

Victoria University of Technology
School of Education



Towards the health promoting retirement village: A Case Study

A thesis submitted in partial fulfilment
of the requirements of Doctor of Philosophy

by
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Towards the health promoting
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Candidate’s Declaration

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Candidate’s Declaration

I certify that the research paper entitled **Towards the Health promoting Retirement Village: A Case Study** and submitted for the degree of Doctor of Philosophy is a result of my own work, except where otherwise acknowledged, and that this research paper (or any part thereof) has not been submitted for a higher degree to any other university or institution.

Signed:

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Abstract

The aged care industry along with the public health movement has undergone profound change, yet aged care is a growing concern with an ageing population. Within the Australian context, there remains the need for further research and education especially with regard to the retirement village setting that offers a variety of services including a continuum of care from independent living through to aged care facility living (hostel and nursing home).

Through an exploration of the health promoting settings approach that has been applied to schools, hospitals, workplaces and so on, it can be demonstrated that a retirement village can also move beyond institutional care to one that is a health promoting retirement village.

A qualitative methodological approach was used to gain a social perspective of a retirement village setting with data being obtained through observation and interviews conducted with staff and residents working and residing in a retirement village respectively. Data was analysed utilising Glaser and Strauss' (1967) constant comparative method with data being categorised and applied according to the World Health Organisation's (1986) Ottawa Charter's action areas – building healthy public policy, creating a supportive environment, fostering community action, developing personal skills and re-orienting health services.

It became evident that there is a need for further research, provision of education specific to the field of gerontology and for policy to promote health, wellness and quality of life. Aged care reforms of 1997 and beyond have been instrumental in ensuring accountability of providers within aged care facilities yet there appears to be a need to re-orient health services from the current curative approach to one that promotes health with a social perspective that accommodates residents, staff and relatives. With further reviews of aged care legislation such as the Resident Classification Scale and the Standards and Guidelines for Residential Aged Care Services, it may be possible to implement a holistic approach to the current system, ensuring quality of life for residents, reduced time constraints on staff and a happier place for relatives and the community to visit and participate.

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Introduction

Rationale for study

In Australia, there are approximately one hundred and forty thousand beds available in aged care facilities (nursing home and hostel) for our elderly population. Twenty percent of residents live in nursing homes for over five years with fifty percent residing between one and five years; representing relatively lengthy stays (AIHW and DHFS, 1998). Retirement village living, that is, for those residing within independent units and those in an aged care facility, is an expanding market for an ageing population.

Aged care has been dominated by the medical model with health care being described by Willis (1993) as “organized into a complex hierarchy [with] . . . the medical profession, dominating the health workforce in all respects: politically, socially and financially” (p 98). Other organisations including health care settings such as hospitals have moved beyond this treatment or medical approach to one that is health promoting. Can a retirement village that has been moulded into the medical model for over forty years become a health promoting setting? A challenge identified by Wallace, Fulmer and Edelman (1998) is that the process of ageing differs according to previous lifestyles, “exposure to environmental injury, illness, genetics, stress” (p 635) and so on, making it difficult to measure the benefits or outcomes of health promotion programmes. There are other factors that make this task difficult including

the misconceptions and negative stereotyping of nursing homes and the elderly population. For example the following misconceptions about older people have been identified by Kolcabar and Wykle (1994) cited in Wallace et al (1998):

1. Disease is normal and unavoidable
2. Older adults have no future for which health-promoting activities are relevant
3. Damage to health resulting from inactivity or poor nutrition is irreversible (p 634).

Kimble and Longe (1989) also recognised that society “is still youth oriented” and there remains “some negative attitudes and prejudices toward aging” (p 8). Unfortunately, the elderly also appear to be grouped as homogenous, however they are individuals like other population groups with differing needs and knowledge to share. The only type of categorisation that is reasonable is that which distinguishes those that live independently and those that are institutionalised living in residential care. This present system of aged care is often represented as three levels of care (independent living, hostel and nursing home) which may also tend to exacerbate the “myths and stereotypes” of ageing, depicted as a continuum of care; “a linear progression from the home to the nursing home – a one-way downhill pattern” (Koff, 1986, p 120). I have now worked in aged care for eight years. While working with low level care residents, for example those living in a ‘hostel’, it is not uncommon to hear residents speak of their fear of approaching high level care, for example ‘nursing home’ as this is the final path to death and there is no turning back. However, as stated by Koff (1986), “[n]owhere in this continuum is it suggested that increased wellness is a possible outcome of intervention and change” (p 12).

It appears appropriate that if this linear, three level care approach changed, to one whereby wellness is appropriate, this may help reduce negative stereotypes of aged care. Bonita (1993) suggested that these negative attitudes and misconceptions appear to have led to both limitations in research and to the establishment of health promoting programmes for our elderly population. Stereotyping as well as other life stresses such as “chronic disease, functional disability and living alone can be reduced by educating the public” (Kimble and Longe, 1989, p 8) and introducing research incentives. This latter point is promoted through the Commonwealth Department of Health and Family Services (1998b), Standards and Guidelines Manual that recommends aged care providers initiate continuous quality improvement activities, such as through data collection.

A further incentive that aimed to reduce the negative stereotypes and promoted the diversity and contribution of older people in society was International Year of Older Persons (1999) - ‘Towards a Society for all Ages’. International Year of Older Persons began a trend toward reducing negative stereotyping and commencement of furthering research and development of programmes in Australia. Kellehear (1999) suggested that research may provide the necessary evidence to demonstrate that “extra funding” (p 42) is necessary for promoting healthy public policy within aged care.

It is important to build healthier public policy in aged care to help eliminate misconceptions and educate not only nurses but also other staff and the general population in understanding the importance of health promotion for all age groups, including the elderly, and the contribution they can make to society.

Research Statement

The aim of this project was to examine the applicability of the health promoting settings approach to a case study of a retirement village. To achieve this aim, the following points were considered:

- ◆ The history of health promotion and the settings approach and the role of the Ottawa Charter in that development;
- ◆ A critique of health promotion and the settings approach;
- ◆ The identification of current systems and limitations in aged care, including aged care reforms, with specific reference and analytical view to the Standards and Guidelines for Residential Aged Care Services (Commonwealth Department of Health and Family Services, 1998b) and Resident Classification Scale (Commonwealth Department of Health and Family Services, 1998a);
- ◆ The possibility of moving beyond the institutional or medical model of aged care to one that is health promoting;
- ◆ The provision of a holistic model of health and care – one that is concerned with improving quality of life;
- ◆ The suitability of specific health promoting programmes in a retirement village setting;

- ◆ Means to build healthier public policy in aged care thus reducing the negativity of aged care, promote wellness and quality of life and overall reduce health care expenditure;
- ◆ The exploration of other health promoting settings, including schools, hospitals, cities and the workplace;
- ◆ The biological process of ageing and factors that can promote health and wellness;
- ◆ Increase understanding of a qualitative methodological approach within a retirement village setting, and to gain a social perspective of those that work and live in an aged care setting; and
- ◆ The involvement and perspectives of different constituencies within the retirement village, including residents living within independent units, residents from the aged care facility (low level care) and staff from various disciplines.

It is now sixteen years since the First International Conference on Health Promotion was held in Ottawa, Canada. This conference led to the development of the Ottawa Charter, a charter for action, that continues to be discussed, analysed and implemented in the development of health promotion projects, including healthy cities and the health promoting school. In summary, this study ultimately aims to provide a background into the retirement village system that offers older people a continuum of care and the possibility of this model moving toward a health promoting settings approach.

Kickbusch (2001) described health promotion in terms of empowerment, advocacy and an investment in social relations as follows:

Health promotion is about social processes for health, its essence lies in empowerment. It advocates a power shift in favour of health. It proposes to invest in living and working conditions, and in social capital and social relations. It takes its knowledge base from a broad interdisciplinary enterprise (p 1).

These issues of health promotion are important aspects for those living and working in aged care. For example, Krothe (1997) recognised that elderly people are often not consulted with regard to decisions and suggested that “policy should be formulated based on input from those directly affected”. This study is a means for the voices of the staff and residents “to be heard” (Krothe, 1997, p 223). As stated further by Koch (1998), by “listening”, and evaluating responses, this will enable others to:

improve practice . . . inform social policy . . . facilitate change in organizations . . . allow marginalized groups to have a voice . . . [and] facilitate self-help groups” (p 1183).

As quoted by Bishop (1999a), the Organisation for Economic Co-operation and Development (OECD) “identified seven principles for population ageing reforms”, one of which (point 5) was with regard to “long term care”:

there should be a greater focus on cost-effectiveness. Medical expenditure and research should be increasingly directed to ways of reducing physical dependence and explicit policies for providing care to frail older people should be developed.

In this speech to the National Press Club in Canberra, Bronwyn Bishop (Bishop, 1999a) recognised the need to change our attitudes toward the elderly and said this about older Australians:

Senior Australians are just as diverse as the rest of us – and we have a major need to change our cultural attitudes, whereby we move away from myths and stereotypes and towards valuing the continuing contribution older Australians, as

individuals, do make and must continue to make (Bishop, 1999a).

As Bishop (1999a) has noted here, it is vital that attitudes toward the elderly are represented positively in society, therefore the issue of negative attitudes and stereotypes will be discussed throughout the thesis. It is hoped that policy makers, health promotion advocates, educators and aged care providers will build upon the findings of this study and consider the implementation of the health promotion retirement village model. This model has used the Ottawa Charter's (WHO, 1986) action areas (building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services) and strategies, and the feedback gained from residents and staff gained from the fieldwork. For example the health promoting retirement village may include the following:

- Healthy public policy
 - Policy developed in consultation with stakeholders of aged care, for example, aged care providers, residents, staff, community organisations and representative such as volunteers and relatives; and
 - Collaborative partnerships between stakeholders, government and non government organisations.

- Creating supportive environments
 - a safe, supportive, enjoyable social environment that promotes participation of volunteers, relatives and the community;
 - the provision of support service, staff and personnel, including allied health staff and complimentary therapies; and
 - partnerships between aged care providers and the education sector (primary and secondary schools and universities) to reduce negative stereotypes and promote positive relationships. Topics in the education curriculum may include social and physical effects of ageing, horticulture for the elderly, meal time issues and initiation of texture modified diets, health promotion programmes and project development and positive ageing.
- Strengthening community action
 - a sharing of resources, information and services between aged care and the community; and
 - inclusion and promotion of volunteers, students and relatives.
- Developing personal skills
 - planning, monitoring and evaluating the health promotion programme, including allocation of resources, between all stakeholders; and
 - provision of a holistic education programme offered to management, staff, residents, relatives and the community; and
- Reorienting health services
 - a reorientation from a treatment or medical model of aged care to one that promotes health and wellbeing.

I would like to conclude with the inclusion of a summary and quotes of a compelling personal account of Jan Craney's (2001) own life experience of her father's last year of life. In summary, he had entered into independent living in a retirement village that only offered independent living and hostel care. His health deteriorated resulting in hospitalisation and rehabilitation. He returned back to the retirement village but it was obvious that he required nursing home care. This is the scene that follows when he enters the nursing home:

Admission sets the scene. Forms are completed with questions about my father's background fired at my brother and me, even about subjects like his continence. Our attempts to include him in providing his own personal information come to nothing. He is completely overlooked. It is clear that from now on he is to become a bystander in his own life, with others speaking and acting for him. With uncharacteristic grace he accepts this new lot, but within days it is clear that a new deterioration has set in. I later see his admission coinciding with the complete loss of his will to live (Craney, 2001, p 58).

