident's wishes and needs. The relatives needs are strongly considered in the resident-centred culture. For example, the attentive daughter of a resident was assessed and instructed in manual handling so that she could more fully participate in the care of her mother. Thus, the organisation, the relatives and the resident can feel more confident of her interventions and the safety requirements of the nursing home were not compromised.

### ***Uniforms***

It can be argued that the non-wearing of uniforms at the resident-centred culture signified their tendency to be employed at the service of the resident, rather than the organisation. Clothing is based on individual choice, perhaps reflecting the degree also of individual care given to residents. The free dress code also allows the institution a more homely and less rigid environment in which to operate.

### ***Medications***

The resident-focussed culture uses a prepacked system where the medications are packed by the dispensing pharmacist into allotted times slots in plastic bubbles on a card for each resident. Thus drugs are checked twice before administration, once by the pharmacist and again by the dispensing nurse.

Dispensing staff are required to sign their initials into a time slot for the day that the drugs are administered. There are punishments if the medication charts are not signed in this way. If the Registered Nurse is a casual employee from a nursing agency and left the space on the chart blank, then there are clear instructions that they are to be contacted and asked to return to the nursing home to sign their initials in the appropriate space. If the staff is a regular staff member they would be requested to address the error. If a tablet has been incorrectly given or not given at all, then the staff involved are required to complete a medication incident form that is eventually tabulated by the management. It is irrelevant that a Registered Nurse may have given out several hundred other medications during the course of making their error. They are still expected to recall each medication of individual residents and whether or not they had received it.

### ***Mealtimes***

Breakfasts in a resident-focussed culture are made individually to the resident's needs. Breakfasts are attended as the resident wishes and this approach is encouraged by nursing and carer staff being paid to stagger their arrival times on duty. Staff arrive on duty, staggered in half an hour of each other and this tends to make resident care highly individualised and break down assumptions of routine and ritual that may otherwise have become apparent. Separate kitchens, facilities and food are freely available to the residents, relatives and their carers for all meals. At lunch and tea time, some frail residents in the resident-focussed culture are still seated in a large group in the dining room together despite there being in large portable chairs, leaving some vestiges of mealtimes being a social event retained.

### ***Management In A Resident Focussed Culture***

The management structure tends to be flatter not only in numbers but in that management are directly and continuously involved in the day to day activities of the residents and staff and

discrepancies in actions and opinions are dealt with very directly and quickly. Thus, the management are immediately involved in the commonsense worlds of the other staff and residents and strongly reflexive in contributing to it. The management have a much closer contact with the day to day affairs of the residents and can often be seen attending to them and talking to them by staff, residents and relatives. Complaints are dealt with by management quickly as they are frequently involved in the direct care or supervision of care of the residents. For example , a woman whose mother had recently been admitted to the nursing home for palliative care interrupted the nurses routine frequently by insisting that her mother be repositioned or toiletted by one or two nurses. Some of the nurses resented her constant interruptions to the care they were trying to give to other residents in the nursing home, although they recognised her grief and coping difficulties. They believe that 'everybody should be treated the same' and that this particular resident was receiving more attention than other residents in a similar situation. They also doubt the relative's ability to assist with lifting or moving the resident and felt that it infringed on the duty of care that they owed to the resident. The issue had been resolved by the management, in consultation with those concerned, allowing the relative to assist with lifting and transferring of their loved one after a lifting assessment had been completed to everyone's satisfaction. This way, the relative was allowed to be more involved in the direct care to her loved one, less demanding on the staff and more satisfied that she was making a positive contribution to her relative's care.

### **Summary**

While elements of a resident focussed culture could be found in both nursing homes during the course of this study, it tended to be predominantly at one nursing home resulting in a major cultural identity. The resident focussed culture was supported by a strong research and theoretical basis on which practices served to benefit the residents foremost. It was characterised by a high proportion of permanent staff with permanent but flexible rostering, a



flat management structure that was actively engaged in all aspects of nursing home activities, a theoretical model of care and direction that was actively promoted by the management and that supported the residents social and emotional needs as well as their physical needs. Direct resident care, flexibility of admission criteria and relatives roles, non-wearing of uniforms, organised but flexible medication systems, mealtimes and food provision that were orientated to suiting the resident's needs and a direct means of dealing with complaints and grievances also characterised the resident focussed culture.

## Chapter Eighteen

### Primary Care—The Way Ahead For Aged Care?

It has been argued that resident and staff focussed cultures represent two extreme polarities that have emerged during the course of this study. The resident focussed culture was characterised by relatively high job security amongst staff with flexible working hours and conditions, promoting a high level of client self care with high levels of management and relatives' input and influence, a positive working atmosphere, a sound theoretical and research basis of care, little union involvement and low levels of conflict. The staff focussed culture was characterised by relatively low job security and flexibility of working hours and conditions, low levels of client self care and management input, little direct input accepted from relatives, a negative working atmosphere, medical models of care and a historical rather than evidence based basis of care with high levels of conflict and union involvement. Both of the nursing homes studied conveyed elements of both polarities of cultures, with one nursing home tending to be more resident focussed and the other, staff focussed. The nursing homes also had elements of some aspects of culture in common. These are further discussed along with recent advances in nursing in an effort to forge a forward path for aged care.

#### ***'Everyone's The Same'***

A recurrent theme at the nursing homes amongst the staff is that all the residents 'are the same' and were therefore entitled to the same standard and level of care. While this could drive a motivation to be positive and fair to all residents it also served to reduce the emphasis on providing individualised care, particularly given that in practice all residents were not the same and that their relative power increased with their, or their significant others' ability, to assert their needs. An anthropological and sociological argument that explores this concept now follows.

According to Barrett (1991) humans contrast with other animals in that they live in a world of symbols and conventional understandings. Culture is defined as the systems of agreed-upon meanings that serve as recipes, or guidelines, for behaviour in any particular society. The use of the terms 'agreed upon' here means symbolic. A symbol is something that has meaning bestowed upon it by those who use it. The capacity for symbolism, the ability to bestow meaning on things and then to live according to these meanings, has been said to be the main distinguishing factor between human and other life. This is stated even though it is only to the best of our knowledge and fails to acknowledge that other forms of symbolism may occur between animals and nature that are foreign to our understanding.

In Barrett's (1991) analysis, meanings are bestowed upon nature. Human learning is cumulative as an innovation in one generation is passed on and reworked until it becomes the basis for another innovation in a subsequent generation. He argues that animal learning is far more limited as their learnt traits seem to be of a repetitive rather than cumulative nature. The difference between animals and humans is at least partly described by the knowledge that animals cannot re-create and transmit experience in symbols as we know it. In order to learn from an activity Barrett asserts that animals must directly witness it and are limited to imitative or experiential learning. However, humans may store up and pass on information suggesting that individual experiences can eventually become the experiences of others.

Variety in human behaviour is also attributable to the notion that human conduct is largely symbolically based on conventional meanings. The capacity to modify conduct by changing the guides, rules or plans means that humans can adjust in remarkably short periods of time to changing circumstances. Compared to the relatively very slow rate of biological change, cultural modification can occur very quickly.

Socialisation or enculturation, is the process through which individuals become cultural beings. Both terms refer to the manner in which individuals take on the norms, customs and conventionally approved behaviour of their society. A child is also an heir to human tradition that has been socially transmitted for many generations. In turn, each individual becomes a receptacle through which information is transferred to the next generation. Enculturation does not end with childhood and individuals continue to learn different aspects of their culture throughout their life span.

Anthropologists have gradually abandoned the notion that the shared patterns of behaviour found in society arise from the fact that the individuals are basically alike. The abandonment of this idea has been based on the findings that indicate all individuals are different when subject to closer scrutiny. This is at least partially due to the process of socialisation. Socialisation as a process that produces much diversity in many behaviours. It is most successful, when it frees individuals from a series of fixed responses that would reduce their capacity to cope with the many problematic and ambiguous situations of everyday life. Socialisation increases a person's repertoire of behaviour; extending the range and increasing the complexity of responses which they have at their command and being free of limiting stereotyped responses. The individual is able to richly discriminate between a variety of social situations.

