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Health Research  
& Practice Development  
Nursing Homes Ireland

# **THE LIVED EXPERIENCE OF NURSING HOME RESIDENTS IN THE CONTEXT OF THE NURSING HOME AS THEIR 'HOME'**

August 2017

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## FOREWORD

Nursing Homes Ireland (NHI) and the NHI Nursing Committee are delighted to partner with Ulster University in commissioning this major research project exploring the lived experience of nursing home residents across Ireland. This partnership above all demonstrates our members' commitment to ensuring that the residents who call nursing homes "home" are provided with the highest quality care and services. At present, private and voluntary nursing homes are a "home away from home" for over 22,000 residents who require specialist, dedicated, continuous care in the community.

This study is particularly timely given the growing demand for private long-term residential care in Ireland due to a continuing increase in the numbers growing older and living longer. Figures from Census 2016 reveal that for the population aged over 85, the male population increased by 24.8 per cent to 23,062 while the female population increased by 11.4 per cent to 44,493. In this context, exploring the perspective of older people receiving such care is key in planning for the future.

The results of this research can play a significant role in informing and educating key stakeholders across the healthcare spectrum and wider society of the contribution of nursing homes and their staff. As the research concludes, nursing homes can and *are* perceived as "home" by many residents. This can be attributed in significant part to compassionate, responsive and dedicated staff who on a daily basis help create a welcoming environment for residents in nursing homes across all parts of the country. However, the study points out that nursing home care in Ireland can be undervalued and be subject to unfair criticism. This has proven to be a key contributory factor in

hindering the supply and availability of highly skilled and ambitious nurses and care assistants in Ireland. With an ever-aging population, it is essential that Government and health policymakers ensure that workforce planning addresses the challenges of attracting and retaining high-quality staff in our sector.

One of the other key findings emerging from this research is the need for greater collaboration between the HSE and individual nursing homes. This is something which NHI has long advocated. As residents' transition from a hospital environment or from their own home to a nursing home setting, there is a need for strong cooperation and effective communication amongst all stakeholders in this process.

NHI looks forward to partnering with other actors in the long-term care sector to ensure this transition is as smooth as possible. It is vitally important for current and future residents, relatives and staff that the move into a nursing home is rightly recognised as a positive life choice.

Finally, I would like to take this opportunity to commend the work of the research team at Ulster University's School of Nursing and the Institute of Nursing and Health Research, and in particular Dr Kevin Moore and Professor Assumpta Ryan. The recommendations put forth will help frame our members' future policies to ensure all residents feel "at home" in their local nursing home.

A handwritten signature in black ink, appearing to read 'Tadhg Daly', with a stylized flourish at the end.

**Tadhg Daly**  
**Chief Executive Officer Nursing Homes Ireland**

## **Acknowledgements**

The research team would like to thank all those who assisted with this study in any way. Firstly, we wish to extend our sincere and deepest thanks to all the nursing home residents and staff who contributed to this research by giving their valuable time, to offer insights and to share their feelings and experiences by participating in the focus group interviews. Your participation and contribution to this study is acknowledged with our sincerity and gratitude.

We wish also to thank the Nursing Committee from Nursing Homes Ireland (NHI), who participated within this study. Moreover, we wish to acknowledge the ongoing facilitation and support of the NHI Practice Development Facilitator, Mrs Sinead Morrissey and her colleagues, especially Mrs Gaynor Rhead, who assisted with the early part of the project. We wish to thank them for their time, patience, consideration and invaluable contribution throughout the entire study.

We are grateful to all the nursing homes registered with Nursing Homes Ireland, for facilitating and enabling access for the research team from Ulster University. All of the nursing homes that participated accommodated the research team with all aspects of the data collection and demonstrated a willingness for active participation in the research. The important contribution and foresight of Nursing Homes Ireland, who were involved in the initial development of the research proposal, is acknowledged with gratitude.



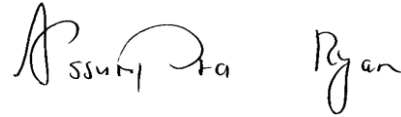
This study would not have been possible without funding from NHI and we wish to thank Mr Tadhg Daly, Chief Executive Officer, NHI, for supporting this important and timely study.



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The full research report entitled: *The Lived Experience of Nursing Home Residents in the Context of the Nursing Home as their 'Home'* is accessible via:  
<http://www.science.ulster.ac.uk/inhr/pcp/publications.php>

The citation for this research report is as follows:

Moore, K.D., & Ryan, A.A., (2017). *The Lived Experience of Nursing Home Residents in the Context of the Nursing Home as their 'Home'*. July 2017. Ulster University (2017).

## **Project Background**

Independent Nursing Homes Ireland Limited (trading as Nursing Homes Ireland) (NHI), and the NHI Nursing Committee has undertaken a review of its strategic approach to advancing nursing and care practices in its member nursing homes. This has included a regionalisation process of training, a review of education/learning priorities and increased funding mechanisms as well as the identification for on-going research that can support, in a robust manner, the advancement of knowledge and evidence-informed practice in the nursing home sector.

NHI had already established informal links with the Person-centred Practice Research Centre (PcPRC) at Ulster University. The PcPRC focuses on the enhancement of knowledge and expertise in person-centred practice. NHI subsequently engaged in further research and practice development activities to ensure that nursing care is delivered in a dignified and compassionate way, that not only centres on the needs of residents but also on the staff who work within such homes. To this end, NHI funded this major research project 'to explore the lived experience of nursing home residents in the context of the nursing home as their *'home'*'. Staff experiences of working within the nursing home sector are interconnected directly to the experiences of nursing home residents and thus including their experiences within this study was deemed essential. The overall aim of the project was to advance knowledge within the sector and to add to, the dearth of literature, within this area, to inform and enhance evidenced-based practice and educational standards and guidelines among its members.

## **ABSTRACT AND SUMMARY**

### **Abstract**

#### **Background**

A worldwide demographic trend elucidates significant global transitions to an older population as people are living much longer. This grounded theory study was designed to explore the lived experience of nursing home residents in the context of the nursing home as their '*home*'. Further, the study also explored how staff employed within the nursing home sector in the Republic of Ireland, facilitated the creation of a homely environment for their residents. The transition to long-term care can be an emotional and stressful experience for older people and their families and whilst much literature reports on such transitions, very few studies have explored the concept of the nursing as the residents' *home*.

#### **Aim**

The overall aim of this study was to explore the lived experience of nursing home residents in the context of the nursing home as their '*home*'. Moreover, it also aimed to evaluate and critique the role of nursing home staff in enabling and maximising a '*homely*' experience for their residents.

#### **Design and Methods**

This was a grounded theory study, which used qualitative data collection methods. A semi-structured interview schedule was operationalised within focus groups with both nursing home residents and nursing home staff. Interviews lasted approximately one-

hour and were recorded and transcribed verbatim. The total number of participants was 92 comprising 44 staff members and 48 residents. A total of eight staff groups and eight resident groups participated in sixteen focus groups which were conducted in both urban and rural areas and which contained a mixture of nursing home types (single operator and groups) from the private and voluntary sectors.

## **Analysis**

Data were analysed using open, axial and selective coding methods. Manual analysis of transcripts, charting, field notes and collages contributed to the earlier stages of analysis and then QSR NVivo was utilised, which assisted in the retrieval and storage of participant data. This facilitated the emergence of sub-categories to support the core category and subsequently the development of a substantive theory on the context of nursing homes as 'home'.

## **Conclusion**

***'Understanding'*** and ***'knowing'*** the ***'person'*** was central to the concept of ***'homely care'*** in participating nursing homes. This theory describes the centrality of the experience for both the recipients of nursing home care and the staff who provide this care.

# **Chapter 1: Background to the Study**

## **1.0 Introduction**

A worldwide demographic trend elucidates significant global transitions to an older population as people are living much longer (Want et al., 2008; Gitlin et al., 2009). The approximate world population is over 7.3 billion people, with an estimated annual growth of world population of 1.13% (GeoHive, 2016). The population of Ireland is approximately 4.7 million (4,757,976) and the population growth of Ireland is 0.544% annually (GeoHive, 2016; Central Statistics Office, Ireland [CSO], 2016). The United Nations [UN] Population Division (2016) reports that approximately 20 countries in 2000 had over one-fifth of their total population aged 65 years and over. Population projection figures suggest that many of these countries will have well over 35% of their total population aged 65 years and over by 2050. Further, they suggest that in most regions and countries of the world, the population aged 60 or more is growing faster than younger adults and children, and this has important consequences for the family, the labour market, and public programs directed to different generational groups (UN, 2016).

Some authors report that the population projection figures for Ireland may increase to approximately 14.2% in the over 65 years' age category (Layte, 2009; CSO, 2016) with a 21.6% projected increase in those living in Ireland over 85 years of age in comparison to the 2011 census data (CSO, 2016). Life expectancy has thus increased significantly over the years and many people are now living well into old age and

terminology such as the young old (60+) and the very old (85+) are evident within the literature (Curtin, 2004; Layte et al., 2009).

These demographic trends are significant policy drivers throughout Ireland, the United Kingdom (UK) and Europe consistently recognise the ageing population and the challenges that this entails. When other issues, such as the normal physiological and psychological factors of ageing are considered, then clearly chronological age is not the only consideration in terms of the challenges for health care provision (National Council on Ageing and Older People, [NCAOP], Murphy et al., 2006; Layte et al., 2009). The resultant myriad of potential issues that people may face are enormous. These include chronicity of ill health, cognitive decline, physical ill health and mental health diseases. Moreover this will provide significant challenges for the provision of effective and responsive models of health and social care, (Cowan et al., 2003; NCAOP, Murphy et al., 2006; Layte et al., 2009; Glendinning, 2010; The McKinsey Report, 2010; Transforming Your Care (TYC), DHSSPS, 2011; Livindhome, 2011; The Appleby Report, 2011).

A recent Health Services Executive (HSE) publication 'Dementia-Understand Together' (HSE, 2017) reported that there are now 55,000 in Ireland living with dementia with an estimated 4000 people each year developing the condition. The statistics also revealed that 1 in 10 people diagnosed with dementia in Ireland are under 65 years of age and approximately two-thirds of people living with dementia in Ireland are women. These figures are consistent with the rising occurrence of dementia worldwide. The oldest old (i.e. those aged 80 years and older) make up a high proportion of the estimated population of people with dementia. Clearly, expertise

in caring for this group, many of whom will have coexisting illnesses and disabilities, is needed, and this will present challenges for provision of effective nursing care for older people. The 'Dementia-Understand Together' report also suggests that over 180,000 people in Ireland are currently or have been carers for a family member or partner with dementia with many more providing support and care in other ways (HSE, 2017). Assuring the quality of life for people with cognitive decline presents many challenges for the nursing home care of these vulnerable people (NCAOP, Murphy et al., 2010; Cahill and Diaz-Ponce, 2010; Cahill and Diaz-Ponce, 2011).

Indeed, some authors clearly articulate that they perceive some of these challenges as major inhibitory factors within all aspects of health and social care provision that may contribute to a poor quality of life expectancy for the older person. Meyer and Owen (2008) reported on the European Commission's Health and Long-term Care in the European Union [EU] (2008). They suggested that a number of challenges could be anticipated for long-term care such as access for all; finance; co-ordination between social and medical services; promoting home or community based care, improving recruitment and working conditions of formal carers, and supporting informal carers.

Some authors have suggested that the quality of care today is sub-optimal in some areas with the identification and need for strategic government action and direction. Furthermore, questions arise as to the environs for such care and how it is to be financed in the longer term (Meijer et al., 2000; Livindhome, 2011). The evidence suggests that the number of people being cared for and wanting to be cared for at home, is increasing with both Irish and UK Government strategic drivers emphasising this (Health Services Executive [HSE], 2011; DHSSPS, 2011; Care Quality

Commission, 2013). According to the Irish Medical Organisation's (IMO) Chief Executive George McNeice, elderly citizens value their independence and prefer to remain in their homes within their own community (IMO, 2016). Moreover, other empirical evidence suggests that an older person's first choice and preference would be to remain in their own homes (Moore, 2013; Ryan and Moore, 2013; Moore and Ryan, 2014; Hillier and Barrow, 2015). Meyer and Owen (2008) suggested that the changing nature presented by such global ageing would rearrange the geopolitical order of the next century.

There are thus significant implications for governments in the provision of effective health and social care services, and more importantly in assuring the quality of standards for the recipients of such complex care (McClimont et al., 2004; Layte et al., 2009; Health Information and Quality Authority, [HIQA], 2012, 2016a). Additionally, the need to explore the perspectives of older people receiving such care and their perceived quality of life should remain high on the research agenda (Hellström and Hallberg, 2001; NCAOP, Murphy et al., 2006; Owen et al., 2012; Moore, 2013; Moore and Ryan, 2014; Hillier and Barrow, 2015). Moreover, the need to explore the nature of the lived experience of 'home' will be central to the effectiveness of such care provision (Lawrence and Banerjee, 2010; Riedl et al., 2013). A workforce that is strategic and responsive to individual, societal and government demands, and one that enables and supports independent living, promotes respect, dignity and person-centeredness, whether this occurs in the person's own home or in a nursing home, is thus an essential and important facet to assuring that service provision is fit for purpose.



Ryan et al., (2009) outlined the importance of ensuring that effective mechanisms of support are in place to enable people to live at home and Genet et al., (2011) asserted that services provided at home were becoming increasingly important. Clearly, a need exists for a more comprehensive insight into the context of care at 'home' in Europe as a whole, utilising uniform frameworks, standards and methodologies. The Livindhome Report (2011) provides important insights into home care as the research focussed on identifying the drivers for change in each country and that country's response with regard to the organisation, provision, regulation and quality of home care. However, it does not explore the context and nature or meaning of 'home', nor does it offer a sufficient operational definition.

Moore and Ryan (2014) explored the role of home care assistants and highlighted a disconnect in the centrality of such roles and their recognition within the wider health and social care contexts. Thus, many countries, including Ireland, have identified the need to strategically drive improvements in healthcare in order to provide high quality, reliable and safe care to the population in the most effective, efficient and accessible way within the resources available. There are many positive examples of good healthcare (NCAOP, Murphy et al., 2006; Phelan and McCormack, 2012; Day, 2016). There are also examples of service users being let down by serious failings in such health and social care systems, within the Republic of Ireland (HSE, McCoy Review Group, 2016), Northern Ireland (The Regulation and Quality Improvement Authority (NI) [RQIA], 2014) and mainland UK (The Francis Report, 2013). The literature does not refute the necessity of assuring the quality of care provision, but it does allude to the complexities that exist in achieving such quality.

HIQA (2012) reported on the need for greater reliability and less variation in the quality of Irish healthcare and the need for the setting and implementation of standards and monitoring compliance with them as important levers in driving improvements in quality and safety in healthcare. HIQA (2012; 2016a) also suggested that such standards in healthcare were key to safeguarding patients and to delivering continuous quality improvement in care provision.

Notwithstanding this important concept of living in one's own home independently for as long as possible, an ageing population with complex care needs coupled with changes in family size and structure mean that many older people will invariably require nursing home care (Nakrem et al., 2012). The deterioration of physical and mental health coupled with challenges to independence following a fall at home; appear to be significant precursors for a move to a nursing home. This is compounded particularly if the person has sustained a hip fracture because of such a fall, (HSE, 2008; Lisk and Yeong, 2014; World Health Organisation, 2016; Irish Hip Fracture Database National Report, 2016; National Hip Fracture Database Annual Report, 2016). Moving into a nursing home can be a major challenge and many authors have articulated the issues related to this transition (Ryan, 2002; Reed et al., 2003; Davies and Nolan, 2004; Davies, 2005; Ellis, 2010; Gill and Morgan, 2011; Riedl et al., 2013; Couture et al., 2012; Phelan and McCormack, 2016).

HIQA (2012; 2016a) reported that there are many examples of good health care provision in the nursing home sector within Ireland and often these are under-reported. Phelan and McCormack (2012; 2016) explored nursing expertise in residential care in Ireland as they viewed such expertise as an essential component of care excellence

in this sector. They presented seven themes, which they asserted represent nursing expertise in residential care of older people:

1. *Transitions: the transition to a nursing home was considered traumatic for the older person and often linked to a decline in health status.*
2. *Context of the nursing home: the idea of communities of practice where knowledge is shared and belonging to a group who have mutual goals.*
3. *Saliency: this involves examining how the expert nurse uses skills related to picking up on and responding to cues in daily practice.*
4. *Holistic practice knowledge: expert nursing depends on the integration of multiple knowledge forms to optimise therapeutic responses.*
5. *Knowing the resident: a central part of person-centredness is personhood, this was apparent in all of the nurses' actions and verbal communications.*
6. *Moral agency: this was evidenced through careful communication strategies that promoted self-determination of residents, respected individuality, promoted dignity and demonstrated value and respect for one's beliefs and those of others.*
7. *Skilled know how: being able to lead and adapt appropriately to situations and mobilising the appropriate resources for individual situations underpinned the skilled know how of the expert nurse.*

(Phelan and McCormack, 2016, 2529-2532)

Phelan and McCormack (2016) advocated that by rendering this expertise visible, the need for appropriate and adequate skill mix for a growing residential care population is presented. Further, they also suggested that the work of these nurses in residential care can often be invisible, and, therefore, unrecognised and it was important that additional attention was given to this area within the published literature.

Williams et al., (2012) suggested that relationship difficulties can emerge early within the transition to a nursing home, suggesting that they could in fact be somewhat antagonistic due to nurses taking over the roles primarily provided by the family up

until this point. Ryan and McKenna (2015) advocated for the need to develop caring partnerships that enabled families to continue providing care to their relatives after the transition into the nursing home. They suggested that this would provide them with a sense of belonging and attachment to the nursing home community (Ryan and McKenna, 2015). This sense of belonging and concern for the residents' resilience and adaptation can underpin both their physical and mental health outcomes for many years (Mossey et al., 2005; Leong et al., 2007; O'Neill et al., 2015).

Therefore, whilst much empirical evidence exists relating to the transition into a nursing home, paradoxically there appears to be a dearth of research evidence that exists on exploring the residents' lived experiences in the context of the nursing home as their '*home*'. Phelan and McCormack (2012; 2016) alluded to this being a complex phenomenon, which encompasses many aspects of care delivery in a person-centred framework. McCormack et al., (2012) articulated the importance of appreciating the 'person' in long-term care, whilst Dewar and Nolan (2013) advocated the importance of 'appreciative caring conversations' to promote compassionate relationship-centred care. Buckley et al., (2013) asserted the importance of valuing narrative in the care of older people and advocated a framework for nurses that enables confirmation of the older persons' identity by taking into account the biography of their lives.

This study sought to redress the dearth of literature on this topic particularly within an Irish context. The overall aim of this study was therefore to explore the lived experience of nursing home residents in the context of the nursing home as their '*home*'. Moreover, it also aimed to evaluate and critique the role of nursing home staff

in enabling and maximising a '*homely*' experience for their residents. The objectives of this study were:

- To identify the context and meaning of 'home' from the perspective of residents and staff in the nursing home sector.
- To identify, compare and contrast the residents' context and meaning of 'home' prior to admission to the nursing home.
- To examine current levels of nursing home practice that determines a '*typical day*', thus enabling identification of the factors that may maximise or minimise the lived experience of 'home'.
- To explore the factors that influence current practice and service provision that promotes or inhibits a 'homely' experience.
- To make recommendations to NHI that will inform policy, practice, education and research.

## **Chapter 2: LITERATURE REVIEW**

### **2.0 Introduction**

This Section of the report presents the review of the literature, the importance of which, within the research process, is well documented (Polit and Beck, 2013; Saks and Allsop, 2013). Some authors suggest that it should be completed at different stages in the process, particularly in terms of whether the researcher is utilising qualitative, quantitative or mixed methods (Polit and Beck, 2013). When this is extended to grounded theory then the discussion is somewhat more contentious (Corbin and Strauss, 2008). Glaser (1998) emphasised that the reading of the literature is a problem for many people doing grounded theory, suggesting that the starting point in the research should be with as little formulation of theory as possible. Corbin and Strauss (2008) identified the importance of background in professional and disciplinary literature, gained quite often through prior study within a given field and suggested that the challenges come from deciding how best to utilise this within the data analysis. The Principle Investigator of this study (AR) has significant expertise in research on long-term care and this was important in ensuring that the study objectives addressed a gap in the literature on the concept of home in a nursing home setting.

Therefore, a full literature review was not undertaken initially, rather it was undertaken to augment the data collection and analytical procedures consistent with a grounded theory approach. Therefore, whilst the literature was gathered throughout the entire research process, it was not comprehensively reviewed until there was absolute

confidence about the emergence of core and sub categories during analysis. Once this occurred it became an enabling influence to peruse further literature in a more focussed and comprehensive manner. In fact, the initial emergence of sub categories combined with the ongoing literature search enabled deeper and more critical exploration of nursing home care in a complimentary and interconnected manner. Issues such as the quality of long-term care provision, exploration of the concept of person, constructions of dignity, valuing narrative and appreciation of the 'person' within long-term care did not arise until well into the data collection process.

The search strategy commenced with a review of databases in CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE (Medical Literature on Line) and PubMed, using cross referenced terms: nursing home, quality of life and care homes, wellbeing in nursing and care homes, mental health and care homes, residents' experience of nursing homes and staff expertise in nursing homes. This resulted in a large volume of literature, even with limiters applied to: language of publication (strictly English) and to years of publication (last ten years except in the case of seminal research in the topic). In searching for references using the bibliographic databases, Ovid, EbscoHost and Proquest offered detailed information retrieval that was reasonably easy to use with good on screen support to enable expansion or limiting the search criteria with keywords. It was also possible to combine searches using key words (Refer Table 1). Polit and Beck (2013) suggested that for qualitative studies the key words should be the central phenomenon of interest. This enabled the literature to be categorised as excellent, very good or good. An additional review of publications, reports and policy documents was undertaken within the websites of the Central Statistics Office (CSO) in Ireland and the World

Health Organisation and GeoHive world statistics reports, the Department of Health and Children, the Department of Health, Health Services Executive and Health Information Quality Authority Ireland. Finally, the Ulster University and the Royal College of Nursing Libraries were also searched for books of relevance to the study. These can sometimes be referred to as fugitive literature and it is important that any such literature is included, including unpublished thesis documents (Polit and Beck, 2013).

*Table 1: Search History CINAHL*

| Search ID | Search Terms                          | Search Options Limiters                           | Last Run Via   | Results |
|-----------|---------------------------------------|---|--|---------|
| S1        | Mental Health                         | English Language                                  | Interface- EBSCOhost<br>Advanced Search<br>Database CINAHL | 70,425  |
| S2        | Mental Health<br>AND Care<br>Homes    | English Language                                  | Interface- EBSCOhost<br>Advanced Search<br>Database CINAHL | 64      |
| S3        | Well Being                            |   | Database CINAHL  | 22,400  |
| S4        | S2 & S3                               |   | Database CINAHL  | 6       |
| S5        | Quality of Life<br>AND Care<br>Home   | English Language                                  | Interface- EBSCOhost<br>Advanced Search<br>Database CINAHL | 85      |
| S6        | S3 & S5                               |   | Database CINAHL  | 5       |
| S7        | Nursing<br>Homes AND<br>Patients      | English Language -<br>Boolean/Phrase              | Interface- EBSCOhost<br>Advanced Search<br>Database CINAHL | 37,578  |
| S8        | Long term<br>care                     | Limiters- English<br>Language -<br>Boolean/Phrase | Interface- EBSCOhost<br>Advanced Search<br>Database CINAHL | 10,489  |
| S9        | S7 & S8                               | Limiters Years<br>2007-2016                       | Database CINAHL  | 5989    |
| S10       | S7 & S8 & S9<br>& Life<br>Experiences | Limiters Years<br>2007-2016                       | Interface- EBSCOhost<br>Advanced Search<br>Database CINAHL | 101     |

## **2.1 Older People in Ireland and Challenges to Care Provision**

The population of Ireland is reflective of the worldwide phenomenon in terms of population growth and in particular the growth of an ageing population (UN, 2016;



CSO, 2016). Tables 2-4 outline the specifics of the population growth and changes from the 2006 census data, of older people in Ireland and clearly show a total of 535,393 people over 65 years of age live in Ireland. This is a 14.4% increase overall in the 2006 census data. It also demonstrates that the population increase for males over 65 years of age was up 17.5% and for females of the same age; it was up 12% (CSO, 2016). Of note, the growth of the population over 85 years of age was 24.5% and 20.3% respectively; with females in this age category nearly double that of their male counterparts. This clearly demonstrates that life expectancy in Ireland is increasing significantly with females on average living much longer [81.6 years] than males [76.8 years] (CSO, 2016). This is also reflective within worldwide trends (GeoHive, 2016; UN, 2016).

*Table 2: Population by Sex, Age Group, Statistical Indicator and Year*

| Age Range         | Both Sexes | Population Change | Population Increase Rate | Single Persons | Married Persons | Widowed Persons |
|-------------------|------------|-------------------|--------------------------|----------------|-----------------|-----------------|
| 65 years and over | 535,393    | 67,467            | 14.4%                    | 75,987         | 312,109         | 147,297         |
| 70-74 years       | 131,190    | 12,038            | 10.1%                    | 17,174         | 87,034          | 26,982          |
| 75-79             | 102,036    | 9,570             | 10.3%                    | 15,287         | 54,528          | 32,221          |
| 80-84             | 70,113     | 5,229             | 8.1%                     | 11,898         | 26,914          | 31,301          |
| Over 85           | 58,416     | 10,388            | 21.6%                    | 11,012         | 12,357          | 35,047          |

HIQA (2016b) identified that at the 31<sup>st</sup> December 2015 there were 577 active centres providing 30,106 beds registered within the sector. This was an increase from 565 centres the previous year. They identified that the vast majority of residential services are offered by private providers (76%) with the remainder being managed by the HSE (21%) and voluntary organisations (3%). HIQA (2016b) also reported that the overall size of centres had not significantly changed since 2014 but reported that 6% of

centres were registered to care for less than 20 residents. 33% had between 21 and 40 residents, 55% were registered to provide care to between 41 and 100 residents and a total of 6% were centres with over 100 residents. The largest number of centres was in County Dublin (112) with over 7383 beds and the smallest number of centres was in County Longford (4) with 288 beds. NHI (2016) had a total of 447 nursing homes registered on their database, 390 private and 57 voluntary. Most of these (n=375) are members of NHI and 72 are non-members.