Having worked in aged care, this scenario did not seem surprising. I have noticed that older people who have been discharged from hospital may need one on one nursing care and dietary supplementation. This retirement village also necessitated that the older person move to a facility that offered high care. This further clarifies that retirement villages that offer all levels of care provide older people with the continuum of support services that may be necessary. Having to urgently locate a nursing home places stress on family members and to the older person. In this situation, when a bed is required urgently, choice is not necessarily considered important, a bed and the level of care is the necessity. Craney's father was placed in a shared room, the story continues:

In a shared room, my father is obviously and painfully dying. He is only the regulation 900 mm cloth-curtained space away from Bert, a man in charge of all his faculties who must be painfully aware of what's happening right next to him . . .

does he really need to be reminded of his own mortality . . . ?
(Craney, 2001, p 59).

The following two chapters that is the research context and literature review continues discussion on aged care models and an outline of the historical context of the aged care industry spanning the last 4 decades. A background into the public health system and the role of the Ottawa Charter in the development of health promotion will also be discussed.

Chapter One

The Research Context

This chapter will investigate issues relating to historical and current practices in Australia's aged care industry, as well as the public health movement represented as the old public health and the new public health models.

According to Kickbusch (1989) the old public health focused primarily on the treatment of disease whereas the shift toward the new public health focuses on prevention, health promotion, healthy public policy, supportive environments and community action. The new public health movement emerged in the mid 1980s and led to a conference being held in Ottawa, Canada. The foundation of the 'Ottawa Charter' has been instrumental in the movement toward health promoting settings. The settings approach and implementation of the Ottawa Charter's five action areas will be used as the framework for this research from the methodology phase through to the analysis of data in an attempt to develop the concept of a health promoting retirement village. In this process, it is necessary to briefly outline practices and models within the aged care industry, the biological processes that occur during the ageing process and the historical context of the public health movement.

1.1 Public Health Movement

There has been a shift in the public health movement from the paradigm of the old public health during the period of Australian settlement through to the mid 1980s. During this stage, the aim of the public health system was to treat disease and infections, but during the latter part of this period there was increasing awareness and the emergence of preventive programmes. In 1986, an international conference was held for the first time to discuss new directions in public health and this resulted in the Ottawa Charter for health promotion, focusing on prevention and promoting health and wellbeing, being referred to as the era of the new public health.

1.1.1 Toward a New Public Health

The history of Australia's public health can be represented by two main phases – the old public health and the new public health. The paradigm of the old public health will be briefly discussed, as categorised by Baum (1998) consisting of four eras - colonial, nation-building, promise of medicine and lifestyle.

British and European settlement into Australia was detrimental to the health of indigenous people who had no immunity to disease, having lived a nomadic lifestyle and using natural remedies which prior to settlement helped illness and prevented disease. However, the sheer density of the settlement population created a 'pool' of infectious disease, particularly amongst the young (O'Connor and Parker, 1995). As a response to theories on disease and plague, this era saw the emergence of legislation, including the Public Health Act and Quarantine Act. These Acts involved improving sanitation and providing clean water (Burns, 1997; Baum, 1998) thus significantly reducing mortality rates (O'Connor and Parker, 1995).

During the nation-building era (approximately 1890s to 1940s), the Commonwealth Department of Health and the National Health and Medical Research Council was formed. The focus during this period was on “strengthening the nation by improving the health and fitness of white citizens” (Powles, 1988, cited in Baum, 1998, p 25).

As noted by Baum (1998), the promise of the medicine era occurred post war to the early 1970s, and as the name suggests, it was an era when “new drugs were developed, diagnostic techniques became more . . . sophisticated and surgery opened up many new areas of medical intervention” (p 27).

The final stage of the old public health system, referred to by Baum (1998) as the lifestyle era (1970s to mid 1980s) saw the beginning of a new era, marked by the ‘Lalonde Report’ (1974) in Canada. Green, Poland and Rootman (2000) attributed the “rise of health promotion as an organized, distinct field in health policy and practice” to “Marc Lalonde, the Canadian Minister of Health and Welfare [who] released a monograph titled ‘A New Perspective on the Health of Canadians’” (p 2). O’Connor and Parker (1995) suggested that the Lalonde Report, as it is referred, focused on lifestyle and behaviour as determinants of health.

In Australia, preventive health projects began to be part of the agenda and the Community Health Programme was introduced “to complement the new Medibank” (Baum, 1998, p 31) enabling all Australians access to health services. This was the beginning of a shift toward the paradigm of the new public health movement.

The evolution of the new public health emerged as a result of the development of the Ottawa Charter in 1986 that focused on prevention and health promotion. The new public health era does “not reject behavioural and lifestyle approaches” (Baum, 1998, p 36) which in fact foster ‘personal skills’ in attaining health (O’Connor and Parker, 1995, Burns, 1997 and Baum, 1998). Nor does it reject the medical approach however it does shift responsibility on the public to make changes through education and preventive medicine. This was a time of establishing the Better Health Commission (1985), “Health Promotion Foundations in Victoria, South Australia and Western Australia” (Baum, 1998, p 41) and the Australian Association of Health Promotion Professionals. Kellehear (1999) recognised that “health protection (laws and regulations), preventive medicine, health education and policy, and community action” (p 10) have all been part of the health promoting agenda during this time.

In comparison to the era of the old public health, the new public health recognises the need to focus not solely on the “physical environment [but also] to encompass social, cultural, political, and economic factors which impact on health” (Goltz, Coquhoun and Sheehan, 1997, p 17-18). Within the new public health there is an emphasis on developing public policy, personal skills, community participation and empowerment.

1.1.2 Public health initiatives

There have been a number of public health initiatives during the era of the new public health however I will only discuss a few that relate specifically to this study. For example, the Ottawa Charter (WHO, 1986) will be discussed as this Charter for action forms the framework for this study. Other health promotion initiatives including ‘Health for all Australians’ (AHMAC, 1988), and the ‘Goals and Targets for

Australia's Health in the Year 2000 and Beyond' (Nutbeam, Wise, Bauman, Harris, Leeder, 1993) will also be briefly described.

1.1.2.1 The Ottawa Charter and the evolution of the new public health

An International Conference on Primary Health Care, held in Alma-Ata, USSR, in 1978 (WHO, 1978) called for “national and international action to develop and implement primary health care throughout the world” and to promote the health of all by the year 2000. This conference made the following Declaration:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right (WHO, 1978, p 1).

Duhl and Sanchez of the World Health Organisation's Regional Office Europe (1999) suggested that this definition: “is evidence of the public health pendulum swinging away from a medical model and back towards a social model – the new public health paradigm” (p 7). However, Buetow and Kerse (2001) recognised that the World Health Organisations definition of ‘health’ is often ‘criticised’. They further noted that the definition “is not conducive to health promotion . . . [as it] implies that anything less than complete well-being is not health” and neglects people with ill health (p 74). Working on this theory could imply that the elderly population will be neglected and be stereotyped as a group with ill health.

In 1986, the first International Conference on Health Promotion was held in Ottawa, Canada. This conference “built on the progress made” through the Alma-Ata (WHO, 1978) and the World Health Organisation (1986) recognised that: “This conference was primarily a response to growing expectations for a new public health movement around the world” (p 1). A Charter for action, the ‘Ottawa Charter for Health

Promotion' was developed by participants from 38 countries including Australia (WHO, 1986). As noted by Baum (1998), this Charter:

builds on a number of social and public health movements, including nineteenth-century public health, feminism, the green and consumer movements and experiments in community development from the 1950s (p 43).

The World Health Organisation's (1986) Charter recognised that the pre-requisites for health are "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity" (p 1). The Charter proposed five means or action areas toward health promotion – building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and lastly re-orienting health services.

The Ottawa Charter's (WHO, 1986) definition of health promotion is:

The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. . . . health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being (p 1).

To succeed in enabling people to reach a state of well-being the Ottawa Charter recommends that health promoters have the skills necessary to 'advocate', 'mediate' and 'enable' all people to achieve health through supportive environments.

Subsequent international conferences and meetings were held to 'clarify' and discuss the Ottawa Charter's health promotion strategies. For example, the second international conference, held in 1988 in Adelaide, South Australia built on the Ottawa Charter's action area 'building healthy public policy'. This conference recognised the importance for government sectors to value health equity in policy

development (WHO, 1988). In 1991, the Third International Conference on Health Promotion was held in Sundsvall, Sweden, that focused on the detriment to the global environment and the need to make “environments more supportive to health” (WHO, 1999, p 1).

This Charter was reviewed and reflected on almost eleven years on, at the Fourth International Conference on Health Promotion, entitled ‘New Players for a New Era – Leading Health Promotion into the 21st Century’. This conference was held in Jakarta, and as noted by the World Health Organisation (1997) this conference was “the first to be held in a developing country, and the first to involve the private sector in supporting health promotion” (p 1).

A further conference – the Fifth Global Conference on Health Promotion: Bridging the Equity Gap, was held in Mexico in 2000. This conference included participants by “Ministers and Ministerial Delegations to share experiences and challenges they faced in the promotion of health” (Mexico Ministerial Statement, 2000, p 275). A Ministerial Statement for the Promotion of Health was signed by delegates from 73 countries who recognised the need to draw on the ‘expertise’ of the “WHO and its partners” (p 276) and support research to advance knowledge. The Ministers concluded:

that health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and better health for all (p 275).

Ilona Kickbusch (2001) reflected on the information gained at this conference and from the feedback of participants. She believed that “health promotion is kept alive” and that:

There are few public health documents that have been so widely disseminated, translated and debated as the Ottawa Charter. Much that was considered new in 1986 is now an accepted way of thinking about health (p 1).

The Ottawa Charter provides a holistic model for health promotion and has been instrumental in a number of programmes and incentives including the settings approach, discussed in the following chapter (Chapter 2 – Review of Literature). The Ottawa Charter and the settings approach have been effectively used in developing health promoting settings, and forms the foundation for this study which investigates whether or not this approach is applicable to aged care, that is, retirement villages that offer all levels of care. Shortly following the development of the Ottawa Charter, Australia initiated various health promotion programmes, some of which targeted the elderly population, two of which will be briefly discussed in the following section.

1.1.2.2 Health for all Australians

In 1987, the “Australian Health Ministers’ Advisory Council established the Health Targets and Implementation (Health for all) Committee to develop a set of health goals and targets” (AHMAC, 1988, p 4). The four aims of the World Health Organisation were utilised by the Australian Health Ministers’ Advisory Council (1988) which included “equity in health”, promoting health to add “life to years”, reducing morbidity to add “health to life” and to reduce premature mortality by adding “years to life” (p 5). The overall aim was to achieve a healthier society and reduce the inequalities in health status among population groups.

Nutbeam (1991) recognised that a set of health “targets can be used to determine the pace of change, and facilitate an assessment of progress”. These targets can “form the

basis for closer accountability of health service planners and managers towards the goal of improving health status in the population” (p 170).