Nonconformity and deviant activities are universal features of human society. Morris Freilich (1989) illustrates this point by comparing smart with proper behaviour. Proper behaviour is the conduct that follows cultural guidelines closely and describes the way things ought to be done from the point of view of cultural ideals. By comparison, smart behaviour is any form of practical, resourceful or innovative conduct that is not guided by established rules. The aim of smart behaviour is simply to solve problems in a practical manner. Culturally unorthodox solutions are found to problems that arise out of unprecedented circumstances for which there

are few or no cultural guidelines. Innovations arising from 'smart behaviour' may become the normal way of coping with the same problem in the future. Therefore rules, like values are never applied unquestioningly. People must make decisions on courses of action that best fit circumstances. What people actually do is therefore more important than rigorous adherence to a principle. Without some social elasticity, cultural change could occur only with great difficulty. Society must engender conformity to the existing order but must also allow for those people who have a strong degree of original idealistic creativity. No person, however, should have authority beyond criticism, as their position could congeal to an immutable form (Barrett, 1991).

Therefore, developing a system of nursing that exemplifies individual variation and behaviour, rather than that that systemises it into standard routines and rituals that may have lost supportive meaning for the individuals concerned, may be a challenge for nursing in nursing homes that are similar to the ones studied. 'Smart' behaviour, innovated from the rules and guidelines, could be developed in a supportive, efficient culture that was not negative and punitive by nature. An examination and critique of the behaviours identified would be necessary to accomplish this task.

### ***Rules And Norms***

Rules regarding behaviour are shown by Garfinkel (1967) to be very insufficient as explanations or directives to human action. Rules are always relative to contingent application and cannot determine the specifics of behaviour no matter how deeply internalised they are. Therefore, having rules and regulations regarding nursing care, for example, regarding the application of restraint, may be insufficient to ensure that residents' needs are primarily considered. Processes of assessment and evaluation are required to ensure that care is maintained at a resident, rather than nurse centred, application. Garfinkel (1967) argues that if cognitive shifts occur, the moral arena will undergo corresponding alternatives. Therefore, if

shifts are made by implementing resident-focussed rather than staff-focussed care, a full and ongoing education programme is implemented, to which the staff actively contributed, and nursing models rather than medical models are used in the process of delivering that care, an alternative pattern and focus of care may be implemented.

### ***Using A Primary Care Model***

By implementing social valorisation approaches in the predominately resident focussed culture, the staff have been persuaded and encouraged to look more carefully at the residents' needs rather than imposing constraints of the staff on them. This approach has succeeded in laying some of the psychological and social foundations for a primary nursing approach which may further enrich the lives of the residents involved. For example, residents at this nursing home are encouraged to choose their own routine on waking and eating. Team work is emphasised not only in theory but also in practice with a strong emphasis on direct nursing management involvement. Nurses are held accountable to the residents by being encouraged to see them as individuals with unique identities, as well as other staff with whom they have direct contact. Several of the nurses relate stories to the researcher about each other and confrontations regarding direct patient care and clearly hold each other accountable for their actions.

The staff-focussed approach to care may be residual from the custodial type of nursing apparent in earlier European and Australian history. The presence of untrained personnel to care for older people is reflective of earlier and contemporary times. Pearson, Punton and Durant (1992) suggest that the earlier medical model of nursing has also added to these care strategies. They outlined a model of nursing, Primary Nursing, and differences between this and the older medical model approach are elaborated. In doing so, the difficulties inherent in changing from the old to the new approach are highlighted. The authors suggest widespread changes so that the task-orientated approach of traditional nursing is abandoned and replaced

by a holistic, patient-centred approach. Here, these changes are augmented by nursing care becoming more systematic, and conceptual analyses of the role of nursing being developed then applied as frameworks for assessment and intervention (Pearson, Punton & Durant, 1992). By implementing basic tenets of primary nursing at a small rural community hospital in Britain, Pearson (1988) and Pearson, Punton and Durant (1992) illustrate the progress that primary nursing makes with respect to the therapeutic care of patients, in comparison to the older, medicalised style of care. For example, rather than seeing patients as old and dirty, they are more likely to be seen as individuals who need help to become independent. Freedom for patients to have their 'own nurse' and choose their own routine, be involved in self care and read their own notes is also granted, rather than patients passively submitting to an imposed routine. Furthermore, in primary care, nursing is changed from that being given by any worker in a routinised and task centred fashion, to that which is given only by nurses. Then, it is flexible and individualised, non-directive and systematically planned. Additionally, physiotherapy is taught to both the patient and the nurse and incorporated into the care plan in the emerging model to promote patient independence.

In primary nursing, there is also a shift of emphasis from Doctors being 'unquestioned leaders' admitting and discharging all patients, to that of team work, with primary nurses as co-ordinators. The doctor's leadership is questioned when the patient's problems are not primarily medical. Nurses also become more involved in the admission and discharge of patients. Patient 'ownership' is moved from that of Doctors so that the patients can more readily be associated with those who give the most ongoing care. Goals for treatment are shifted from being cure and routine orientated to aiming for the patients to being independent. The nurses have a new role of providing care rather than supervision and operating on Doctor's orders. Rather than being accountable to the doctor or nursing officer, nurses are accountable to the patient and their peer group (Pearson, Punton & Durant, 1992: 6).

### ***Economic Restraint In Aged Care***

Aged care is subject to significant economic constraints that may severely curtail the involvement of Registered Nurses from implementing the Primary Care nursing model as suggested by Pearson (1988) and Pearson, Punton and Durant (1992). The same economic constraints may also severely limit the educational opportunities for unskilled carers and nursing staff to change their practices to this primary care model of care.

The ageing of the population is accompanied by an increase of use in Medicare services in Australia. The average number of Medicare services used per person in a year increased by 41 percent from 7 services in 1984-85 to 10 in 1993-1994. The increase in the use of services per person is due mainly to increases of the population size and the number of services per head of population with an additional effect of the ageing population. The greatest use of Medicare services were made by people aged 75 years or over. They averaged 20 services for men and 23 for women during 1994-1994. General practitioner services represented 38 percent of the total value of benefits processed, pathology services 15 percent and specialist attendances 15 percent (Australian Bureau of Statistics, 1995c and 1996a). However, an American study estimates that of the activities performed by physicians, 50 to 90 percent could be relegated to nurse practitioners (Capan et al, 1993). The employment of nurse practitioners has also been shown to allow a greater continuity of care as well as provide considerable cost savings.

### ***The Nurse Practitioner***

There has been a growing cost of health care services to older people where many of the associated medical interventions are 'cure' rather than 'care' orientated. This growing cost will be further aggravated by the increasing proportion of aged people in society. The aggressive medical 'cure' orientation can prove futile in some situations, therefore nurse



initiated 'care' may be a preferred mode of therapy. Ruler (1997b & 1998a) makes a strong argument for the incorporation of a Nurse Practitioner model of care in preference to the cure orientated medical model in aged care that affects many practitioners including some nurses. She argues that the specialisation of nurses in this role could allow this segment of the population a far healthier and cost contained ageing that is not apparent in current services. Practices incorporated in the nurse practitioner model include nurse initiated prescribing, pathology, diagnostic imaging and referral to other services following specialist training in these roles. An American study by McGrath (1990) suggests that the savings that may result from employing a nurse practitioner instead of a physician was calculated to be 24 percent. However, the American system of Gerontological Nurse Practitioners has been in place in some form since the 1970s and their current range of therapeutic practices is far broader than those currently being proposed in Australia. The use of such a model in Australia could be incorporated in a more appropriate 'care' rather than 'cure' orientated approach. The medicalisation of aged care developed in the 1960s accompanied by bureaucratic and funding controls reinforcing a medical model of care. However, the time has come whereby aged care could spiral and complement its beginnings and subsequent history with nursing care, rather than medical cure, and remove some of the frustration to achieving positive outcomes for the aged and the community that supports them. Nurse Practitioners could help to incorporate a 'resident centred' culture into organised care of the aged by being seen to participate in it at a personal and professional level. Nurse Practitioners could also exert a healthy pressure on other nurses and professionals to include a greater 'care' orientation to their work.

### ***A Resident Centred Approach To Care***

Implementation of a resident centred approach to care would enable similar objectives that the primary approach to aged care as suggested by Pearson (1983), to occur. Care could remain individualised and holistic, however different from primary care in that the carers would not

all be Registered or Enrolled Nurses. An emphasis could be put on meeting the psychological and sociological needs of the resident, as is placed in the Social Valorisation Model. However, the spiritual, physical and cultural needs of the individual also need to be incorporated into this model. This would enable a philosophy of individualised nursing care to be implemented more fully, incorporating such care needs as pressure area care, toileting needs, mobility, and sensory requirements that have an emphasis on resident's needs, rather than being nursing or medical staff centred.

A totally resident care focus is probably not possible to achieve, as staff potentially could be overwhelmed by demands placed on their capacities. The exploration and use of appropriate and positive defence mechanisms is required to allow staff to function appropriately in a resident focussed culture (Vaillant, 1992; Conte & Plutchik, 1995).