*Table 3: Population by Male, Age Group, Statistical Indicator and Year*

| Age Range         | Both Sexes | Male    | Population Change | Population Increase Rate |
|-------------------|------------|---------|-------------------|--------------------------|
| 65 years and over | 535,393    | 243,314 | 36,219            | 17.5%                    |
| 70-74 years       | 131,190    | 63,476  | 6,936             | 12.3%                    |
| 75-79             | 102,036    | 46,631  | 6,510             | 16.2%                    |
| 80-84             | 70,113     | 28,423  | 3,729             | 15.1%                    |
| Over 85           | 58,416     | 18,486  | 3,641             | 24.5%                    |

*Table 4: Population by Female, Age Group, Statistical Indicator and Year*

| Age Range         | Both Sexes | Female  | Population Change | Population Increase Rate |
|-------------------|------------|---------|-------------------|--------------------------|
| 65 years and over | 535,393    | 292,079 | 31,248            | 12.0%                    |
| 70-74 years       | 131,190    | 67,714  | 5,102             | 8.1%                     |
| 75-79             | 102,036    | 55,405  | 3,060             | 5.8%                     |
| 80-84             | 70,113     | 41,690  | 1,500             | 3.7%                     |
| Over 85           | 58,416     | 39,930  | 6,747             | 20.3%                    |

When we compare these figures to the Northern Ireland context we can see that by 2047 there will be twice as many people aged 65 years of age and over than there is currently today (Northern Ireland Statistics and Research Agency, [NISRA] 2016). Moreover, the Department of Health and Social Services and Public Safety Northern

Ireland (DHSSPS NI, 2010) suggested that an increasing number of older people would most likely be cared for in residential and nursing homes (DHSSPS, 2010). The Northern Ireland Audit Office (2010) have identified the significance of ensuring effective mechanisms are in place to ensure the quality of care delivery within the care home sector.

## **2.2 The Quality of Long-term Care**

In the context of this ageing society with a clear indication of increased life longevity, the Government must ensure that health and social care provision and resources are underpinned with an effective strategy. To this end, the need to provide care at home and nursing home care is most likely going to continue to rise concomitantly with such population changes (NCAOP, Murphy et al., 2006; Meyer and Owen, 2008; Moore, 2013; Moore and Ryan, 2014). Thus, the complexity of health and social care provision is compounded by a myriad of factors such as the changes in health and dependency levels of people living in the community, with reports indicating an increase in the number of increasingly complex cases (Dorr et al., 2006; Laing and Buisson, 2008). Moreover, the need to finance health and social care provision cognisant of these challenges poses significant complexities (Meyer and Owen, 2008; Livindhome, 2011). Providing enhanced public health nursing input that addresses expressed needs and that enables a person to live at home for as long as possible, requires complex multifaceted input from all aspects of the multi-disciplinary team. Moreover, when the need for care in a residential or nursing home setting becomes inevitable, this care must conform to the standards as identified by the regulatory body, the Health Information and Quality Authority (HIQA, 2012).

Residential care is regulated by HIQA, which was established under the Health Act 2007. HIQA monitors compliance against the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland (2016). Under Section 8 (1) c of the Health Act (2007), HIQA has the function to monitor compliance with the aforementioned standards and to advise the Minister for Health and the HSE accordingly. These standards are articulated into four broad themes. **Person-centred care and support** – how services place the service user at the centre of their delivery of care and this includes the concepts of access, equity and protection of rights; **Effective care and support** – how services deliver best achievable outcomes for service users in the context of that service, reflecting best available evidence and information. This includes the concepts of service design and sustainability; **Safe care and support** – how services avoid, prevent and minimise harm to service users and learn from when things go wrong; and **Better health and wellbeing** – how services identify and take opportunities to support service users in increasing control over improving their own health and wellbeing (HIQA, 2012).

HIQA (2012, 8) further suggested that delivering improvements within these quality dimensions depends on service providers having capability and capacity in four key areas:

1. *Leadership, governance and management – the arrangements put in place by a service for clear accountability, decision-making, risk management as well as meeting their strategic, statutory and financial obligations.*
2. *Workforce – planning, recruiting, managing and organising a workforce with the necessary numbers, skills and competencies.*
3. *Use of resources – using resources effectively and efficiently to deliver best possible outcomes for service users for the money and resources used.*

4. *Use of information – actively using information as a resource for planning, delivering, monitoring, managing and improving care.*

(Health Information and Quality Authority, 2012, p8)

HIQA (2016b) reported after conducting over 411 inspections in 343 nursing homes, (49% unannounced and 51% announced) that, whilst most centres had an acceptable level of overall compliance with the regulations and standards; many needed to improve their approach to governance, the provision of high quality premises, risk management, fire precautions and staffing levels.

HIQA (2016a) have the authority to apply to the courts to de-register any nursing home that does not comply with these National Standards. According to the Department of Health (2016), nursing homes in Ireland are a mixture of private, public and voluntary care facilities. Table 5 outlines the long stay summary statistics available from the Department of Health for 2014 based on a 79% response rate to statistics collation for all voluntary, private and long term care facilities (Department of Health, 2016). These figures clearly show the demands placed on these services from the older population, with total bed occupancy at 93.4%, which represents a 3.8% increase overall in occupancy rates since 2005. Moreover, those aged 85 years of age and over accounted for 49.2% of the total number of residents in long-term care facilities at year-end. The patients' dependency levels were also reported at 39.8% for the maximum amount of care.

Figure 1 (Department of Health, 2016) clearly shows the increase in the number of people aged 85 years in long-term care over a ten-year reporting period. It should be noted that these figures are based on return rates (79%) and must therefore be

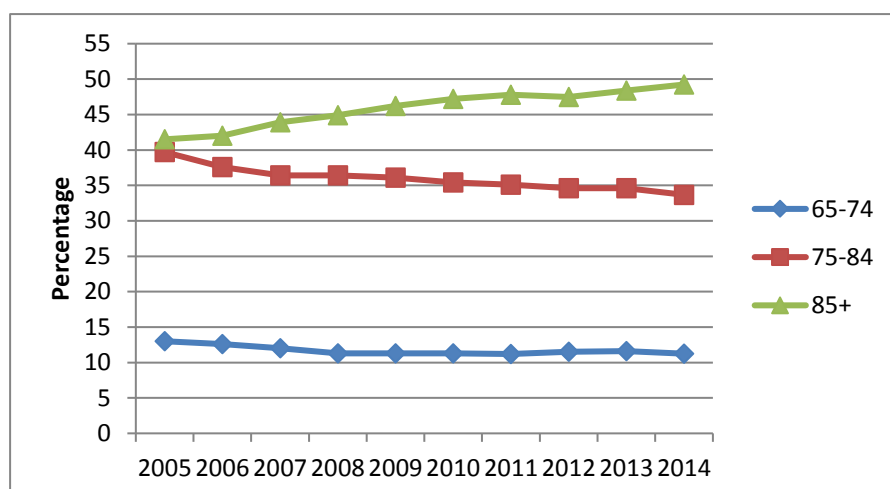
interpreted with a degree of caution (Department of Health, 2016). It is also argued that dependency levels in the Long-Stay Statistics are not measured using a validated tool. Therefore, they may be skewed as this data is not borne out in practice or when compared with more accurate methodology as is in use in the Fair Deal care assessment processes.

*Table 5: Long-stay care summary statistics, 2014*

| Details                              |            | 2014   |
|--------------------------------------|------------|--------|
| Number of Beds                       |            | 23,002 |
| Number of Patients Resident at 31/12 |            | 21,486 |
| % of Beds Occupied                   |            | 93.4   |
| Age Distribution (as % of total)     | 65-69yrs.  | 4.1    |
|                                      | 70-74 yrs. | 7.1    |
|                                      | 75-79 yrs. | 12.9   |
|                                      | 80-84 yrs. | 20.8   |
|                                      | 85+ yrs.   | 49.2   |
| Level of Dependency (as % of total)  | Low        | 12.4   |
|                                      | Medium     | 20.8   |
|                                      | High       | 26.5   |
|                                      | Maximum    | 39.8   |

These figures represent unequivocal evidence of the growing population trends within Ireland that are reflective of world demographic trends. Therefore, there will be a concomitant increase in the presentation of people with complex care needs who will invariably require high levels of health and social care. Consequently, the need to ensure the quality of long-term care within the care home sector has received significant attention within the published literature.

*Figure 1: Long-stay care: percentage of residents aged 65+ years, by age group, 2005 to 2014 (Department of Health, 2016).*



Of equal importance to the aforementioned standards (HIQA, 2012; 2016a), are the individuals' health outcomes before, during and after this important life transition into a care home. These must also be to the forefront of the decision-making process (Ryan and Scullion, 2000a; Ryan and Scullion, 2000b; NCAOP, Murphy et al., 2006; Cahill and Diaz, 2010; Holder and Jolley, 2012; Kirsebom et al., 2012). Many authors have reported significant changes in the quality of life particularly with respect to physical, psychological and social functioning in later life that are directly related to the individuals need for a nursing home admission (Gerritsen et al., 2004; Meyer and Owen, 2008; NCAOP, Murphy et al., 2010). In addition, falling at home and sustaining fractures, particularly hip fractures, increases exponentially the likelihood of a nursing home placement (World Health Organisation, 2016; Irish Hip Fracture Database National Report, 2016).

It is also reported that quality of life is a predictive variable for individual autonomy and independence and inextricably linked to one's perceived sense of mortality within

the ageing process (Ho et al., 2002; Dorr et al., 2006). Further, The Institute of Public Health in Ireland (2016) have examined the prevalence of loneliness and suggested that the quality of life for older people may be impacted by the experience of loneliness. They further suggested that loneliness was linked to many health outcomes including depression, nursing home admission and an awareness of one's own mortality.

Masso and McCarthy (2009) explored various issues related to the provision of effective residential care and in particular explored the relevance of management, quality improvement initiatives and the utilisation of evidenced-based practice in these settings. They alluded to the need for effective and collaborative involvement from all stakeholders while also recognising that participation in ongoing education and training for staff was central to high standards of care. More recent authors have also endorsed these earlier assertions (Phelan and McCormack, 2012; Phelan and McCormack, 2016; Penny and Ryan, 2017).

Murphy et al., (2006) reported on the National Council on Ageing and Older People (NCAOP) and the National Economic and Social Forum (NESF, 2005) assertions that enhancing the quality of life of older people in different settings should be a key policy priority. They alluded to the fact that '*quality of care is a key determinant to quality of life*'. The NCAOP (Murphy et al., 2006) thus stated that a core objective of long-stay care service delivery must be rehabilitation and the enhancement of quality of life.



They recommended:

*“All future legislation, policy documents and service statements relating to long-stay care services for older people, whether public, private or voluntary, at a local, regional and national level, assert that a core objective of these services is promotion of quality of life and rehabilitation”.*

NCAOP (Murphy et al., 2006, 14)

The NCAOP highlighted four broad domains of quality of life in long-stay care, which were:

- 1. Independence and autonomy of the resident;*
- 2. A resident's ability to maintain his/her personal identity and sense of self;*
- 3. A resident's ability to maintain connectedness, social relationships and networks within and outside the care setting*
- 4. A resident's engagement in meaningful activities.*

NCAOP (Murphy et al., 2006, 15)

In order to promote such independence and autonomy and to maximise quality of life, it is important that the ethos of care is collaborative and collegiate, facilitating choice and self-sufficiency. Further, care should be focussed on person-centredness and on enabling residents to live, insofar as is possible, in a manner akin to their own homes (NCAOP, Murphy et al., 2006). The NCAOP (Murphy et al., 2006) firmly believed that a new focus on improving the quality of life of residents would require a change of mind-set and a new vision for long-term care, which, among other things, challenges stereotypical assumptions about old age and promotes rehabilitation and quality of life.

Owen et al., (2012) reported on a three-year longitudinal study and the lessons learnt from the My Home Life Programme in the UK examining what works in the promotion of 'voice, choice and control', for older people who live in care homes. They posit that the principles of 'voice, choice and control' align well with the three My Home Life (MHL) Personalisation themes, namely: '*Maintaining Identity*', '*Sharing Decision-Making*', and '*Creating Community*'. Furthermore, they believed that attaining 'voice, choice and control' in a care home was more complex due to the fact that the individual needs and aspirations of the person had to be negotiated with others within the wider collective living community of the home.

Meyer and Owen (2008) had reported earlier on the evidence base for MHL indicating that the research explored on two primary objectives: '*what residents want from care homes*', and '*what practices work in care homes*'. They put forward eight integrated themes:

1. *Managing Transitions: supporting people both to manage the loss and upheaval associated with going into a home and to move forward.*
2. *Maintaining Identity: working creatively with residents to maintain their sense of personal identity and engage in meaningful activity.*
3. *Creating Community: optimising relationships between and across staff, residents, family, friends and the wider community. Encouraging a sense of security, continuity, belonging, purpose, achievement and significance for all.*
4. *Sharing Decision-Making: facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life.*
5. *Improving Health and Healthcare: ensuring adequate access to healthcare services and promoting health to optimise resident quality of life.*
6. *Supporting Good End of Life: valuing the 'living' and 'dying' in care homes and helping residents to prepare for a 'good death' with the support of their families.*

7. *Keeping Workforce Fit for Purpose: identifying and meeting ever-changing training needs within the care home workforce.*
8. *Promoting a Positive Culture: developing leadership, management and expertise to deliver a culture of care where care homes are seen as a positive option.*

(Meyer and Owen, 2008, 293)

Their definitive conclusions were that the inclusive nature of these eight themes offered a vision for care homes together with a framework to deliver quality of life in these settings. This vision is underpinned by relationship-centred care and the Senses Framework (Nolan et al., 2006); where there is acceptance that the care home is a shared community of staff, residents, family and friends, all of whom are interconnected to assuring quality of care and improvements within practice.

Penny and Ryan (2017) provided a review of the literature on leadership support and practice development in care homes for people with dementia. They reported that whilst there is a considerable diversity in the methodologies used to develop and evaluate leadership support and practice development initiatives, once they have been implemented they tended to be effective. Further, if such approaches to practice development are based on relationship-centred care and action learning, these appeared to be particularly effective within the care home sector, especially if coupled with leadership support initiatives (Penny and Ryan, 2017).

Munyisia et al., (2011) suggested that whilst staff in nursing homes valued their face-to-face interactions with their residents, and viewed this as a core component to successful care delivery, there remained an important need to extrapolate and analyse further on this specific form of communication as a means of assuring the quality of

care provision to residents. Cahill and Diaz-Ponce (2010) also recognised the complexities of defining quality of life in long-term care, particularly when the resident has cognitive impairment and within their study, they suggested that the term was akin to happiness, a subjective term with different meanings to different people. Cahill and Diaz-Ponce (2010) thus incorporated the criterion as afforded by the World Health Organisation (WHO, 1991) on the broader interpretations and domains of health as intrinsic to quality of life. The World Health Organization Quality of Life (WHOQOL) project was initiated in 1991. The aim was to develop an international cross-culturally comparable quality of life assessment instrument. It assesses the individual's perceptions in the context of their culture and value systems, and their personal goals, standards and concerns. The WHOQOL instruments were developed collaboratively in a number of centres worldwide, and have been widely field-tested. The WHOQOL-BREF instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment (WHO, 1991).

Clearly, the literature on the quality of life is complex and multi-faceted. Murphy et al., (NCAOP, 2006) advocate that objective domains are those such as the physical and care environment, physical and mental health, level of functioning, and socioeconomic status. The subjective domains are psychological well-being, autonomy and independence, purposeful activity, social relationships, spirituality and identity/sense of self. They concluded that the emergence of such domains confirms the complex, interrelated and multidimensional nature of quality of life for older people.

Patomella et al., (2016) who conducted a cross-sectional study pointed out that residents with higher levels of thriving in nursing home environments had shorter length of stay in the facility, higher functioning in Activities of Daily Living, less cognitive impairment, lower frequency of behavioural and psychological symptoms and higher assessed quality of life. The ability to walk and to spend time outdoors were higher among residents with higher levels of thriving.

## **2.3 Transition to a Nursing Home**

There is a significant degree of published literature on the transition to nursing or residential care facilities. Guihan et al., (2011) predicted that the need for long-term care would continue to grow due to the 'baby boomers age'. Some authors focused on how the move was perceived as a forced relocation (Holder and Jolley, 2012) that resulted in detrimental effects to the wellbeing, survival and overall health profile of residents. Others reported on the transition as a significant life event, resulting in anxiety symptoms with severe emotional results being experienced by both the older people concerned and their families (Cheek et al., 2007; Ellis, 2010; Kirsebom et al., 2012). Katz et al., (2013) suggested that a commonly held view about moving to a care home was that it was often seen as a last resort, particularly by family members. Brandburg et al., (2013), pointed out that an understanding of the strategies that facilitate residents to make a successful transition to long-term care, would enable nurses to provide support at this difficult time. They identified over 21 facilitative strategies, which were underpinned by the core category of personal resilience. Resilience refers to a person's ability to adapt successfully to challenges within life

that are often described as negative, traumatic or stressful (Cohen et al., 2006, cited Brandburg et al., 2013).

Wilson (1997) suggested that the transition to a nursing home occurred in three phases: 'overwhelmed', 'adjustment', and the 'initial acceptance phase'. Whilst she acknowledged that these phases were unique to each person, they were nonetheless clearly evident and different depending on whether the move was a planned or unplanned event. Bridges (2004) also identified three transitional phases resulting in some form of psychological reorientation for the person. Phase 1 was 'endings that involved letting go and experiencing loss in some form'; Phase 2 was 'the neutral zone', a type of in-between phase, usually associated with significant uncertainty; and finally, Phase 3, was described as 'a new beginning that may also involve a new focus or new identity'.

Davies and Nolan (2004) suggested that making the move to long term care required an exploration of the relatives' experiences as they ultimately were closely linked to the final decision making process. They identified three phases to the transition from the relatives' perspective: 'making the best of it', 'making the move', and 'making it better'. Lee et al., (2013) accepted that the move into residential care was associated with increased stress and anxiety for the person and their families and their research sought to explore qualitatively older people's experiences and the importance of narrative analysis. They suggested that professionals should move away from considering the transition as a stage-based process ending in acceptance. They suggested that instead they should focus on how residents perceive relocation in relation to previous life experiences, unspoken fears evoked by moving and how the

environment and relationships with staff may be altered to assist residents in maintaining their identity and sense of control.

Davies and Nolan (2004) asserted strongly that health and social care practitioners have enormous potential to influence relatives' experiences of nursing home entry and that such experiences are enhanced if family-carers perceive that they are able to work in partnership with care staff in order to ease the transition for the older person. Many other authors have also explored experiences and views of family members and carers in this transition process (Smallegan, 1985; Kellett, 1999; Ryan and Scullion, 2000a and 2000b; Ryan, 2002; Sandberg et al., 2002; Davies and Nolan, 2004; Couture et al., 2012; Ryan and McKenna, 2015). Many authors have placed significant emphasis on the availability, or not, of supportive mechanisms to support families through the adaptation process and on the need for effective communication between the nursing care team and the family.

Ryan et al., (2012) specifically focussed on rural family carers' experience and suggested that older people had a deep attachment to their own homes and entry to care was seen as a last resort. They suggested that family carers had close relationships with health and social care practitioners and felt supported in the decision-making process. The resultant choice of care home was, they asserted, linked to a sense of familiarity that existed in rural communities. Moreover, this sense of familiarity also influenced the timing of the placement and the responses of family carers. Moore (2013) and Moore and Ryan (2014) elaborated upon the importance of rurality within health and social care provision and noted much more empirical research was needed within this area.

Some authors have suggested that moving into a care home is a significant challenge to one's identity (Wiersma and Dupuis, 2010; Riedl et al., 2013), whilst others suggested that there are many psychological implications (Ellis, 2010) and more recently Stevens et al., (2015) provided a clear analysis of the need to 'choose the right path' to a nursing home. They attributed the lack of knowledge regarding options available and suggested that ethical issues arise when an older person is admitted to a care home facility to receive twenty-four-hour care, when perhaps they needed minimal support for their clinical needs (Stevens, et al., 2015).

Research by Cooney (2012) identified four categories as critical to identifying and 'finding home' in long-term care settings. These were 'continuity', which she believed helped to create a sense of security, comfort and predictability for the person. The second category was, 'preserving a personal identity', which she asserted centred around having time on their own, privacy and personal belongings and most importantly feeling known and valued as an individual. The third category focussed on the resident feeling as part of a group, having companionship, relaxation and fun and this category was labelled 'belonging'. Finally, she suggested that 'being active and working' with structured activities within the home helped many residents gain a sense of satisfaction within their daily lives. Cooney (2012) concluded that long-term care settings are first and foremost a resident's home and moving beyond the technical and procedural aspects of care enabled nurses to meet the holistic needs of the individual.



## 2.4 Delivering Dignity in Care for Older People in the Nursing Home Sector

There is no denying that dignity and respect should be core constructs intrinsic to effective and compassionate care for all people, not just older people. Indeed, Yalden and McCormack (2010) stated that dignity was a pre-requisite for flourishing in the workplace. The vulnerability of many older people with multiple and complex needs, coupled with resource constraints can make it difficult for staff to deliver care that is person centred, respectful and courteous. That said, allegations of abuse within the caregiving relationship and identification of a deviation from basic care standards associated with a loss of dignity are not acceptable to anyone (Meyer, 2009; Commission of Dignity in Care, 2012; Oosterveld-Vlug et al., 2013).

Meyer (2009) reported on the high numbers of complaints that had been received about the lack of dignity, respect and compassionate care within the NHS in the UK. According to the Commission on Dignity in Care (2012) report:

*“Undignified care of older people does not happen in a vacuum; it is rooted in the discrimination and neglect evident towards older people in society”*

(Delivering Dignity: Securing Dignity in Care for Older People Report, 2012, 4)

Some authors (Dwyer et al., 2009) have attempted to explore dignified caregiving by nursing home staff in end of life situations care and reported that dignity was presented within the main theme of *‘maintaining self-respect – being shown respect’*. The authors felt that nursing home staff dealt with a moral conflict between what they were able to deliver and what they would like to deliver and this represented a conflict between *‘the ideal and the reality’* (Dwyer et al., 2009). Following on from their

facilitated active learning approach within which they attempted to make sense of dignity, Yalden and McCormack (2010) concluded that dignity was interlinked with actions that promoted person-centredness in developing a palliative approach to care.

Oosterveld-Vlug et al., (2013) concurred with some of these earlier assertions and felt that waiting for help, being dictated to by nurses and not receiving timely attention could result in a consequential loss of one's dignity. However, they also put forward a different perspective to refute the apparent general view in society that living within a nursing home always-undermined one's dignity. They believed that one did not need to have less self-worth simply because they were in a nursing home. They posited that good professional care with a supportive network can help to preserve the persons' dignity and that people must pay more attention in broader terms to how older people are being treated by both relatives and society as a whole (Oosterveld-Vlug et al., 2013).

Wadensten et al., (2009) reported on what they believed was the dearth of literature on what constituted good communication and good encounters in nursing homes for older people. They asserted that good encounters were those where caring was delivered with equality, integrity and provided support and security for the recipients. However, they acknowledged that for this to happen, nursing home staff must be empowered and must receive more training and supervision to enable them to develop and improve their encounters with older care recipients. Similar assertions underpin those offered by the Commission on Dignity in Care (2012) and their

articulations that every staff member is responsible for dignity in care provision and they postulated '**Always**' events as the foundation for dignity in care:

- **Always** treat those in your care as they wish to be treated, with respect, dignity and courtesy;
- **Always** remember nutrition and hydration needs;
- **Always** encourage formal and informal feedback from older people and their relatives, carers and advocates to improve practice;
- **Always** challenge poor practice at the time, and learn as a team from the error;
- **Always** report poor practice where appropriate, the people in your care have rights and you have professional responsibilities.

Commission on Dignity in Care (2012, p12)

The empirical literature reports the importance of home and its meaning in people's lives. Gillsjo and Schwartz-Barcott (2010) reported that home for many older adults is the centre of their daily life and increasingly important as a place where health care is delivered, but suggested that, as a concept, it was theoretically and empirically underdeveloped. If the nursing home is the persons' home, then it is fundamentally important that their views are heard and respected to ensure preservation of dignity and inclusivity within the caring relationship. However, Nakrem et al., (2012) attempted to describe residents' experiences of living in a nursing home related to the quality of care and found, what they termed 'ambiguities, concerning the nursing home as a home and place to live; a social environment in which residents' experience most of their social life; and, an institution where professional health care is provided. They believed that high quality care was evident when ambiguities were managed well and a home could be created within the institution.

The centrality of the therapeutic relationship has been extensively evaluated within many disciplines, particularly nursing and in particular mental health nursing (Barker, 2009; Egan, 2010). Gallant et al., (2002) highlighted the importance of 'partnership' within the nurse-client relationship but also indicated that conceptual definitions differ in scope and vary according to the context of the partnership and types of partners. The concept of hope and self-efficacy are reported within the literature and according to Duggleby et al., (2009) are important aspects for spiritual well-being and job satisfaction in continuing care assistants. The principles of caring for a person within a formal paid caring relationship has many facets, resulting in perhaps both a positive, or perhaps a negative, caring experience for the carer and the care recipient (Gallant et al., 2002).