This was to be achieved by providing preventative health care methods in preference to the traditional medical approach to treatment. At the time the Australian Health Ministers’ Advisory Council report (1988) recognised that an estimated fifty percent of older people lived in poverty and suffered from conditions such as “incontinence, chronic pain, arthritis, deafness, periodontal disease, and hypertension” (p 144) that could be reduced and even prevented. It is interesting to note that the current ‘Aged Care Standards and Guidelines’ produced by the Commonwealth Department of Health and Family Services (1998b) incorporated these conditions within the 44 Outcomes. For example, incontinence, expected outcome – 2.12 Continence Management, chronic pain, expected outcome – 2.8 Pain Management, deafness, expected outcome – 2.16 Sensory Loss, and periodontal disease and expected outcome – 2.15 Oral and dental care. As noted further by the AHMAC (1988), preventive measures were likely to reduce premature death, provide cost savings in the future and enhance quality of life. Intervention management may have been in the form of physical, psychological and social programmes. Studies conducted by Isakkson and Pohjolainen (1994) revealed that the latter two programmes were frequently given “little attention” (p 13). Nevertheless this study has attempted to investigate means to incorporate holistic health promoting programmes within a retirement village catering for residents, relatives, staff and community needs, as identified by participants in the study.

The Health for All Committee (1988) recognised the need to establish health goals and targets to improve the health of older people which resulted in a more comprehensive set of national goals and targets - ‘Goals and Targets for Australia’s Health in the Year 2000 and Beyond’, briefly discussed below.

1.1.2.3 Goals and Targets for Australia’s Health in the Year 2000 and Beyond

The Commonwealth Department of Health, Housing and Community Services prepared a report in 1993 entitled ‘Goals and Targets for Australia’s Health in the Year 2000 and Beyond’. This report identified four principle areas – preventable mortality and morbidity; healthy lifestyles and risk factors; health literacy and health skills; and healthy environments. Each area consisted of goals and targets for population groups, in which the elderly were targeted in all four areas. ‘Health literacy and health skills’ are discussed further in Chapter 7 – Developing Personal Skills, yet the report did recognise that the elderly population has been negatively stereotyped and that there remained a need to provide education to promote positive relationships.

Health concerns identified under ‘preventable mortality and morbidity’ included cardiovascular and peripheral vascular disease, cancer, injury particularly those occurring in residential settings, organic mental disorders particularly dementia, depression, physical impairment, and disability including musculoskeletal disorders, arthritis, osteoporosis, and edentulism (loss of teeth) (Nutbeam et al, 1993).

Implementation of ‘healthy lifestyles’ required an analysis of ‘risk factors’. Those that were identified in the elderly population by Nutbeam et al (1993) included

obesity, hypertension and inappropriate drug use. Inappropriate drug use, or polypharmacy is a term that has been commonly used in aged care to describe the multiple use of medication. For example in Australia, McCallum and Geiselhart (1996) suggested: “[e]ight out of ten nursing home residents receive at least one type of medication” and tranquillisers are overused in an effort to manage disruptive behaviour. McCallum and Geiselhart (1996) continued, estimating that almost fifty percent of older people incorrectly use drugs; they either take too many or take drugs out of date (p 57-58). Nevertheless, Victorian legislation relating to the Health Services (Residential Care) Regulations 1991, amended in 1997 (State of Victoria, 1997) stated that the distribution and administration of drugs by residential care staff must be “administered in accordance with the instructions of a medical practitioner; and . . . correctly documented in the records” (p 12).

The goals and targets also identified the need to view the ‘environment’ as a whole. For the elderly population, creating a form of transport that is less polluting and accessible is necessary especially for those living independently who require “shopping, health services, recreation” (Nutbeam et al, 1993, p 198). Nutbeam et al (1993) also acknowledged that the provision of adequate and safe housing for the elderly person is necessary to reduce the incidence of unnecessary hospitalisation or being placed prematurely in an aged care facility.

1.2 The aged care industry in Australia

Retirement living provides the opportunity for elderly people to be assured of security, a social environment and various types and levels of care. Clinical and support services are often offered dependent upon the retirement village community.

Each village differs, however, they are frequently based upon either, the traditional three levels of care, the flexi-care system or five levels of care. These models are briefly outlined in an attempt to provide insight into aged care services in Australia.

1.2.1 Retirement village models

The Wesley Central Mission offering aged care in Sydney conducted a study in 1983 on elderly people living in their own home. The study revealed ninety percent of people would consider living in a retirement village and seventy-nine percent felt that the move would not alter their social life. The survey revealed a “high regard” (Wilson, 1984, p 48) for retirement villages suggesting village life will remain sought after. As noted by Howe (1986) retirement villages provide a social environment whereby individuals who are physically restricted live amongst ‘peers’ who are able to provide support in comparison to isolation that may occur more widely within the community. A number of studies were also conducted by a housing developer Mirvac, in Sydney. Mirvac’s research as indicated by Kearney (1986) showed that elderly people prefer retirement villages that offer security, a social environment, building designs specifically for elderly persons (for example ‘ramps’), location close to transport and services, affordability of ongoing costs, a continuum of care and an “emergency call system” (p 228). In a later study conducted by Gardner (1994), findings supported previous studies, suggesting that older people move into retirement villages to gain a “supportive physical and social environment” that can lead to increased “autonomy and a richer social life” (p 39). These findings provide similar responses for reasons why older people move into retirement villages. That is, maintaining a social life and provision of a safe environment; this latter already

identified as important in the ‘Goals and Targets for Australia’s Health in the Year 2000 and Beyond’ report (Nutbeam et al, 1993).

It is recognised though that each village differs - some offer independent living, whilst others offer a variety of living arrangements and facilities which people can choose dependent upon the needs of the individual person. This study has intentionally chosen a village that offered all levels of care from independent living through to aged care facility living. This model in combination with a health promoting environment is believed to be a holistic approach to aged care helping ensure elderly people have a home for life with a continuum of care. In comparison to this, other models that offer elderly people one level of care may result in an individual being forced to move to other facilities to accommodate their needs.

Within the retirement village sector, there are various models, three of which have been identified and will be discussed below. Yet the traditional approach that continues to predominate aged care is the three-tier model consisting of nursing home (high level care), hostel (low level care) and independent living for the healthier elderly person (see figure 1.1). This figure, also demonstrates the degree of independence, from those living within independent units who are fairly independent, through to the nursing home whereby residents become increasingly dependent.

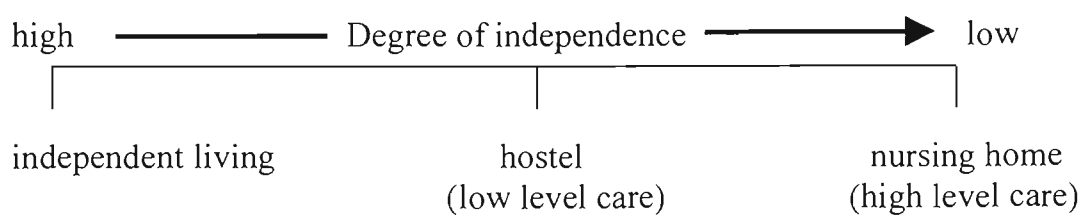


FIGURE 1.1
Traditional 3 levels of care

Nevertheless, Koff (1986) recommended that we review this continuum of care from being one that is linear (see figures 1.1 and 1.3) to one whereby “services . . . [flow] freely in separate orbits around the person served” (p 121). This approach is aimed toward reducing the negative stereotyping attributed to reduced health in aged care, through the traditional linear model. This study therefore has defined continuum of care as Koff (1986) described, with a view that an elderly person can move backwards and forwards between various levels of care dependent upon their state of health (see figure 1.2).

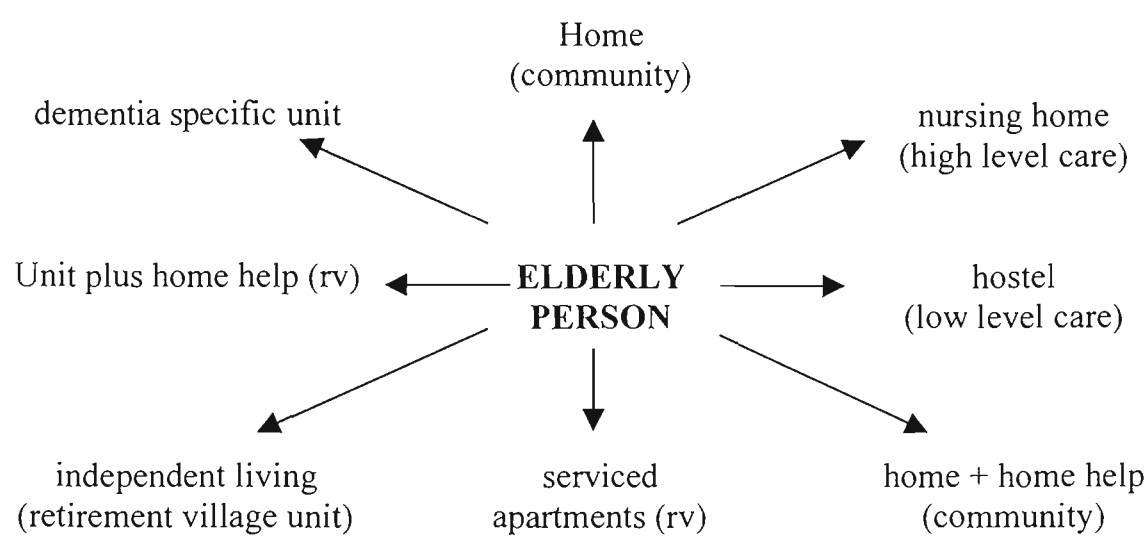


FIGURE 1.2
(note rv = retirement village)
Circular continuum of care as described by Koff (1986)

As demonstrated in the circular continuum of care (see figure 1.2), the elderly person has the opportunity of remaining in their own home and ‘age in place’ within the community and/or being offered home help, such as meals-on-wheels. When appropriate the person may then move into a unit within a retirement village. Whilst living in the village they then have the opportunity of remaining in the village, being provided all levels of care such as fully serviced apartments that offer some nursing or allied health care and home care, hostel and nursing home care and dementia specific

care. This model does have limitations, as there may not be a suitable room or bed vacant between the various levels of care that can then lead to an older person having to locate another aged care facility in the interim. This circular model of care can be represented as a five level approach (see figure 1.3), similar to the downhill model of the traditional three levels of care. Nevertheless the five level approach compared with the three levels of care provides a more flexible approach to the continuity of care. This enables the older person to maintain independence for a greater period of time, utilising the services that are available. This five level approach helps to ensure high level care (nursing home) is provided to those in greatest need, consistent with the theory on ageing in place.

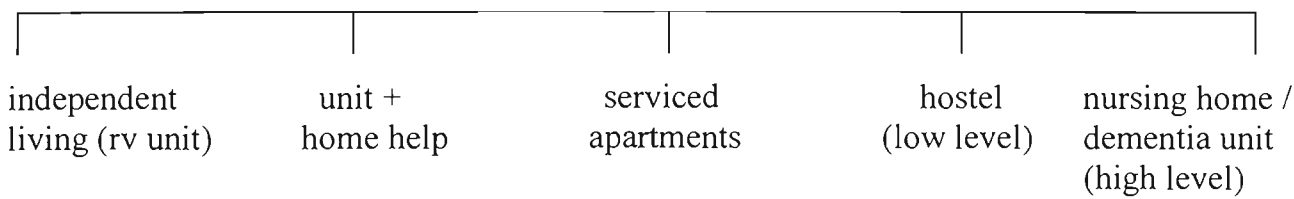


FIGURE 1.3
5 levels of care

The following section will briefly define the various types of services and levels of care that may be offered within a retirement village community.