### ***Defining Nursing***

Nursing appears to have allowed for the consideration and inclusion of the environment and nature in its theoretical domain. Nursing has also been challenged to include social, political and economic realities in its definition to allow for transformation (Stevens, 1989). However, what nursing is, is not clearly delineated and neither are its objectives although part of it could be said to promote health in the community. The focus of the discipline of nursing has been said to represent 'health' (Jones & Melies, 1993) or 'the experience of caring in the human health experience' (Newman, Sime & Corcoran-Perry, 1991) or the wholeness or health of humans, recognising that humans are in continuous interaction with their environments (Donaldson & Crowley, 1978).

### ***Descartes And The Duality Of Thought***

Many instances of the duality of thought as influenced by Descartes philosophy have appeared during the process of this study. Some include notions of subject and object, where the subjects are the staff who act upon the objects (the residents). The medical model leads to

objectification of the individual to being a 'patient'. The objectification in this model may be used by health workers to distance themselves from the patient's or resident's lived experience (Walsh, 1994).

However, in the study of culture, another outstanding duality of thought is that which separates the natural world from the human. Plumwood (1993) argues that this has evolved from egoism and self/ other dualism. She suggests that the structures of self involved in human domination and colonisation have resulted in the reduction of non-human nature to an instrument. This duality evolves from Descartes philosophy, who provides a general philosophy of the irrelevance of ethics to the human-nature relationship. Plumwood (1993) suggests that the same basic structures of dualism results in the treatment of those seen as less possessed of reason as inferior and as instruments for the supposedly more civilised western society. She argues that women, children and non-human nature are frequently perceived as being less possessed of reason and that the subsequent treatment of women as inferior others embodies a 'thinly disguised instrumentalism' (Plumwood, 1993: 143). She believes that the model of human egoism is a deeply entrenched one. For example, even an apparently altruistic action can be attributed to an egoistic, self interested motive. She cites the example of one who sacrifices their life for another as being attributed to selfishness in that they were motivated by their reputation to act in this way. It has been suggested that a motive for nurses to heal may also be in part a selfish one, in that nurses heal themselves in the process of doing so (Ruler, 1998 b).

Animals are insensible and irrational machines, according to Descartes. They are incapable of feeling pain and their movement is mechanised, like clocks. They cannot be harmed or suffer as they do not have minds. Animals are unconscious, in Cartesian sense of the term. By comparison, humans had souls and minds. Humans are defined by their ability to think. Descartes basic principle is 'I think therefore I am'. This dualism, the separateness of humans

and nature, justifies any acts of cruelty and indeed any human action toward the environment. Descartes contends that humans are the 'masters and possessors of nature'. All beings, organic and inorganic, apart from humans become 'things'. This objectification of nature is forwarded by Descartes as an important prerequisite to the progress of science and civilisation (Stumpf, 1994). It is however severely problematic because humans are after all animals also and must like all nature, adapt to the environment in which they live or not survive.

### ***Problems Of Human Culture***

Dualistic thought that has separated humans from their place in nature has contributed to a number of pressing environmental problems that cannot be ignored if human and other life forms are to continue to co-habitat the globe. A primary truth of environmentalism is that everything is connected. The consequences of disruption to one part of the ecosystem ripple throughout the whole. Much environmental degradation transcends traditional economic and political boundaries. Global environmental problems that are now being faced are human overpopulation, the loss of animal, bird and plant species, fossil fuel pollution, the production and use of ozone depleting chemicals, the ocean pollution that comes with oil dependency, the sulphur dioxide emissions that destroy forests and lakes, the stripping of tropical forests for timber and cattle-ranch farming, to name but few. These problems have been caused by the insatiable appetites of the rich and the by-products are fouling the environment. Rich countries continue to enhance their wealth by expanding their resource reach beyond their own borders while frequently exporting their problems. There are limits to global tolerance. Carcinogenic chemicals, nuclear waste or the toxic by-products of industry cannot be stored safely. There is no safe way of dispersing many harmful gases that are vented into the atmosphere (Seager, 1990).

Because powerful generalisations can be made about the responsibilities of the rich world, it tends to preclude the exposure of local examples of environmental degradation that surround

all of us. However, issues such as the destruction of wildlife habitat, the pollution of waterways and fuelwood scarcity may be at their most serious at a regional level. The implications and experience of environmental decay are often different for men and women and between social classes. The most affected people by environmental degradation are those who live in slums with limited access to safe water, food and health care. Wealthier people tend to be insulated from environmental problems by their privilege (Seager, 1990).

Thus, environmental issues are a most important nursing concern and it is important to recognise the role of individuals in influencing environmental fates. The relationship of people to those institutions that hold the balance of power on environmental issues is of utmost importance.

Plumwood (1993) traces the dualising process to show how reason has progressively divided, devalued and denied the colonised other which is nature. She suggests a future stage to this process that is a more intense and totalising form of instrumentalisation where the colonised are offered the alternatives of elimination or incorporation. Those who survive allow themselves to be incorporated into the empire of self and offer no resistance. Reason systematically 'devours' the other of nature and the instrumentalisation of nature takes a totalising form. The landscape offers no resistance and does not answer back because it no longer has a voice and language of its own. Complete control over nature is achieved as 'biotechnology and other mastering technologies repopulate the world with assimilated, artefact life and the master science strives to harness all global energy- flows to the Rational - Economy' (Plumwood 1993: 193).

However, these arguments and contentions have seemingly had little impact on the study of sociology which remains entrenched in dualistic thought in the study of culture and the human experience. Humans have been identified as separate from animals and nature

generally through the means of their culture. Consequently, humans have engaged in many maladaptive behaviours that threatens their survival. How can nurses help to address these problems?

## ***Towards A New Ethic***

Surely culture needs to be defined in a broader manner, which includes rather than excludes nature and that encompasses the whole of living experiences? The impact of human culture needs to be justified and rationalised on better terms than simply its contrast with the natural world to be more ethically acceptable.

Plumwood (1993) recognises that people are active and intentional subjects and that they can still effect change, on themselves and on the future of the social world. She suggests that recognising and ejection of the master identity in culture, in ourselves and in political and economic structures may prevent a total rationalisation of existence. She equates this project with one necessary for the human race to survive. Reason needs to be remade differently. Rationality, for long term survival, must find a way of being sensitive to conditions that are required for existence on earth. This new form of reason needs to be one that 'recognises and accommodates the denied relationships of dependency and enables us to acknowledge our debt to the sustaining others of the earth' (Plumwood 1993: 196). The rationality of the mutual self can be explored in such a way that others are acknowledged, appreciated and strengths grown from differences. Like this, the diversity of the world can be used to enrich all that it encompasses and nurses can be an integral part of this process.

### ***Summary***

It has been argued that the study of culture can shed some of its pretensions and be able to incorporate those behaviours that have been described to deviate from norms, in a more accepting and supportive manner. Perhaps the acceptance of life and death processes, the position of the human race placed in perspective with the rest of life and ultimately the acceptance of those who deviate from the standard human norms of behaviour rests in our ability to redefine culture and nature in such a way so that people who are different are

tolerated and understanding is valued and undertaken. Residents, patients and staff cannot be separated out in their contributions to maintaining a nursing culture as they all reflexively make a contribution to it. However, an individual's behaviour is an individual choice. If people chose to change their behaviours then they also reflexively contribute to changing the environment in which they participate. By exerting a reflexive influence on different cultures where values are aimed at promoting awareness, tolerance, and insight every individual may chose to become part of a process of change in a given culture where these values become the ideals for norms of behaviour. Nurses can play an integral part in this process as they are intimately involved in all aspects of life in the course of their work and their behaviour can set new standards and help to redefine culture. Ultimately, it may be necessary for our survival to do so.



# Chapter Nineteen

## Conclusion

There are increasing numbers of older people both within and external to Australia and this trend is expected to continue (Australian Bureau of Statistics, 1996b). A large number of older Australian people report having a disability resulting in increased health expenditure and the provision of residential care (Australian Bureau of Statistics, 1995a). At the same time, concern has been expressed as to how increasing numbers of older people, many of whom are disabled, will continue to be supported in a society that has declining birth rates (Australian Bureau of Statistics, 1996b; Australian Institute of Health and Welfare and The Office for the Aged, 1997).