There is also much evidence within the empirical literature that extrapolates upon the qualities of caring and person centred ideologies (McCormack and McCance, 2006; McCance et al., 2008; McCormack and McCance, 2010) that are connected to human flourishing and dignity within caring relationships. Caring has been viewed as a human trait, as a moral imperative, as an interpersonal interaction, as an affect, and as a therapeutic intervention (McCormack and McCance, 2010). Caring can be viewed as both formal and informal within the relationship and both are viewed as complementary aspects to effective provision of complex activities of daily living (Dale et al., 2008).

The primacy of the nurse-patient/nurse-client relationship has been well documented within the literature and many have drawn upon the influence of early scholars in the field of interpersonal relationships, (Rogers, 1951; Peplau, 1952; Buber, 1958;

Orlando, 1961). Moreover, on their more recent assertions by the same authors (Rogers, 2003; Buber, 2010; Peplau, 2016) on the provision of compassionate and dignified care. Preserving dignity, respect for the person, promoting advocacy and valuing people as individuals are all advocated within the literature (Coyle and Williams, 2001; Naden and Eriksson, 2004; Dwyer et al., 2009; Yalden and McCormack, 2010).

Anderberg et al., (2007) suggested that the attributes for preserving dignity are individualised care, control restored, respect, advocacy and sensitive listening. Some authors have suggested that, in the absence of a therapeutic relationship or therapeutic alliances within care, mutuality of trust, respect and dignity cannot occur (Ross et al., 2014; Farrelly et al., 2014). Bach and Grant (2011) suggested that nurses must deploy effective communication skills to engage patients and thus to provide significant and meaningful care. Thus, the establishment of an effective rapport, trust and a sense of compassion for the person (Johnston, 2008) can help promote dignified and compassionate caring.

Many authors (Benner and Wrubel, 1989; Edwards, 2001; Horrocks, 2002) have put forward their beliefs surrounding the concept of caring and its intrinsic link to dignified and compassionate nurse-patient interactions. An evolutionary concept analysis of caring is further postulated by Brilowski and Wendler (2005) but they suggested that the concept of caring remains ambiguous. Caring has thus been well documented within the academic literature (McCance et al., 2001; Hudson and Moore, 2006). The compassionate care and treatment of each individual as a unique person is a cherished value within nursing (Suhonen et al., 2002). Furthermore, the provision of

hope, self-efficacy and well-being, (Duggleby et al., 2009) and empowerment of the person (Finegan and Laschinger, 2001; Toofany, 2007) are viewed as intrinsic to compassionate and dignified care.

Person-centred care is regarded as an optimum way of delivering health care (McCormack and McCance, 2010) and has been broadly defined as valuing people as individuals (Coyle and Williams, 2001). McCance et al., (2008) highlighted the need for the formation of therapeutic relationships between professionals, patients and others significant to them in their lives and emphasised that these relationships should be built on mutual trust, understanding and a sharing of collective knowledge (McCance et al., 2008; McCormack and McCance, 2010).

McCormack (2004) discussed the meaning of the word 'person' and the way that this was translated into person-centred practice. McCormack (2004) stated there are four concepts underpinning person-centred nursing:

- i. *Being in relation;*
- ii. *Being in a social world;*
- iii. *Being in place and*
- iv. *Being with self.*

(McCormack, 2004, 31)

He stated that the application of these concepts involved seeing beyond the immediate needs of the person in order to reach a stage of genuinely knowing the person. More recently, McCormack et al., (2012) suggested that nurses working with older people need to understand the importance of their role in developing meaningful relationships with older people themselves, families and colleagues to foster a culture of effectiveness.

## **2.5 Summary**

This review of the literature has highlighted the growing population of older people in Ireland as reflective worldwide demographic trends. Further, the review has demonstrated the challenges and complexities that exist with respect to the provision of care to older people, cognisant of increasing demand on service provision, particularly from those living beyond 85 years of age and over.

The review has also demonstrated the intrinsic link with respect to an increasing older population and the need for effective models of community and long-term care provision, particularly for older people with multiple and complex needs. The review has highlighted the increasing dependency levels in Ireland as a precursor for 24-hour nursing care provision, particularly evident within the 85+age group.

This review has also presented an evaluation of the current literature as it relates to transitions to a nursing home, as this is a recurring, and often predominant, theme within the published literature. Transitional phases have been identified within the review, as has the nature of associated trauma, as evidenced in many older individuals and their families during the move to a nursing home.

Moreover, this literature review has also focussed on an evaluation of the literature as it relates to the interconnected nature of providing quality orientated, compassionate and dignified care within the nursing home sector. The review has highlighted the intrinsic need for quality of life standards, care standards and benchmark criteria within the provision of care to older people whether this is care

delivered/received at home or within the residential sector. This review has also put forward some interesting theoretical constructs on how older people 'find home', in long-term care settings. The importance of dignified and respectful care within the

confines of the therapeutic nurse-patient relationship and the need for a person-centred or relationship centred ethos have been extrapolated upon as core constructs for the effectiveness of care provision within this sector.



## Chapter 3: METHODOLOGY AND RESEARCH DESIGN

### 3.0 Introduction

The methodological approach used within this study allows for the generation of rich data from a variety of sources, thus providing multiple perspectives to generate a clearer and more succinct description of the lived experiences of residents and staff within the nursing home sector in Ireland. Polit and Beck (2013) identify that, in general, a qualitative research design is one that:

- *Is flexible and elastic, capable of adjusting to what is being learned during data collection.*
- *Often involves merging together various data collection strategies.*
- *Tends to be holistic, striving for understanding of the whole.*
- *Requires researchers to become intensely involved and can necessitate a lengthy period of time.*
- *Benefits from ongoing data analysis to guide subsequent strategies and decisions about when data collection is done.*

Polit and Beck (2013, 266)

The approach adopted for this study was grounded theory. Grounded theory according to Corbin and Strauss (2008) is a useful research approach where there is minimal knowledge of the phenomena. Cutcliffe (2000) contends that a grounded theory approach is most suitable where the researcher is already aware that there is a lack of knowledge in the area and where the remit about the phenomenon lies outside the researcher's expertise or specific areas of interest. These assertions are also well documented and advocated within the current literature (Bryant and Charmaz, 2012;

Silverman, 2011; Polit and Beck, 2013). Despite the existence of detailed studies on the transition to life in a nursing home, there remained a paucity of research on the context of a nursing home as home and a grounded theory design was therefore deemed most appropriate for this study.

### **3.1 Grounded Theory**

Corbin and Strauss (2008) posited that grounded theory is used in a generic sense to denote theoretical constructs derived from qualitative analysis of data and they put forward the following definitions:

- *Methodology: a way of thinking about and studying a social phenomenon*
- *Methods: techniques and procedures for gathering and analysing the data*
- *Philosophical orientation: a worldview that underlies and informs methodology and methods*
- *Qualitative analysis: a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge.*

Corbin and Strauss (2008, 1)

Creswell (2009) pointed out that a researcher who is close to the field may already be theoretically sensitised and familiar with the literature on the study topic. Use of the literature or any other pre-knowledge should not prevent a grounded theory arising from the inductive-deductive interplay, which is at the heart of this method. Reflexivity is needed to prevent prior knowledge distorting the researcher's perceptions of the data. Birks et al., (2006) argued that grounded theory methodology offers a practical approach to researching problems of significance to nursing practice and suggested

that it has transformed social science research. A grounded theory approach enabled the researcher to explore the broader range of factors that may impact, either in an advantageous or disadvantageous way, on the reported experiences of living in a nursing home from the perspective of residents and staff in nursing homes.

The principles that underpin grounded theory are constant comparative analysis, theoretical sampling and theoretical sensitivity (Corbin and Strauss 2008).

### **3.1.1 Constant Comparative Analysis in Grounded Theory**

Constant comparative analysis involves comparing incidents that are similar to each other within a category over time and then attempting to integrate these categories and their discrete properties into a process of building and delimiting a theory. These steps help the researcher to develop and write up a theory. While the process appears linear, this is not the case as each step is intrinsically linked throughout the data analytical process. What occurs is that each stage informs the next stage and so on, until the theory emerges (Corbin and Strauss, 2008). The process of constant comparison techniques enables and generates the actual properties of the developing theory.

Corbin and Strauss (2008) suggested that there are two types of comparison making, the first is constant comparative analysis and the second is the making of theoretical comparisons. Constant comparative analysis relates to the simultaneous collection, coding and analysis of data, where each item of data is compared with every other item. As data are continuously collected, they are analysed for any comparisons and

similarities that may be evident. Any specific incidents that demonstrate similarities with each other are grouped accordingly and continuously compared for contextual elements. Corbin and Strauss (2008) define this grouping as a higher-level descriptive concept. The purpose of exploring these codes and groups as they emerge is to ensure that the researcher has uncovered all potential meanings and applications within the phenomenon.

### **3.1.2 Theoretical Sampling in Grounded Theory**

Theoretical sampling is the process of collecting data for the purpose of generating theory. The constant comparative analysis procedures inform the researcher where to go next to sample and collect data, thus sampling is quite flexible and guided primarily by the ongoing analysis of the data. Corbin and Strauss (2008) define theoretical sampling as:

*“A method of data collection based on concepts/themes derived from the data. The purpose of theoretical sampling is to collect data from places, people, and events that will maximise opportunities to develop concepts in terms of their properties and dimensions, uncover variations, and identify relationships between concepts”.*

Corbin and Strauss (2008, 143)

The questions that arise with respect to data collection are where to go next, why go there and how to collect the data whilst there. The fact that the sampling is responsive to the data assists the researcher in these efforts. Corbin and Strauss (2008) suggested that there are two questions that must be addressed within theoretical sampling. One pertains to its advantages over other forms of sampling and the other relates to how best to proceed with theoretical sampling.

Corbin and Strauss (2008) suggest that achieving data saturation is both simple and complex. Simple, in that all the data are gathered to the point of 'saturation', when no new concepts are appearing. Complex, insofar as the sense of arriving at data saturation is not that easily attained. A questioning approach throughout the data collection processes will facilitate the continued need for the researcher to continue collecting data, analysing this data until 'saturation' is achieved. Data saturation is achieved when major categories with depth and variation in terms of their development emerge and whilst Corbin and Strauss (2008) suggest that total saturation (complete development) is probably never achieved, most researchers will continue data collection and data analysis procedures until they feel that they have achieved this state.

The literature reports that the process of theoretical sampling has many advantages over other forms of sampling (Reed and Runquist, 2007; Corbin and Strauss, 2008; Bryant and Charmaz, 2012). It is reported that theoretical sampling results in a cumulative process of sampling in that each event sampled and subsequently analysed builds upon capacity for the next event. Whilst at the same time it enables reduction and more specific attempts at interpretation with the questions that are asked as the study progresses. The researcher becomes much more judicious with what is enquired about as they aim to achieve saturation of the emerging categories. Corbin and Strauss (2008) suggested it is like 'fishing', in that you are hoping for something, but do not know what.

### **3.1.3 Theoretical Sensitivity in Grounded Theory**

Guba and Lincoln (1994) suggest that as researchers, we all bring something from our own lives, our own paradigm into the research process. These can include experiences, training, biases, skills and knowledge all of which directly influence our cognition, affect and behaviour. For these reasons, Corbin and Strauss (2008) assert that there is clearly no such thing as objectivity within the qualitative paradigm, arguing that it is in effect, a 'myth'. The challenge they suggest is how do we use what we bring into the research process in order to increase sensitivity to what participants are telling us. They suggest that the best way to address this issue is to focus on sensitivity.

The need to be sensitive to the participants will of course lie within an ability to establish a professional relationship with the individual or group. Effective interpersonal skills are essential in any such process of ensuring what could be referred to as a therapeutic presence (Silverman et al., 2005; Hargie and Dickson, 2011; Brandler and Roman, 2012). The need to be tuned in, identify issues and to present the views of the participants is particularly important within theoretical sensitivity. Corbin and Strauss (2008) assert that professional experience will enhance sensitivity and can enable the researcher to understand the significance of things more quickly. Caution must be applied however to prevent analysts from reading the data incorrectly. In practical terms, Corbin and Strauss (2008) offer three points of consideration in conducting the data collection and analysis. Firstly, ensure that the data collected are compared against the researcher's knowledge and experiences trying to ensure that the data are not lost amidst these. Secondly, the researcher must remain focussed on the participants' statements, narrative, and work

within the concepts in terms of the properties and dimensions. Thirdly, the researcher must be ever mindful that it is not their perception of the event that really matters at this time, but it is more about the meaning that the participants attach to it, what they are saying, and their own personal interpretations. The capacity for the researcher to have facilitated a therapeutic milieu will ensure that the participants will have provided deeper and more meaningful interpretations. This process will enhance the sensitivity to the nuances within the data as it emerges. Corbin and Strauss (2008) state:

*“Background, knowledge and experience not only enable us to be more sensitive to concepts in data, they also enable us to see connections between concepts”.*

Corbin and Strauss (2008, 34)

### **3.2 Research Questions**

Corbin and Strauss (2008) assert that all research enquiries necessitate a question of some sort to guide the inquiry. Corbin and Strauss (2008) acknowledge that in terms of framing research questions within qualitative enquiry there is an assumption that all of the concepts pertaining to a phenomenon have not been identified. This supports the view that it is necessary to frame questions in a manner that enables flexibility and freedom to explore the topic or phenomena in more depth. The conclusion is that further exploration within any topic is necessary to increase understanding. This study utilised focus group interviews with broad subject and question areas outlined therein to help initially guide the researcher with the data collection. A different focus group topic guide was designed for the resident groups (Refer Appendix 3) and for the staff groups (Refer Appendix 6).

### **3.3 Focus Groups**

Focus groups have been broadly defined as in-depth, open-ended group discussions of 1-2 hours that explore a set of issues within a particular topic. The focus group normally comprises five-eight participants with someone acting as a facilitator and the group discussion is usually recorded (Parahoo, 2006; Curtis and Redmond, 2007; Bowling, 2009). A focus group interview was chosen for the study due to the many advantages of such an approach. Facilitating a focus group interview is not without its challenges and particular skills are required to encourage participants to contribute, comment, explain, disagree, share feelings, experiences, and demonstrate values or attitudes, all from their own perspectives. Each transcript was analysed prior to going back out into the field to conduct more data collection. All transcripts and data were stored in a locked filing cabinet, accessible only to the research team.

During each focus group, the researcher's prior research experience and psychiatric nurse training was utilised to establish an effective orientation. Appropriate sensitivity and therapeutic presence (Hargie and Dickson, 2011) were conveyed to participants within the confines of the storming-norming process of group formation (Brandler, and Roman, 2012). Moreover, as Curtis and Redmond (2007) suggested, the researcher's focus can be an important strength as it can be used to generate data that is relevant to the topic of interest. The therapeutic use of self and self-awareness was pivotal to this process.

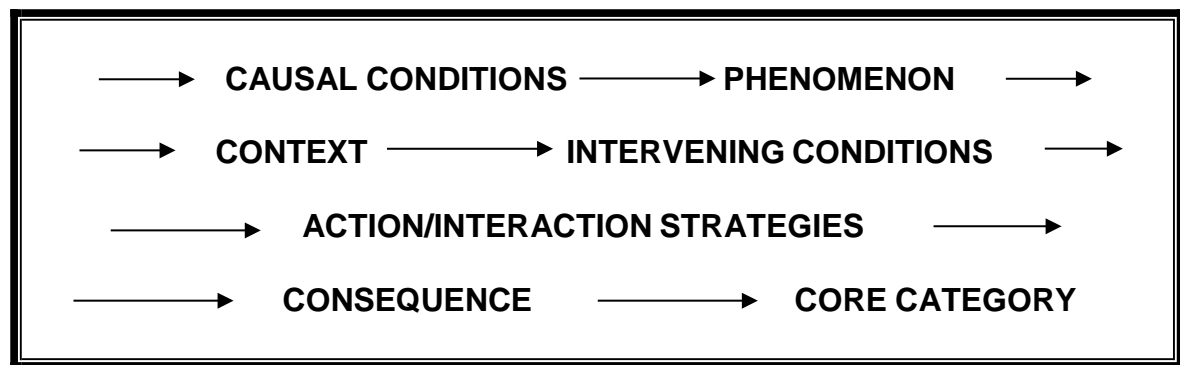


Constant liaison had been established with NHI, which was vital and instrumental to data collection. Moreover, it was important to establish effective and strategic working relationships, which assisted in minimising any potential disruption to the theoretical sampling and constant comparative analysis processes. No disadvantages to the utilisation of focus group interviews presented other than the fact that some homes did not wish to participate once they had been selected for inclusion (n=3). Various reasons were given about the unsuitable timing of the research aligned to the necessary preparation for a HIQA inspection (n=1). The other homes (n=2) afforded no explanations, and none were elicited.

### **3.4 Data Analysis**

Corbin and Strauss (2008) offer a model with rules and procedures to follow that are designed to assist not only the novice but also the competent researcher utilising grounded theory methods, this is referred to as the paradigm model. They suggest that it is not complex in its determination and they offer valuable demonstrations of the model in an attempt to guide the researcher with the coding and analytical procedures. Some authors assert that the model offers a degree of detail and structure, which, enhances transparency in the coding and analysis, processes. This can be subsequently demonstrated to others to enhance the credibility and trustworthiness of the findings, thus establishing and enhancing rigour.

Figure 2: The Paradigm Model



Corbin and Strauss (2008) also suggested that there are three basic components to the paradigm as follows:

1. *There are conditions. These allow a conceptual way of grouping answers to the questions about why, where, how and what happens.*
2. *There are inter/actions and emotions. There are the responses made by individuals or groups to situations, problems, happenings and events.*
3. *There are consequences. These are the outcomes of inter/actions or of emotional responses to events. Consequences answer the questions about what happened as a result of those inter/actions or emotional responses.*

Corbin and Strauss (2008, 89)

### 3.5 Trustworthiness in Grounded Theory

The methodological skills, integrity and sensitivity of the researcher to respond to the participants in a meaningful manner can influence the quality of the data collected within qualitative research (Patton, 2002). Lincoln and Guba (1985) put forward four criteria for developing the trustworthiness of a qualitative study: *credibility*, *dependability*, *confirmability* and *transferability*. This model was subsequently criticised within the literature and this perhaps accounted for their review in later

writings when they added a fifth criterion, that of *authenticity* (Guba and Lincoln, 1994). Creswell (2009) further proposed different procedures for achieving what Lincoln and Guba (1985) called credibility and trustworthiness of findings. These included prolonged engagement and persistent observations in the field, triangulation, using peer review or debriefing, negative case analysis, clarifying researcher bias, member checks, rich thick description and external audits.

Chiovitti and Piran (2003, 430) delineated a list of criteria for achieving rigour in grounded theory research (Refer Table 6). Corbin and Strauss (2008) suggested that following this list will no doubt establish rigour but they reported that the list is devoid of context, process, density, creativity or usefulness. They further suggested that it does not contain the criteria for validity, as there is nothing about vividness, creativity, thoroughness, congruence or sensitivity. Charmaz (2006) offered a further list of criteria for evaluating grounded theory. This list had four categories, credibility, originality, resonance, and usefulness. Corbin and Strauss (2008) suggested that this was the most comprehensive listing available and put forward one criticism of the approach requiring self-evaluation during and after the research, as they believed that this is difficult requiring a degree of sophistication to avoid bias.

This study did not attempt an eclectic approach involving more than one of these postulations as this would be exceptionally difficult, and has not been tested nor evaluated within the literature either. Consequently, the model afforded by Chiovitti and Piran (2003) that has previously been tested, with good results related specifically to its application to grounded theory was operationalized for this study to enhance trustworthiness of the data.

*Table 6: Eight Methods of Research Practice for Enhancing Standards of Rigour*

| <b>Standards of Rigour</b> | <b>Suggested methods of research practice</b>   |
|----------------------------|---|
| <b>Credibility</b>         | <ol style="list-style-type: none"> <li>1. Let participants guide the enquiry process</li> <li>2. Check the theoretical construction generated against participants' meaning of the phenomenon</li> <li>3. Use participants' actual words in the theory.</li> <li>4. Articulate the researcher's personal views and insights about the phenomena explored by means of a: <ul style="list-style-type: none"> <li>• Post comment interview sheets as a tool</li> <li>• A personal journal</li> <li>• Monitoring how the literature was used</li> </ul> </li> </ol> |
| <b>Auditability</b>        | <ol style="list-style-type: none"> <li>5. Specify the criteria built into the researcher's thinking</li> <li>6. Specify how and why participants in the study were selected</li> </ol>  |
| <b>Fittingness</b>         | <ol style="list-style-type: none"> <li>7. Delineate the scope of the research in terms of the sample setting, and the level of the theory generated</li> <li>8. Describe how the literature relates to each category, which emerged in the theory.</li> </ol>   |

### **3.6 Ethics**

Ethical approval was obtained prior to the commencement of the study. This involved several important steps in the process. Firstly, an application for ethical approval was submitted to Ulster University Research Ethics Committee. This necessitated at least three independent peer-reviews of all the information and procedures relating to the study. Secondly, once ethical approval was obtained from Ulster University, a copy of all documentation (as submitted to Ulster University for ethical approval) was submitted to the Nursing Committee of NHI to seek approval from NHI and to provide NHI with assurances that all research and governance procedures were being

adhered to by the research team. This was accompanied with the Ulster University final ethical approval report, RG3 (Refer Appendix 8). NHI reviewed all of the relevant material and permission was subsequently granted to proceed with the study.

A letter of invitation for residents (Refer Appendix 1) accompanied with a participant information sheet (Refer Appendix 2) were devised. Further, a letter of invitation for staff (Refer Appendix 4) accompanied by a participant information sheet (Refer Appendix 5) were also drawn up for the study. These explained the purpose of the study as it related to each of the participant groups. The letter of invitation and the participant information sheets were distributed to all of the randomly selected homes registered on the NHI database and were accompanied with a communication from NHI. This contained details of the Principal Investigator, should any of the potential participants wish to request additional information prior to their participation in the focus group interview. All participants, both residents and staff prior to the commencement of the focus group interviews, then signed a consent form.

The participant information sheet made it clear that participation was voluntary for all and that the interviews would be recorded and transcribed by a professional secretary. The researchers also reiterated that withdrawal at any time, during the interview was permissible, and if this occurred, any information that may have been recorded would not be used.

Effective group management skills are also essential within the research process (Brandler and Roman, 2012). The need for researchers to take due cognisance of the sensitivity of participants is paramount and has been clearly documented within the

empirical evidence base (ICN, 2006; Curtis and Redmond, 2007; Polit and Beck, 2013). Simons and Usher (2000) highlighted the need for researchers to situate their ethics in a way that is appropriate and relevant to local situations. Taking due cognisance of the potential effects of a transition to life in a nursing home and the role of care staff within the nursing home sector necessitated such a position.

The Belmont Report (1978, cited Polit and Beck, 2013) identified three specific ethical principles to guide researchers, beneficence, respect for human dignity and justice. The International Council of Nurses (ICN) developed the ICN Code of Ethics for Nurses, which was recently updated in 2006. The inherent principles within this report underpin all aspects of ethical considerations for this study. In particular, the ethical principles that underpinned this study were informed consent, anonymity, justice, autonomy and beneficence.

### **3.7 Conclusion**

This chapter has presented in detail the methods and data collection and analytical procedures for this study. This study was underpinned by a grounded theory methodology and the researchers have established the effectiveness of these methods to help achieve the study aim. A grounded theory approach enabled a comprehensive exploration and extrapolation on the lived experience of nursing home residents in the context of the nursing home as their '*home*' with due regard to the centrality of staff in maximising a 'homely' experience for their residents.

## **Chapter 4: FINDINGS**

### **4.0 Introduction**

This chapter details an analysis of the findings from the data collection procedures, in accordance with the paradigm model (Corbin and Strauss, 2008). All identifying names of nursing homes, participants and specific geographical locations where focus groups were conducted have been removed to protect participant and home anonymity and confidentiality, and have been assigned into either an urban or rural context. Furthermore, a randomised interviewee number has been assigned to all participants to protect their confidentiality and anonymity. Anonymity according to Polit and Beck (2013) is the most secure means of protecting confidentiality and occurs when the researcher cannot link participants to their data. In this case, all transcripts were coded and all participants within each focus group were assigned a randomised interviewee number, which cannot be linked to their own data in any way.

The explication of the paradigm model, represented as it is in diagrammatic form could suggest that each aspect of the model is a discrete component as such and that somewhat of a linear approach to data analysis could be effected if each step were followed accordingly. This is clearly not the case as the centrality of the model is underpinned by a synergistic connection at every level of the models explication. At each stage of the data analysis there is an existent complex interplay of rich qualitative narrative, obtained from the data collection process. This is subjected to data analysis using open, axial and selective coding (Corbin and Strauss, 2008) resulting in the emergence, comparison and cross comparison of concepts, phrases, sub-categories

and categories. These are then further critically evaluated against the next data collection process resulting in a further collecting of rich qualitative narrative within yet another transcript. This process of theoretical sampling continues until theoretical saturation is believed to have been achieved. At each stage, the researcher will have compiled complex diagrammatic representations and conclusions of the data and this is an aid to the audit trail process. Further, it helps to demonstrate correlations and relationships between the sub-categories, categories and the richness of the raw data as evidenced by the quotations from the participants.

Information regarding the participants will be presented within two sub-sections for ease of presentation, and these pertain firstly to the data collection from the residents (Section 4.1) and secondly, data collection involving nursing home staff (Section 4.2). Further, the data will be presented under sub-headings relating directly to the data analytical processes and the formation of sub-categories within the grounded theory approach as evidenced within the paradigm model, which will be presented in full at the end of Chapter 4 as it relates to this study and the integration of all findings from the residents and staff.

#### **4.1 Findings from Residents' Participation**

Eight focus groups were conducted with residents in both urban and rural nursing homes registered with NHI. Five focus groups were conducted within an urban area and three focus groups conducted within a rural area. The sample included nursing homes designated as private, group homes or voluntary nursing homes. A total of 48 residents participated in total within the focus groups. Table 7 provides a more detailed



breakdown of participants from the respective nursing homes. This clearly illustrates that the age range for residents' participation was from 35 years to 98 years of age with the mean average age overall at 78 years of age. The total time of residency in a nursing home was placed at from four months' minimum to 11.5 years' maximum; the mid-range average here was approximately 4.2 years.