1.2.1.1 Independent living units within a retirement village

Independent living units or cottages are for those elderly people who decide to move into a retirement village for a variety of reasons – security, community living, declining health, finance or no longer wanting the responsibility of maintaining their own home and so on. Living within the retirement village’s independent units may also enable increased activity and social life and an ability to maintain independence compared with those that live in a hostel or nursing home (aged care facility).

As noted by Coulston (1995), often elderly people move to aged care facilities “when independent living is no longer possible because of chronic physical or mental illness, loss of home, or impairment of activities of daily living” (p 295). Unfortunately, Cobiac and Syrette (1995) recognised that those that live in institutions are more likely to be less healthy from increased dependency, a further suggestion that change in aged care is necessary.

1.2.1.2 Aged care facilities offering low and high level care

Hostel care (low level care) and nursing homes (high level care), supposedly referred to jointly as an ‘aged care facility’ are for elderly people who are no longer able to live independently. Both levels of care offer support services such as “meals, assistance with bathing, supervision of medication, laundry and room cleaning” (Wilson, 1984, p 13) however nursing homes provide greater nursing care with the resident being highly dependent.

In the 1980s Wilson (1984) pointed out that nursing homes “vary little because they are ‘locked-up-tight’ by government regulation, which also ensures they are cast in the medical mould” (p 29). This is an interesting point, if one compares the events and debates that occurred as a result of the aged care reforms of 1997. At this time the role of the government was to regulate the aged care industry to ensure compliance with the Aged Care Act (Commonwealth of Australia, 1997a) and other legislation including the aged care Standards (Commonwealth Department of Health and Family Services, 1998b) (discussed further in Chapter 2). This is a further example of being ‘locked up tight’ as described by Wilson (1984).

Wilson (1984) recommended that there was a need for nursing homes or high-level care facilities to provide the resident with private single or double rooms in which they can retain their dignity and personal items in preference to the often shared rooms, similar to a hospital ward. A later study conducted by Fiveash (1997) revealed a predominant feeling by residents of reduced privacy with sharing accommodation with strangers. This probably needs to be determined and discussed by the older people themselves as some people may prefer single private rooms while others prefer to share and have the company of others. This latter point may be appropriate for residents who have limited mobility and would prefer the company of others to reduce what could eventuate in isolation. Fiveash (1997) conducted an ethnographic study with aged care residents of two nursing homes in New South Wales during 1993/94 that consisted of open-ended interview questions to eight residents. Results also revealed the majority of residents were not involved in the decision making process of moving to a nursing home. Once living in this setting, residents' activities of daily living were found to be generally monotonous, and routine. There were mixed feelings toward staff from being those that are caring to others that were abusive. As noted further by Fiveash (1997), residents need to:

experience a sense of worth, a purpose to life. They [residents] were not only self-sacrificing, but bored by the monotonous inactivity of each day and the unproductivity, purposelessness and futility of waiting to die" (p 29).

This latter point demonstrates the stereotyping often attributed to the downhill progression of living in aged care. However, Koff (1986) and Wilson (1984) demonstrated the ability to provide services that promote ageing in place, or a continuum of care that offers services for the older person to maintain their independence.

1.2.1.3 Flexi-care service offering a flexible approach

Through an extensive planning strategy the Wesley Central Mission, an aged care provider in Sydney developed the flexi-care services concept. This system provides ‘support services’ to residents in their own units in preference to moving them into hostel care. As noted by Wilson (1984), the “flexi-care model reduces the number of moves . . . to ensure optimum care and contentment of residents rather than optimum convenience to the provider of services” (p 57). This system also provides nursing home care for those with extreme frailty including dementia, and is similar to the five levels of care approach in comparison to the traditional three levels of care that does not offer as much flexibility.

The flexi-care service attempts to retain the independence of the resident, in the same unit with the resident not needing to move as in the three-level or five-level approach. However, one has to question whether this type of service can operate with a population that is currently ageing. If an aged care facility can provide increased services, supervision and direct care for residents who are becoming older and increasingly frail, thus reducing anxiety and stress, the older person may in fact witness an improvement in their health and well-being.

A brief overview of the historical and current practices of aged care in Australia from the early 1800s through to the current system will now follow. Current practices will be discussed in greater detail during the analysis of data.

1.2.2 Historical and current practices in aged care

McCallum and Geiselhart (1996) noted that in Australia during the late 1800s: “[t]he destitute elderly were incarcerated in ‘protective’ asylums and offered only the most basic support” (p 72), with some even placed in prison. The majority of these people were men, with women being ‘cared’ for or used for unpaid work by relatives (McCallum and Geiselhart, 1996).

Fortunately standards in aged care were developed through voluntary organisations and religious groups and in 1954 the Aged Persons Home Act (1954) stipulated that housing was to be made available for elderly people. This was the beginning of the traditional retirement village, consisting of 3 levels of care – independent living units, hostel care and nursing home. There was a forty-eight percent increase in nursing home beds and a significant increase in hostel beds during 1963 with the introduction of nursing home subsidies (Department of Community Services, 1986, and Howe, 1986). During this period, general practitioners referred people into aged care, which has become the responsibility of the Aged Care Assessment Service (previously the Aged Care Assessment Team).

In the mid 1980s Wilson (1984), as described above, recommended a new model for retirement village living called flexi-care. He identified that the three-tier model represented “rigid categorization and stereotyping” and that the model required “restructuring and improving” (p 6-7). Wilson (1984) further stipulated that an elderly person entering a retirement village could access care within their home similar to the type of care available to older people living within the community.

In 1987 nursing homes became regulated by the federal government, with Standards Monitoring Teams (SMT) assessing homes according to the thirty-one standards. By 1992 improvements had been made to resident's quality of life, this being credited to the SMT influencing nursing homes to comply with the Standards. However, as noted by Braithwaite, Makkai, Braithwaite and Gibson (1993), public opinion towards nursing homes remained poor; exacerbated by media coverage.

Willis (1993) recognised that up until the 1970s health care was researched from "the paradigm of medical knowledge" (p 100). Research shifted to other disciplines such as from the social science perspective. Willis (1993) noted that the limitation to applying the medical paradigm of health care research is its "exclusion" of "social relations between practitioners and their patients" (p 101).

The Australian Institute of Health and Welfare (AIHW, 1996) reported by 1985-86, there were 1,410 nursing homes in Australia with 72,168 beds compared to 1,466 nursing homes and 74,233 beds in 1997. In 1998, the Australian Institute of Health and Welfare (AIHW) and the Department of Health and Family Services (DHFS) jointly (AIHW and DHFS, 1998) reported a ratio of "48 beds per 1000 people aged 70 and over" (p 1). The occupancy rate was approximately ninety-seven percent with women representing seventy-one percent of the population. In comparison, during 1985-86, there were 851 hostels with 39,816 beds (AIHW, 1996) compared to 1,547 hostels and 64,825 beds in 1997; a ratio of 41.6 beds per 1000 people aged 70 plus, with an occupancy rate of ninety-three percent. Three percent of hostel beds were used for respite residents (AIHW, 1998) in comparison to one percent in nursing homes (AIHW and DHFS, 1998). As can be seen from these figures, there has been a

significant shift in nursing home to hostel ratio; 64:36 in 1985-86 to 57:43 in 1993-94 (AIHW, 1996, p 146). These changes occurred with the introduction of 2,387 community aged care packages established by the Commonwealth government in 1994 with the aim of accommodating “less frail older people in hostels rather than in nursing homes” (Donovan, 1995, p 81 and AIHW, 1996, p 163).

The nursing homes and hostels review (Department of Community Services, 1986) pointed out the necessity of hostels and nursing homes remaining flexible with the level of care provided. For example, “hostels would expand their role to cater increasingly for the frail aged while nursing homes would concentrate on the most highly dependent group” (Department of Community Services, 1986, p 6). This eventuated with the aged care reform of 1997 whereby nursing homes and hostels became jointly referred to as aged care facilities in an attempt to reduce the negative stereotyping as well as to promote ageing in place. During this stage a multitude of events and changes occurred.

There were several publications, including those produced by the Commonwealth Department of Health and Family Services in 1998/99 such as the ‘Residential Care Manual’ (Commonwealth Department of Health and Family Services, 1998c and revised 2001 – Commonwealth Department of Health and Ageing, 2002), the ‘Documentation and Accountability Manual’ (Commonwealth Department of Health and Family Services, 1999), ‘The Resident Classification Scale Training Workbook’ (Commonwealth Department of Health and Family Services, 1998a) and the ‘Standards and Guidelines for Residential Aged Care Services Manual’ (referred to as the Standards) (Commonwealth Department of Health and Family Services, 1998b).

These latter two manuals will be discussed in greater detail throughout the following chapters.

The Aged Care Standards and Accreditation Agency (referred to as 'the Agency', was also established under the Aged Care Act 1997 (Commonwealth of Australia, 1997a) which commenced assessing residential aged care services in January 1998. Aged care services were required to be accredited by January 2001 to receive 'residential care subsidies' from the Commonwealth Government. During this three-year period (January 1998 to January 2001), aged care services were assessed on Standards two, three and four (Aged Care Standards and Accreditation Agency, 1998, p A1, Department of Health and Family Services, Aged and Community Care Division, 1998). The Standards included and continue to include:

- Standard One – management systems, staffing and organisational development;
- Standard Two – health and personal care;
- Standard Three – resident lifestyle; and
- Standard Four – physical environment and safe systems.

From January 2001, aged care providers were expected to comply with all four Standards, having had a suitable period of time (1998-2001) to set up the management systems, as per Standard One. The accreditation system is based on quality assurance and compliance of all four standards. Each of these Standards has a set of expected outcomes, with a total of 44 expected outcomes. This is a comprehensive set of standards with aged care facilities being responsible for continuous improvement, regulatory compliance and the provision of education and staff development across the four Standards. The 'Standards and Guidelines for Residential Aged Care

Services Manual’ provides a resource for management and staff to ensure compliance of the Standards. The Manual provides ‘Guidelines’ to assist management and staff to apply the Standards within their service policy and procedure manual. The guidelines however are not “prescriptive” and state:

They (the Guidelines) recognise that no two residential care services have identical needs and that the quality systems required will vary according to the particular needs of each service and its residents (p G-1).

The Manual recommends that it is the responsibility of management that staff, residents and relatives are able to identify and understand legislative requirements through the provision of education and training (Commonwealth Department of Health and Family Services, 1998b). (Discussed further in Chapter Seven – Developing Personal Skills). Aged care quality assessors from the Agency assess aged care services according to the specific words of each of the 44 expected outcomes, and not the information contained in the Guidelines. These expected outcomes will be discussed and utilised throughout the following chapters.

In conjunction with the introduction of the Standards, there were changes made to Commonwealth funding through the Resident Classification Scale (RCS) (Commonwealth Department of Health and Family Services, 1998a). The RCS necessitated assessment of residents care needs and categorisation of residents, for example level one through to eight, with level one being high level or nursing home care to level eight as low level care or hostel care.