Institutionalisation in either a nursing home or psychiatric facility may result in the older person losing the last vestiges of personal autonomy or power (Williamson et al, 1982). It has been identified that a balance therefore needs to be achieved between institutionalisation and deinstitutionalisation; dependency and self reliance (Jones, 1990). This can be achieved by older people, increasingly better informed and educated, overcoming opposition by being united with common interests and goals.

The care of the aged in Australia has evolved from a mixture of influences including the British legal and medical systems, charitable institutions and convict and free settlement. In the eastern states of Australia early institutions were mainly staffed by convicts, but in South Australia, by free settlers. Formal nursing training was introduced to these early settlements in the late nineteenth century and tertiary education for nurses in the twentieth century.

It has been established that nursing needs to be based on a sound background of practice, research and education to provide best practice to consumers. There are a scarcity of theories that account for the contribution of nursing practices in aged care. The aim of this study is to understand how the nursing homes and their practices have become sanctioned by the broader community using the philosophy of ethnomethodology and ethnography to inform the method. Alternative practices are suggested where appropriate. In doing this, the study offers an original contribution to nursing knowledge.

Ethnomethodology describes how a common world between actors can be established as they take it for granted that their view point may be the same despite being located in physically different places and having differing motivations and aims. Through a continuous process of adjustment the actors succeed in resolving the discrepancies in their perspectives which could otherwise throw doubt on the shared nature of their perceptions and cognitions. The qualitative method of ethnography is described as incorporating participant observation as the means by which data is described and elicited (Spradley, 1980; Morse, 1994; Muecke, 1994). Data is incorporated from research resulting from a larger project (Pearson et al, 1997; Pearson et al, 1998). The cultures of two nursing homes of different origins are examined after the usual processes of ethical approval and screening.

The nursing homes studied are described along with details of the residents and attendant staff. One nursing home, Cedar, is government funded and the other, Maple, privately organised but not for profit. The practices at the nursing homes are identified to help to understand how sanctions and patterns of behaviour have evolved. Examples of behaviours seen as deviant are identified and described. Two cultures emerge as a result of this study: staff focussed cultures and resident focussed cultures. Although both nursing homes have a mixture of elements of each type of focus, Cedar Nursing Home tends to be more staff

focussed than Maple nursing home, which is predominantly resident focussed. By the use of examples, it is shown that people with cognitive or physical impairments can be seen to engage in behaviours that do not complement social norms and expectations of behaviour. Much seen but unnoticed work is undertaken by these people to compensate for their inability to function as social norms dictate. When these people are concentrated in an institution such as a nursing home it is observed that the negative sanctions placed on their behaviours may contribute to the culture of the nursing home as a whole.

The meaning of culture is identified and is shown to be frequently limited to a dualistic imposition of human culture on the rest of the world (Barrett, 1991; Plumwood, 1993). Much behaviour within this meaning of culture is deeply ritualised, providing conventionalised competition particularly for resources such as food, shelter and land (Gordon, 1976). It is suggested that rituals of behaviour can be based on typified recipe knowledge, which is unquestioned even when the original circumstances and situations of the behaviours are changed. The problem is made more pronounced by the nature of intersubjectivity where it is contended that humans can never have identical experiences of anything although for all practical purposes they assume that they do. Therefore some objects can be seen, heard and manipulated by one person and not another and vice versa. Likewise, some rituals may be altered by one person, but their meaning and enactment unchanged by another (Garfinkel, 1967; Heritage, 1984). These problems encountered in ritualisation of behaviour are described and observed to be quite common in nursing practice. Some rituals or series of behaviour fall within a persons' circumstances and are necessary parts of human life thereby drawing one closer to the environment and can be comforting to the people concerned (Parse, 1981; Parse, 1987) Behavioural sequences in bathing, feeding, moving, waking, sleeping and dressing are examples of rituals that suit and complement the environment and wider universe. The term 'fitting' has been ascribed to these rituals. Displaced rituals are those that need to be reconsidered as they may no longer be helpful and

may even be harmful in the course of patient care (Braun and Linder, 1979). Transfer to a nursing home, admission, the changing of the water, medication rounds, handover, general communication, storage of dangerous drugs of addiction and keys, mealtimes, toileting, personal hygiene and touch, bedtime and doctors rounds were examples of nursing rituals given that were common to both nursing home cultures, often with mixed elements of fitness and displacement. These patterns of behaviour need to be further examined and reviewed perhaps in future research so that displaced rituals can be identified and removed and fitting rituals be more fully implemented into the daily lives of residents.

In a staff focussed culture, it is shown how nursing care can be initiated to defend the staff's positions rather than to benefit the resident, although the resident may also benefit from some of the care. The staff focused culture tends to focus on the staff members needs and choices in preference to the resident's. The staff centred cultural focus described is characterised by a steep hierarchal management structure, separation and tension between the workers and management where the registered nurse is relatively isolated and powerless. It is further characterised by poor and distorted communication, a strong and inflexible sense of routine, limitations on admission of new residents, mandatory uniforms, routine medication delivery, high levels of sedative and drug usage and an indirect means of dealing with complaints in the first instance. Furthermore, strong elements of a custodial and medical model of care persist in the staff focussed culture. All of these aspects of culture require ongoing review and further research so that improved outcomes can be sought.

The resident focussed culture tends to relate more to practices that focus on the resident's needs and choices. It is described as supported by a strong research and theoretical basis, and characterised by a high proportion of permanent staff and a relatively flat management structure. Additionally, a theoretical model of care and direction is actively promoted by the management and supports residents' social, emotional needs and physical needs. Other

characteristics of a resident focussed culture are the provision of direct resident care, flexibility of admission criteria and relatives' roles, non-wearing of uniforms, organised but flexible medication systems, mealtimes and food provision orientated to suit the resident's needs and a direct means of dealing with complaints and grievances .

Although a recurrent theme in the nursing homes is that 'everybody is the same' and all residents are therefore entitled to the same treatment, it is argued that this is not the case in practice, as resident's needs are highly individualised and may depend on factors outside of the nursing homes' control. To support the notion of individual care, it is suggested that a primary care model be implemented where the resident's needs are examined more closely in preference to imposing constraints of staff on them (Pearson, 1988; Pearson et al, 1992). As the aggressive medical 'cure' orientation may be futile in some situations, nurse initiated 'care' may be a preferred mode of therapy. A nurse practitioner model of care in preference to the cure orientated medical model in aged care may therefore be more appropriate (Ruler, 1997b; Ruler, 1998a). A resident centred approach to care that meets the psychological and sociological, spiritual, physical and cultural needs of the resident is proposed.

The study of culture is identified as being entrenched in dualistic thought, holding human ideals as separate from those of other animals and nature (Barrett, 1991; Plumwood 1993). It is proposed that the concept of culture be defined in a broader manner which includes human and the rest of non - human nature and the whole of living experiences. Nurses can play an integral part in the process of redefinition as they are intimately involved with life processes in the course of their work. Nurses can identify the ways that old people 'fit' or 'pass' despite their deviant status and resident focussed practices allow nurses to assist older people to feel valued by directly recognising, allowing, supporting and encouraging their attempts at 'normality'. This will help to integrate older people within the workplace and therefore in the

broader community. Together, nurses can make further contributions to the quality of life for all to enjoy.

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(\* Title of Nursing Home changed to protect confidentiality.)



## APPENDICES

## **Appendix A**

***Letter to Maple Nursing Home Management.***

June 5 1996

Dear Mrs Gadland

Thankyou for your enquiry today which was most appreciated. I enclose a letter from the research co-ordinator which gives an overview of the project and I have also enclosed a copy of my research proposal which outlines the ethnography that I would like to do. Please read these at your convenience and I will look forward to meeting with you on July 11 along with the Director of Nursing to discuss any aspect of this research.

Yours Sincerely,

Amanda Jane Ruler, R.N., B.A.(Hons) PhD Candidate

## **Appendix B**

***Letter to Cedar Nursing Home management.***

13 February, 1997.

The Chairperson  
Cedar Nursing Home

Dear Mrs Gately,

Thankyou for your recent approval to conduct the research "The Culture of Nursing Homes" within the Cedar Nursing Home. I enclose a copy of ethics approval from the Royal Adelaide Hospital also for your information and wish to advise that all materials distributed from the university regarding this project are subject to ethics approval from The Royal Adelaide Hospital. Do you have any further enquiries subject to this matter, or do you also wish to sight materials prior to their distribution within the centre?

As stated in the proposal sent to you , the initial consent will be of an institutional nature and then consent from staff, relatives and residents will be sought independently. I enclose an institutional consent form to be signed and returned to me so that the research may be commenced, probably in early April.