*Table 7: Details of Nursing Home Residents' Participation.*

| <b>Nursing Home</b> | <b>Total Participants</b> | <b>Age Range</b> | <b>Average Age</b> |
|---------------------|---------------------------|------------------|--------------------|
| 1                   | n=7                       | 35 - 84          | 62.42 years        |
| 2                   | n=6                       | 74 - 98          | 84.5 years         |
| 3                   | n=6                       | 74 - 85          | 80.0 years         |
| 4                   | n=6                       | 82 - 89          | 86.16 years        |
| 5                   | n=4                       | 44 - 91          | 73.5 years         |
| 6                   | n=4                       | 60 - 94          | 76.0 years         |
| 7                   | n=9                       | 55 - 86          | 79.33 years        |
| 8                   | n=6                       | 71 - 90          | 83.83 years        |
| <b>Totals: n=8</b>  | <b>Totals: n=48</b>       | <b>35 - 98</b>   | <b>78.21 years</b> |

#### **4.1.1 Reasons for Admission to the Nursing Home**

The need for admission to a nursing home primarily occurred in the context of the person experiencing some degree of physical or psychological impairment or decline that resulted in significant challenges to independent living. The residents spoke openly and with detailed vivid recall and provided deeply personal accounts of being admitted to a nursing home. This was quite often phrased within the context of needing more help and not being able to cope anymore as evidenced in the excerpts below:

*R8: I became very ill, I realised from other people as time went on I would get worse, I was right and that's why I came here.*

*R21: It's really hard to go into detail. I was on my own, frightened.....  
It's very hard to put into words, I couldn't walk properly and had no one to care for me, so I got a bedroom here.*

*R41: I was in hospital and they told me I was fit to go home and I wasn't really able to be on my own so my daughter in law got onto this home and they had a room and after one or two months I got in here.....*

*R15: I could not get out of bed and would get carer to wash myself and I couldn't do normal things for myself anymore. It's upsetting to talk about it now too.*

Many of the residents spoke also of the complex circumstances that prevailed at the time or just before their admission to the nursing home. This often related to a hospital admission following a fall or deterioration of a current illness within their own homes. A common recurring catalyst for admission was a fall, with and without, sustaining any fractures:

*R1: All my family are married and gone from home and my husband is dead. I fell and broke a bone and had to go to hospital. I got on OK in hospital and when I came home I couldn't walk very well and couldn't do very much, and my family couldn't be with me all the time and I got nervous and depressed. then decided to come here. My daughter told me about this place and I'm happy thank God.*

*R34: I was living at home and I fell. I had 2 broken shoulders and I went into hospital and I was 10 months in hospital and I had a choice of going home or go into a nursing home. My family wanted me to go to live with them – I have a special needs daughter as well but my other 2 children wanted me to live with them but I decided it wasn't fair to any of them so I came here.*

*R43: I came here to live because of illness. I was in hospital for 3 months for surgery. I came through it so I knew then I was out of range in doing my usual daily chores. I couldn't cope any more with the pressure.*

Some residents expressed that the primary reason for admission to the nursing home was that they had now found themselves alone in the world, with no living relatives, or relatives who lived in close proximity. Others reported that they had buried their long-

term spouses and felt that they did not want to cope and manage their large homes anymore. Residents openly described, in many cases, a sad sequence of personal tragedies and events in their lives that had resulted in the move to a nursing home:

*R48: I was living with my sister who was born in 1919 and died at the age of 91, and I wasn't myself, little nervous and upset about different things, so they thought it would be better to come to a nursing home so I came here.*

*R38: It started with illness and my husband that I had known for 60 years had Alzheimer's, he went into hospital, then a nursing home and I stayed in my own house for about a year, but I was lonely and saw nobody during the day. It was not nice and I was always upset and frightened.*

In terms of two of the homes, where the age range was low at 35 years and 44 years of age respectively, both of these residents had been admitted to a nursing home due to their complex nursing needs related to physical ill health and their inability to cope. The 35-year-old was admitted following a horrific road traffic crash and had been left as a quadriplegic and could not receive 24-hour nursing care elsewhere. He very eloquently described his personal feelings at the time:

*R16: My life has changed a lot. I was in a steady job for over 20 years, I worked as a manager in Dublin and at the start, going through all this, they told me I couldn't live on my own any more, all I wanted to do was curl up in a ball and die. I made my feelings clear to my sisters, I wanted them to get a gun and shoot me, I felt so depressed. As time went by you learn to look at things differently. This is the path that was chosen for me and a path I have to walk,..... and like, you see other people who are worse off, it gives me great courage.*

Other residents also described how they did not want to be a burden on their family or indeed neighbours and felt that, with their increasing age and their need for assistance with daily living, they needed to go into a nursing home. Many residents also reported

that, as they had no surviving relatives that they came to depend on the public health nurse or other health care workers for assistance with daily living. It was also more noticeable in rural areas that some of the residents had come to rely heavily on neighbours and no longer wanted to be a burden on them:

*R26: I had decided that I would stay in my own house until I was 90 but I got a severe pain in my leg last year and was less able to do things. I lived alone and didn't have many relatives in the area and didn't want to impose on them or my neighbours who were always very willing to help me and visit me.*

*R17: I just had nieces in the area, my siblings are all dead. I found the responsibility of a house too much for me and it didn't seem necessary to maintain a property for an 89-year-old. I felt a burden most of the time and that upset me. At times, there was nobody to take care of me.*

*R4: My family didn't feel the burden, but I felt it myself. I suppose I felt in the way, don't know how to explain it....that they had to do things for you that you didn't want them to do, but couldn't do for yourself, even like simple things like getting dressed.*

Some participants stated that initially they had come to the nursing home for respite following a fall or illness that had resulted in a period of hospital admission. This respite eventually led to a permanent residency within the nursing home. Others were deemed unfit to return home after a prolonged period of hospitalisation, despite their protestations to the contrary. On one occasion, a resident reported an elongated stay in an acute hospital bed for over ten-month duration, whilst a nursing home placement was determined. Consequently, when a bed became available, their admission to the home was the first and only contact with the actual home:

*R22: I had my sister in law only and they [the home] said they would take me for convalescence, I thought it would only be 4 weeks, now 4 months. It's not right you know!*

*R46: My sister shipped me here, I never wanted to come here really. I had been in hospital after a bad fall at home. Was in hospital for months. They wouldn't let me come back to my own home. She [my sister] told me it would only be for four weeks. But sure, it has been four weeks, then another four weeks and then another four weeks. I actually don't know really how long I have been here now, over six or eight months.*

In conclusion, the reasons and causes for admission to a nursing home were multi-factorial and complex. They demonstrated an intrinsic need for nursing expertise for an ageing population within the nursing home sector. Furthermore, there was clear evidence that supported the view that complex bio-psycho-social needs for their residents were managed in a holistic and person-centred manner. They also demonstrated that on occasions, there appeared to be a disconnect between those who chose personally to enter a nursing home and those for whom a decision was made by their family members. For those who made a personal decision to move, many made the decision, as they were unable to cope at home with their increasing activities of daily living needs and accepted, reluctantly at times, the importance and necessity of such a move. Others specifically chose to move as they felt that this was the right decision for them at this time. For some, they did not agree with the decision by family members and this resulted in many personal issues in such a transition.

#### **4.1.2 Experiences of Transition to the Nursing Home**

Residents spoke openly about their transition to the nursing home, with most expressing satisfaction about the move but others, expressing concern about the way the move was planned. In some cases, particularly in urban areas, the move to the nursing home was directly from hospital and it appeared that the resident did not always get a choice in the decision-making process. In rural areas, it was apparent

that some residents specifically choose the nursing home based on geography but also on the quality of a personal recommendation. There also appeared to be a sense of 'personal knowing' or 'societal knowing' of the home which was attributed to local knowledge or the 'local grapevine'. In some cases, residents had already visited other family members or friends within the home and this was a contributory and important factor in their decision-making process as evident within these residents' experiences:

*R2: I would say it was a good move for me, everyone appears to be happy here, I know that I am.*

*R42: Two of my sisters had been in the home and died here and it is the nearest one to my area and I spent a fortnight here in 2006 convalescing so I was familiar with it and liked the spacious grounds and shrubs and trees. It suited me well.*

*R44: My husband's mother in law and cousin's mother in law all ended their days here so I thought maybe I would repeat the process. They were well taken care of. I had heard good reports about it from various people. It's important to get to know the ins and outs of the place beforehand I think.*

*R5: I don't really know, think that it was the social worker who came to me and said about here. Then I tried it, so I'm still here. First time I saw it was coming out of the back of the ambulance from [name of hospital].*

Some residents were quite assertive in their belief that the move into a nursing home was the right thing at the right time for them whereas for others, it took a while for them to settle in:

*R29: My nieces were very supportive of my decision. They know that when I made a decision that was it and they helped me to prepare for leaving my house which I had sold a year or two previously but I had the right of residence for another few years. Very good organising my transfer to the home. I am more than happy with my decision, it was the right one for me and at the right time in my life.*

*R33: While we would all prefer our own home, things have changed and we have to change with it. I wasn't happy when I came here at the start, but I had*

*no choice, I was powerless to do anything about it as I had fallen at home on my own. Things are different now though, but it's taken a long time coming.*

Many residents reported a sense of personal relief and satisfaction as a result of coming into the nursing home, with many expressing their willingness to adapt and change within their new environments. Some residents spoke candidly about the importance of having a new set of friends and some company. There was overwhelming evidence that supported the view that assistance with the activities of daily living was central to many aspects of care provision within the nursing home:

*R7: I have good friends here. [Name] is like a mother to me. If I'm not well she looks after me. [Name] and I chat away. I feel happy among them.*

*R23: I'm happy as well, all are my friends.*

*R35: Staff should be very proud of themselves, all so patient, sometimes an individual can be a little bit trying but I have never seen them lose their temper, it's a miracle sometimes, they can calm a person down in such a lovely way, wonder how they can do it, never get frustrated. Should pride themselves on the care that everyone gets.*

*R27: Well, I'm very happy at the moment here, and the main thing is my memory, very poor, trying to put up with that because I see other people who are much worse off than I am so I thank God that I'm as well as I am. They help me with everything, I need for nothing. Washing, bathing, shaving and the like, always willing to help me.*

*R3: Well I didn't have much choice, I suppose I could have gone to any nursing home, I just wanted someone to look after me because I can't look after myself. I can now a bit. I can talk alright but not physically fit, and can't get around, I couldn't live at home even if I had a home.*

Again, there are many complexities surrounding the process of transition into the nursing home sector and it is evident that when it appears that the transition has gone well that there has been input from the resident, their family or significant others. Collaboration and communication between potential residents, their relatives and the

nursing home staff appear to have been a key contributory factor influencing a smooth transition. Conversely, a poor transition and delayed acceptance of move appeared to occur when these collaborations were non-existent or if the resident was not consulted. The findings suggest that some residents were admitted to the home in the belief that it was to be a short-term arrangement. However, it appeared that their families were planning a more permanent arrangement and this presented ethical issues for staff in trying to have an open and honest relationship with the resident and the family. However, families' reluctance to discuss the permanent nature of the placement with their relative must be interpreted in the context of the personal upset and distress that they believed this would cause to their relative and to themselves, further highlighting the need for more open and honest conversations between potential residents, relatives and staff.

#### **4.1.3 Dignity and Respect within Care Delivery**

The residents identified the concept of dignity, respect and promotion of independence as central to the provision of effective care within the nursing home. Maintaining a level of independence appeared to be a core component of individuality within the home as was the importance of involvement and choice in decision-making. Respecting residents' choices was linked to how well the staff knew the residents and for many residents, truly knowing them as a person meant respecting their choices, affording them respect within all communications and promoting their independence:

*R31: It affords me the independence I like and I have a lot of interests. I'm just the ideal person if you wanted to sell the whole nursing home idea.*



*R3: Well I could never manage at home on my own, I wouldn't be able. I can do nothing with my hands. I can hardly hold a cup. They usually give me a glass. I can hold a bit of bread and use the fork in my right hand. It's my bad arthritis, but they are very good with me and help me along.*

*R18: Very happy and content and very secure because times I get pain and be sick, and they're more than attentive, they were there right away, just on the ball. Very generous with their time. They respect me a lot and I respect them and I know they do good work too.*

*R5: I prefer to be in my room, and they let you do that? They let me do that. And when I want to go out and get a newspaper or something in the shop, I can do that to. I love going to mass and they help me to do this as well.*

Further, many of the residents spoke about the importance of staff preserving their dignity, treating them with sensitivity and compassion particularly when delivering aspects of care related to nutrition or elimination needs:

*R3: Well when I need to go to the toilet, especially if I have had an accident, they are always very kind, to a fault, I couldn't complain, they're all great really.*

*R23: They do everything for you in such a dignified and professional manner, nothing is a bother to them, even if I have had an accident. I do try not to, but it can't be helped. They don't judge me in any way and they use the cream and pads and leave me good as new. They always feel as if it is no bother to them, even when they're run off their feet.*

A further perspective provided by an eighty-two-year-old woman, who had been a cook before she had retired, now living in a nursing home, that she had chosen herself personally to come to, due to living alone and feeling lonely, in an urban area stated:

*R24: The staff are like we were, years ago, when we cared for our grannies. They care for the elderly. I'm glad to get here, it's very nice as the staff treat you like normal people, accepted for who you are, dignity as a person. They are so respectful and they know us all so well. I personally couldn't ask for anything better really. They are so caring, now I mean genuinely caring. Why would I want to go home?*

Involvement in decision making and providing appropriate explanations was viewed

as an important component to resident satisfaction. It was often the little things that were appreciated, particularly related to expressions of choice and respecting their decisions:

*R16: Given my choice, I would stay here. When I came in I was a bit in awe of the big dining room and the crowd, but the woman in charge told me I could have my meals in my room so I chose to have them in my room for a while and one day [Name] said to me could you come to the dining room today because we're short staffed. So, I came to the dining room and I am still there. But at least they respected my decision and if I still wanted to eat in my room, I can. Often, I like to get my breakfast in bed and this is never a bother to them.*

*R20: Well they listen to anything I say to them and they treat me like a civil person, which I think I am still, and anything I ask for they do their best, I don't feel I'm being walked over or anything like that. It's all to do with choices and changes in my life.*

*R11: Talk about care, you couldn't get that at home as they [staff] understand older people and that's important as is introducing yourself and explanations are essential.*

Independence was a recurring theme for many of the residents and they viewed this as important within the home. Being able to come and go, go to the shop, wander out for a walk into town, attend to their spiritual needs and not to feel in any way constrained by the rules and regulations of the nursing home:

*R11: I suppose their ability to take on board anything in so far as there is no difficulty. You're never made feel that's this is a big thing, it's very normal. Everything will be made simple. I would also find if I should be out and not going to be back I rang and they said no problem. I find there is that ease, don't have to give a full account. It's a bit like home from home.*

*R13: When I came in here I had a journal and what I wrote that evening was oh my God, what have I done? But I knew I was so incapacitated and little power in hands and arms and I knew I could never live alone I would be practical and like my independence and like [name of fellow resident] there was no way I wanted to be a burden on any of my children. Independence is very important to me. I go out and about, I go to my children, I go out for overnights, for meals, I go anywhere I like, I have a motorised wheelchair. The buses in [name]*

*can bring me around, it's ideal. Ok, there's a bit of institutionalisation here so far as meal times etc., but I let them know if I'm not going to be here and that's ok. I find I have the greatest of freedom and there's help at hand, if I need it.*

For other residents, it was the sense of belonging and routine and diversity within the nursing home that helped them feel positive and fulfilled. Contact with other residents was described as enabling. Moreover, it helped to reduce the fear of isolation and loneliness experienced in their own home. For some residents, this was described as a new lease of life. Some residents reported on the importance of connectivity with their family and loved ones as being central to their living within a nursing home:

*R28: I think there's a great sense of belonging with the other residents. They're very caring and they come over regularly from [place] during the day and we are all together at mass in the morning and those of us who are able to get up for mass. Others wouldn't be able. Then we have once a month a concert in here and we enjoy that. Last Thursday we had a party and we had a musician and we were all out on the floor, people I never thought would dance, all enjoying themselves. The [names] were here as well taking part. I think this a great unity between staff and residents and it speaks a lot for both the residents and the staff.*

*R9: I suppose it's as homely as you want it to be and if I see my sister I will be excited and happy. Sometimes my friend comes to see me too and this makes me happy, you can go out too and have fun, makes you happy, you forget your own situation for a while, but sometimes even in this environment....[long pause]... that you still feel lonely and that you feel that more activities would help break the loneliness for you.*

Promoting independence for some residents was not always operationalised and quite often some residents felt that it was easier for the nurses to do it, rather than give them time to do it themselves. This resulted in a degree of passive/reluctant acceptance of the situation for some:

*R36: I had difficulty accepting, I had to get accustomed to the fact that the staff had other people to look about and that somebody might come to shower me at 9.10 but might not come the next week to 10.10 and as well as that, I'm not being critical of the staff, they have responsibilities here and crisis can arise for them.*

#### **4.1.4 The Residents' Wider Experiences of Nursing Home Care Delivery**

A recurring theme with all of the residents was their perceived positivity with many aspects of the twenty-four hour caring experiences. Repeatedly residents spoke about how the promotion of their dignity related to effective communications within the nursing home. They had a very strong sense and feeling that they were being listened to and valued. This was particularly evident if they had raised issues of concern within residents' meetings, which staff subsequently addressed. Many reported excellent standards of satisfaction with the care they received in the home and drew comparisons with their own home and the nursing home as 'a home from home':

*R2: It's a bit like home from home for me, they do all they can to make me happy and feel valued and belonged here. I couldn't fault any of them.*

*R40: Not only is this our home, our families are made so welcome when they come, it's like it's their home as well. My sister has her dogs with her and nobody tells her to take them out.*

*R24: First of all, the surroundings. Inside you have the warmth of the rooms and the care that the girls give us. And a doctor coming in every week and a hairdresser every week, chiropodist when we want one. What more could you want? I didn't have this kind of caring in my own home.*

*R46: They are always on time and respectable, pleasant and happy with me and treating my belongings with respect.*

In terms of the day-to-day life within the home, many residents depicted understanding that there was a routine within the home but that they were also able to adapt their own routines if they choose to. Many residents described a typical day that focused around the activities of daily living particularly in the earlier part of the day, with the afternoons given over to activities, games, outings, family visits and a number of other choices. There were mixed reports from residents about the availability or otherwise of meaningful activities. It was also evident that where a nursing home had employed an activities coordinator, this role was recognised and valued by the residents:

*R48: No day is the same. But a typical day would be, I need assistance to get up, they wash and dress me and help me into my chair. Then breakfast. It depends what kind of day it is. A lady comes in to do a little bit of aerobics, always something to do, but a typical day is what you make of it. Some days we could be feeling a bit down, other days you feel great, going around everybody, having fun. Just day by day. See how you feel that day. Get out for the day. Music and bingo on days. They do their best to keep you occupied.*

*R7: I wake up very early, I do the normal things, eating, sleeping. I don't normally do anything out of the ordinary, whatever I fall in with, generally I'm busy and meeting a lot of different people and doing different things in the home, so on the whole my days are quite interesting.*

*R1: Very ordinary, normal kind of day, no surprises. The way I like it really.*

Residents demonstrated a clear understanding, and quite often a significant degree of acceptance regarding some of the complexities with respect to the caregiving relationship. Some residents believed that staffing levels impacted on the provision of care meaningful activities within the home:

*R14: We went out yesterday and that was once in many months.*

*R47: Bingo, the little things we used to do and we had a book club and we came down to the back-sitting room and had singing and that, not now, so many staff*

*have left. Sad really because it affects us. Now it's my iPad – I use my iPad all day.*

Other residents appeared to find aspects of communal living a particular challenge, especially in situations where the behaviour of other residents caused them upset.

Contrastingly, some residents demonstrated a degree of reciprocity within the caregiving relationship and felt that staff in the home became integrated into their new family. Consequently, they expressed sadness related to staffing changes and staffing levels and felt that this had an impact on their day-to-day living:

*R38: The lack of activities, yeah, linked to the turnover of staff. Staff are like our family, you grow to care about them and you love them and then they're gone. Now I know that nobody can do anything about someone who wants to leave – there are reasons why they leave but there are reasons why they might stay. I'd say it's not the hard work that drives them away anyway.*

Many residents articulated the need for their own space within the nursing home. They valued a place of privacy and a place that had meaningful things, like personal possessions, which were central to their own sense of self. They also identified the importance of simple, yet vital things for them, like staff knocking on their door, prior to entry. Further, they reported on the other steps and measures taken by the nursing home staff that they felt was enabling in this regard:

*R10: You wouldn't need to go into my room unless you're a Liverpool supporter. If I didn't have my room the way it is, it's my personality, and if I wasn't allowed to express that I would feel my room would be a dull place. You are encouraged to have it the way you want it. Own furniture. To me anyway privatisation of your room is a big thing, you're encouraged.*

*R32: I have a nice room and can see part of the town. I'm not very decorative, just have it plain. My choice, but it makes me happy.*

*R22: My room is part of me, my personality; personalisation of my room is a big thing for me.*

For other residents, the transition, despite the best efforts of staff, was more difficult:

*R37: I have my bedroom set out with a lot of my own things, furniture, paintings, I have my bedroom set out like as if I was at home. I am independent and that's what makes it home for me. But even with all of this, it's not really the home that I want to remember; the home that I raised my children in; the home I waked my husband in; the home I loved so well with my dog. But this is it now for me, so I have to make the best of it, but if I could, and I'm sure we all would, we would go back to our own home in the morning to be sure.*

In more broad terms what was described as 'genuine caring' was reported by the residents and linked to a 'sense of truly knowing' and 'respecting diversity' of needs even when residents had difficulties with verbal communication. An expression of likes and dislikes was always incorporated into care management by the nursing home staff. Often it was the little or simplest things that were undertaken and completed for the residents that appeared to provide an increased sense of belonging, and increased levels of satisfaction:

*R11: You know it's the little things that I'm content about, I am totally content with what I have*

*R46: More carers. The carers are great. They work so hard and that's all day. They're always available which is just outstanding. They can't do enough for you, all your needs attended for, even for those residents who have dementia. They think about all the residents all the time. So, dedicated. It's a very high vocation they have.*

*R39: Old age and disabilities make life different so that home and nursing home, it's not right, life at home with a disability wouldn't be what life was before the disability. They do care for us, this I know. I can't fault them unless I was being really picky.*

*R32: I suppose their ability to take on board anything in so far as there is no difficulty. You're never made feel that's this is a big thing, it's very normal. Everything will be made simple. It really is the simple and small things they do for me that makes me happy. Doing my nails or helping me choose nice clothes to wear for mass. Yes, small things matter to me and lets me feel respected you see.*

A further profound and intrinsic nature to knowing the residents was described by some residents as 'experienced nurses' or 'intuitive nurses'. The residents reported that these nurses genuinely knew when they were having a bad day or felt down. They felt that these staff members were able to notice, and respond to, their little nuances that perhaps hitherto before only family members had done so. The importance of rapport, trust, genuineness and empathetic caring is very evident and demonstrated in the words of residents:

*R10: Yes, [name] really knows me, my ups and downs. I don't even have to speak, she just knows. But then she's been at it a long time and has a sixth sense, very intuitive and caring. I feel her love and compassion for me as a person not just one of her residents. She can see past my crippled body in this wheelchair. Sometimes when I am just pondering the day, she'll just come and sit with me, hold my hand, share her experiences over a cuppa and a bit of home-made scone bread. Days like these, I can survive my pain.*

*R13: You couldn't get better staff, can't say a word against them. They are very friendly and helpful. I'm still getting to know people but as far as I'm concerned, they are very pleasant, very nice. Look in at night to see if I'm alright.*

*R44: It's welcoming here, they're always glad to speak to you; you feel so wanted and involved all the time.*

#### **4.1.5 The Residents' Experiences of Standards and Inspections within the Home**

Some residents demonstrated an awareness of the importance of standards within the home and were aware that the home was subjected to inspections. Some residents



indicated that they knew when the home was going to have an announced inspection as they felt that the anxiety levels of staff appeared to heighten around this time:

*R44: As I said I have my own bedroom and all set out like as if I was at home but I am aware that it is a home that is subject to inspection at time. The staff always appear to be more anxious in preparation for such inspections and visits.*

Some of the issues that residents found fault with within the home related to the fabric of some of the buildings, some of which were very old, personal room size, positioning of doors and such like. They had also indicated that they had raised these issues but had accepted that the building could not change its outer fabric. For some residents they would like to see changes but overall these were not regarded as significant issues for the majority of residents:

*R6: I have another architectural change..... down my corridor, the doors of each bedroom are directly opposite one another, it's an old building, which means that if I'm sitting in my chair and the door is open, I am looking directly across into that room, if the doors had been staggered it would have given more privacy.*

*R41: This is a terribly old home, very small rooms, so I try not to think about it really, as nothing I can do.*

It is important to note that some residents who were living in larger more modern nursing homes with a choice of communal areas, larger spaces for walking about in, excellent parking facilities and lifts, sometime felt constrained that they could not necessarily come and go as they pleased. On occasions, it appeared that the needs of the home to protect and safeguard the residents taking due cognisance of the HIQA

(2016a) standards appeared to be at odds with the residents' perceived need for independence:

*R39: The locked doors, and then having to sign in and out are a pain. Why can't I go out on my own? I used to drive before I came here and my car is parked in the car park, but I never get to drive it as the nurses tell me it's too risky. I do challenge them and they tell me it's the rules. Whose rules I say?*

*R23: If I could change things, I'd say the surroundings, move around, go anywhere you like, no restrictions.*

An interesting concept of personal adaptation to the process of change within their lives was evident in the interviews with some residents. Moreover, the concept of their lived experience of their own 'home' was often compared and contrasted to the nursing home within the broader confines of nursing home care. This was evidenced by the following:

*R41: It compares a lot to your own home when you're not able to do things.*

*R38: Well I lived alone and I see more people here during the day than many a day at home and I like doing my own thing and I'm allowed to do it.*

*R:5 I still come back to the thing that old age changes things and that home is not what it was when we were younger. Life changes and you have got to change with it.*

*R14: I used to be on my own, I like to be on my own sometimes and I like to go for walks.....and they respect this, and help me to do these things that I could not really do in my own home.*

There is clear evidence of attempts within the nursing home sector to promote the concept of home and a 'homely experience' for their residents, within the confines of day to day care. However, there are clearly inherent challenges that still need to be overcome as evidenced by this resident's feelings:

*R29: They can make it as close as possible to the real thing but nothing replaces home. They can only do so much, it's a good nursing home and they do their best here.*

#### **4.1.6 Summary**

In summary, the residents interviewed shared and recalled memories and feelings about their experiences within the nursing home in an open, honest, frank, and sometimes very sad and reflective manner. It was difficult not to sense the brevity and depth of expressed emotions from many residents, due to their honesty and positivity, and their sense of fun and laughter.