As part of the reform package, the Conservative Coalition Government “committed itself to ongoing review of the reform policy and its implementation” (Gray, 2001, p xxi) and in 1998, the former Minister for Family Services, Warwick Smith appointed

Professor Len Gray to conduct a 'Two Year Review of Aged Care Reforms'. The Review reported on eight issues, some of which will be discussed during the analysis of data, particularly within Chapter 4 – Building Healthy Public Policy. Issues that were reviewed included:

1. Quality of care including staffing levels and implementation of the accreditation system, sanctions and Complaints Resolution Scheme;
2. Efficiency for the provider, resident, family and government including government expenditure and documentation required for accreditation, and funding through the Resident Classification Scale (RCS), and government subsidy;
3. Choice and appropriateness of care including a continuum of care and the promotion of ageing in place;
4. Access to care through the continuum of care;
5. Considerations relating to dementia care;
6. Programmes specific to Australia's States and Territories;
7. Affordability; and
8. Viability of the aged care industry.

This report provided background information relating to information prior to the reforms, the types of information or data collected and overall recommendations and comments. It should be noted, that Professor Len Gray was appointed by the Federal Government to complete the review of the reforms. It was important for the Government to show evidence that their systems and reforms had improved aged care services. During this period, there was growing public concern about the standard in

aged care and the government acted upon this through the reforms. Overall, Gray (2001) concluded:

It is my conclusion, on completion of the Review, that the reforms have delivered substantial improvements to the aged care system (p xxxi).

Since implementation of the reforms, there have been numerous media releases, to promote these changes, from the then Minister for Aged Care, Bronwyn Bishop. Bronwyn Bishop acknowledged the negative stereotyping of our elderly population, and thus promoted recognition of International Year of Older Persons, 1999 and health promotion projects. She also acknowledged and defended aged care facility closures as a response to aged care provider's non-compliance to accreditation (Bishop (1999; 2000)). Also, at an early stage of the accreditation rounds, there were a number of media releases by Bronwyn Bishop to congratulate each State and Territory on meeting the accreditation standards. She commented:

This is the beginning of an exciting new era for older Australians and their families with the successful commencement of a quality assurance system that aims to guarantee that aged care facilities offer quality care and services to residents (Bishop, 1999e).

The overall objectives of the aged care reform were to improve services and quality of care to elderly people living in residential care (Commonwealth Department of Health and Family Services, 1998b). And Bishop (1999c) suggested that aged care reforms needed to consider a "holistic approach" in which:

older Australians participate at all levels in the workforce, within the family, in the community, through good health, with access to information and with good quality care for those who need it.

Nevertheless, these reforms eventuated in a number of media 'scandals' such as facility closures, that will be discussed in Chapter 4. The reforms neglected to include

the area of independent living for older people living within independent units of the retirement village, apart from the fact that there was an emphasis on elderly people remaining in their own home. This latter concept though, often referred to as 'aging in place' encourages the older person to remain living within their own home with community home care supposedly being made available more readily, as an aspect of the continuum of care provided to the older population. Bronwyn Bishop promoted this policy, and recognised the need for further research, as demonstrated in this media release:

the areas of health research and health and aged care policy are challenges facing Australia as our population ages . . . With appropriate policies, we can assist older Australians to remain as independent as possible and to provide them with quality care (Bishop, 1999g).

Nevertheless, the Department of Community Services (1986) recognised that residential care is required for older people who are unable to gain support or for those who prefer the social life often available in the retirement village's aged care facility. And, it appears appropriate that this type of accommodation is available for an ageing population.

With an ageing population, there is a need for continuance of aged care settings to identify existing problems. The most effective means to approach this would be through discussion with those that work and live in aged care. This will provide a means for residents, staff and relatives to live, work or visit a healthier, health promoting environment crucial in this expanding market.

In order to facilitate an understanding of the needs of the elderly population, an overview of the ageing process will be described below, helping to identify suitable

programmes to alleviate the biological process of ageing as well as to reduce the misconceptions and stereotypes associated with the elderly. As noted by Lindell (1986):

we must understand the process of ageing . . . that . . . starts at conception . . . [and] understand physiologically what is happening – what’s happening to bones, to the chemistry of the person, to behaviour, to social attitudes, and to the abilities of older people (p 267).

1.2.3 The biological process of ageing

Ageing can be defined as a process that occurs in every phase of life, however as defined by Bidlack and Wang (1995) dysfunctional ageing or senescence “refers to those changes associated with accelerated morbidity and mortality rates during the latter phase of adult life” (p 25). The elderly population can be divided into two age groups, firstly, the young elderly who are aged between 65 and 74 years, and secondly, the older elderly aged 75 years and above. The generic term ‘elderly’ is utilised in this research, nevertheless, as noted by Herne (1995) the latter age group are more likely to live in aged care as there is an increased risk of degenerative diseases such as Parkinson’s disease, motor neurone disease, Huntingdon’s chorea and multiple sclerosis (p 12). Biological ageing may also contribute to the elderly person requiring residency in a retirement village.

As one ages the bladder becomes smaller which can lead to urinary incontinence, and motility of the intestine is lessened which can result in constipation. Other contributing factors to degenerative bowel and bladder function include poor diet, reduced activity, medication usage and an “environment that decrease[s] privacy” (Wallace, et al, 1998, p 641). Decreased privacy is difficult to solve particularly in aged care facilities where residents are more likely to share dining facilities,

bathrooms and living areas. As noted by Baum (1998, p 396-398) when building communities it is important to recognise the need for privacy and space. Confined space and reduced privacy may also contribute to altered sleep patterns.

Sleeping disorders often occur with ageing and may be as a result of pain. The person may have difficulty “in getting to sleep and staying asleep”. To reduce anxiety Wallace et al (1998) suggested that “teaching [the older person] about the normal changes in the aging sleep system may reassure them” (p 646) and for those who suffer pain, effective pain management may be beneficial. Exercise programmes may also benefit the resident.

Ageing also affects the five senses and this was identified as a consideration within the Aged Care Standards under Outcome 2.16 – Sensory Loss with staff expected to identify sensory loss and plan programmes to manage them (Commonwealth Department of Health and Family Services, 1998b). Vision becomes less acute and older people are more prone to develop cataracts and glaucoma. Hearing becomes diminished and as noted by Koff (1986) staff who have knowledge of the ageing process such as hearing loss can use techniques such as talking face to face thus reducing confusion. Wallace et al (1998) also recognised that loss of taste buds and “smell sensation” (p 647) can alter the flavour of food leading to poor appetite, loss of weight and even malnutrition. It is therefore important that teeth, gums, ears and eyes are regularly checked and looked after.

Finally as noted by Wallace et al (1998) the sense of touch becomes lessened as the skin becomes “thinner, wrinkled, and more fragile” (p 648). Disease may also

contribute to the elderly person losing the “ability to feel pain and pressure through the skin”. Older people therefore need to be aware of these changes to reduce the risk of injuring themselves unnecessarily and Wallace et al (1998) further suggested that “skin assessments should be performed . . . to detect alterations in skin integrity” (p 648). The Standards also include issues relating to skin integrity under expected outcome 2.11 – Skin Care, that reads: “Residents’ skin integrity is consistent with their general health” (p S-24). Staff working in aged care facilities are therefore responsible for providing an initial skin integrity assessment, and develop a care plan that is reviewed and evaluated.

Relationships also change throughout the lifespan with a person playing a variety of roles within the family from being a child, a sibling, parent, spouse, grandparent and even great grandparent. Loss of these roles as well as the loss of intimacy and sexual relationships may contribute to depression.

Herne (1995) proposed that depression affects thirty to fifty percent of the elderly population and may be as a result of loss or illness. It may therefore be recommended that staff be aware of identifiable behaviours including “lack of appetite, loss of weight, sleeplessness, fatigue, decreased ability to think or concentrate, psychomotor agitation, decreased participation in daily living activities and social activities, and suicidal ideation” (Wallace, et al, 1998, p 653). Treatment of depression ought to be immediate as this may be a cause for suicide. The “highest rates of suicide in Australia occur in men over 75 years of age and . . . at least 90% of suicide victims have a mental disorder, predominantly severe depression” (Geriacton, 1998c, p 26).

Wallace, et al (1998) recommended that it is important for the older person “to fulfil the human need to touch and be touched” (p 652). Unfortunately, older people are often perceived by society including aged care workers as asexual and Lyder (1994) stated: “intimacy is often viewed uncomfortably by people as either “cute” or “disgusting” (p 61). It may therefore be necessary for staff to be provided education to accurately assess residents’ sexual needs and or problems and gain relevant information from relatives. Identifying and accommodating the resident’s spiritual beliefs may be a means of reducing depression and suicide rates. As identified by Wallace et al (1998), this is sometimes difficult, as there are many differing types of spirituality, however resident assessment can include ‘open-ended questions’ or communicating with resident family and friends to gain insight (p 654).

These areas have been identified as biological changes that occur with ageing, however it is recognised that every individual ages differently and there are environmental and genetic factors contributing to illness and disease, including dementia. The effects and management of dementia however is extensive and will only be briefly mentioned in this study.

SUMMARY

This chapter has reviewed briefly the history of Australia’s public health and the movement toward health promotion with the emergence of the Ottawa Charter in 1986. The Ottawa Charter provided insight, understanding and impetus to the need to move toward a new public health. This led to government initiatives to identify health problems and the means of rectifying the inequalities through health promoting

programmes. Subsequent International Conferences on Health Promotion also reinforced the focus of the Ottawa Charter in health promotion and health for all.

The Australian Health Ministers' Advisory Council (1988) and the Commonwealth Department of Health, Housing and Community Services (1993) both identified health problems associated with the elderly population that can be prevented through intervention programmes. Many of these problems appear to have been recognised by the Commonwealth Department of Family Services (1998b) with the Aged Care Standards and Guidelines Manual incorporating these within the 44 outcomes. Nevertheless, other types of programmes aimed at the elderly population that have been implemented will be identified in the latter part of this research through the literature review as well as those discovered during the research phase. To progress from this an insight into the ageing process has been discussed to illustrate that there is a need for understanding and knowledge of the needs of the elderly population.

As can be seen from the above discussion, aged care has developed a great deal in such a short history of around four decades, especially in the last decade with aged care being made more accountable. To ensure continuance of funding, aged care facilities undergo accreditation ensuring aged care standards are being met. These changes however could be strengthened by offering a supportive environment that empowers aged care professionals and the community to work together toward a health promoting retirement village that is satisfying for all to live, work and visit.

As noted by Wilson (1984), "all decisions affecting old people are made by younger people" (p 50). It is for this reason that this study has encompassed views, ideas and

decisions of residents living in the retirement village as well as the staff themselves who are experienced and working in this environment. Involving the elderly persons themselves may help to reduce stereotyping of the elderly population and provide an avenue for them to become “valued” citizens (Wilson, 1984, p 51).

In working toward a health promoting retirement village, it is necessary to understand the settings approach that has been implemented in other institutions, for example, schools, colleges, universities, hospitals, cities, workplaces, prisons and palliative care. The health promoting school, hospital, city and workplace will be discussed in the next section to provide an understanding as to the methods, ideas and concepts for working toward the health promoting retirement village.