Once again ,thankyou for your interest in this project . I enclose a copy of our interim report of the project and would like to assure you and your committee that a copy of the final report will be sent to you after the project work has been completed and the results known.

Yours Sincerely,

Amanda J. Ruler, R.N., B.A., (Hons)  
Grad. Dip. Gerontological Nursing, PhD candidate.

## **Appendix C**

### ***Research Proposal***

**AMANDA RULER**

**Research Proposal**

**THE CULTURE OF NURSING HOMES**

**Supervisor : Professor Alan Pearson.**

**The Department of Clinical Nursing.**

**The University of Adelaide.**

## **RESEARCH PROPOSAL**

### **The Culture of Nursing Homes.**

#### **Statement of the question:**

Nursing homes are a common feature of the Australian culture. Their existence evokes mixed responses from the community. They are often perceived as places where people go in the final phase of their life or as a last resort, to die. They have been present in various forms throughout Australia's white settlement history, and their character has been transformed along with changing social demands and pressures. There have been very few studies that have gathered qualitative data on the experiences of relatives of nursing home entry, as the majority of studies have focussed on the residents themselves or on the experiences of carers out in the community. Thus the question has evolved:

*What is the nature of the culture within nursing homes and how does this affect the admission process of the new resident to the nursing home?*

The benefits of the research will be increased understanding of the experience of nursing home care and the provision of a research base to inform nursing practice.

#### **Introduction**

##### **Relocation:**

The Australian population is ageing and more demand is being placed on existing resources such as nursing homes despite a trend to care for the elderly in community based settings. It has been estimated that about twenty five percent of people aged sixty-five plus will experience being admitted to a nursing home. For those over 75, the probability of institutionalisation increases with each additional year. As hospitals face prospective reimbursement for their services, economic pressure to relocate the elderly quickly into nursing homes is more prevalent.

The community generally has a very negative perception of nursing homes and people who are recommended for treatment in them are often reluctant to go, preferring to be cared for in the community or more directly by other family members. Some of the many negative perceptions of institutionalisation are institutional neurosis, (Hendricks and Hendricks, 1981); infantilisation (Romaniuk et al, 1982), and the concept that an institution is a place to die (Chenitz, 1983).

Most studies point to the process of relocation for the elderly as being a traumatic process but other studies have examined the wellbeing of carers and generally concluded that much could be done to improve their situation also. The statistics found on the mortality of the elderly following institutionalisation or relocation were disheartening. It was estimated that 37 per cent of those who died at 65 years or older in 1986 were in nursing homes. Some 25 percent died within a month of entering a nursing home, and 50.8 percent within six months (Friedan, 1993). In a study by Armer (1993) choice in relocation, predicability, perceived social support from family and friends, and cognitive appraisal of the move as a threat or challenge were found to correlate significantly with adjustment. Likewise a study by Mikhail (1992) found that the pre-move life circumstances, physical and mental health at the time of admission, and whether the move was voluntary or involuntary play major roles in the residents ability to adapt. Borup et al (1979) compared a large group of movers with nonmovers who were relocated interinstitutionally. Their findings indicated that relocation did



not bring about an increase in mortality. The same group also looked at relocation and its effect on health, functioning, and mortality of similar elderly in an institution. The findings reported positive outcomes of relocation on health and functioning. Schultz and Brenner (1977) suggested that an individual's response to relocation is largely determined by the perceived predicability and controllability of the events surrounding the move and the difference in controllability between pre- and postrelocation environment. Wolanin (1978) validated the hypothesis that careful planning and orientation resulted in no loss of mental status as measured by urinary incontinence, wandering, nocturnal wakefulness and disorientation. No increase in mortality was found, but improvement in socialisation was noted. Many relocation studies during the 1980's refocused their direction into long-term care settings and discover how to mitigate the negative effects.

There has been little interpretative or ethnographic work done on the process of admission to a nursing home. Chenitz's (1983) work involved a qualitative study to guide nursing interventions with older adults during adjustment crisis shortly after relocation to a nursing home. Three conditions causing the elder's response to the relocation were discussed. The first condition was the desirability of the move. The second, legitimation, was the procedure by which the elders accepted the move as valid and plausible. The last condition was reversibility of the move and this related to how the older adults perceived their duration of stay in the nursing homes. A sociological term "a major life passage" has been employed to explain the status of entry into a nursing home. Similarly, Aquila and Messick (1978), described in Rosswurm (1983) also suggested a nursing intervention model in preventing postrelocation crisis by assisting older adults and their families with the following:

1. To gain realistic perception of the event
2. To provide adequate situational support; and
3. To promote adequate coping mechanisms.

Only two recent Australian studies have focussed on the specific experiences of spouses who have placed their loved one into a nursing home (Tilse, 1994), (Kaplan and Ade-Ridder, 1991). The majority of studies focus on carers in the community and are grounded, to a greater or lesser extent, in positivistic methodologies which generally ignore the subjective, lived world of carers and relatives.

### Carers.

Bunting (1989) found that often the individual carer neglects his or her own health to continue to give care. Families sincerely committed to keeping an afflicted relative at home may opt for institutional care as the only solution when their personal resources for coping become exhausted (Hirschfeld, 1983). Barusch (1988) found that caregivers preferred to manage situations on their own, although they reported a high incidence of loneliness, depression, resentment, guilt, fear of the future and interpersonal problems with the spouse. These results were similar to those of George and Gwyther (1986) where the well-being of family caregivers of older memory-impaired adults was examined in four dimensions: physical health, mental health, financial resources, and social participation. Results indicated that, relative to random community samples, caregivers are most likely to experience problems with mental health and social participation. In a study by Fitting et al (1986) spouse caregivers of dementia patients were compared on measures of burden, family environment, social networks, psychological adjustment, demographic data, and feelings about the dementing illness. Here, female caregivers were more distressed than men and younger caregivers were lonelier and more resentful of their role than older caregivers. A study by Deimling and Poulshock (1985) revealed that caregivers' attitudes concerning institutional care are at least as important as elders' physical and emotional health and caregivers' stress in determining which elders are placed in a nursing home subsequent to an elder health crisis. Characteristics of the caregiving situation were more closely associated with caregiver well being than were illness characteristics of the patients. In a study by Zaire et al (1980), the amount of burden of caregivers was found to

be less when more visits were paid to the dementia patient by other relatives. Here the authors suggest that providing support to caregivers was a critical step in the community care of elderly persons with dementia.

### Nurses and Care .

In a study of patient's relative's needs by Carter (1991), it was found that the relatives' greatest single need and cause for concern related to information about the patients condition, diagnosis, prognosis, treatment, and discharge plans. In addition, relatives needed to feel useful and involved in what was happening. However their greatest concerns related to their perceived lack of knowledge about the patient's condition and future needs. None of the relatives expected the nurses to be concerned with their needs, which might have diverted attention from the patient. Instead, their main source of support came from the family and friends. The nurses notes and handover reports revealed very few references to relatives other than as 'next of kin'. The nurses' contact with and knowledge of specific relatives appeared to be superficial. Individually, the nurses were more perceptive of the relatives needs but there was little suggestion that recognised need was necessarily followed by nursing response. The study emphasises the need for nurses to include relatives in their plans for total patient care.

A paper by Crossfield (1990) suggests that in caring for relatives, nurses need to be aware of the principles of good communication. and to be able to adapt these principles to any situation. He sights compassion as being the key element required for all communications. A study by Davis et al. (1992) revealed that a support group can be an effective intervention to decrease feelings of stress in bereaved individuals. Likewise, Lazarus et al. (1981) found that a time limited discussion group for relatives of patients with Alzheimers disease was very helpful in that the relatives learnt new ways of coping, as they began the process of disengagement from their loved one.

Because placement is often made because no other remedies are readily apparent, there is an obvious need to maximise alternate arrangements or to improve on the existing nursing home arrangements. It is paramount for researchers and policy makers to continue their studies and efforts toward helping nurses ease the older adult group through a "major life passage."

## Research Design.

### **Philosophical foundations.**

This qualitative study will use an ethnographic approach. In this approach, details of transactions will be kept to discover the shared systems of meanings at the nursing home with the author acting as a participant observer. Spradley (1979) believed that the emphasis during an ethnographic interview should be put on learning from people rather than collecting data from people and he asserted that it is this "learning from people" process that primarily distinguishes ethnographic studies from empirical scientific analysis. At the essential core of ethnography is a concern with the meaning of actions and events to the people who are being studied. Culture is a force that categorises, encodes and defines the world in which people live. Thus the culture in the nursing homes will be captured in such a way that its effect on residents, as they are being admitted in the nursing home and as they exist in the nursing home, will be described through the use of field notes and by the researcher joining in with the activities of the nursing home.