Many shared moments of sadness as they reflected back to what was, their lived experiences of 'home' and their transition to what is now, their new 'home'. While some residents accepted the changes associated with the aging process, other wanted to return to the ways things were, not because of poor care, but just because they remembered times past when they enjoyed good health and were surrounded by family and friends.

The residents interviewed valued the safety and security of the nursing home environment where they had regular contact with other human beings. This fulfilled for them, a need for companionship, which had not been evident when they lived alone in their own homes. Others took a more philosophical perspective of their current life trajectory. Many demonstrated a capacity for adaptation and change and in essence portrayed a picture that emphasised that they were making the most of later life and

enjoying the new relationships, both with staff and residents that they had formed since moving into the nursing home.

#### **4.2. Findings from Staff Participation**

A total of eight focus groups were conducted with nursing staff working in both urban and rural nursing homes registered with NHI. Five focus groups were conducted in urban areas and 3 in rural areas. The sample included staff from nursing homes designated as private, group homes or voluntary nursing homes and staff from NHIs Nursing Committee. A total of 44 staff participated in total across the 8 focus groups. Staff were drawn from all grades of staff and included, cooks, physiotherapists, occupational therapists, activity therapists, care assistants, registered nurses, and administrative personnel. Within the registered nurses group, participants included Staff Nurses, Assistant Directors of Nursing and Directors of Nursing. Table 10 provides a more detailed breakdown of staff designation by participating home. The largest participating group was drawn from Registered Nurses (n=20) and the next largest group comprised Health Care Assistants (n=14). Initially during the early phases of data collection, the staffing groups were drawn primarily from non-nursing groups and had no staff nurses in attendance. This was addressed as data collection progressed to ensure that a range of opinions informed this part of the study.

Table 8 provides a more detailed breakdown of participants. It illustrates that the work experience range for staff participation was from 3 months to 46 years (552 months). The mid-range number of years' experience was 7.25 years (87 Months). The mean

average work experience overall was 9.338 years (112.056 months). The total work experience in years for the entire sample was 410.9 years (4931 months).

*Table 8: Details of Nursing Home Staff Participation.*

| <b>Nursing Home/Group</b> | <b>Total Participants</b> | <b>Work Experience Range</b> |
|---------------------------|---------------------------|------------------------------|
| 1                         | n=6                       | 9 months – 25 years          |
| 2                         | n=4                       | 3.0 months – 8 years         |
| 3                         | n=6                       | 4 years – 8 years            |
| 4                         | n=6                       | 4.0 months – 11 years        |
| 5                         | n=5                       | 6.0 months -10 years         |
| 6                         | n=5                       | 2 years – 46 years           |
| 7                         | n=3                       | 1 year – 6 years             |
| 8                         | n=9                       | 16 years – 30 years          |
| <b>Totals: n=8</b>        | <b>Totals: n=44</b>       |                              |

*Table 9: Detailed Breakdown of Years of Experience from Staff Participation.*

| <b>Years of Experience</b> | <b>Total</b>  | <b>Work Experience Range in Months</b>                               | <b>% of Total Sample</b> |
|----------------------------|---------------|--|--------------------------|
| Up to 1 Year               | n = 7         | 3,4,4,6,6,9,12   | 15.99                    |
| Over 1 Year – 5 Years      | n = 8         | 18,24,24,36,48,48,48,60  | 18.18                    |
| 6 Years – 10 Years         | n = 20        | 72,72,72,84,84,84,87,90,96,96,96,108,108,108,108,120,120,120,120,120 | 45.45                    |
| 11 Years – 15 Years        | n = 3         | 132,132,180  | 6.81                     |
| 16 Years – 20 Years        | n = 1         | 288  | 2.27                     |
| 20+ Years                  | n = 5         | 300,360,480,552  | 11.36                    |
| <b>Totals:</b>             | <b>n = 44</b> | <b>Range 3 – 552 Months (0.25 years-46 years)</b>                    | <b>100%</b>              |

Table 9 highlights that 15.9% of the sample were working in the nursing home sector for less than one year with a further 18.18% working in the sector less than five years,

therefore a total of 34% of staff within the sample had less than five years' experience. However, 45.45% of the staff were working in the sector from between 6-10 years in total, demonstrating that the majority of the sample were experienced nursing home staff. A total of 11.36% of the sample were very experienced members of staff working in the sector for 20+ years.

*Table 10: Detailed Breakdown of Staff Participation: Staff Designation.*

| <b>Nursing Home/Group</b> | <b>Total Participants</b> | <b>Staff Designation</b>   |
|---------------------------|---------------------------|--|
| 1                         | n=6                       | Chef (n=1)<br>Health Care Assistant HCA (n=1)<br>Domestic (n=1)<br>Activities Co-ordinator (n=1)<br>Administrator (n=1)<br>Registered Nurse RN (n=1) |
| 2                         | n=4                       | HCA (n=3)<br>RN (n=1)  |
| 3                         | n=6                       | Physiotherapist (n=1)<br>Senior HCA (n=1)<br>HCA (n=1)<br>RN (n=2)<br>Activities Co-ordinator (n=1)  |
| 4                         | n=6                       | HCA (n=3)<br>RN (n=1)<br>Chef (n=1)<br>Social Care Facilitator (n=1)   |
| 5                         | n=5                       | HCA (n=3)<br>RN (n=2)  |
| 6                         | n=5                       | HCA (n=2)<br>RN (n=1)<br>Occupational Therapist OT (n=1)<br>Physiotherapist (n=1)  |
| 7                         | n=3                       | RN (n=3)   |
| 8                         | n=9                       | RN (n=9)   |
| <b>Totals: n=8</b>        | <b>Totals: n=44</b>       | <b>RN (n=20) HCA (n=14)<br/>Physiotherapist (n=2) OT (n=1)<br/>Activities/Social (n=3) Other (n=4)</b>   |

#### 4.2.1 Reasons for Admission to the Nursing Home

The various staffing groups demonstrated expert contextual knowledge in terms of the reasons for residents' admissions to their nursing home. Broadly speaking, these related to changes in life circumstances and a deterioration of the persons' physical and psychological wellbeing.

Most staff recognised that there was a growing older population in Ireland and that this reflected worldwide demographic trends. The staff demonstrated full appreciation and acceptance of the reality that many of the residents had become increasingly dependent on others for care as evidenced by their increased need for assistance with multiple activities of daily living:

*S28: Many residents come here because their health is so poor and they are unable and their families are perhaps unwilling to provide for their needs anymore. Many of the older residents have multiple needs and illness and need lots of care, so here is the best place for that. Being at home, they'd never get the care they need as the community services couldn't cope either.*

Further, staff also articulated that many of their residents, particularly within the primary urban nursing homes had been admitted from an acute hospital. This was often directly following a fall, or an illness at home, as evidenced in these statements:

*S2: Many of our residents have come here from hospital following a fall at home and their own families can't look after them anymore.*

*S33: Many of our residents have nobody to look after them and they have many complex needs so they have no choice but to come here, I suppose.*

*S19: We had one resident who came here after she broke her hip at home and was in hospital for over six months and she only had an elderly sister who*

*couldn't cope with her increased needs now, so I think that a lot of times there is no choice.*

Various staff groups raised the issue of choice related to entering a nursing home. Many of whom believed that relatives or social workers and not necessarily the residents made some of the initial decisions, without fully consulting the potential resident:

*S24: People obviously come to nursing homes maybe through illness, they might not be able to cope at home any more, they could be living alone, family may not be able to provide the 24-hour care that they may need. There are many different reasons why people come to a nursing home. Maybe they choose to come, they feel that they cannot do it themselves and the best choice for them and those involved is to come to a nursing home where there is 24-hour care provided. Many families do tend to make these decisions especially if their loved one is in hospital and it just isn't practical for them to do what needs to be done any more for them at home.*

*S16: The family or the social worker sometimes comes here, often they don't they just call to arrange a bed. Often, they say it's for respite, but that doesn't fool anyone as often their relative comes here and they never go home. The respite is continuous until there is no other choice really. That's the difficulty.*

Choosing to come to their home [for some residents] was regarded by staff as important due to local knowledge, or knowing someone else either in the home currently, or who had been in the home previously. Local nursing homes staffed by local people living in the local community and known perhaps by the potential resident suggests that a sense of familiarity was thus evident and portrayed as important by staff, significantly but not exclusively, in rural areas:

*S15: I would feel much the same for families that are struggling at home and for choosing this one here, I do feel that residents that come would be local and they would know a lot of people in here. They'd be able to feel at home in familiar surroundings much more quickly also.*



*S34: The main reason, [name] is here since 1981 and is well known in the community and there is so much of respite, you hear from the residents, family members and community. Maybe that is the primary reason why people know the place and people know the staff through being relatives or friends, so it's like an extended community, people are happy, feel safe, and that their relatives would be happy to continue the rest of their years in [name of nursing home].*

*S44: To be looked after and cared for. Some of their families can't afford to look after them..... we can provide a home from home. They know we are close by and they can call in anytime, so their loved one doesn't feel lonely or isolated as such.*

*S17: I think they come here because we've always had a good name around the local community and it's a home from home really. Everybody knows us and knows where we are and what level of good nursing care we can provide. We are proud of this, why shouldn't we be. That's why our residents choose to come here and many do make that decision for themselves.*

Some staff suggested that their residents' autonomous decision making upon entry to the nursing home was a core component to ensuring that they settled quickly into the home. This also facilitated a smooth integration into the nursing home. They spoke of the active steps pursued to ensure a smooth transition. This included detailed preparatory visits; increased communication with potential residents and their families, private conversations with fellow residents and making sure that their room was as homely as was possible.

*S39: Coming and staying here is important for us as a home, so we do all we can to make the transition as smooth as possible. It's very individualistic and focussed on that person and their family. Choice, respect, listening to what they have to say and addressing any queries they have, especially if they think it's a bad thing to come here. It takes time, we value this mostly. I'd say the minute they come through the door, they're treated like a family member of my own.*

*S13: All I can say is that this place is home from home and 100% here. We involve all of our residents in the decision-making they are truly autonomous. They can attend the residents meeting in advance also if need be and visit and speak to anyone. Moving into our home is a very important thing; we need to get it right as first impressions can be the lasting ones.*

*S21: Putting the person and their family at ease. Information vital for this. Seeing for themselves, talking to other residents, staff or families. It all helps. It's respectful and dignified, as it should be. It might after all be their last move in their lives.*

However, some staff also recognised that actions taken by them, albeit well intentioned, could result in residents feeling that some of their choices could not be realised, for example coming and going freely without notifying staff of their whereabouts:

*S11: We make sure they still have their say and I think that is something we shouldn't be taking away from them. Probably a little bit of their freedom is taken, for example, if they want to go out on their own*

#### **4.2.2 Setting the Provision of Nursing Care in the Nursing Home into Context**

All members of the staff groups suggested that they provided detailed and comprehensive care to their clients. In describing the care, they provided, they used words such as holistic, person-centred, patient-focussed, kind, nurturing, supportive but also challenging and complex:

*S22: This is the only home I've worked in but I find the quality of care is just great, I feel gratified personally and [name] herself as the owner is constantly here and involved in the home, every one of the residents feels that she makes everyone feel special, she puts them at the centre of their care.*

*S1: You do become very attached to the person because there is a nice feeling about this place and people are all very close. It's a special and rewarding experience to work with the elderly.*

*S41: Well within my role, care assistant, all about the residents' care, from nurses through to all care staff and I suppose everything that is put in place has to be implemented and overseen, and resident input is important, we need feedback.*

*S20: Providing 24- hour nursing care is complex for some of our residents, but we are very respectful of them and their needs. We treat them always with dignity and respect and try to maximise on their independence whenever possible. It's not always easy, but that is the way it is.*

*S39: On Sunday, a lady told me she was going out on Tuesday. I do her hair for her and she asked me could I come in and I came in on my own time to do it because it gives them that wee bit of friendliness and that we are always there for them, try to help them out. That would be just one thing I would say about here, because everybody goes above their duty. We treat them like our own family.*

Many staff identified the importance of working as part of a team, and the effectiveness of teamwork amidst the complex challenges for care provision. Collaborating within teams and with clients and families was reported as a significant precursor to the provision of person centred care and holistic care practices. As some staff pointed out:

*S43: think our selling point is a caring, friendly environment. Not only do we care for you but we care about you and that's the definitive part. We look after families as well. We know all sorts of things that are going on in families lives, they would have no problem expressing that to us. Family also the support network for the resident. We are like friends and neighbours. We all work together for the resident right from my level as the Director of Nursing to the care assistants and the cooks. They are very important.*

*S5: Being able to work as part of a team is helpful. We [care assistant] have our jobs and they [staff nurses] have theirs. They [staff nurses] will do a lot of the medical stuff and the medicines and then they liaise with us as we will have done a lot of the other aspects of caring like washing, dressing, feeding and it all comes together well.*

Not all care assistants necessarily concurred with these expressions of staff collaboration, suggesting some role tension, and perhaps a lack of understanding of the multiple demands on registered nurses within the nursing home environment. They perceived that they primarily delivered nursing care and that the nurses focused on paperwork and medication as suggested by this comment:

*S30: The nurses spend a lot of time in the office really and doing lots of paperwork, rarely on the floor with us. We deliver the nursing care and they do the medical stuff like the medicines, dressings and pharmacy.*

However, these latter assertions were not commonplace and more often than not, nursing home staff articulated their abilities to truly know and care for their patients as being a core construct for person-centred care. They identified the relevance of expert knowledge in knowing the person. This was linked to knowing them as a person not just here and now, but in life, what they did for a living, what they like to do now, what connections they have with family or significant others? This was evidenced by:

*S36: We treat the residents like we would want to be treated. We know their 'ins' and 'outs' their own little mannerisms, their 'ups' and 'downs'. Knowing them and all about them is central to providing compassion with all we do. Respect for their diversity, their religion, their beliefs are all important to us. Demonstrating respect for this is fundamental. It's who most of us are anyway, or we wouldn't be here otherwise.*

*S32: Making sure that patient centred care is provided at all times and ensuring that all legal requirements – all the boxes are ticked regarding their rights, needs and maximising their independence and making sure they have chance to give feedback and making sure all requirements in relation to inspections is in place so that we have the evidence based practice to show we are doing the right thing and making sure residents given right choice. Let them choose for themselves, it will make them feel involved and part of their own care, as it should be.*

This type of knowing extended into what the literature refers to as the art and science of nursing. The science relates quite well with evidence-based practice, person-centred care, care standards and the overall perceptions related to the quality of care provision. The majority of staff demonstrated the essential nature of this aspect of professional knowledge as it related to direct care for their resident as evidenced by:

*S6: My role here is to promote independence and for the residents to live a meaningful life, to receive high quality, patient-centred care, and I suppose independence would have been something they would have valued at home in terms of their self-determination and that would be something that I would value very much in my role that they maintain here or if they are in respite care try and go back to their base line for their return home.*

*S40: So many residents and family members comment. Can't believe how resident has changed since coming here and that person looks so happy. I'm talking about recent admissions, not about years ago. Few comments from relatives makes us feel rewarded, something done 100% right. Even the inspectors have mentioned they have seen that caring kindness, even as a feedback I always get it. Good quality care and standards helps everyone all around, really.*

*S23: Every resident is really valued here, we are all very aware of how they like to spend their day, what level of care and attention they need, be it in their room or amongst the rest of us, but we would never force anyone to go along with our own pace or what we want to do.*

The art of nursing care relates to intuitively knowing the resident as a person as evidenced by the following:

*S38: I have been nursing a long time now and I have many years' experience under my belt, both as a mother and home carer. But being a nurse in charge is totally different. Looking after my own mother with cancer and children helps me to appreciate caring and good care, but it's not just that, that I need in here. You bring it all together in your dealings with the residents. You know when things aren't right, they don't even need to tell you. Sometimes they'll say they're ok and you just know by looking at them and sensing that all is not ok. This is when time for them is essential, listening with empathy and concern. You never know what is going on unless you show genuineness and concern for the things that matter the most to them. And, sure some days it's major, like their bowels, and the next time, it's not so major, and they just want your company. That's ok too. This is why I became a nurse, because I do genuinely care for people. Showing that to my residents is my focus for care.*

Further, a sense of working with the person and seeing the person as a human being, even if they presented with unique challenges, was linked to an art of caring. Fundamental to this, was the centrality of respect for individuality and autonomy and

active involvement in care practices and decision-making. Many nurses articulated the essential nature of being self-aware and of reflecting on their practices as a means of improving said practice:

*S3: Everyone is treated with respect, this is the residents' home, lest we forget. We always ask for permission to come into their rooms, respect their privacy. We know when they're happy and the care is very good, we can tell by their faces if they're comfortable and relaxed. It's perhaps a fine art more than a science. Communication with the person is so important, especially if they have dementia. We do try and understand, but it's difficult. I often stop myself and think, am I doing the right and most purposeful thing for this person?*

*S42: Truly knowing the person is important for me, even when they themselves can't find the words. I still know that they are communicating with me. I will always try to involve them and show respect for them. I will also try to promote a culture of residents' needs first and foremost, despite the inherent difficulties it might cause.*

Involving the resident in a collaborative manner and keeping them at the centre of care delivery and decision making was important in many homes:

*S20: Our residents' meeting provides a strong voice for them collectively, demonstrates involvement in care practices. We have to account back to the residents' committee if things are raised and appear not to have been addressed by the care staff. Very powerful process of collaboration and voice.*

#### **4.2.3 Nursing Care in the Nursing Home in the Context of Homely Care**

Many participants within the staffing groups spoke in a very open and frank manner about the centrality of their roles, as they perceived them to be, within the nursing home. They also compared and contrasted this care for the resident as if they were in their own homes. Multiple phrases and concepts occurred repeatedly within the data collection that demonstrated a clear appreciation and understanding that the transition

was a complex journey not just for the resident, but also for their families and for staff within the nursing home. This was evidenced by some of these comments:

*S7: I think the fact that our residents get up and dressed as they would do at home, nobody is in their PJs all day. We are lucky we have the garden; they can go out there. I feel it's much better for the residents here because they have company all day, we have some quiet areas too, but company and safety. At home the hours drag by for them it's not like that here at all.*

*S8: Some of the residents will bring some of their own stuff from home, which is brilliant. The move is difficult for everyone concerned. They bring the pictures from home, so everything looks familiar and they are more comfortable. I think they're all happy enough here, you can see it every day. But having their own possessions, that's important. Choice and promoting independence also. Normally we would ask them about getting up in the morning, some are early risers, also some get up late so we give them the choice. We have activities every day. They decide, we want this to become their new home.*

Many staff spoke about how they worked in a positive manner with the resident to help them adapt to the changes in their daily lives, the changes to their day-to-day environments, and the transition into something different and new. Again, emphasis was placed on the centrality of knowing the person and their lives prior to the nursing home entry and operationalising this information into every facet of care delivery. Some staff spoke about residents who they felt accepted changes quickly, albeit somewhat reluctantly, and how for others it was a slower and more difficult process with an eventual reluctant acceptance; that this was perhaps it, as they were powerless to effect change:

*S18: Just try to make it more of a home setting than a clinical setting. Some of the newer homes are very clinical. We are trying to maintain a home setting. Get them to smile and be happy, if they need anything you get it for them, just make them comfortable, and they're not anxious. Loads of seating areas. Some people like to sit in the seating areas, other people like to sit in the foyer. Moving is painful for some and it's really hard to let go. It's upsetting for me*

*when they are distressed and just want to go home, even though they know, and I know, that this isn't possible.*

*S9: I was relief chef in 30 different nursing homes, but the thing here is the actual homeliness and the time the carers have for the residents as opposed to some others. Good quality of care here too and I think if somebody falls into a role you treat somebody the way you would want to be treated yourself, feel loved, that's what I try to do. I can see the nurses helping them to come to terms with the changes also. Me, I try to make sure they get what they like to eat. Lots of elderly like fish on Fridays and especially no meat for the Catholics on the first Friday's. You've got to really get to know them, lest they get annoyed or offended. It's the little things really.*

Clearly, there was also a diversity of explanations and feelings as to what constituted homely care within the nursing home for the residents. A core construct appeared to be treating the person, as they themselves would like to be treated:

*S40: As I see it many residents are going through a difficult time in their lives and our role is to take time with them, to demonstrate genuineness within our caring approach, to make them feel involved, to make them feel loved, to make them feel belonged, so that they don't feel that this is their end. We often have residents who have been given a new lease of life. Respite from their own homes and perhaps for some the loneliness that they felt. This is not the home they might want to be in, if they had a choice, but our role is to make it as homely as possible working alongside them in doing so.*

*S35: I always treat the resident as I would like to be treated, this is with dignity, respect, with manners. This helps them to settle in and eventually with all of their own things in place, they'll come to accept this as their home. We are all together in this.*

*S18: There's a great deal of analysis done on the initial admission and I think that's reflected in the amount of information that each carer would have in regard to each resident. Just take a walk along the corridor, the names are on the door but also there's a reflection of whatever the resident may have. They know we know what they do, if it's boxing, music, sport whatever, their personalities are reflected on the door and it reminds you what to discuss with the resident. That's from day one, that we know exactly what will make it home for them. We know it won't ever be the same, but at least we continue to try and help them cope with the changes.*



In attempting to maximise a homely experience for their residents, staff accepted that there was an inevitability of change required in the residents' lives and that accepting this change was fundamental to their acceptance of this nursing home, as their new home. However, despite this level of awareness, staff still worked hard to help them to feel at home as evidenced by some of these assertions:

*S23: Personally, I see my role as enhancing whatever I can in their lives. All we can bring is assistance and support, we can't live the life they live but we can try to identify with it.*

*S32: We would say to family we are here to support that person to live their life and to live it in the same manner as they would have done at home and that families should do that as well.*

#### **4.2.4 Care Standards in the Context of Homely Care**

All staffing groups demonstrated awareness and articulated the importance of care standards within the nursing home environment. None of the participants suggested that standards of care in a nursing home were not a good thing. Members of staff identified the important role of inspections and the regulation of residential care repeatedly. Some staff spoke about care standards as providing positivity and assurances for effective care delivery. Some articulated the necessity of the role of HIQA as central to effective standards and a focus on the person-centred care delivery:

*S12: The invention of HIQA – what they represent has improved the delivery of service and the experience for the resident – all very positive. We are all trying to meet the legislation but aspire to do better. Standards were very weighty in that sense. Looking at someone's experience, good thing, sometimes so busy doing tasks that we forget what it's like for the person on the other side of that task perhaps. I think that HIQA has been instrumental in changing things for*

*the better. Now much more going towards social model. Think residents do think they are better cared for. More person centred and the person and their experience is at the centre.*

*S29: We always follow the standards, whatever is required, we make sure it is always by the book, always with the standard.*

*S31: Rules can affect choice, like types of bed linen, mattresses, choices of furniture, all problematic if they are non-compliant with health and safety inspections or if they are not fire retardant. But, all we can do is do our best, but I do think at times that it can take away from the homely environment the staff work hard to maintain.*

Some very experienced care staff suggested that they had been in the system a long time and it was their personal belief that before HIQA, the standards of care were not very good. They felt that HIQA did what they were supposed to do, assure the public of better standards of health care provision as evidenced:

*S29: Before HIQA, I would not like to tell you what it was really like. I'm not saying that staff were bad to patients, but the standard was just the minimum and you had nothing to compare it to other than other homes or places that you worked. It was sometimes hard to get a good home with good standards.*

However, other staff felt that there were now too many rules, regulations, and this did not necessarily lend itself to the provision of homely care, particularly if the resident had expressed a choice to the contrary:

*S21: I think it has a lot of rules that don't make sense. They contradict some of their rules by saying it's all residents' choices or infection control, to me personally, I think all residents should have their own commode in their room, but now they're not allowed those kinds of things. I understand places need to be regulated, protects residents, staff and everybody, but mainly the residents' rights. But occasionally, and it's when you're caring all your life, you have to go through every change, from there being no regulations. I do get that but I also think it costs homes lots of money. It's responsible for the care slipping. I worked in a home where we had the place painted, not just for the inspection, but for the residents. They came in the first day of the inspection and asked us*

*to change the colour, and we had just paid €15,000 and it had to be changed with a deadline. That to me doesn't make sense.*

*S27: Sometimes the resident chooses to have the bed rails up because it makes them feel safe. We have involved the family in the decisions as well, and then the HIQA inspector makes out that this is not allowed.*

In some situations, whilst due cognisance was given to the need for standards, staff nonetheless felt that there was too much focus on clinical and medical matters, that staff perceived to detract from a homely experience:

*S18: I think it's a very positive influence. I think sometimes they are trying to take us away from the homeliness. Thinking are they trying to bring nursing homes to be too clinical/medical. Holding our own at that end. Trying to keep away from being so clinical because I think that takes the home away from nursing home.*

*S14: Certain things we would be looking to keep things homely and they would be looking to bring in more evidence. You would think they are trying to make us look like a mini hospital instead of a nursing home.*

In one home, the Director of Nursing reported feeling under extreme pressure in relation to deadlines, paperwork and meeting regulatory requirements. She felt that the HIQA approach was also threatening and that it often depended on who the HIQA inspector was:

*S10: Very difficult within 2 days to get an essence of what things are like and they need to see proof. In order for us to prove that we are doing what we say we are, we're devising paperwork to show we are doing things. Last year's theme was nutrition and end of life care and we're having conversations – a more-gentle approach is needed. We devised an advance care directive and devised a flow chart of nutritional intervention. That's all very clinical so from the nurses' end of things, that's very clinical. For nursing staff to try and show the evidence- quite clinical.*

In other situations, the Director of Nursing and the staff felt pressure aligned to providing care because of an outbreak of flu in the home but believed that the inspector did not appreciate the genuine difficulties that they were experiencing at this time. They felt that the demands of repeated inspections were just too much and resulted in compromising the homely care of residents. One home that had a severe outbreak of flu felt that the degree of scrutiny by the inspector was excessive and that preparation for repeat inspections detracted from the time available to provide nursing care for residents:

*S25: Every single staff member here [name] and I felt many times that it's compromising the care of the resident by spending so much time with documentation. Myself, out of 8 hours if I count going back to [Year], I wasn't even on the floor 15 minutes out of 8 hours just because I had to get the documentation right.*

This experience was evident across both urban and rural homes as evidenced by this comment:

*S26: The documentation was not up to their expectation. But at the same time, I felt threatened. For example, we were having fire training coming up, and we had an unannounced inspection and out of four staff working that night only one was having the fire training done that year, the other three had done it the previous year but the inspector made me get the fire training done that night at 7pm otherwise they won't be able to work. It was, you know, it wasn't easy.*

Suffice to say that there was a mixed response to the role of inspectors within the inspection process and perhaps some discontent regarding the completion of these processes in themselves. It is important to note that it was not the overall requirement to uphold standards that was anxiety-provoking for staff but rather, it appeared to be the disconnect in terms of expectations of staff and those of the HIQA inspectors:

*S37: Their expectations are very very high. I remember when I first started here we had the craic with the residents, chat away to them and carry on with them, now when we went on an abuse course now the way we carry on with them and have some craic is now classed as abuse.*

*S44: Again, it's one way, talking about inspections it's a feeling of safety whenever the residents are staying in a nursing home. For example, relatives, they are having mum or dad here and they are feeling safe, they're offered that at least and that this place is regulated so they will not be able to do anything without having adequate staffing, and making sure we comply with all the safety regulations, infection control. There's a good point but sometimes it's too over the top that we are going through due to documentation and all that, that we are not giving 100% of our time to the residents because we have so much documentation, to say what we did throughout the day.*

#### **4.2.5 Summary**

In summary, nursing home staff groups shared their feelings and experiences about working in their nursing home environment. This was in an open, honest, and reflective manner. It was difficult not to sense the altruistic tendencies of the staff within their caring roles. They explored in detail the nature of caring within the care giving relationship and expressed positive emotions whilst talking about the residents they cared for. It was evident that there was reciprocity within the caregiving relationship and nursing expertise, nursing knowledge, and the provision of compassionate care were core constructs to effective care provision.