Chapter Two

Review of Literature

The previous chapter reviewed the history of the public health movement particularly focusing on the development of health promotion since the World Health Organisation's Ottawa Charter (1986). This chapter will continue discussion with a focus on the 'settings approach'. The health promoting setting concept has been applied to various organisations, but only the health promoting school, hospital and workplace will be discussed in this chapter. I will then suggest how aged care may work toward a health promoting setting, utilising the settings approach framework of the Ottawa Charter's (WHO, 1986) action areas – building healthy public policy, creating supportive environments, fostering community action, developing personal skills and re-orienting health services.

2.1 Health promotion and the settings approach

Green et al (2000) recognised that there has been a variety of 'approaches' to health promotion initiatives, that is, the 'issue approach' focusing on problems such as drug abuse, the 'population approach' whereby initiatives are targeted toward population groups such as the homeless and finally, specific to this study, the 'settings approach'. These approaches are often referred to as the three p's – problems, population and places. The concept of the health promoting setting emerged from the growing expectations of moving beyond the traditional treatment and medical model from the old public health to the ideals of the new public health and health promotion. In the

United States of America, following the Lalonde Report (1974), the U.S Office of Health Information and Health Promotion was established in the late 1970s and “organized itself around settings” (Green et al, 2000, p 11). Green et al (2000) also recognised:

The World Health Organization, especially its Regional Office for Europe, has provided considerable leadership and momentum for the “settings approach” to health promotion (p 11).

In 1987, the WHO initiated the healthy cities project building on the Ottawa Charter, with other settings beginning to emerge (Green et al, 2000). The World Health Organisation has been instrumental in the development and leadership of the settings approach through ongoing conferences such as the International Conferences on Health Promotion (Green et al, 2000). The first International Conference held in 1986 was the venue for the development of the Ottawa Charter (1986). Subsequent conferences have reflected on and “clarified the relevance and meaning of health promotion” (WHO, 1997). For example, the Jakarta Declaration (WHO, 1997) reinforced that the ‘settings approach’ provides the ‘organisational base’ for health promotion. Settings have been applied to schools, hospitals, the workplace, prisons, cities, and as noted by Galea, Powis and Tamplin (2000) at an early stage in the development of healthy islands. The initial three (schools, hospitals and workplaces) will briefly be discussed in this chapter.

Dr Sattar of the WHO South-East Asia Regional Office (WHO, 2000) presented a paper on the concept of healthy settings and defined a healthy setting:

A healthy setting is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and

in developing themes themselves to their maximum potential (p 2).

As noted by Goltz et al (1997):

The 'setting based' approach to health promotion intervention starts with a target population within a given setting . . . The approach then centres around planning interventions which are relevant to the health problems of the population within that setting (p 16).

Within the South East Asia region, the healthy city programme was initiated in Indonesia in the early 1980s and continues to be expanded and promoted throughout the region "through a yearly healthy city competition" (WHO, 2000, p 18). Dr Goldstein of the World Health Organisation/United Nations Environment Programme (1993) "stressed the need for a settings approach to ensure the programmes are more focused and practically oriented" (p 5). Stone (2000) initiated a health promotion project in Bunbury, Western Australia, using the healthy cities framework and concluded that the strength in the programme was the establishment of partnerships with community organisations that facilitated greater participation and ownership. As noted further by Baum (1998) and Johnson and Baum (2001) the setting or organisation must be committed to change and develop during the process of working toward being a health promoting setting. The organisational structure will undergo change, from being hierarchical to network based which will be a learning experience for all. As Baum (1998) recognised there is a need for staff to work as a team, and in larger organisations to create "small, self-managing teams" (p 360) that are able to work autonomously with guidance and support from management. This is in comparison to managers organising and introducing programmes that may run the risk of limited participation. Resource allocation may also require redirecting from "curative care to prevention and health promotion" (Baum, 1998, p 362) as "curative

medicine alone can make relatively little contribution” (O’Donnell and Gray, 1993, p 11).

Healthy settings need to be participatory and empowering and “consider the social, political, resources and other contextual factors during their implementation” (Baum, 1998, p 457). As noted further by Baum (1998), successful health promoting organisations include partnerships with the community, empowerment of staff, developing healthy public policy that considers the environmental impact and fostering networks “to assist with its task of health promotion” (p 466). These features are consistent with the strategies of the Ottawa Charter (WHO, 1986).

The above information promotes the settings approach, nevertheless, it is important to note that there are critics. For example, Whitelaw, Baxendale, Bryce, Machardy, Young and Witney (2001) suggested that the “settings field has reached a point of maturity” that needs critical review:

The conceptual development, practical use, formal evaluation and reporting of settings based activity appears to have been largely of a constructive and positive nature. On the other hand, as the area has evolved and matured, quite naturally a range of critical questions have been asked about, for example, the conceptual consistency of the approach . . . and the ultimate effectiveness of the interventions (p 340).

This issue becomes a little more evident in the review of the three settings described below. This information indicates that the deficiency in the settings approach may be the focus on behavioural change and its limitation to ensure a holistic conceptualised approach. It is for this reason, that in the development of a health promoting setting, that there is a collaborative effort to build partnerships in the development,

implementation and evaluation of a setting that incorporates the five action areas of the Ottawa Charter, as demonstrated within this thesis.

2.1.1 The health promoting school framework as a foundation for working toward a health promoting retirement village

The health promoting school will be briefly discussed as there are similarities between a school and a retirement village and these comparisons will be made in this section. Both offer a supportive environment for a population that could be in a powerless situation and are to some degree dependent upon others. The school and a retirement village are also settings that are a community in their own right. Also as noted by Colquhoun, Goltz and Sheehan (1997) the health promoting school is difficult to define as like all institutions including retirement villages, schools vary considerably.

Health promoting schools like other settings has utilised the Ottawa Charter's five areas of action as its "foundation" (NSW Department of Health, NSW Department of School Education, Catholic Education Commission, Association of Independent Schools 1996, p 4, Commonwealth Department of Human Services and Health, 1996, p 1) and will be utilised to consider its application in a retirement village.

Prior to the health promoting school concept, health education was taught "with the traditional bio-medical approach . . . and its primary role was to raise awareness of public health issues" (Dommers, Ingoldby and Heart Foundation, 1996, p 5). The New South Wales Department of Health et al (1996) recognised that schools have "policies and procedures for protecting and promoting student health" however they note that there is also the need for schools "to enhance health promotion for the whole school community" (p 7). This may also be applicable to policy development in aged

care that may remain focused on the traditional medical model and three levels of care. It may be appropriate to refocus on promoting the concept of health and wellness of the community, including the empowerment of the staff, residents and their families. This would enable residents to increase their 'control' over their own health (Dommers et al, 1996). Students themselves have become empowered by being offered the opportunity to be involved in community activities, such as that described by Morellini (1999) through a Student Community Involvement Programme in which students learn about volunteering.

Angley, Young, the SA Health Commission and Department of Education and Children's Services Initiative (1996) recognised that the health promoting school "acknowledges that confidence, self-esteem, communication and relationship skills are all vital to well-being and mental health" (p 4) as is the need for those involved in aged care, including staff and residents. For example, staff require proficient communication skills to liaise with a variety of residents, other health professionals and families of the resident and be knowledgeable as to the types of communication methods required. Communication varies dependent upon the scenarios from communicating with the dying person and their family compared with times of celebrating a resident's one-hundredth birthday. Skills in building relationships may also be a necessary component in aged care with a variety of relationships between the various stakeholders in aged care, that is, residents, management, staff, health professionals, the community and relatives.

The health promoting school was categorised by Young and Williams (1989) into three elements, first school ethos, second health education curriculum, and third,

family and community. In 1996 the National Health and Medical Research Council (1996) revised the Young and Williams (1989) model and incorporated these elements into a framework for the health promoting school in Australia (see figure 2.1). This framework illustrates the interconnectedness between the three domains and may also be applicable to an aged care setting, as demonstrated in figure 2.2.

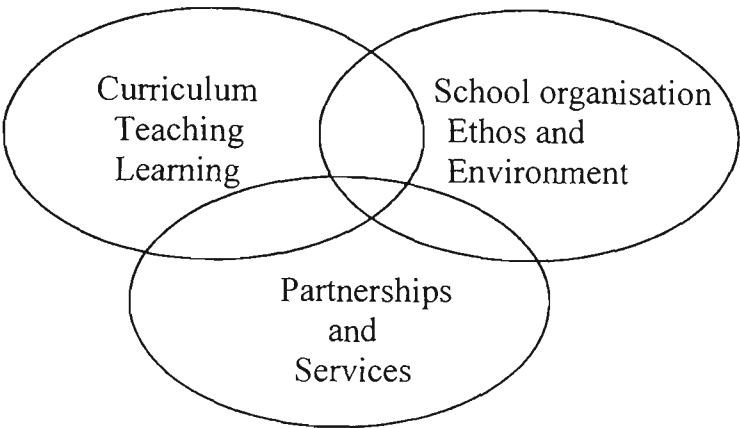


FIGURE 2.1
National Health and Medical Research Council (1996, p 38)
Framework for the Health Promoting School

The Commonwealth Department of Human Services and Health (1996) and the National Health and Medical Research Council (1996) made these comments with regard to the framework of the health promoting school:

Each of these three components contributes to and reinforces the work and modelling role of the others. Collaborative and democratic decision-making processes act as a unifying theme” (Commonwealth Department of Human Services and Health, 1996, p 3).

The framework “recognises the need for . . . health care personnel, local community agencies, and other important interest groups to actively participate in shaping and implementing health promotion programs and policies” (NHMRC, 1996, p 37).