Garfinkel (1967) was able to elucidate that the constitutive expectancies of the attitude of everyday life are treated by individuals as normative and morally sanctionable matters. Associated with this discovery is Garfinkel's (1967) view that 'norms' of all kinds are most productively regarded as constitutive features of perceivably normal environments (Heritage, 1984).

Garfinkel's philosophical predecessor was Parsons, who during the 1930's and 1940's had a major influence on the evolution of social philosophy. In order to provide for the existence of normative constraint in conduct, Parsons supplemented the individual's habit of routine conformity with norms with a conception of internalization which positively motivates such conformity. Parsons viewed the individual's capacity to adopt a reflexive or manipulative stance towards their actions as threatening to the normative underpinnings of social order (Heritage, 1984). Viewed as an analysis of normative constraint, Garfinkel's treatment yields the opposite conclusion. Whatever the level of habit in generating 'perceivably normal' conduct, a source of underlying constraint which breaks through on occasions of actual or contemplated breach derives from the reflexive orientation to norms of conduct which individuals attribute to one another and in terms of which they hold one another accountable. Garfinkel's perspective tends to identify the phenomena of normative internalization, introjection or identification as empirical phenomena. His perspective argues that internalization is fundamentally cognitive and moral. Thus the norms of a nursing home culture may be derived from conduct that people attribute to each other and for what they hold each other accountable, rather than an internalised standard. Therefore it is necessary to closely examine these features of behaviour in any analysis of nursing home culture (Heritage, 1984).

Garfinkel (1967) stressed that understanding language was based on understanding actions and utterances which are constructively interpreted in relation to their contexts. This involves viewing an utterance against a background of who said it, where and when; what was being accomplished by saying it and in the light of what possible motives it was said. Garfinkel's approach to the phenomena of mundane description is consistent with his overall focus on the accountable nature of social action. He views social action as designed with reference to how it will be recognised and described. The ways in which descriptions firstly make reference to states of affairs and secondly occur in particular interactional and situational contexts make them to be understood as actions which are chosen and consequential. Accounts like actions are understood by reference to a mass of unstated assumptions and that the sense of an account is heavily dependent on the context of its production (Garfinkel, 1967). Therefore in any study of nursing home culture, conversation analysis must be kept in context with detailed descriptions of the situational and environmental surroundings.

Garfinkel (1967) found that the everyday world is an institutionalised and institutionally provided for domain of accountably real objects, events and activities from the society member's point of view, a natural, moral world. Sexual status is not excluded from this characterisation. In fact, sexual status illustrates Garfinkel's analysis of the mutual inpenetration of the natural with the moral, and he was able to illustrate this in his case study of Agnes (1967). That the 'natural distribution' of sexual status is simultaneously a 'moral' distribution is revealed by ordinary reactions to persons who perceivably deviate from the distribution. These reactions commonly take the form of moral retribution. Thus sexual status is an important element to consider when describing the culture of a nursing home or the experiences of residents within a nursing home such as during the admission procedure.

The studies of work programme raised the prospect of a direct analytic engagement with the specifics of concrete work practices and this in turn foreshadowed the development of an observationally founded science of mundane work activity. The gap in the social science literature on occupations consists of all the missing descriptions of what occupational activities consist of and all the missing analyses of how the practitioners manage the tasks which for them are matters of serious and pressing significance. One result of this gap is that occupational practitioners frequently fail to recognise themselves or their daily concerns in social scientific accounts and for this reason, and just as frequently, they find the latter to be uninteresting, misleading or plain exasperating. Ordinary activities are thus examined for the ways in which they exhibit accountably competent work practice as viewed by practitioners. Competences are exclusively treated from within scenes of commonplace work activity and by mundanely competent practitioners. Occupations are thus understood, not as the products of normative socialisation, unstated conventions, beliefs or tacit assumptions but primordially as self-organising domains of recognisably competent work practices which compose themselves through vernacular conversations and the ordinariness of embodied disciplinary activities. And work competences are found, not in the privacy of individual consciousness, but as publicly observable courses of specific, local and temporally organised conduct (Heritage, 1984). There is a great need in nursing to elucidate just what it is that nurses do. Likewise there is a gap in knowledge of the missing analysis of how the practitioners manage their tasks. The self-organising domains of recognisably competent work practices of nurses are not generally described although the work may be publicly observable. A task of an ethnography of nursing homes, particularly during the admission process of residents to nursing homes, may be to elucidate these points.

Ethnographers ask questions that are first of all broadly descriptive, and they then may narrow their focus to specific details of the environment of situation. Spradley (1980) suggests studying a few isolated domains in-depth while still attempting to gain a surface understanding of the cultural scene as a whole. The participant observer may firstly engage in activities that are appropriate to the nursing home and also to observe the activities, people and physical aspects of the situation. The researcher needs to become explicitly aware of things usually blocked out to avoid overload. In a sense the researcher will need to use themselves as a research tool by increasing introspectiveness. Descriptions from the ethnographer may include their thoughts and feelings as well as entities of space, object, acts, activity, events, time, other people and their goals and feelings. The ethnographer will also need to experience being an insider and an outsider to the situation simultaneously.

### **Research Methods : Data collection , management, and analysis**

Ethnography is chosen as a method that will lead to a discovery of the knowledge that people use socially and culturally to understand their experience and organise their behaviour (Germain, 1993). The ethnographer starts with discovering what is there in its empirical reality and, then, through long-term participant observation, learns and analyses its local meanings. (Spradley, 1980). There may be a wide variety of types of information, including written texts such as poetry, media, verbal transcriptions, maps, film, drawings, or other

visual representations, oral recitations and music. The ethnographer gathers a variety of data types that go beyond the visible facts and that identify the experiential connections that link those facts in people's lives. The ethnographer lives a process of analysing data while collecting them, engaging in an interactive process of gathering and verifying information. In ethnographic work much information is arrived at intuitively and informally. The ethnography should guide the people's ways of living with each other and continuing their society. The ultimate purpose of an ethnography is to make the social action of a society understandable to an audience of another society or to the rest of the same society. The central method in an ethnography is participant observation, where the researcher becomes part of the culture. There will be detailed and substantial ethnographic case studies of two nursing homes. The case studies will concentrate on each unit as a whole without paying specific attention to the admission of new residents, but including it as part of the units' everyday work. This broad approach to each case study will minimise the possibility of the field researcher overly focusing on the admission process, as any intrusion would be inappropriate. Such an approach will contextualise the experiences explored in the previous phase of the study and will identify patterns of practice. Data will be collected in the form of field notes, interviews with informants from within the groups and the reflective accounts of the participant observers own experiences in the setting (Spradley, 1979). Field work will occur over a six week period in each of the two nursing homes, during the day and night. The specific times of the field work will be negotiated with the nursing staff in charge of the nursing home and are expected to be continuous. Depending on the amount and quality of data collected, the researcher in this study may need to revise the time spent in the nursing home. Demographic data about nurses and residents observed will be included as a means of describing the participants. Further supplementary data that will also be used in this study will include patient records of those people in the nursing home at the time of field work, and written procedures and policies relating to the nursing home.

## **Consent**

Consent for field work part of the investigation is institutional; that is, all people present in the nursing home setting at the time of field work will be observed and therefore included in the study. This type of consent allows the researcher to move about the environment, opportunistically gathering data as the research question demands (Germain, 1993). The researcher will visit the nursing home staff and explain the nature of the research prior to its commencement. Further explanations about the research will be offered each time the researcher enters the setting, and on an ongoing and as needed basis. Verbal consent will be solicited each time the researcher approaches a new person in the setting. Any person can refuse to engage in the research or may cease to participate at any time but all relevant observations will be included. Only those who are not cognitively impaired will be interviewed so that a deeper meaning for their experiences can be gained. In this study the researcher will invite a selection of the registered nurses, who have been observed during field work, to be interviewed in an effort to uncover deeper meanings and enhance the understanding of the inside view of nursing home nursing care. Data from these interviews are based on a sample of nurses, who can validate, refute and/or expand the researcher's observations. The exact nature of the questions will be ascertained as the study evolves. The interviews will range from unstructured to semistructured, so that a comprehensive view of the nursing care of patients can be ascertained. These interviews will be audiotaped and transcribed for analysis. Written consent will be obtained from these nurses on a form that further explains the details of the study in plain language. The interviews can be terminated at any time by the participant, without any consequences to them. Likewise written consent can be withdrawn at any time.