There was strong evidence of valuing and respecting the residents' culture, beliefs, attitudes and autonomy within the nursing home environment. Moreover, promotion of choice and working with the person were intrinsic values for many staff. Interconnected to these values and beliefs was the promotion of a 'home from home' experience. There was also evidence that staff promoted flourishing, human, and social connections within the nursing home. It was perceived that these enabled and

facilitated an easier adaptation for the residents to the current changes in their life circumstances.

Staff aspirations and nursing care delivery took place within a regulated environment that many felt, at times, negated a truly 'homely experience'. Despite these beliefs however, staff worked tirelessly to promote their residents' independence, autonomy, choice and personal way of life. They did what they felt was necessary and appropriate in their day-to-day engagements and nursing care, whilst trying to ensure that the nursing home did not move too far away from that important concept of a 'homely environment'.

#### **4.3 Chapter Summary**

This chapter has presented the findings from the resident and nursing home staff groups that participated in the focus groups, within two discrete sections for clarity of presentation. A total of  $n=48$  residents participated and a total of  $n=44$  staff participated, thus a total of  $n=92$  participants. A total of  $n=8$  focus groups were conducted with residents and a total of  $n=8$  focus groups were also conducted with nursing home staff across urban and rural settings.

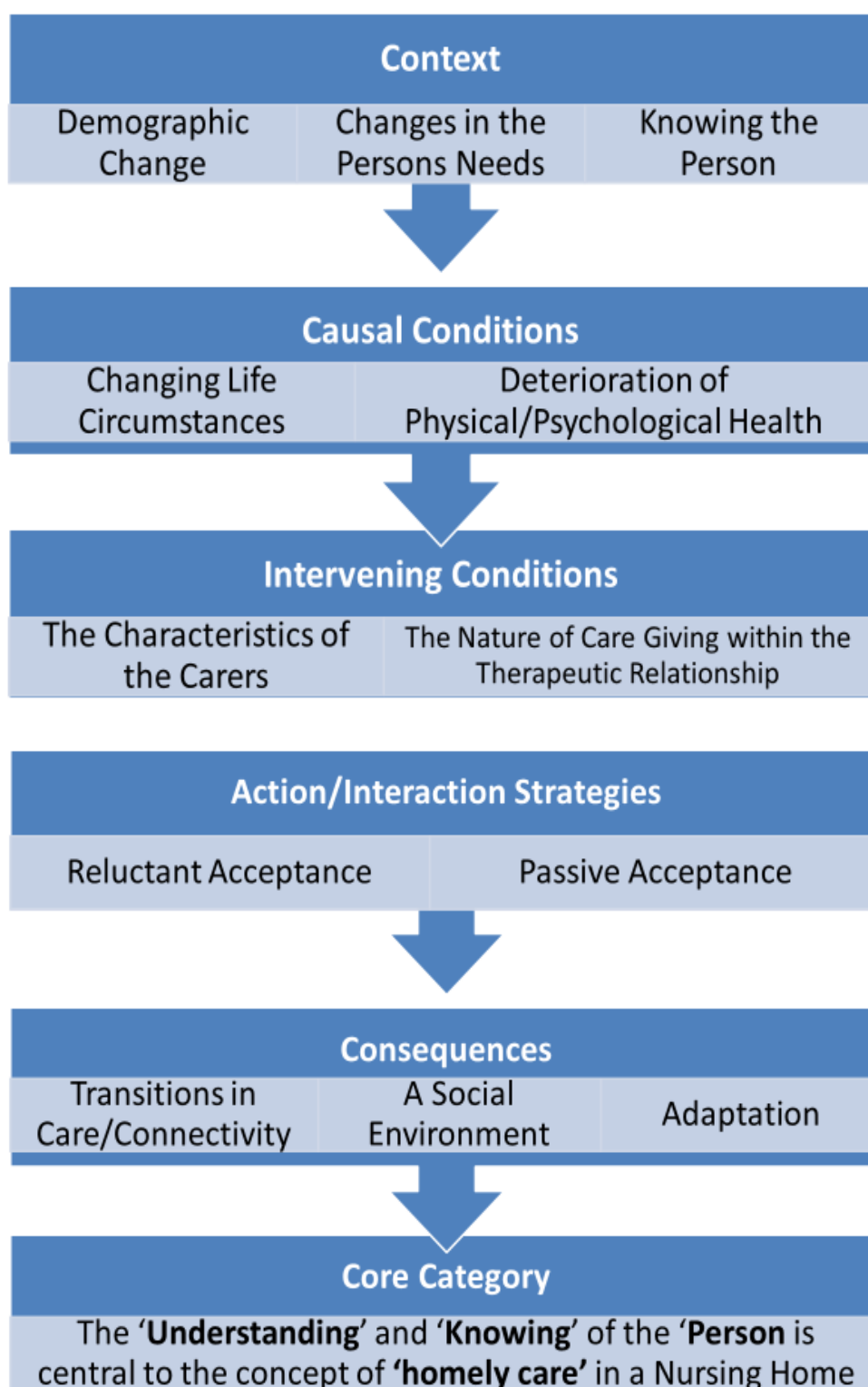
The paradigm model, Figure 2 (Corbin and Strauss, 2008) presents a framework for data analysis within a grounded theory study. Figure 3 now presents the application of the model to the data derived from this study. This identifies the development of the core category and the ways in which all other categories relate to it as extrapolated

and discussed within this chapter. The theory grounded in the data from this study is thus:

***“Understanding and knowing the person is central to the concept of homely care in a nursing home”.***

This theory describes the centrality of the experiences for both the recipients of nursing home care, the residents', and the staff who provide this care within the nursing home sector. However, it is evident there remains a dearth of qualitative literature that explicates and provides insight into these actual experiences, particularly for those of the residents. Because there is little published about this particular area within gerontological nursing, the theory generated herein, is best described as a descriptive theory.

Figure 3: Core Category and How All Other Major Categories Can be related to it



Chapter 5 will provide some discussion and academic discourse related to these findings and will conclude with some recommendations.



## **Chapter 5: DISCUSSION AND CONCLUSION**

### **5.0 Introduction**

The research and empirical evidence presented within this report has provided a meaningful insight into the multi-faceted and inherent complexities of providing care to older people within nursing home settings. There is significant evidence reported within the published literature and research reports, particularly regarding the demographic picture of a growing older population and the concomitant challenges of increasing dependency levels within this population group. Much of the research has focussed on the deterioration of physical or psychological functioning and on the need to develop effective models of care provision for older people residing in their own homes or in a nursing or residential care environment.

Much literature within the field of gerontological nursing also pays particular attention to depression, cognitive decline and the challenges related to a diagnosis of Alzheimer's disease, or dementia in all its forms. The complexities of providing care to individuals with mental ill health, cognitive impairment and challenging behaviour are thus compounded by an increased need for assistance within all of the activities of daily living. Consequently, the need for continuous 24-hour nursing care arises and thus receives considerable attention within the published literature. Moreover, the necessity of providing nursing care that maintains quality of life, dignity and inclusivity within the caring process for the older person; and one that is also respectful of families, receives considerable attention. Subsequently, there is much reporting on the transitional process of moving from one's own home to a nursing home. Varying

perspectives are explored with many authors reporting and providing clarity on the transitional phases that are perceived to co-exist within this process (Ryan, 2002; Bridges, 2004; Meyer and Owen, 2008; Ellis, 2010; Riedl et al., 2013; Couture et al., 2012; Ryan and McKenna, 2015). However, fewer studies have reported on the residents' experience of the 'nursing home as my home' (Cooney, 2012; Nakrem et al., 2012), but the literature reports that exploring this concept has been recognised as essential (de Veer and Kerkstra, 2001; Cooney, 2012; Brandburg et al., 2013) to develop further qualitative understanding. Cooney (2012) put forward a grounded theory on how older people 'find home' in long-term care and this study's findings are broadly supportive and consistent with some the core categories as postulated within this work. There is thus a clear and increasing necessity for an analysis of this phenomenon, particularly given the increasing demand for nursing home placement (Nakrem et al., 2012). To understand what nursing home residents' view as high quality person-centred care is clearly an important prerequisite in providing this type of care. With this in mind, and due to the intrinsic link between care provision and staff, there is also a need to capture the views of care home staff with respect to their roles in ensuring that their residents experience the 'nursing home as their home'.

This relatively uncharted territory was thus the focus of this study and it has demonstrated an enlightened understanding of both resident and staff perspectives and experiences. Many of this study's findings are supportive of the literature already published in this area, but the findings also highlight challenges associated with the transition from home to a nursing home and around the provision of a home like environment within a regulated setting.

For many residents, moving into a nursing home, presented various personal and psychological challenges such as a sense of upheaval associated with the transition, maintaining contact with family and/or friends and adapting to their new environment while maintaining a sense of self. Residents who had resided in the home for some described a sense of belonging and adaptation to the home environment with many expressing overall contentment with multiple aspects of their daily lives and thus a degree of 'passive', and for some, 'reluctant acceptance' of their new circumstances. For others, it was an acceptance of their current circumstances, coupled with their profound sense of belonging within the home and having day-to-day purposeful and meaningful activities and company, which appeared to underpin their contentment and happiness. The authors describe this as an indication of 'passive acceptance' with their current realities.

However, there was also some evidence of an internal personal conflict that co-existed. The authors describe this as 'reluctant acceptance' of their current realities. This personal conflict related to their full and personal acceptance of their current circumstances, with an underpinning desire to return to their own homes. This personal and ethical conflict co-existed despite their acute awareness of their reasons for coming to the nursing home in the first instance, which, directly related to their inability to cope at home alone. It also co-existed despite their awareness that they were not going to be returning home, and for many this was their current and lived reality, which they had accepted, albeit for some, reluctantly.

Meyer and Owen (2008) have previously reported on what they regarded as the essentiality of maintaining the persons' identity within the nursing home and thus

creating a sense of community. A sense of community where the person can flourish and have 'value' in their day-to-day living experiences. They suggested that the promotion of this positive culture combined with effective leadership within the home are enablers for ensuring that care homes can be seen as positive options for older people. The evidence within this study suggests that for the residents living in the nursing home sector that it is a very positive option for many older residents.

There is a direct correlation on the varying perspectives of nursing home staff, who participated in this study, to staffing mix and/or length of service, expertise and knowledge. Nursing practice expertise and knowledge have been evidenced as core requisites for the provision of effective nursing care and support within the nursing and residential sector (Parquay et al., 2007; Tolsen et al., 2011; Phelan and McCormack, 2012; McGilton, 2012; Phelan and McCormack, 2016). Nursing home staff with considerable knowledge and expertise are thus better able to engage in meaningful interactions with residents in their care. There was also evidence of reciprocity, through a process of truly understanding, knowing and responding empathetically between the staff and residents who participated in this study. The way in which staff worked collaboratively to promote a culture of person-centredness or resident-centredness with effective communication within the environment was crucial to the provision of care that was valued by residents.

For many residents, the day-to-day normal routine of activities was important and central to their sense and feeling of home, as it created a sense of community and belonging and of significant importance for many residents was outings and leisure type activities. Many of the residents reported how they perceived that these were

affected by reduced or low staffing levels, or when a staff member left the nursing home. Many of the residents considered the latter issue of staff leaving as crucial as they had often established close relationships with these staff members and appeared to miss them when they left. Other residents reported that high turnover of staff often resulted in a limitation of activities and outings for them.

Siegel et al., (2012) reported on such organisational difficulties that could in fact hinder an ethos of person-centredness. They reported that work design and staffing practices/patterns are two critical aspects of the organisational context, which have major implications for personhood-focussed care. Furthermore, they further suggest that limited staff and high turnover are major barriers to implementing care practices that promote autonomy and independence and, consequently, individualised care (Siegel et al., 2012). The findings of this study broadly support these assertions.

Staff participants demonstrated their understanding of the importance of established routines within the home but at the same time, they recognised the need to tailor these routines, where possible, to the choices of individual residents. Individual choice was considered important at all time and examples of this included mealtime, choosing to have a lie on in the mornings, and for some residents, preferring to eat in their own rooms or the dining areas. Despite this, some of the staff believed that rules and regulations imposed by HQIA could make life in a nursing home more restrictive for their residents than perhaps it should be. Indeed, Siegel et al., (2012) has suggested that organisational issues can undermine a sense of personhood within long-term care and advocated the importance of leadership, teamwork, staff decision making,

communication and staff empowerment as components of supportive organisational behaviour.

However, an analysis of these day-to-day interactions and experiences as determined within this study appears to suggest that for many residents and staff daily interactions are significantly purposeful and meaningful within the therapeutic alliance and often result in transformative and illuminating caregiving.

In an attempt to capture some of the complexities associated with caregiving from different perspectives (and to set the scene for a more comprehensive discussion within this section of the report), the authors wish to present a reflection on practice utilising a case vignette (Refer to Table 11). This occurs following an exchange that one of the authors experienced in their own day-to-day practice as a nurse educator.

To aid clarification the authors have utilised the Gibbs (1988) reflective cycle. The case vignette focusses on an interaction at 7.00am, in a dementia assessment unit, between a 78-year-old woman with cognitive impairment, a second-year mental health student nurse, an experienced registered mental health nurse, with 25+ years of nursing experience and the author, with 32+ years of nursing experience, who was there to conduct a summative assessment on the student. Clearly, in this scenario there is a need for the registered nurse to focus on this apparently ordinary interaction to bring new meanings to the experience. These interactions are what enables a more effective provision of 'homely care' from the residents' perspectives, reinforcing a significant degree of reciprocity and genuineness in the caregiving experience. Dwyer et al., (2009) has articulated the importance of dignity in the provision of care to nursing

home residents as evidenced by trust and respect for the person and seeing the person's individuality within everyday activities.

Cooney (2012) also reported that preserving personal identity and a sense of belonging were important in helping older people to find home in a nursing home. Of significant importance was feeling known and valued as an individual, which helped to maintain a person's sense of identity coupled with a feeling of belonging or a feeling of being at home (Cooney, 2012).

**Table 11: A Case Vignette Reflection**

|   |  |
|---|--|
| <b>Description<br/>What happened:</b>                             | The initial meeting between the resident and the author occurred at the entrance to the facility when the resident, who had been knocking and banging on the exit door, attempted to leave the environment as the author was entering. She clasped me by the arm firmly upon entry. She was visibly tearful and upset and wanted to exit the ward past me.   |
| <b>Feelings<br/>What were you thinking and feeling:</b>           | I wondered where she was looking to go to at this hour of the morning, or what or who was she looking for? She was impeccably dressed, ready for some journey, with a set of purple beads around her neck and an accompanying handbag on her arm, as she grasped my arm tightly as I entered, I felt the softness of her hands. I thought about how best to perhaps divert her attention, ease her apparent anxiety levels, and re-focus her thoughts. I asked her where she was going and she replied "I don't know". I remember feeling a bit saddened. The student came and said "I'll take her away from you now", as if her interpretation was that I was unable to cope. This made me feel even more saddened as the resident had been referred to as 'her', but I indicated to the student that I was able to cope. The Staff Nurse came soon after, quickly appraised the situation as it was unfolding and she informed me that [name of person] had a similar 'love in life' to me, and was usually always looking for this, and then left to undertake other nursing tasks. Instinctively and with intuition, I knew this 'love in my life' was for me and thus her, our family pet, the dog. I now had more essential information about this lady, a love for pets, and of course her first name. Knowledge and an appreciation for this person now underpinned my next course of actions and interactions with this person. |
| <b>Evaluation<br/>What was good and bad about the experience:</b> | We talked and walked arm in arm into a close by sitting room and sat down, I immediately took out my phone and began to play a 2-minute clip of me using a hair dryer with my dog the previous night, and as we both sat and watched the clip [name] attempted to touch and to show some form of affection towards the dog on the screen. Her tears had now left, her angst on her facial expression had changed and for a period of time, we shared what I felt was a therapeutic presence. She was smiling and clearly reminiscing about times gone by in her life and spoke about her love of dogs. This was a good and meaningful aspect to this encounter, what was bad was that the student appeared to misunderstand what I was doing and the nature and complexities of this interaction did not register with her, like it had done so to me.   |
| <b>Analysis<br/>What sense can you make of the situation:</b>     | I comprehended the complexities and need for effective nursing and caring interventions therein quite quickly and acted upon these comprehensions and my professional interpretations therein, based on knowledge, skill, and expertise. This was a person with cognitive impairment, someone's relative and loved one. The comments from the Staff Nurse also demonstrated intuitive knowing both of the older person in her care and of me; essential components to affect a therapeutic management of this situation. One, which had a focus on dignity, respect and in some ways the principle of autonomy and choice for the person as she subsequently interacted with me through choice, albeit as a result of my appreciation of her as a person and my direction to choose to take out my phone and show her a clip of a pet being groomed. The student in my company appeared confused for the most part   |
| <b>Conclusion and action plan:</b>                                | In the end analysis when the student was asked to consider what she had just witnessed, and to tell us what she had seen, she stated that "I saw a seventy-eight-year-old patient, attempting to abscond from the ward; she was agitated and potentially aggressive in her mannerisms and behaviour as she banged on the ward exit door". Inherent within these assertions, and possible course of actions that could ensue, lies a disconnect for both the qualified experienced practitioner and the student. This was not what either of the registered nurses had seen. Hence the clarion cry by the infamous Kate's Poem, (Bornat, 2008) [Refer Appendix 9] 'What do you see, when you look at me'? The level of expertise and knowing of this person is critical. Thus, something quite ordinary becomes rather extraordinary or perhaps more succinctly, profound. The need to assist learners, or more junior members of staff, within these interactions, to comprehend and appreciate the nature of the interaction, is also important for the registered nurse.   |



The case vignette demonstrates how something somewhat ordinary in terms of day-to-day interactions between residents can become quite extraordinary if a level of reflection or analysis is applied as a result of knowing and appreciating the person. This study has presented data on the staff members' appreciation of the 'intrinsic nature of 'knowing the person' in nursing home care' and this was particularly evident among the nursing staff who participated in the study. It also illuminates the existence of an occasional disconnect between registered nurses' interpretations, or ways of knowing the person, and that of other staff members. Some of the health care support workers interviewed in this study reported that the staff nurses did mostly paper work and medicines and consequently, were not directly involved in certain aspects of nursing care. However, this was not supported by the findings of the resident interviews, thus reinforcing the importance of effective leadership and management within the nursing home environment (Meyer and Owen, 2008).

The findings of this study also highlight the ethical issues that nursing home staff have to navigate on a daily basis. An example of this occurs when a resident wants to move freely in and out of the home (an autonomous assertion). However, staff who have a duty of care to safeguard their residents, do what they believe to be best (beneficence) in terms of promotion of safety and prevention of harm (non-maleficence). This course of action occurs even though care home staff know that this runs contrary to the resident's wishes. This study has presented similar ethical challenges evident in residents who wanted to perhaps leave and return home, but the reality was that this was not a possibility due to their ongoing need for complex care needs.

This finding is supported by Nakrem et al., (2012) who stated that the challenge for nursing home staff is to meet the competing psychosocial and physical care needs at the same time, so as to reconcile the tension of 'home and not home' in order to promote a sense of 'at-hominess'. Reconciling this tension will help nursing homes improve their resident's feeling 'at-hominess', thereby improving quality of life for residents, relatives and staff. In practice, they felt that this meant creating a home despite the fact that it is not an ordinary home, to ensure individual and dignified care, in an environment of community and fellowship, even though the residents may have few, if any, things in common (Nakrem et al., 2012).

## **5.1 Admission and Transition to a Nursing Home**

An ageing population presenting with a myriad of complex care needs coupled with changes in family size and structure will mean that many older people will invariably require nursing home care (Nakrem et al., 2012). There is undoubtedly a critical role for the nursing home sector within a well-functioning health service. Further, the impact on acute hospitals can be minimised in terms of bed occupancy rates, particularly related to continuous complex nursing care needs and physical deterioration in older people, within a vibrant and sustainable nursing home sector. The population growth within Ireland reflects worldwide demographic trends (CSO, 2016, UN, 2016), thus there is an important need for nursing home beds as identified clearly by Wren et al., (2012) who attempted to provide a predictive model for such long-term care needs within both Ireland and NI.

As evidenced from this study, admission to a nursing home was often triggered by a deterioration in physical or psychological health with a concomitant increase in self-care needs. These led to ever-increasing risks associated with day-to-day living for the resident, within their own home environments. On many occasions, the primary carer had been the resident's partner who was also an older person, or a family member such as an older brother or older sister. More often than not, where the husband or wife had pre-deceased the resident, the primary carer was generally another female family member who lived elsewhere and this compounded the situation even more so. According to Brandburg et al., (2013), an important factor that influences the need for long-term care is the lack of traditional family carers as women from all cultures continue to move into the workforce at higher rates. Many residents were well aware of the difficulties their families experienced in attempting to care for them at home and there appeared to be a recognition that the arrangement was not sustainable in the longer term. Family relatives had often moved away from the family homestead and many residents had family members living abroad. This concurs with the assertions of Lee et al., (2013) who articulated the challenges for families of an ageing population.

The complexities of skills required to care for their relatives often resulted in a families' inability to continue their caregiving role. Moreover, other issues related to location and their personal unavailability due to their own family or social circumstances also negated their ability to continue caring for a loved one. None of the residents identified reluctance on behalf of their families or friends as a potential inhibitory factor. In fact, on many occasions, residents did not wish either to be perceived as, or to be, a burden on their families. The issue of feeling like a burden within families has been reported

elsewhere in the literature. While many residents, had deep attachments to their homes, their failing health meant that living at home was never going to be the same as it was when they enjoyed better health and were surrounded by family and friends (Brandburg et al., 2013).

The data collected within this study also suggests that residents who moved into the nursing home directly from their own homes appeared to be more actively involved in the decision making process around the choice of home. This involvement in the decision-making is considered crucial for successful transitions to occur (Lee et al., 2013; Ryan and McKenna, 2015). Moreover, such a move from one set of living conditions to another can be construed as a stressful life event resulting in the need for significant adaptation that can strain people's abilities to cope to the point of clinical distress (Armstrong et al., 2011). Some residents reported feeling distressed during the transition process and identified the factors that minimised this distress such as effective communication, facilitation of choice, effective caring relationships with staff, effective consultation and collaboration with them and their families. Conversely, other residents stated that their relatives were asked to stay away whilst they adapted to their new environment and these residents found that this impacted negatively both on their transition and on their relationships with their families. This poses a challenge for society as a whole but particularly for potential residents and families to work in a more open and honest way with nursing home staff to facilitate a smoother transition for all concerned.