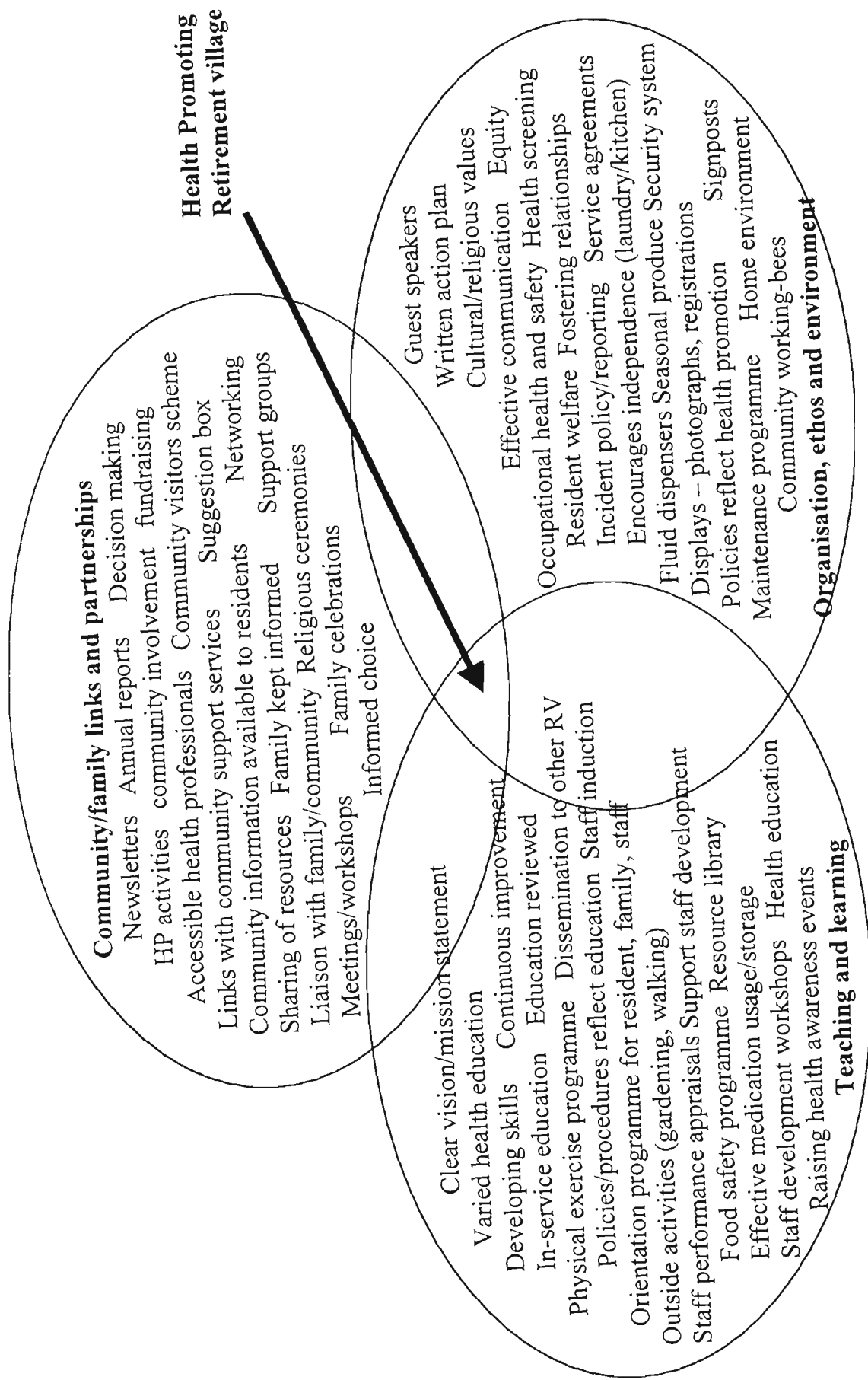


FIGURE 2.2
Modified Young and Williams (1989) model.
Toward a health promoting retirement village

Comparing these domains between the school and retirement village, the first domain, curriculum, teaching and learning includes both the health education programme and professional development for educators (Northfield, St Leger, Marshall, Sheehan, Maher and Carlisle, 1997). Health education within schools and in aged care is important and this was recognised by the Commonwealth Department of Health and Family Services (1998b) through the ‘Standards and Guidelines for Residential Aged Care Services’, as part of the aged care reform package. As acknowledged by Young and Williams (1989) “healthy living must be an issue of major importance for everyone” (p 5).

The second element, school ethos may be reflected within a setting by promoting positive relationships, providing an easy to follow signpost and a reception area that includes seating, newsletters and notice-boards about the organisation (NSW Department of Health, 1996). The New South Wales Department of Health (1996) recognised that the social environment that promotes positive relationships between people is imperative. As noted further by the NSW Department of Health (1996):

A positive social environment . . . is characterised by enthusiasm, low staff absenteeism, and . . . [h]igh staff morale (p 8).

The physical environment of an organisation is also an important aspect and the NSW Department of Health (1996) suggested that “[t]he design, layout, quality and condition of the school buildings and facilities” (p 9) be taken into consideration. As noted further by O’Donnell and Gray (1993) buildings must not only conform to the “requirements of health and safety” but also upgraded for “conducive productive work” (p 29) and allow space for conducting activities. This is also applicable to the design of an aged care facility which may offer Universal Design, that is, building

adaptable for all ages (Fletcher, Breeze and Walters, 1999, Sutherland, 2000) which takes into account “older people’s abilities rather than their disabilities” (Lindell, 1986, p 273). Lindell (1986) further suggested that the design can reflect a “supportive” (p 270) environment in preference to an institutional or medical model, for example one that offers an “outlook” (p 271) – providing the resident with the visual senses as to the time of day and the weather (Lindell, 1986). As can be seen, the physical environment is an important factor however Northfield et al (1997) recognised barriers such as limited resources, and the design and location of the building, that may prevent the setting from meeting their needs unless the organisation had been forward thinking prior to building.

The third element of the National Health and Medical Research Council’s (1996) framework of the health promoting school was one that fostered family and community partnerships to involve these people in project development and decision-making (Dommers et al, 1996, p 18). This was supported by the New South Wales Department of Health (1996) which recognised that:

Collaborative partnerships will help to ensure that specific health issues are not treated in isolation and that effective use is made of expertise, resources and support services (p 11).

It is an interesting concept to illustrate the similarities between the two settings, however all settings and institutions are individual and as recognised by Galea et al (2000):

There is no common frame of reference between many of the settings that are being used as the basis of health promotion (p 170).

Therefore, health promoting initiatives require to be developed in line with the organisational needs, and abilities of the setting, but in consultation and collaboration

with those that are integral to the setting, including those in the community and established networks.

2.1.2 Hospitals as a health promoting setting

The concept of the health promoting hospital was established in 1991 by the Budapest Declaration on Health Promoting Hospitals (WHO cited in O'Connor and Parker, 1995). However, as noted by Schmitz (1989) programmes were developed in the 1980s as a response for more cost-effective methods:

Those that provide well-planned, adequately funded, dynamically marketed health promotion programs will stand a much greater chance of survival in the unpredictable and unforgiving hospital environment (p 21).

Johnson (2000) also acknowledged that consumers are becoming increasingly “interest[ed] in disease prevention and health promotion” and are aware “of the limitations of acute medicine” (p 180) and therefore expect hospitals to offer health promotion programmes and services.

Researchers such as Baum (1998) and Johnson and Baum (2001) have suggested that the health promoting setting approach does require promoting organisational change. Johnson (2000) acknowledged that this was supported by the International Network of Health Promoting Hospitals, founded in 1990 and sponsored by the World Health Organisation, which “recognized that hospitals must undergo profound organizational change to orient themselves toward the promotion of health” (p 179).

As noted by Johnson and Baum (2001) hospitals have attempted to implement the five strategies of the Ottawa Charter, but suggest that much of the “practice[s] have simply relied on behaviour change strategies” (p 282). Nevertheless, O'Connor and Parker

(1995) pointed out the inclusion of health promotion activities within Australian hospitals has included patient and employee education, occupational health and safety programmes, childcare facilities and “screening services to the local community” (p 237). O’Connor and Parker (1995) recommended the aims of a health promoting hospital are to:

- develop a common corporate identity within the hospital which embraces the aims of the health-promoting hospital
- encourage an active and participatory role for patients according to their special health potential
- create healthy working conditions for all hospital staff
- maintain and promote collaboration between community-based health promotion initiatives and local government bodies (p 243-244).

Johnson and Baum (2001) also recognised that “there can be a variety of interpretations of the meaning of a health promoting hospital initiative”. Nonetheless hospitals that support “organizational reform supported by strong policy and leadership” appear to hold the promise for future direction, thus meeting the needs of the ‘patient, family, staff, organisation, the physical environment and the community’ (Johnson and Baum, 2001, p 286).

2.1.3 Beyond occupational health and safety to health promotion within the workplace

The notion of the health promoting workplace “developed out of the concept of workplace health promotion” (WHP) (Chu, Breucker, Harris, Stitzel, Gan, Gu and Dwyer, 2000, p 156) which evolved in Australia during the late 1970s (O’Connor and Parker, 1995 and Chu et al, 2000). Chu et al (2000) recognised that until the mid 1980s the focus on WHP was “on the behaviour of the worker rather than the conditions of the workplace”. This is consistent with other health promoting settings, such as hospitals that focused on strategies to promote behaviour change during the early stages of implementing health promotion programmes. Occupational health and

safety systems emerged at this time which addressed “industrial hazards” and “employers’ duty of care” (p 160). In 1992, there was an estimated thirty-four percent of health promoting activities conducted within the workplace (National Coordinating Committee: Health Promotion in the Workplace 1992 cited in O’Connor and Parker, 1995, p 210). Health promoting activities that have been introduced into the workplace are occupational health and safety programmes for example smoke free environment, protective clothing and safety training while other programmes have included healthier canteens, stress management, exercise and health screening.

Health promotion within the workplace can help reduce disease and illness, as well as unacceptable injury and death rates, for example during the period 1991/92, \$4.8 billion was spent on workers’ compensation claims (Worksafe Australia: National Institute Report, 1993 cited in O’Connor and Parker, 1995, p 217). As Chu et al (2000) recognised:

The concept of the health-promoting workplace is becoming more important and more relevant as more private and public organizations increasingly recognize that future success in an increasingly globalized marketplace can only be realized with a healthy, qualified and motivated workforce (p 155).

Gardner (1999) and Chu et al (2000) both suggested that there remains barriers to workplace health promotion and the health promoting workplace in the Australian context. For example Gardner (1999) recognised the difficulty in funding workplace health and safety initiatives, while Chu et al (2000) stressed that it remains dominated by “behaviour-oriented measures” (p 163). O’Connor and Parker (1995) and Gardner (1999) also noted that there has been minimal implementation of health-promoting programmes within the workplace and other settings. Part of the reason for this is from insufficient longitudinal research that could show evidence of the benefits of

health promotion projects. For example, Gardner (1999) recognised that there is an abundance of “literature relating to the cost effectiveness of workplace based health promotion programmes . . . from the USA” (p 17) and concluded by identifying that in Australia there are “very few large scale studies . . . to truly determine their health benefits” (p 19). Further studies are required specifically in the Australian context that identifies the positive outcomes (O’Connor and Parker, 1995). Ziglio (1999) referred to this as “indicators” of health promotion programmes, such as health benefits, economical factors, staff absenteeism rates and overall “health impact on the population” (p 9) including the individual, collective staff, families, the community and society.

The above has provided a brief overview and history of three health promoting settings – schools, hospitals and workplaces. All have experienced some form of limitation, such as the focus on behaviour change, nevertheless, the advantages appear to outweigh the difficulties encountered. The following section will discuss reasons for developing the health promoting settings within a retirement village.

2.2 Reasons for working toward a health promoting retirement village

There may be various reasons for working toward a health promoting retirement village. One could suggest that aged care may benefit from moving beyond the institutional or medical model to one that is health promoting, with a goal of improving quality of life for all individuals including residents, their relatives, staff and the community and overall the retirement village setting and society. As Bonita (1993) noted:

Because of the higher rates of disease in elderly people, health promotion has the greatest chance of doing good among them... Health-promotion programmes need a greater focus on successful ageing and improving the quality, rather than the quantity, of life (p 208).

Australia has a population that is ageing which will increase demands on health and welfare services (Campbell, 1993, p 69), therefore providing preventive services and programmes that will meet the needs of the elderly community will be economically more viable than treatment for both government expenditure and to the aged care sector. With the decline of mortality rates resulting in increased illness, often there is greater use of health care services and costs in health care. As noted by Kimble and Longe (1989): “health promotion initiative[s] provide knowledge, skills, and support services to help seniors improve their health and well-being” (p 3). And finally, health promotion initiatives can help “prevent social isolation” and provide opportunities for older people to “adapt to social changes” (Kimble and Longe, 1989, p 4-8). Social isolation may increasingly become apparent for an ageing population particularly in Australia with the sprawl of urban development.

Nutbeam (1998) and Isaksson and Pohjolainen (1994) recognised the limited number of health promotion programmes available to older Australians. Nutbeam (1998) recognised that State and Federal governments have not shown any commitment to health promotion programmes apart from “ad-hoc projects associated with specific issues” such as falls prevention and safer use of medications (p 121). Isaksson and Pohjolainen (1994) also stated that: “[l]ong-term health promotion programmes among the elderly population have not been implemented in any great quantity” (p 16).