## **Ethical issues**

All participants in this research will remain anonymous through the use of identification codes and pseudonyms. Inconsequential detail of the general nursing home used for the study will be altered in a further effort to assure anonymity.

Nurses and residents may feel uncomfortable about being observed and their discomfort may be reduced by the researcher making herself known and familiar to them. It is important to maintain a non-judgmental stance as their behaviour and responses may become affected. It is the researcher's responsibility to form relationships that allow the inside of the culture of the nursing home to be revealed. Time spent in the unit early in the course of fieldwork will enable the researcher to build familiarity and trust and to establish healthy working relationships with the staff in an effort to build confidence and trust.

All data: field notes, personal field journals, audiotapes of interviews and their transcriptions will be stored in a locked office and be accessible to the researcher only.

### **Reliability and Validity Provisions.**

The aim of this study is to capture the lived, cultural meaning of the nursing homes. The perspective from the inside, the emic data, such as those meanings elicited from informants, will be compared to the etic data, observations and theoretical speculation of the researcher. Validity of this research is dependent on the extent to which the captured descriptions and observations match those who know the culture. Through the use of key informants and through continuous analysis the researcher of this study will check her information with key informants. The comparison of what key informants say and what they strengthen may add reliability to the study as will investigation of discrepancies.

### **Timetable**

#### 1996

Gain University approval to execute research  
Continue planning and expand literature search

#### 1997

Continue with planning and literature search.  
Gain access to ethnographic study sites.  
Month 3-6 Case study field work  
Month 7-12 Analysis of field work data

#### 1998

Month 2-4 Data Analysis  
Months 4-12 Writing up of thesis.

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## **Appendix D**

### ***Staff Information Brochures.***

## **Project Outline of the Culture of Nursing Homes.**

The Australian population is ageing and more demand is being placed on existing resources. The demand for nursing home places is rising and given Australia's ageing population, a change in public perceptions towards nursing homes is needed to avoid a health crisis.

Statistics found on the mortality of the elderly following institutionalisation or relocation are disheartening. It was estimated that 37 per cent of those who died at 65 years or older in 1986 were in nursing homes. Some 25 percent died within a month of entering a nursing home, 50.8 percent within six months (Friedan, 1993).

The ideas of this project are based on the findings that relocation of loved ones to a nursing home can be traumatic for all concerned. The question to be answered during this study is:

*What is the nature of the culture within nursing homes and how does this affect the admission process of the new resident to the nursing home?*

The process of relocation has been studied in depth along with the experiences of the carers and nurses application of nursing care during the admission process. Most studies point to the process of relocation as being a traumatic process but other studies have examined the wellbeing of carers and have generally concluded that much could be done to improve their situation also. Despite the trauma involved in relocation, many studies have found that with appropriate intervention during the planning, implementation and later stages of relocation that it may even have a beneficial effect on the residents health. The literature generally divides relocation into three areas. They are: relocation from institution to institution, relocation from home to institution and relocation from within the same institution. Some studies have found that choice in relocation, predicability and controllability of events surrounding the move, physical and mental health at the time of the move, perceived social support from family and friends and cognitive appraisal of the move as a threat or challenge were found to correlate significantly with adjustment. A literature review has been undertaken to clarify the major issues in these areas in the project.

Only two recent Australian studies have focussed on the specific experiences of spouses who have placed their loved one into a nursing home (Tilse, 1994), (Kaplan and Ade-Ridder, 1991). The majority of studies focus on carers in the community and are grounded, to a greater or lesser extent, in positivistic methodologies which generally ignore the subjective, lived world of carers and relatives. An American study by Chenitz in 1983 involved a qualitative study to guide nursing interventions with older adults during adjustment crisis shortly after relocation to a nursing home. Three conditions causing the elder's response to the relocation were discussed. The first condition was the desirability of the move. The second, legitimation, was the procedure by which the elders accepted the move as valid and plausible. The last condition was reversibility of the move and this related to how the older adults perceived their duration of stay in the nursing homes. A sociological term "a major life passage" has been employed to explain the status of entry into a nursing home. Similarly, Aquila and Messick (1978), described in Rosswurm (1983) also suggested a nursing intervention model in preventing postrelocation crisis by assisting older adults and their families with the following:

1. To gain realistic perception of the event
2. To provide adequate situational support; and
3. To promote adequate coping mechanisms.

### **Carers.**

Studies have found that relatives are most likely to place their loved ones in Nursing homes after all avenues of other assistance have been exhausted. Caregivers have been found also to suffer a high level of mental and physical ill health, along with impaired social participation. In fact the wellbeing of the carer has been found to have more influence on the nature of the situation than the illness characteristics of the patients. It has been suggested that sharing the burden of caregiving can do much to alleviate the pressure and that this, in turn benefited the patients. Providing support to caregivers is a critical step in the community care of elderly persons.

### **Nurses and Care.**

It has been found that a relatives greatest single need may be for information about the patients condition, diagnosis, prognosis, treatment and discharge plans. Additionally, relatives need to feel useful and involved in what is happening to their loved one. Nurses contact with and knowledge of specific relatives has been found in some studies to be superficial and relatives recognised needs were rarely followed by an appropriate response. For this reason it has been recommended that that nurses include relatives in their plans for total patient care. It has been suggested that compassion and good communication are the most important skills when helping relatives. Support groups for relatives have been recently suggested for recently bereaved relatives .

### **Philosophical Foundations.**

Philosophical foundations will come from a qualitative perspective on research design and method. The study will use an ethnographic approach where details of transactions will be kept to discover the shared systems of meanings at the nursing home with the author acting as a participant observer. The philosophical foundations for this work will be reviewed with reference to ethnographic literature. The culture in the nursing homes will be captured in such a way that its effects on residents, as they are being admitted to the nursing home and as they exist in the nursing home, will be described through the use of field notes and by the author joining in with the activities of the nursing home.

Because placement is often made because no other remedies are readily apparent, there is an obvious need to maximise alternate arrangements or to improve on the existing nursing home arrangements. It is paramount for researchers and policy makers to continue their studies and efforts toward helping nurses ease the older adult group through this major life passage.

### **Research Methods : Data collection , management, and analysis**

Ethnography is chosen as a method that will lead to a discovery of the knowledge that people use socially and culturally to understand their experience and organise their behaviour (Germain, 1993) .The ethnographer starts with discovering what is there in its empirical reality and , then, through long - term participant observation, learns and analyses its local meanings. (Spradley, 1980). There may be a wide variety of types of information, including written texts such as poetry, media, verbal transcriptions, maps, film, drawings, or other visual representations, oral recitations and music. The ethnographer gathers a variety of data types that go beyond the visible facts and that identify the experiential connections that link those facts in people's lives. The ethnographer lives a process of analysing data while collecting them, engaging in an interactive process of gathering and verifying information. In ethnographic work much information is arrived at intuitively and informally. The ethnography should guide the people's ways of living with each other and continuing their society . The ultimate purpose of an ethnography is to make the social action of a society understandable to an audience of another society or to the rest of the same society.

The central method in an ethnography is participant observation, where the researcher becomes part of the culture. There will be detailed and substantial ethnographic case studies of two nursing homes. The case studies will concentrate on each unit as a whole without paying specific attention to the admission of new residents, but including it as part of the units ' everyday work, This broad approach to each case study will minimise the possibility

of the field researcher overly focusing on the admission process, as any intrusion would be inappropriate. Such an approach will contextualise the experiences explored in the previous phase of the study and will identify patterns of practice. Data will be collected in the form of field notes, interviews with informants from within the groups and the reflective accounts of the participant observers own experiences in the setting (Spradley,1979).

Field work will occur over a six week period in each of the two nursing homes, during the day and night. The specific times of the field work will be negotiated with the nursing staff in charge of the nursing home and are expected to be continuous. Depending on the amount and quality of data collected, the researcher in this study may need to revise the time spent in the nursing home. Demographic data about nurses and residents observed will be included as a means of describing the participants. Further supplementary data that will also be used in this study will include patient records of those people in the nursing home at the time of field work, and written procedures and policies relating to the nursing home.

In summary, the processes used to gather information will include the presence of a Nurse Researcher on the premises of the nursing home for a period of six weeks who will be listening to conversations , and observing practices between staff, relatives, patients, doctors and others and recording this either by means of a pen and paper or by noting into a portable laptop computer. She will also be obtaining circumstantial information by looking into policy, procedure and other available ward information and may be taking copies of that information. Confidentiality will at all times be respected and anybody may withdraw from participating in the research at any time without consequence.