The preadmission circumstances of many residents were compounded by a fall at home, which resulted in a hospital admission. In some cases, the length of their

hospital admission was extended due to either their complex care needs, poor mobility or other health challenges. There was evidence to suggest that the co-existence of these challenges and their families' inability to cope was the primary reason for their admission to a nursing home. This is in keeping with the published literature in this area (HSE, 2008; Lisk et al., 2014; World Health Organisation, 2016; Irish Hip Fracture Database National Report, 2016; National Hip Fracture Database Annual Report, 2016). Indeed, Reed et al., (2003) suggested that factors related to the changes within the person or the unsuitability of their own home environment are 'push' factors for a nursing home admission. Conversely, the 'pull' factors are those considered to attract people to new environments, such as proximity or ease of access to amenities or families.

For some residents in this study, a consequence of a prolonged hospital admission was that they went directly to the nursing home, without ever returning home to their own homes. Family members were involved in the choice of nursing home for their relatives and on some occasions, residents reported that their relatives facilitated them to return home for belongings and personal effects. Davies (2005) reported the enormous benefits if family carers perceive that they are able to work in partnership with care staff in order to ease this transition and Ryan and McKenna (2015) further identified the significant advantages to this approach. For some residents who had not had such facilitation and involvement this invariably resulted in transitional problems that appeared to lengthen their adaption to their new environment. Again, the findings of this study are very much in keeping with the published literature regarding such transitions (Davies, 2005; Bruus et al., 2011; Lee et al., 2013; Riedl et al., 2013; Sussman and Dupuis, 2014, Ryan & McKenna, 2015).

On at least one occasion, the first time that the resident saw the nursing home facility was at the point of admission to the facility. Some residents reported that while they were satisfied with their relative's choices, they felt that it had nonetheless presented them with a multitude of personal problems with adapting and accepting the change. These problems related to their perceived lack of control regarding the move and lack of choice therein. These issues of choice, acceptance, adaptation, and perceived loss of control also appear to prevail within the published literature relating to aspects of a transition to a nursing home (Bruus et al., 2011; Lee et al., 2013). However, the potential existence of such a situation is directly contrary to the Nursing Homes Support Scheme Act (2009) which advocates that the applicant (resident) may select the relevant facility or approved nursing home in which to receive care services. NHI strongly support and advocate the inherent principles within the Act related to such decision and choices for all nursing home residents.

Lee et al., (2002) reported the inherent difficulties in admitting a person to a nursing home who appeared to passively accept their circumstances during the transition as resulting in a high degree of conformity to routines. They cautioned that research needs to explore more the issues related to transition not just after the move, but rather as a continuous evolving adjusting process. Moreover, it is clearly acknowledged within the published literature that family support has been articulated as a significantly important construct at this time of transition (Ellis, 2010; Gill and Morgan, 2011). This suggests that collaborating and working with families must underpin the transitional process of admission to a nursing home, but there does appear to be some inconsistencies therein. One such inconsistency appears to relate to the effectiveness of communications. Kiresbom et al., (2012) highlighted that communication and

coordination between nursing homes and hospitals is still in need of much improvement. Holder and Jolley (2012) also pointed out that communication difficulties can exist when a resident is being transferred, or has to move due to closure, from one nursing home to another although this was not found in the present study.

De Veer and Kerkstra (2001) acknowledged the impact of interpersonal relationships with nurses as contributing to the best or worst experiences for residents and suggested that resident-centredness is most helpful in helping residents to feel at home. This study has presented evidence to support a resident-centred approach to care as evidenced by the comments of residents and staff alike, although there were some difficulties associated with communication and collaboration prior to the transfer from hospital to the nursing home. Lee et al., (2013) strongly advocates the need to view the transition as an ongoing process rather than as something which only happens during and in the immediate aftermath of the move.

For some residents, particularly those living within a rural setting, who had found themselves living alone after the death of spouses or family member, the issue of moving into a nursing home was often one of choice due to a self-appraisal of their life circumstances. Many were well aware of the local nursing home, given that relatives or friends had previously been residents there. Moreover, due to the closeness of rural communities and an active 'grapevine', potential residents were aware that the home had a reputation for providing a high quality care. Again, this is suggestive of the 'pull' factors identified by Reed et al., (2003).

Frequently the issue of feeling lonely, vulnerable and isolated within the community presented as reasons for moving into a nursing home. This is again reflective of the

published literature (Conry et al., 2010; IPA, 2016). Some residents living in rural locations reported that their contact with others was often limited to the local postal worker. Burgess (2008) identified the challenges associated with providing health and social care in rural communities, particularly in the context of an ageing population, changes in family size and lack of resources while also acknowledging the opportunities associated with social capital.

Social capital was a term utilised by Hanifan (1916) to describe tangible properties that people rely upon mostly within their day-to-day lives, such as goodwill from neighbours and a sense of fellowship that promoted social discourse. The importance of connectedness and familiarity within local communities provides considerable resources and levels of understanding that enables people to build and maintain the fabric of their locale. In so doing they can maintain localised relationships that can become the essence and fabric of the local communities within which they operate. Social capital thus benefits local people by ensuring a sense of community familiarity, bonding and relationships that support and recognise trust and tolerance and promotes a flow of helpful information (Putnam, 2000). The authors suggest that a local nursing home will thus thrive within such a social environment and can offer many significant advantages to residents. The data presented within this study supports these assertions and is consistent with recent literature, which recognises the ties that rural residents have to their local communities and the challenges and benefits of 'ageing in place' (Moore, 2013; Moore and Ryan, 2014; Ryan and McKenna, 2015). It is not considered unusual for well-intentioned families to seek a nursing home placement for an older relative close to the families' place of residence. However, this can result in some older people residing in nursing homes with which



they do not have the same degree of community connection and familiarity. This situation can make a difficult transition even more difficult for the resident and their family. This poses a challenge for all concerned, for homes, for families and residents, to try to create communities within the care home.

The residents who participated in this study clearly articulated the diversity and complexities that underpinned the reasons for their admission to the nursing home. Many of the residents spoke openly and eloquently about their sense of satisfaction on 'arriving' at this point. They described their care, as 'second to none' and they believed that the quality of care they received in the nursing home would not have been possible, had they remained at home. These are considered as contributory and positive elements within the paradigm model in that connectivity with others and having a sense of a social environment were key factors to a positive transition. This is also very much in keeping with the published literature in terms of transitions from the residents' perspectives (Ryan, 2002; Reed et al., 2003; Davies and Nolan, 2004; Davies, 2005; Ellis, 2010; Gill and Morgan, 2011; Riedl et al., 2013; Couture et al., 2012; Phelan and McCormack, 2016).

Acknowledging that nursing homes are communities, the transition experience was also explored from the perspective of staff working in the participating nursing homes. The staff demonstrated a deep understanding of the reasons why residents were admitted to the home and their comments suggest a genuine commitment to 'really knowing the resident' and to 'promotion of their autonomy', 'independence', respect for 'choice', and 'a sense of community'.

The staff were aware that admission was directly related to deteriorating physical and mental health. Further, the need for 24-hour nursing care provision that could not necessarily be provided at home by the family, neighbours or the health care systems was also recognised. Many staff also believed that some residents had come to their nursing home based on individual or family choice and this was intrinsically linked to the perceived high quality and standards of care provided within this home. Staff, particularly those in rural nursing homes, also demonstrated that they often knew the resident and/or the family and that this was important in facilitating the transition for all concerned.

The data presented in this study appears to indicate that the staff members' understanding of and 'ways of knowing' the resident were enabling components that facilitated the older person to adapt to their current life circumstances within the nursing home environment. Exploring this from a qualitative perspective provides illuminating insights into the continuous process of adjustment as experienced by both residents and staff, a point clearly advocated within the literature (Bruus et al., 2011; Cooney, 2012; Siegel et al., 2012; Lee et al., 2013).

Working in an informed, compassionate and person-centred manner with the resident and facilitating the family to cope at this time were reported as core elements to effective care provision and adaptation to life in a nursing home. Ryan and McKenna (2015) articulated the importance of involving the family at this time particularly if they have been involved in providing care to their loved one at home prior to placement. They spoke about the transition from primary carer to visitor as a difficult one and suggested that families welcomed involvement in their relative's care. The data

presented within this study indicates that staff encouraged and placed significant value on such collaborations.

However, some staff also felt that perhaps not all relatives fully understood the challenges associated with care provision in a nursing home. The work of Phelan and McCormack (2012) has highlighted the contribution of nursing to the care of older people in nursing and residential care facilities. Moreover, Duggan et al., (2012) had previously reported on the importance and significant benefits of working with older people in such settings. Identifying these factors much earlier within pre-registration nurse education programmes could help promote gerontological nursing as a positive career choice for new graduates (Tolsen et al., 2011).

## **5.2 Caregiving, Person-Centredness and Knowing in a Nursing Home**

The nature and context of nursing care and all aspects of care delivery within the nursing home sector are intrinsically connected by the effectiveness of the therapeutic relationship between residents and staff as evidenced within this study. Promoting and maintaining a sense of personal identity in a nursing home have been identified as critical components to ensure personhood and person-centredness (Cooney, 2012; McCormack et al., 2012; Brandburg et al., 2013; Nakrem et al., 2012) and there is strong evidence within this study that these principles underpin core aspects of care delivery as evidenced from the residents' perspectives.

Specific caring characteristics, as experienced from their interactions with staff, have been reported by the resident in this study. Some residents specifically related their

care experiences to nurse A or nurse B, but it is not entirely clear if this referred to qualified nursing staff only. The staff interviewed also articulated the caring characteristics that they considered important in providing 'a home from home' environment for their residents.

The academic literature contains much critical debate about care and caregiving. Sourial (1997) suggested that whilst many argue that although nursing is one form of caring, caring is not in itself unique to nursing, so nursing cannot lay claim to being the only form of caring that may be provided. Many authors (Benner and Wrubel, 1989; Edwards, 2001; Horrocks, 2002) have put forward their beliefs surrounding the concept of caring and its intrinsic link to the nurse-patient relationship. An evolutionary concept analysis of caring was further postulated by Brilowski and Wendler (2005) but they also concluded that the concept of caring remains ambiguous. Kitson (2003) conducted a comparative analysis of lay-caring and professional caring. She argued that the quality of care in the professional caring relationship is thought to relate to the extent to which aspects of caring activities, implicit in the lay-caring relationship, are carried into the professional nurse-patient relationship, and made explicit. She suggested that the ability of the nurse to do this emerges as one of the more important aspects of their therapeutic function (Kitson, 2003).

Other authors (McCormack, 2004; McCormack and McCance, 2006) have provided an understanding with respect to the development of a model for person-centred nursing whereas Nolan et al., (2004) posit the position of beyond 'person centred' care and suggested that a 'relationship-centred approach' to care may be more appropriate. Therefore, caring is not unique to professional nursing roles. The assertion here is that

due consideration and attention must be given to the significance of the caring characteristics of all staff within the nursing home setting, as clearly supported by the evidence presented within this study. Residents spoke positively about the care received from all staff within the nursing home and not just the registered nurse. This is also evident within much of the published literature reflective of nursing roles, staffing levels/mix, all of which have been linked to the quality of care provision within a long-term care setting (Scott-Cawiezell et al., 2005; Bostick et al., 2006; Siegel et al., 2012).

With respect to care standards as implemented by HIQA (2016a), there is clear evidence within this study that supports the utilisation of a care standards approach to ensure effectiveness of care as experienced by the residents. Many staff recognised the need for standards in the provision of care and suggested that prior to the establishment of such regulatory frameworks and standards by HIQA (2016a) that they believed that such positive standards for care delivery could not be as easily evidenced. However, it is noteworthy that, prior to the establishment of HIQA, the private sector was regulated and inspected under Nursing Homes (Care and Welfare) Regulations since the establishment of such regulations in 1993 (S.I. 226/1993 Nursing Homes (Care and Welfare) Regulations). It is also important to highlight that such opinions do not necessarily take cognisance of the evidence demonstrated within the NCAOP report (2006). In fact, there was significant evidence within this study of care standards already co-existing that were consistent with the values of an age friendly society. This suggests that care was person focused, needs focused, integrated, holistic, flexible, supported self-esteem and self-respect, facilitated choice

and empowerment, promoted partnership and overall aimed to maximise the well-being of all residents (NCAOP, 2006, 20).

Siegel et al., (2012) extrapolated upon the existence of regulatory frameworks as providing unique standards of care and inspections within long-term care settings. They suggested that while regulations are well intended, providers might take a defensive approach by standardising care to meet regulations and ignoring the individual needs of the older adult. For the residents and staff who participated in this study, this posed ethical challenges. There was a perception that the creation of a safe environment sometimes resulted in limitations to the residents' ability to come and go as they pleased. This suggests the need for a more open and honest debate between key stakeholders with a focus on balancing rights and risks within a regulated environment. There is strong evidence to suggest that many of the registered nurses who participated in this study value the emphasis on care standards within the practice setting. Siegel et al., (2012) highlighted the need for registered nurses to have a solid working knowledge of the regulations and organisational factors in order to combat any uncertainties that could create barriers to personhood-focused care. Siegel et al., (2012) further suggested that if registered nurses were empowered they could devise ways to ensure care documentation compliance without abandoning dynamic bedside care delivery. In the context of the present study, there is clearly a need for a closer and more collaborative working partnership between nursing homes and HIQA with a view to producing more guidance to empower staff to meet and exceed existing standards and regulations.

It is also important to note at this point that the care and treatment of each individual as a unique person is a cherished value within nursing (Suhonen et al., 2002), but this is not something that nursing can claim unique and its own. The core characteristics of caregiving within this study were valuing residents' individuality, promoting and preserving their dignity and empowerment. These caring characteristics are reported within the published literature as intrinsic to provision of effective long-term care standards (Cooney, 2012; Nakrem et al., 2012).

Moreover, staff respect for the individuality of the person, in their care, was evidenced, with many reporting that they cared for the person as if 'they were a member of their own immediate family'. Vaartio and Leino-Kilpi (2005) have argued that advocacy is an integral part of the role of the professional health care practitioner in promoting a patient's well-being. This study's findings suggest strong evidence of the existence of such a guiding ethical principle underpinning all aspects of caregiving for the majority of staff. Correspondingly, residents also indicated that this was a core characteristic of the care that they had received, once again demonstrating significant congruence within participant groups. These characteristics are considered important dimensions in promotion of the person's individuality and sense of identity within nursing home care and are clearly evident within the published literature (Bruus et al., 2011; Cooney, 2012; Nakrem et al., 2012).

The establishment of an effective rapport, trust and a sense of compassion for the person (Johnston, 2008) within the caregiving relationship with residents and families were viewed as important elements in the nursing home environment. Staff acknowledged that residents did not like high staff turnover nor different staff members

coming into either their rooms or their home environment and this in some way helps to enlighten the value placed on 'truly knowing the person'.

In keeping with the findings of Jones (2006), many of the staff interviewed reported their sense of gratification, with a deeper sense of personal fulfilment and personal satisfaction in undertaking their roles and responsibilities in providing care to vulnerable, older or disabled persons and, often within challenging circumstances and with difficult clients and families. There was clear evidence of role fulfilment despite the potentiality of constraints within service delivery, particularly related to what was considered competing demands on their time for effective caring practices.

Person-centred care is regarded as an optimum way of delivering health care, and may be broadly defined as valuing people as individuals (McCance et al, 2008; McCormack et al., 2012). Such approaches have been advocated widely within the literature. They suggested that the existing evidence requires the formation of therapeutic relationships between professionals, patients and others significant to them in their lives and that these relationships are built on mutual trust, understanding and a sharing of collective knowledge (McCance et al., 2008). Such qualities have been clearly identified and evidenced within all staff participants within this study. Moreover, congruence with residents' findings supports the existence of such qualities within all aspects of care delivery and the promotion of personhood within the nursing home environment, thereby dispelling the myth associated with institutional practices across the sector.



McCormack (2004) highlighted the need to see beyond the immediate needs of the person and establishing a relationship to facilitate 'knowing the person'. McCormack et al., (2012), in their attempts to demonstrate further understanding of the 'person' in long-term care, suggested that in care homes where there is a collective living, good relationships are key to quality of life, quality of care and quality of management. McCormack et al., (2012) pointed out:

*“There is a need for more research on the best practices to consistently support these relationships and should focus not only on the needs of the residents, but also on the needs of the relatives and the needs of the staff. Without an evidence-informed approach to the development of effective person-centred relationships that are inclusive of all persons, and that takes account of the wider health and social care context, then person-centred care is unlikely to be achieved”.*

(McCormack et al., 2012, 292)

The majority of staff participants reported truly knowing and respecting their clients as a real person and this was further evidenced in their capacity to see beyond their immediate care needs and to address the individualistic nature of personhood within all aspects of care delivery. Whilst it is acknowledged that there were some examples of institutionalised practices, as voiced by a small number of residents, the overwhelming finding appears to indicate that nursing homes are residents' homes as evidenced by the autonomy and choice they enjoy on a daily basis.

There finding is also supported by the majority of residents who reported that their dignity was always upheld, that they were included in decision making and felt valued within the caring process. The findings of this study thus resonate with many of the positive assertions within the literature that advocate person-centredness and

personhood in long-term care settings while also supporting the assertion by Cooney (2012) that long-term care settings are first and foremost a resident's home.

### **5.3 Conclusion**

In conclusion, the significant role that a nursing home fulfils in the provision of a 'home from home' for its residents must be recognised and acknowledged. The exemplary standards of care provision and excellence that promote a person's sense of security, independence, belonging, dignity and respect within the long-term care sector must be clearly recognised as intrinsic to the provision of person-centred care and personhood. Succinct and eloquently articulated lived experiences of nursing home residents' are detailed within this report. Further, it provides an insightful and meaningful interpretation of their lives at a critical point within their life's trajectory. It is a time of momentous change for the person and their family, involving significant personal, psychological and psychosocial responses in a process of adaptation and coping. For the individual resident it exhibits human resilience, vitality, spirit, determination and love for enjoying later life. A personal sense of purpose within community living that is interconnected in a positive manner with daily living, that takes due cognisance of truly understanding, knowing and appreciating the person will enable and maintain a focus on those important things that help to create 'home', within the nursing home.

Further, the role that staff play within the interconnected processes of care delivery to the residents that enables and maximises a homely experience must also be recognised and acknowledged. Staff play a critical role in promoting a therapeutic and caring milieu, and one that respects the residents' autonomy, identity, belonging,

community, independence and personhood. The provision of compassionate, responsive and meaningful care ensures that residents can feel personally fulfilled and happy within the nursing home environment, as it is the existence of these exemplars that will enable and facilitate the creation of a 'homely experience', for the resident. Moreover, the caring and sharing within this milieu is one that demonstrates mutuality of respect resulting in the presence of reciprocity within the caring and dialogic exchange.

The wider health and social care environs must recognise and understand the effectiveness and residents' quality of life and care standards within the long-term care sector. This is critically important particularly at a time when such nursing care is perhaps undervalued or subjected to unfair criticism within the media. Moreover, a lack of understanding that underpins the complexity of such caring interventions within the long-term care sector can often result in misrepresentation with respect to procedural aspects of care. Consequently, assertions that care delivery is focussed on tasks or solely on the activities of living, and not individualised and holistic, only serves to complicate misconceptions about the nature and quality of care within the nursing home sector. Co-existent financial restraints to effective care provision for older people may underpin some assertions within the literature but it is clearly not the only important issue of note that must be given due consideration within long-term care provision.

The concept of providing homely care within the nursing home sector is further compounded by the ageism and stigma, albeit largely unsubstantiated, that continues to prevail around long-term care settings. These are exacerbated by the belief that

admission to a nursing home is viewed as the end phase of an older person's life trajectory. Such rigid views negate the essence and meaning of the lived experiences of nursing home residents within this study. It further negates the evidence within this study regarding the importance of relationships, community and a sense of contentment and belonging. As one resident succinctly put it:

*"What we have here is second to none, the care is excellent and I have no complaints. I get up every day feeling positive and content. I have nothing that I would want to change about living here". R 44*

This study has identified core categorical dimensions that underpin the effectiveness of the quality of care provision to residents in long-term care and details the lived experiences from the residents' perspectives in the context of home as their 'home'. The study highlights the centrality of exploring the nature of the therapeutic alliance between residents and staff inherent in the creation of a 'home', within the nursing home setting. The study presents multiple examples of the complexity of the care giving relationship within nursing homes and puts forward a theory grounded in the study's evidence and applicable to residents and staffs' experiences of the nursing home as home in the context of the lives that residents are now living. Therefore, the challenge is not to try and replace residents' interpretation of 'home' (as experienced before the admission to the nursing home) but rather to focus on creating a new home. If one subscribes to the belief that *'home is not a place but a feeling'*, perhaps the question is not whether the nursing home is perceived as the resident's home but rather whether it is perceived by them as their home *now*.

## 5.4 Recommendations

Several recommendations based on this study's findings are now presented to further enhance our understanding of the context and meaning of home within a nursing home. The recommendations address issues relating to policy, practice, education and research.

### 5.4.1 Recommendations for Practice

- Moving into a nursing home is a major life event. Potential residents, their families and nursing home staff should work honestly and collaboratively, with due regard to the centrality of the resident in the decision-making process, to ensure a smooth transition for all concerned.
- Accepting the sensitivities associated with families addressing the issue of long-term care, it appears that health and social care professionals have a key role to play in this regard. As objective professionals, they are ideally placed to initiate discussions with the older person without fear of reprisal. Such discussion should not be deferred until the older person becomes ill but rather comprise part of the regular contact with GPs or public health nurses in a pro-active manner.
- The assessment of older people in acute care settings should also address these issues as an integral part of the assessment process. Questions such as *'Where would you choose to live if you were no longer able to manage*

*on your own*’? Could be used to ‘*sow the seed*’ about long-term care arrangements.

- Nursing home managers should pro-actively demonstrate through effective leadership and management strategies the value placed on the multiple roles and responsibilities fulfilled by their staff.
- The creation of a ‘homely environment’ depends on staff ‘knowing the person’. However, turnover rates can result in a loss of intrinsic and intuitive knowing of the resident and nursing homes should consider additional and more creative ways of retaining staff to promote greater continuity of care.
- Assessments and care plans within nursing homes should be underpinned by a resident-centred approach and supported by actions which recognise the contribution of residents, relatives and staff to the creation of a homely environment within the nursing home.
- The assessment process should include clarification about what constitutes meaningful activities for each individual resident and these activities should be able to be provided by other staff in addition to the activities co-ordinator.
- Existing documentation should be reviewed to ensure that rich biographical information about residents is captured and documented in the initial assessment but of equal importance is the need to comprehensively review care plans so that they remain tailored to the changing need of the residents.

- This study has highlighted the core components that help to create a 'home from home' experience for residents and every effort should be made to recreate a 'homely' experience for all residents by promoting a sense of belonging, maintaining identity, feeling respected, valued and appreciated as a person while also being actively involved in decisions about their care.
- Shared decision making should begin prior to the nursing home placement and every effort must be made to ensure that families and staff are guided by the Nursing Homes Support Scheme Act (2009). This advocates that the applicant (resident) may select the relevant facility or approved nursing home in which to receive care services. In light of the findings of this study, Fair Deal Placement Officers should ensure that residents are central to the decision-making process about their choice of nursing home. It is also recommended that these officers should provide nursing homes with all the information they require in order to meet the resident's needs and in doing so to facilitate a positive transition.
- As the transition from an acute hospital was particularly stressful for the residents in this study, there is an immediate need to put effective systems in place to ensure greater communication and cooperation between HSE staff and nursing homes.

#### 5.4.2 Recommendations for Policy

- As evidenced by this study, government and HSE policies should facilitate older people to 'age in place' by supporting locally based respite and long-term care facilities, particularly in rural communities.
- The findings of this study have implications for health and social policy and for the organisation, management and inspection of nursing homes. Quality of care should be less about the physical environment and more about the extent to which older people actually feel '*at home*' as evidenced by their degree of decisional autonomy in day-to-day activities.
- If nursing homes are to become and remain 'homes' for their residents, then residents should be more actively involved in the inspection process and have their voice heard and acted upon. This needs to go beyond the existing models in operation and be truly used to fully triangulate inspection findings for the benefit of residents.
- As many staff expressed frustration around regulatory and inspection processes and procedure, there is an urgent need for HIQA and the nursing home sector to work in partnership to address these issues. While both parties have a remit for the maintenance of standards, it appears that much more can be done to ensure that the inspection process does not have adverse consequences for residents and staff.



- The findings of this study provide detailed insights and understanding into the experiences of residents and staff and into the perceptions of nursing homes as '*home*'. Recognising the negative media publicity often associated with this sector, it is imperative for actual and potential residents, relatives and staff that the narrative around nursing home life is rewritten to reflect the move as a positive life choice as evidenced by residents in this study. This can be achieved by raising the profile of the sector through publications, conference presentations and through increased media engagement and by involving residents, families and staff in these activities.
- Recognising the power of language, there is a need to challenge the public perception and use of ageist terms such as 'elderly' and 'institutions' as these perpetuate stereotypes that mitigate against quality care provision for older people.

#### **5.4.3 Recommendations for Education**

- The role of gerontological nursing at both under-graduate and post-graduate or specialist level requires greater recognition and attention within the educational, clinical practice and academic arena.
- The development of pre and post registration nursing programmes should be informed by the views of older people and their carers with input from experienced nurses across all settings providing care to older people

- including nursing home staff. This would help to ensure that nurses in general are better prepared to work in the sector.
- The decision of pre and post registration nurses to pursue a career in the nursing home setting can be influenced by their own personal experiences. It is recommended that education providers and nursing homes work in partnership to provide high quality practice learning experiences for undergraduate and postgraduate students.
- Continued professional development (CPD) with an emphasis on the specific and changing training and education needs of nursing home staff vis a vis person-centred care, advocacy, dealing with ethical issues, advance care planning and end of life care, should be developed by education providers in collaboration with nursing home staff to ensure relevance to this area of practice.
- The findings from the study highlight the critical role family, friends and personnel such as social workers, discharge coordinators and advocates can fulfil in easing the transition to nursing home care and supporting day-to-day living. There is a need to ensure greater public awareness about the key role that nursing homes play in the long-term care of older people.