The benefits of the research will be increased understanding of the experience of nursing home care and the provision of a research base to inform nursing practice.

## **Appendix E**

***Consent for Cedar Nursing Home.***

I , being authorised at the Cedar Nursing Home hereby give institutional consent to the research "The Culture of Nursing Homes" being conducted at The Cedar Nursing Home. The research has been explained to me and I understand that I can withdraw the institution from the research. I understated that the premises will be used for research purposes only and that the anonymity and confidentiality of the nursing home and all of those people in it will be maintained at all times.

Signed: \_\_\_\_\_ (Print Name)

Designation \_\_\_\_\_

For Cedar Nursing Home

Date: \_\_\_\_\_

Signed Amanda Jane Ruler

The University of Adelaide: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix F**

### ***Consent for Maple Nursing Home***



I , being the Director of Nursing at Maple Nursing Home hereby give institutional consent to the research "The Culture of Nursing Homes" being conducted at Maple Nursing Home. The research has been explained to me and I understand that I can withdraw the institution from the research. I understated that the premises will be used for research purposes only and that the anonymity and confidentiality of the nursing home and all of those people in it will be maintained at all times.

Signed: Andres Namesi,  
For Maple Nursing Home : \_\_\_\_\_

Date: \_\_\_\_\_

Signed Amanda Jane Ruler,  
The University of Adelaide: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix G**

***Poster for nursing homes.***

# The Culture of Nursing Homes Study.

The Department of Clinical Nursing, The University of Adelaide, in collaboration with Monash University in Melbourne and Southern Cross University in Lismore, NSW, has commenced a Research Project on elderly care titled, *Relatives experience of Nursing Home entry: Meanings practice and discourse.*

Australia's population is rapidly ageing and, with this, Nursing Home entry is experienced by an increasing number of Australians. We are aware that conflicting emotions are often encountered by those that make the difficult decision of choosing Nursing Home care. This difficulty can often centre around the conflict between loyalty as a partner or sibling and the special needs and supports of an elderly person.

The majority of studies on Nursing Home admission to date have focused upon the experience of residents or, alternatively on issues concerning community care. There have been very few studies that have gathered qualitative data on **the relatives experience of Nursing Home entry**. Our proposed study therefore aims to address this by re-focusing upon the pre-conceptions and experience of Nursing Homes for relatives rather than residents, with particular focus upon the admissions process.

The processes used to gather information will include the presence of a Nurse Researcher on the premises for a period of six weeks who will be involved in conversations, and observing practices between staff, relatives, patients, doctors and others and recording this either by means of a

pen and paper or by noting into a portable laptop computer. She will also be obtaining circumstantial information by looking into policy, procedure and other available ward information and may be taking copies of that information. She may ask questions also that will help to clarify procedures. Confidentiality will at all times be respected and anybody may withdraw from participating in the research at any time without consequence.

Ultimately through this project we want to formulate some more general understandings about elderly care, relatives and care-givers and Nursing Homes, that will positively inform policy makers in this area and improve the practice of healthcare professionals.

The project has been provided major funding from **The National Health and Medical Research Council** and will extend over a three year period. In accordance with this, the project has been organised in to three main phases of data collection and analysis and uses the following three discrete methodological approaches: discourse analysis, hermeneutical interpretation and ethnography. At the end of each year a report will be generated that we want to send to various participants to canvass their response which will then be integrated in to the study. In the third year a final report presenting the entire project findings will be produced.

# **About the Researcher.**

The researcher is Amanda Ruler, who is being supervised by Professor Alan Pearson through the Department of Clinical Nursing, The University of Adelaide. Amanda was granted a scholarship to do this study, which will be the centre point of her PhD thesis. She will be seen doing her work in the nursing home over a period of six weeks for several hours a day, evening or night.

Amanda is a Registered Nurse who has additional qualifications in Gerontological Nursing. She has worked in Nursing Homes in both the city and country areas of South Australia for more than eight years. Amanda will also be conducting similar research in other Nursing Homes in South Australia and the aim of her work will be to influence government policy on issues that are relevant to Nursing Homes, in collaboration with other researchers.

## **Appendix H**

***Plain language statement.***

### **Information Sheet: The Culture of Nursing Homes Study.**

The Department of Clinical Nursing, The University of Adelaide, in collaboration with Monash University in Melbourne and Southern Cross University in Lismore, NSW, has commenced a Research Project on elderly care titled, *Relatives' experience of Nursing Home entry: Meanings, practice and discourse.*

Australia's population is rapidly ageing and, with this, Nursing Home entry is experienced by an increasing number of Australians. We are aware that conflicting emotions are often encountered by those that make the difficult decision of choosing Nursing Home care.

The majority of studies on Nursing Home admission to date have focused upon the experience of residents or, alternatively on issues concerning community care. There have been very few studies that have gathered subjective data on the relatives experience of Nursing Home entry. Our proposed study therefore aims to address this by re-focusing upon the pre-conceptions and experience of Nursing Homes for relatives, staff and those residents who are able to understand and respond to an interview with particular focus upon the admissions process. In order to do this it will be necessary to interview relatives, staff and residents and, with their permission, gain information about how they have experienced the admission process of the new resident. The researcher will be on the nursing home premises for about six weeks to gather the information and will be approaching people with a view to obtaining the above information, which will be treated as anonymous and confidential at all times. Anybody approached may refuse to be a part of the study at any time and this decision will be respected with no effects on the person's care or situation at the nursing home..

Ultimately through this project we want to formulate some more general understandings about elderly care, relatives and care-givers and Nursing Homes, that will positively inform policy makers in this area and improve the practice of healthcare professionals.

The processes used to gather information will include the presence of a Nurse Researcher on the premises for a period of six weeks who will be engaged in conversations, and observing practices between staff, relatives, patients, doctors and others and recording this either by means of a pen and paper or by noting into a portable laptop computer. She will also be obtaining circumstantial information by looking into policy, procedure and other available ward information and may be taking copies of that information. Confidentiality will at all times be respected and anybody may withdraw from participating in the research at any time without consequence.

The project has been provided major funding from the National Health and Medical Research Council and will extend over a three year period. In the third year a final report presenting the entire project findings will be produced.

The Chief Investigators (Professor Alan Pearson, Professor Rhonda Nay and Professor Bev Taylor) would appreciate your interest and responses to this study and also any further information you may wish to contribute.

The researcher, Amanda Ruler, or her supervisor Professor Alan Pearson, can be contacted at The Department of Clinical Nursing, The University of Adelaide, Royal Adelaide Hospital; Ph: 3033595 ; Fax: 3033594 to discuss any aspect of this study.

You may also contact the Chairman of the Research Ethics Committee at The Royal Adelaide Hospital on 82224139 regarding any aspect of this study.

## **Appendix I**

### ***Consent from participants***



**Consent Form (Residents) The Culture of Nursing Homes Study.**

**Investigators:** Professor Alan Pearson, MSc (Clinical Nursing), PhD,  
Professor of Clinical Nursing, The University of Adelaide.

: Ms. Amanda Jane Ruler, R.N., B.A., (Hons), Grad. Dip. Gerontological  
Nursing, PhD Candidate,  
The University of Adelaide.

1. The nature and purpose of the research project has been explained to me. I understand it, and agree to take part.
2. I understand that I may not directly benefit from taking part in the study.
3. I understand that , while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
4. I understand that I can withdraw from the study at any stage and that this will not affect my medical care, now or in the future.
5. I have had the opportunity to discuss taking part in this investigation with a family member or friend.
6. I understand that there is no payment to me for taking part in this study.

Name of participant: \_\_\_\_\_

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: \_\_\_\_\_

(Investigator)

**Consent Form (Staff). The Culture of Nursing Homes Study.**

**Investigators:** Professor Alan Pearson, MSc (Clinical Nursing), PhD,  
Professor of Clinical Nursing, The University of Adelaide.  
: Ms. Amanda Jane Ruler, R.N., B.A., (Hons), Grad. Dip. Gerontological  
Nursing, PhD Candidate, The University of Adelaide.

1. The nature and purpose of the research project has been explained to me. I understand it, and agree to take part.
2. I understand that I may not directly benefit from taking part in the study.
3. I understand that , while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
4. I understand that I can withdraw from the study at any stage without consequence.
5. I have had the opportunity to discuss taking part in this investigation with a family member, friend, or colleague.
6. I understand that there is no payment to me for taking part in this study.

Name of participant: \_\_\_\_\_

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: \_\_\_\_\_  
(Investigator)