#### **5.4.4 Recommendations for Further Research**

- The findings from this study explicate issues on the meaning and context of home within a nursing home. Further research is needed to test the relevance of this theory across a more diverse sample of nursing homes.
- Developing and testing a measurement tool for a larger quantitative sample from the qualitative data contained within this study may enable Nursing Homes Ireland to provide further evidence on nursing homes as home. However, in light of the richness of data collected in this qualitative study, a degree of caution is recommended as the good work being done by staff, as evidenced in this study, may not be accurately captured in a more quantitative study.
- This study has highlighted pertinent issues related to rurality and location as a potentially positive contribution to the provision of a homely experience within 'local' nursing homes and this could be explored in greater detail in future studies.
- Future research should include an exploration of the transition from life at home to life in a nursing home in a more longitudinal manner that would follow the resident from preadmission phase through the transition and to the point of adaptation or maladaptation to their new environment.

## 5.5 Limitations

There are a number of limitations to this study. Firstly, this study was conducted using a relatively small sample of both urban and rural nursing homes registered with Nursing Homes Ireland (NHI). While a small sample size is a limitation in quantitative research, this is not equally applicable to qualitative research methodologies. Moreover, whilst the total number of participating homes within this study may be regarded as small, the overall participation from both the resident and staff groups is appropriate for qualitative research studies. However, a larger scale study that incorporated a larger inclusive sample size of homes, residents and staff could perhaps generate further perspectives. Also, a further phase to this study that attempted to test theory relevancy and applicability within a wider sample using quantitative methodological approaches could have also enhanced the study findings.

Secondly, whilst the study has presented a grounded theory approach and presents a theory grounded within the data, a degree of caution should be exercised in making generalisations that are considered applicable to all aspects of long-term care. As identified above, further research must be conducted to explicate theory relevance to a wider population sample.

Thirdly, this study highlighted important findings that appeared to be more prevalent in rural nursing homes and although there is some support for this in the literature, these findings must be viewed with a degree of caution in light of the small and localised sample of rural nursing homes in the study. However, given the nature of the debate concerning rural proofing all aspects of health and social care provision

and ageing in place, this study makes a valuable contribution to the body of knowledge on rural health care provision suggesting a need for much more comprehensive considerations of urban and rural experiences of nursing home care provision.

Finally, the focus of the study was on the lived experiences of nursing home residents and on the role of the staff groups in facilitating a homely environment. The views of residents' families may have offered additional insights. While this may be considered a limitation, it must be considered in the context of the large body of evidence that already exists with respect to the families' perspectives and involvement in long-term care relative to the paucity of research on residents' experiences.

In summary, the researcher's contention is that this study's findings provide an enlightened insight to account for the dearth of literature in this area. The assertion is that this study will most definitely add to the academic debate on the importance of residents' and staffs' experiences in creating and maintaining an ethos of 'home', within the nursing home environment.

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## **APPENDICES:**

### **APPENDIX 1:**

#### **LETTER OF INVITATION TO PARTICIPANTS FOCUS GROUP INTERVIEW**

***Dear Nursing Home Resident***

***TITLE: 'The lived experience of nursing home residents in the context of the nursing home as their 'home'.***


We are writing to seek your help with the above study and we hope that you will be willing to assist us. The aim of the study is to explore the nature and meaning of your lived experiences in the context of 'home', whilst living in this Nursing Home.

Nursing Homes Ireland (NHI) wishes to engage in further research and practice development activities to ensure that care is delivered in a dignified and compassionate way that centres on your needs whilst you are a resident in one of the nursing homes registered with NHI. To this end, the organisation has funded this research project to advance knowledge and evidence informed practice among its members. It is hoped that the results from the study will help in the planning and delivery of compassionate and responsive nursing care that is evidence-based and which uniquely addresses your needs well into the future.

We would be very grateful if you would agree to take part in a group interview lasting about forty-five minutes to one hour. Attached, please find an information sheet which outlines the main details of the study and the nature of your involvement. If you have any questions or queries about the information sheet or the interview, please feel free to contact me using the details provided at the end of this letter. If you are willing to take part in a group interview, we would be grateful if you would sign the attached consent form, which will be collected by the researchers prior to the commencement of your group interview.

We would like to express our sincere thanks for taking the time to read this letter and we hope that you are interested in taking part in this important project about your lived experiences in this nursing home.

**Yours sincerely**



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## APPENDIX 2:

### INFORMATION SHEET FOR PARTICIPANTS

#### Focus Group Interviews Nursing Home Residents

##### TITLE

***‘The lived experience of nursing home residents in the context of the nursing home as their ‘home’.***

This information sheet has been prepared to tell you a bit more about the above research study and to answer the following questions:

##### ***Why is this study being carried out?***

Nursing Homes Ireland Limited supports and recognises the importance of on-going research to support the advancement of knowledge and evidence-informed practice in the nursing home sector.

This study is being carried out because we are interested in your views and feelings about living in this nursing home. We are particularly interested in how you feel about living here now and how this might compare with your feelings about when you lived in your own home. We are also interested in how things have perhaps developed or changed for you in any way personally since you came to live here in this nursing home.

##### ***What does the study involve?***

The research will involve holding group interviews in various Nursing Homes that are registered with Nursing Homes Ireland. The researchers refer to these as focus group interviews. The research team will come to your nursing home at a day, date and time convenient to you to talk to you and other Nursing Home residents about your lived experiences within your nursing home. The interview will be recorded so as to ensure that nothing that has been said during the interview is lost or misunderstood. Once the interview is completed the researcher will type up a transcript of the actual interview and this helps the research team to see exactly what has been said. The results from the research will be presented in a report to Nursing Homes Ireland which will highlight the key issues that you have spoken about and it will make a series of recommendations for the future development of your standards of nursing home care and services within the Nursing Home.

##### ***What would we like you to do?***

We would like you to join a number of other nursing home residents in a group interview. During this interview, you will be asked to talk about your lived experiences in this Nursing Home. The time, place and date of the interview will be arranged to suit your needs. The interview should last for about forty-five minutes to approximately one hour and with your permission, the interview will be audio-recorded. This audio recording will be used to obtain an accurate record of the interviewer's questions and your responses. Information from the interviews will be used to develop a detailed report for NHI.

### ***What will happen to the information that you give us?***

The focus group recordings will be transcribed and analysed. All interview details will be held on a password protected computer and audiotapes locked in a secure filing cabinet at the University of Ulster in a locked room. Research data will be stored for a minimum of five years after publication and subsequently all audiotapes and transcripts will be destroyed. Responsibility for storage will rest with the University of Ulster, School of Nursing and Institute of Nursing and Health Research, where the data were generated.

### ***Confidentiality***

Any information we receive will be treated as private and confidential. Participants' names and personal details will be known only to the research team. Personal details or identifying features will not be used in any report arising from the study. Participation will not affect any aspect of your current nursing care within the Nursing Home.

### ***Research Governance***

#### **Statement on indemnity for staff and students conducting research on human subjects.**

The University of Ulster is indemnified, through its insurance policies (and subject to the terms and conditions of these policies), for staff and students engaged in the pursuit of research involving human subjects where the research is being conducted for and on behalf of, and with the prior knowledge and consent of, the University.

However, the University is not indemnified through its insurance for non-negligent harm. Legal liability does not arise where a person suffers harm but no-one has acted negligently. The University cannot offer advance indemnities or, generally, insure against non-negligent harm, although such indemnity can be applied for in specific cases and where it is considered to be an essential element of the study.

Participants in research studies (research subjects) should be made aware in the information provided to them of the University's position.

**If you require any more information or if you have any questions or queries about the study, please do not hesitate to contact me at the following address:**

**Yours sincerely**



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**Dr Kevin Moore**  
**Lecturer in Nursing**  
**School of Nursing and Institute of Nursing Research**  
**University of Ulster**  
**Magee Campus**  
**Northland Road**  
**BT48 7JL**  
**Tel: 028 71 37 5488 (Direct Line) Mobile 07813 955624**  
**Email [kd.moore@ulster.ac.uk](mailto:kd.moore@ulster.ac.uk)**

**If you are willing to give your consent to take part in the focus group interview, please sign the attached consent form. Please note that you can withdraw from the study at any time.**

## **APPENDIX 3:**

### **FOCUS GROUP INTERVIEW TOPIC GUIDE**

#### **Nursing Home Residents**

##### **Introduction**

Researchers' background, interest and expertise in older people care.

Confirm that all participants have received participant information sheet.

Confirm written consent for study has been completed

Reaffirm consent for audio-recording

Assure confidentiality of information.

Refer to HIQA Policy on the 'Protection of Vulnerable Adults from Abuse and Exploitation' and the researchers' obligation to comply with the guidelines therein.

Note start time

##### **Exploration of reasons/nature of stay in this nursing home?**

When and why did you come here to live in this nursing home?

Why did you choose this particular home?

What support (formal/informal) and/or family involvement did you receive at the time?

What was it like for you undertaking this change from your own home to here?

- How did this make you feel?
- How did you cope with this initial change?
- What things perhaps persuaded you that this was the right/wrong move?

##### **Exploration of your initial impressions of nursing care in this nursing home?**

What were your initial thoughts and experiences when you first arrived here in this nursing home?

Can you explain if any of these have changed in any way now and why do you think this is the case?

##### **Changes between your experiences of your 'own home' life, prior to admission, and the experiences of your 'home life' now?**

If I was to ask you to compare and contrast your home life prior to admission to this nursing home and now, what type of things come immediately to your mind?

##### **Exploration of the current context? What are your personal experiences of 'home' in the context of this nursing home?**

Describe for me a typical day for you, outlining the positive and negative things about



living here? How does your day here differ from a typical day at home?

Do you consider this nursing home your home now, if yes why so, if not, why not?

- Changes in situation of care requirements
- Changes in the nature of your day to day experiences
- Physical & Psychological Health
- Family & or social changes
- Factors that make the nursing home more homelike

How would you rate the quality of your care/day to day living experiences in this nursing home?

**The future context?**

Do you have any ideas or recommendations that you feel would assist future planning and care delivery in this Nursing Home?

Does anyone have anything else to add or want to talk about that we have perhaps not spoken about?

**Thank you for your cooperation and assistance. If you find that you have any questions or thoughts for me after I leave today, please do not hesitate to contact me at any of the details in the Participant Information Sheet?**

## **APPENDIX 4:**

### **LETTER OF INVITATION TO PARTICIPANTS FOCUS GROUP INTERVIEW**

***Dear Nursing Home Staff Member***

**TITLE: ‘*The lived experience of nursing home residents in the context of the nursing home as their ‘home’.***


We are writing to seek your help with the above study and we hope that you will be willing to assist us. The aim of the study is to explore the nature and meaning of the lived experiences of nursing home residents in the context of the nursing home as their ‘home’. Staff members play a significant and interconnected part in the provision of nursing care to nursing home residents and thus input significantly into the concept and lived experiences of its’ residents within the nursing home. We are interested in exploring your roles and responsibilities in this regard with your residents.

Nursing Homes Ireland (NHI) wishes to engage in further research and practice development activities to ensure that care is delivered in a dignified and compassionate way that centres on addressing your needs whether you are a resident in one of the nursing homes registered with NHI, or a staff member. To this end, the organisation has funded this research project to advance knowledge and evidence informed practice among its members. It is hoped that the results from the study will help in the planning and delivery of compassionate and responsive nursing care that is evidence-based and which uniquely addresses NHI care needs well into the future.

We would be very grateful if you would agree to take part in a group interview lasting about forty-five minutes to one hour. Attached, please find an information sheet which outlines the main details of the study and the nature of your involvement. If you have any questions or queries about the information sheet or the interview, please feel free to contact me using the details provided at the end of this letter. If you are willing to take part in a group interview, we would be grateful if you would sign the attached consent form, which will be collected by the researchers prior to the commencement of your group interview.

We would like to express our sincere thanks for taking the time to read this letter and we hope that you are interested in taking part in this important project about your lived experiences in this nursing home.

**Yours sincerely**



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**Dr Kevin Moore**  
**Lecturer in Nursing**  
**School of Nursing and Institute of Nursing Research**  
**University of Ulster**  
**Magee Campus**  
**Northland Road**  
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**Email [kd.moore@ulster.ac.uk](mailto:kd.moore@ulster.ac.uk)**

## APPENDIX 5:

### INFORMATION SHEET FOR PARTICIPANTS

#### Focus Group Interviews Nursing Home Staff

##### TITLE

***‘The lived experience of nursing home residents in the context of the nursing home as their ‘home’.***

This information sheet has been prepared to tell you a bit more about the above research study and to answer the following questions:

##### ***Why is this study being carried out?***

Independent Nursing Homes Ireland Limited (trading as Nursing Homes Ireland) (NHI), and the NHI Nursing Committee has undergone a review of its strategic approach to advancing nursing and care practices in its member nursing homes. This has included a regionalisation process of training, a review of education/learning priorities and increased funding mechanisms as well as the identification for on-going research to support the advancement of knowledge and evidence-informed practice in the sector.

NHI has already established informal links with the Person-centred Practice Research Centre (PcPRC) at the University of Ulster in Northern Ireland. The PcPRC focuses on the enhancement of knowledge and expertise in person-centred practice. NHI wishes to engage in further research and practice development activities to ensure that your nursing care is delivered in a dignified, compassionate and responsive way that centres on the needs of nursing home residents. To this end, the organisation wishes to fund this research project to advance knowledge and evidence informed practice among its members.

##### ***What does the study involve?***

The research will involve holding group interviews in various Nursing Homes that are registered with Nursing Homes Ireland with both residents and staff. The researchers refer to these as focus group interviews. The research team will come to your place of work at a day, date and time convenient to you to talk to you and other Nursing Home Staff about your role and responsibilities in delivering care to your residents within your nursing home. The interview will be recorded so as to ensure that nothing that has been said during the interview is lost or misunderstood. Once the interview is completed the researcher will type up a transcript of the actual interview and this helps the research team to see exactly what has been said. The results from the research will be presented in a report to Nursing Homes Ireland which will highlight the key issues that you have spoken about and it will make a series of recommendations for the future development of standards of nursing home care and services that you are interconnected with in terms of delivery within the Nursing Home.

##### ***What would we like you to do?***

We would like you to join a number of other nursing home staff in a group interview. During this interview, you will be asked to talk about your role and responsibilities within the Nursing Home. The time, place and date of the interview will be arranged to suit your needs. The interview should last for about forty-five minutes to approximately one hour and with your permission, the interview will be audio-recorded. This audio recording will be used to obtain

an accurate record of the interviewer's questions and your responses. Information from the interviews will be used to develop a detailed report for NHI.

***What will happen to the information that you give us?***

The focus group recordings will be transcribed and analysed. All interview details will be held on a password protected computer and audiotapes locked in a secure filing cabinet at the University of Ulster in a locked room. Research data will be stored for a minimum of five years after publication and subsequently all audiotapes and transcripts will be destroyed. Responsibility for storage will rest with the University of Ulster, School of Nursing and Institute of Nursing and Health Research, where the data were generated.

***Confidentiality***

Any information we receive will be treated as private and confidential. Participants' names and personal details will be known only to the research team. Personal details or identifying features will not be used in any report arising from the study. Participation will not affect any aspect of your current nursing work within the Nursing Home.

***Research Governance***

**Statement on indemnity for staff and students conducting research on human subjects.**

The University of Ulster is indemnified, through its insurance policies (and subject to the terms and conditions of these policies), for staff and students engaged in the pursuit of research involving human subjects where the research is being conducted for and on behalf of, and with the prior knowledge and consent of, the University.

However, the University is not indemnified through its insurance for non-negligent harm. Legal liability does not arise where a person suffers harm but no-one has acted negligently. The University cannot offer advance indemnities or, generally, insure against non-negligent harm, although such indemnity can be applied for in specific cases and where it is considered to be an essential element of the study.

Participants in research studies (research subjects) should be made aware in the information provided to them of the University's position.

**If you require any more information or if you have any questions or queries about the study, please do not hesitate to contact me at the following address:**

**Yours sincerely**



---

**Dr Kevin Moore**  
**Lecturer in Nursing**  
**School of Nursing and Institute of Nursing Research**  
**University of Ulster**  
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**Tel: 028 71 37 5488 (Direct Line) Mobile 07813 955624**  
**Email [kd.moore@ulster.ac.uk](mailto:kd.moore@ulster.ac.uk)**

**If you are willing to give your consent to take part in the focus group interview, please sign the attached consent form. Please note that you can withdraw from the study at any time.**

## **APPENDIX 6:**

### **FOCUS GROUP INTERVIEW TOPIC GUIDE**

#### **Nursing Home Staff**

##### **Introduction**

Researchers' background, interest and expertise in older people care.

Confirm that all participants have received participant information sheet.

Confirm written consent for study has been completed

Reaffirm consent for audio-recording

Assure confidentiality of information.

Refer to DHSSPS & HIQA Policy on the 'Protection of Vulnerable Adults from Abuse and Exploitation' and the researchers' obligation to comply with the guidelines therein.

Note start time

##### **Exploration of reasons/nature of stay in this nursing home?**

What do you feel are the primary reasons why the residents come here to live in this nursing home?

##### **Exploration of your roles and responsibilities in this nursing home?**

How long have you been employed in this home?

Why did you choose to undertake this role?

What experiences/qualifications did you hold prior to undertaking this role?

What information, training or support did you receive at the time for your role?

Do you feel that you were adequately prepared to take on this role?

##### **Exploration of the current context? What are your personal experiences of providing care in this nursing home?**

Describe for me a typical day for you, outlining the positive and negative things about working here?

- Changes in situation of care requirements
- Changes in the nature of your day to day experiences
- Physical & Psychological Health of residents

How would you rate the quality of your care delivery to residents in this nursing home?

What are your thoughts/impressions/meanings of this nursing home as the residents 'home'?

at this stage of their lives?

- Do you promote the concept of 'home' for the residents and if yes how?
- If not, can you say why not?
- What are your ideas/thoughts on the role of HIQA?
- In what ways do perceive the role of the Regulator and its influence on care and the meaning of 'home' for the residents?

### **The future context?**

Do you have any ideas or recommendations that you feel would assist future planning and care delivery in this Nursing Home?

Does anyone have anything else to add or want to talk about that we have perhaps not spoken about?

**Thank you for your cooperation and assistance. If you find that you have any questions or thoughts for me after I leave today, please do not hesitate to contact me at any of the details in the Participant Information Sheet?**

## APPENDIX 7:

# CONSENT FORM FOR PARTICIPATION IN FOCUS GROUP INTERVIEW

**Title of Project:**

***‘The lived experience of nursing home residents in the context of the nursing home as their ‘home’.***

**Please tick or circle the correct answer**

|  |            |           |
|--|------------|-----------|
| I have read the information sheet for the above study          | <b>Yes</b> | <b>No</b> |
| I understand the information sheet for the above study         | <b>Yes</b> | <b>No</b> |
| I have had a chance to ask questions about the study.          | <b>Yes</b> | <b>No</b> |
| I know that I can withdraw from the study at any time.         | <b>Yes</b> | <b>No</b> |
| I agree for the interview to be tape-recorded and transcribed. | <b>Yes</b> | <b>No</b> |

**I understand the nature and purpose of the above study and I agree to take part in a focus group interview**

Name: .....

Address of Nursing Home: .....

.....

Signed (Volunteer) ..... Date .....

(Investigator). ..... Date .....

(Witness, where appropriate) ..... Date .....

## APPENDIX 8:

### UNIVERSITY OF ULSTER

### RESEARCH GOVERNANCE

#### RG3 Filter Committee Report Form

|                    |   |
|--------------------|---|
| Project Title      | <i>The lived experience of nursing home residents in the context of the nursing home as their 'home'.</i> |
| Chief Investigator | Dr Kevin Moore  |
| Filter Committee   | Nursing and Health Research   |

This form should be completed by Filter Committees for all research project applications in categories A to D (\*for categories A, B, and D the University's own application form – RG1a and RG1b – will have been submitted; for category C, the national, or ORECNI, application form will have been submitted).

Where substantial changes are required the Filter Committee should return an application to the Chief Investigator for clarification/amendment; the Filter Committee can reject an application if it is thought to be unethical, inappropriate, incomplete or not valid/viable.

**Only when satisfied that its requirements have been met in full and any amendments are complete, the Filter Committee should make one of the following recommendations:**

The research proposal is complete, of an appropriate standard and is in

- category A and the study may proceed\* ☐
- category B and the study must be submitted to the University's Research Ethics Committee\*\* Please indicate briefly the reason(s) for this categorisation ☒  

Vulnerable participants (**NB** Rol project)
- category C and the study must be submitted to ORECNI along with the necessary supporting materials from the Research Governance Section\*\*\* ☐
- category D and the study must be submitted to the University's Research Ethics Committee\*\* ☐

Signed: *George Kernohan*  
Chairperson of Filter Committee

Date: 16 Feb. 15

\*The application form and this assessment should now be returned to the Chief Investigator. The Filter Committee should retain a copy of the complete set of forms.

\*\* The application form and this assessment should now be returned to the Chief Investigator so that he/she can submit the application to the UUREC via the Research Governance section. The Filter Committee should retain a copy of the complete set of forms for their own records.

\*\*\* The application form and this assessment should now be returned to the Chief Investigator so that he/she can prepare for application to a NRES/ORECNI committee. The Filter Committee should retain a copy of the complete set of forms for their own records. For all categories, details of the application and review outcome should be minuted using the agreed format and forwarded to the Research Governance section



## Please complete the following

The application should be accompanied by an appropriate and favourable Peer Review Report Form (if not, the Filter Committee should be prepared to address this as part of its review). Please comment on the peer review (include whether or not there is evidence that the comments of the peer reviewers have been addressed).

Peer review is complete and there are no outstanding issues. Committee assumed that the context of study is similar to that found in UK residential care: in the title "nursing home" may be amended if needed.

Please provide an assessment of all component parts of the application, including questionnaires, interview schedules or outline areas for group discussion/unstructured interviews.

This is a large scale, low risk qualitative study to explore the lived experience of people living in Care Homes, using focus groups. In addition, committee would be content for one-to-one interviews to be used, if needed. It may be helpful to clarify what underpinning theory is to be applied: this could affect the methodology: for example whether each focus group builds on the previous analysis, or each one being done independently, with later analysis.

Please comment on the consent form and information sheet, in particular the level of language and accessibility.

Consent can be a challenge in this participant group. Committee noted that formal consent will be obtained where possible. Given the low level of risk, if suitable methods are available, and these are subject to local approval, committee would be content for *process consent* to be elicited. Similarly committee would be content for the PIS to be managed orally, if required to ensure adequate participant understanding.

Please comment on the qualifications of the Chief and other Investigators.

Well qualified Chief and other Investigators for the proposed project.

Please comment on the risks present in conducting the study and whether or not they have been addressed.

The research is low risk: it is not expected that the focus groups will include highly sensitive personal data; the risk of harm or inconvenience from the data collection is minimal. The researchers are advised to observe lone worker policy so their location is known at all times.

Please indicate whether or not the ethical issues have been identified and addressed.

The benefits of new knowledge far outweigh any harm or inconvenience with data collection. Wide variation in practice may be identified and this could necessitate a clear disclosure protocol with escalation to an appropriate authority if needed. This would guide any follow-up actions, for example if unprofessional or low quality care is reported.

Please comment on whether or not the subjects are appropriate to the study and the inclusion/exclusion criteria have been identified and listed

Appropriate subjects have been identified. It will be helpful to finalise the sample size in due course.

C:\Users\le10047419\Documents\George\Admin+Filter\SRE Filter\Winter\_2014\RG3\_Feb\_3.3.doc

## APPENDIX 9:

### "Crabbit Old Woman"

What do you see, what do you see?  
Are you thinking, when you look at me-  
A crabbit old woman, not very wise,  
Uncertain of habit, with far-away eyes,  
Who dribbles her food and makes no reply  
When you say in a loud voice,  
I do wish you'd try.  
Who seems not to notice the things that you do  
And forever is loosing a stocking or shoe.  
Who, unresisting or not; lets you do as you will  
With bathing and feeding the long day is fill.  
Is that what you're thinking,  
Is that what you see?  
Then open your eyes,  
nurse, you're looking at me.  
I'll tell you who I am as I sit here so still!  
As I rise at your bidding, as I eat at your will.  
I'm a small child of 10 with a father and mother,  
Brothers and sisters, who loved one another-  
A young girl of 16 with wings on her feet,  
Dreaming that soon now a lover she'll meet,  
A bride soon at 20- my heart gives a leap,  
Remembering the vows that I promised to keep.  
At 25 now I have young of my own  
Who need me to build a secure happy home;  
A woman of 30, my young now grow fast,  
Bound to each other with ties that should last;  
At 40, my young sons have grown and are gone,  
But my man's beside me to see I don't mourn;  
At 50 once more babies play around my knee,  
Again we know children, my loved one and me.  
Dark days are upon me, my husband is dead,  
I look at the future, I shudder with dread,  
For my young are all rearing young of their own.  
And I think of the years and the love that I've known;  
I'm an old woman now and nature is cruel-  
Tis her jest to make old age look like a fool.  
The body is crumbled, grace and vigour depart,  
There is now a stone where I once had a heart,  
But inside this old carcass, a young girl still dwells,  
And now and again my battered heart swells,  
I remember the joy, I remember the pain,  
And I'm loving and living life over again.  
I think of the years all too few- gone too fast.  
And accept the stark fact that nothing can last-  
So open your eyes, nurse, open and see,  
Not a crabbit old woman, look closer-  
See Me.

By: Phylis McCormack (1966)

The easy way with geriatrics". *Nursing Mirror and Midwives Journal*. IPC Specialist and Professional Press. 136 (1-13): 9. 1973.