Wallace et al (1998) recognised the benefit of community living as a continuum of care and an ideal setting for health promotion. Within this continuum the concept of wellness and 'preventive health care' can be incorporated. The concept of wellness as opposed to illness can be illustrated within the aged care environment that considers the "residents as unique individuals" (Koff, 1986, p 121). Koff (1986) provided examples of a healthier physical environment including use of contrasting colours, safety bars, large letters/numbers, larger doorways and ramps for wheelchairs (p 127). Other factors identified by Nystrom and Segesten (1994) through observational research and interviewing of elderly residents in a Swedish nursing home that contributed to "a healthy life" included "relief of pain and worries . . . [p]ositive self-esteem, a sense of integrity and identity [and] . . . peace of mind" (p 124-125).

Nystrom and Segesten's (1994) review of health promotion initiatives revealed that the resident often feels powerless, even with a team of staff who are compassionate and friendly. Factors contributing to this feeling of powerlessness included increased dependence, fear of the unknown, for example pain and death, and because "life in the institution was seen as a violation" (p 128). These feelings and negative attitudes may be reduced by improving aged care through health promoting activities and ensuring the resident has a home for life by enabling a continuum of care, as illustrated in the previous chapter. It could be assumed that this model allows the elderly person to be provided with the opportunity to make informed decisions as to the type of care and services that they wish to receive. For this reason, the elderly person can 'shop around' for the most suitable retirement village.

2.2.1 Applying the Ottawa Charter in the development of a Health Promoting Retirement Village

The five action areas of the Ottawa Charter have been applied to the development of health promoting schools and other health promoting settings. Colquhoun, Goltz and Sheehan (1997) offered a valuable resource for schools and other settings aiming toward becoming health promoting which also utilised concepts of the Ottawa Charter (WHO, 1986). Kellehear (1999) also offered a useful resource applying the Ottawa Charter to create health promoting palliative care. It could be suggested that the principles of Kellehear's (1999) health promoting palliative care is a necessity within an aged care setting as it is a component of a retirement village in which people live and die. People in this setting may be provided with the choice of where they wish to die – the retirement village (which has become their home) or in a hospital.

The Ottawa Charter's five action areas will now be applied through the literature review as well as throughout the analysis of the data to demonstrate if and how a retirement village can move toward a health promoting setting. However, the action area relating to re-orientation of health services will be discussed in the concluding chapter with reference to all of the Ottawa Charter's action areas. Table I and the following information provides an illustration of the Ottawa's Charter's (WHO, 1986) action areas and a summation of the literature review.

Ottawa Charter for Health Promotion	Health Promoting Retirement Village	Specific references
<p>1. Build healthy public policy “... coordinated action that leads to health, income and social policies that foster greater equity”</p>	<ul style="list-style-type: none"> • to provide policies in accordance with standards and acts that work together for the benefit of residents and staff • provide a means for resident participation in “decision making and policies” (Dommers, 1996, p 17) • prominently display an action plan of health promoting activities • provide clear and concise policies/procedures for staff to accurately meet the health needs of residents • ensure policies compliment each other by capturing the essence of a home-like environment 	<ul style="list-style-type: none"> • Aged Care Standards, Food Act, Aged Care Act, Health Services (Residential Care) Regulations, Retirement Villages Act, Food and Nutrition Policy, Nurses Regulations and Act, Drugs Poisons and Controlled Substances Regulations and Act
<p>2. Create supportive environments “... encourage reciprocal maintenance – to take care of each other, our communities and our natural environment ... Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable”.</p>	<ul style="list-style-type: none"> • provide a safe and secure environment for residents to live, family/friends to visit and staff to work • foster caring and trusting relationships between staff and residents, resident and resident, and staff and family • promotes an outdoor environment conducive to encourage resident interest • provide a social environment celebrating special events, community festivals, and resident religious/ethnic/cultural rituals • provide policies and procedures that reflect the cultural values of the retirement village community • provide policies “that are based on the principles of environmental sustainability” (SA Health Commission, p 33) 	<ul style="list-style-type: none"> • Aged Care Standards – 1.1, 1.4 (suggestion box, questionnaires, meetings/workshops/training), 1.7 (safe equipment and food → training), 1.9 (service agreements), 2.4 (residents involved in care plans), 2.9 (right to die with dignity) • Residents Rights – homelike environment • Health Services Regulations (meals to complement resident culture, fluid dispensers, assistive devices, well organised activity programme)

Table I, Page 1 of 3
 Illustrating the Ottawa Charter’s 5 action areas (WHO, 1986) in relation to a retirement village

Ottawa Charter for Health Promotion	Health Promoting Retirement Village	Specific references
<p>3. Strengthen community action</p> <p>“ . . . draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation . . . “</p>	<ul style="list-style-type: none"> • To maintain strong links with local and state government organisations, eg local council and HACC • Promotes community participation including that of family and friends • Family and friends of residents are involved in decision making and provided with opportunities to attend activities • Provide a means for strengthening community living through networking mechanisms • Recognise the importance of developing support groups 	<ul style="list-style-type: none"> • Standard 1.6 (address grievances and industrial matters), 1.7 (good working relationship with distributors) • Resident Rights (Community Visitors Scheme) • Food Act Part 6 (registration of food service with local council and service agreements)

Table I, Page 2 of 3

Illustrating the Ottawa Charter’s 5 action areas (WHO, 1986) in relation to a retirement village

Ottawa Charter for Health Promotion	Health Promoting Retirement Village	Specific references
<p>4. Develop personal skills</p> <p>“ . . . supports personal and social development through providing information, education for health and enhancing life skills. . . .”</p>	<ul style="list-style-type: none"> • Develop resident skills to promote effective participation in a variety of health promoting initiatives • Provide professional development for staff • Provide opportunities for staff, residents family/friends and community to participate in an effective and varied education programme • Document programme development and assessment for future events • Provide staff training in all aspects of health care to promote identification of resident, staff and family needs enabling accurate referral onto appropriate specialists 	<ul style="list-style-type: none"> • Standard 1.3, 1.6, 2.3, 3.3, 4.3 (in-house training by qualified educator), 2.5 (appropriate trained clinical staff in care and communication skills), 2.7 (training in medication storage and use) • Health Services (Residential Care) Regulation 3 (laundry and kitchen for residents, staff competency) • Food Act (food hygiene and handling training)
<p>5. Reorient health services</p> <p>“ . . . individuals, community groups, health professionals, health service institutions and governments . . . must work together towards a health care system which contributes to the pursuit of health.”</p>	<ul style="list-style-type: none"> • Provide coherent and streamlined approach to services so that all energies are directed to the pursuit of excellence in the delivery of age care • Ensure individualised care plans are regularly assessed and correctly implemented from all health care workers, moving beyond the traditional medical sphere • Integrated 	<ul style="list-style-type: none"> • Aged Care Assessment Services • Aged Care Standards Agency • Commonwealth Department of Health and Aged Care • Standards 1.1 (quality assurance meetings, policy/procedures are accessible to all), 1.6 (orientation programme, performance appraisals, rosters complement resident needs), 2.4 (health professionals/specialists other than medical practitioners), • Health Services 3 (resident choice of practitioners, supportive services – maintain dignity with incontinence) • Food Act 4 (food testing is conducted and documented)

Table I, Page 3 of 3

Illustrating the Ottawa Charter’s 5 action areas (WHO, 1986) in relation to a retirement village

2.2.1.1 Building healthy public policy

The first action area of the Ottawa Charter (WHO, 1986) was ‘building healthy public policy’. As noted by Baum (1998) this action area “recognises the limitations of behavioural approaches to health promotion and puts emphasis on policies in all sectors to ensure protection from disease and injury and promotion of health” (p 364). Colquhoun et al (1997) noted policy implementation is more effective when developed collaboratively with participants of the setting as is the formation of a Vision or Charter for any particular setting. Baum (1998) suggested that advocating activities such as lobbying, communities working with the local council, campaigning, media and information technology in general, can all be instrumental in policy development. Policies need to reflect health promotion activity, including the cultural needs of the setting, education and training, networking and community support, effective communication methods and a safe environment.

Aged care underwent enormous policy change during the 1990s particularly 1997 with the aged care reforms. These reforms have reflected the need of developing the skills of staff working in aged care, community participation and safer environments. The reforms also aim to promote ageing in place and quality of care through continuous quality improvement activities by aged care providers. The funding system also changed. As noted by Gray (2001) the aged care reforms “introduced a single payment system . . . [and] removed any direct regulation of the funds spent on care of residents, and moved responsibilities for spending decisions to providers” (p 84).

Following these reforms, there was much public debate regarding accreditation, aged care facility closures and the ageing population. The Federal Government announced a National Strategy for an Ageing Australia (Bishop, 1999a, 2000d) looking at ways to consider the ageing population and the effects on “economic and social issues” (Bishop, 1999a). For example, for businesses to “recognise that the economic power is moving to a different sphere” (Bishop, 2000d). Bronwyn Bishop, the then Minister for aged care suggested that the majority of older people retain their independence and remain in their own home with a minority requiring residential aged care or assistance through community aged care services. As she described the government’s policy:

Our commitment is to provide good care and services for those who need them but we also must plan for the vast majority of senior Australians who will continue to lead vital, independent lives (Bishop, 2000d).

It still remains important for all older adults to be cared for, whether at home or within an aged care environment. And it is apparent that like the rest of the world Australia has an ageing population. To maintain an ageing person’s independence within their own home or within a retirement village, it may be beneficial to provide them with preventive health services, thus reducing overall expenditure on treatment and promoting quality of care and quality of life. These issues will be discussed in greater detail in Chapter 4 – Developing healthy public policy, through the analysis of data.

2.2.1.2 Creating a supportive environment – reorienting aged care from a medical model to a hospitality model

Baum (1998) recognised that creating supportive environments involves people “work[ing] together towards collective goals” (p 392). It is also necessary to provide the means to empower the community to make informed decisions. Studies specific on the value of social support are difficult to measure. Berg (1998) recommended that

“background information and insights” (p 214) be gathered from those interviewed, and then analysed, to gain an understanding of social support mechanisms. Young and Williams (1989) identified the need for effective and supportive management practices including the provision of an environment conducive to health and one that is “attractive and welcoming” (p 24). In a retirement village this could include friendly staff and residents, and buildings and grounds that are functional, clean, tidy and offer security. A supportive environment may encourage a greater likelihood of bonds between the retirement village’s personnel, relatives and the community. It could be assumed that this bond may create a happier and healthier environment for the residents as family relationships should strengthen and the relatives will feel a greater sense of familiarity, belonging and therefore a willingness to play a supportive role and contribute to retirement village activities.

Other means to create a supportive environment may be through promoting a hospitality environment as a means to re-orient health services from a medical model to one that fosters “social interaction” (Moore, 1999, p 151) and one that promotes health and wellbeing. This may include provision of support services or services that are offered in the hospitality industry, such as accommodation that is safe, comfortable and welcoming, meals including provision of nourishment and hydration, laundry and activities. Baron (2000) suggested promoting a hospitality service within aged care. This is supported within aged care policy in the Quality of Care Principles – Aged Care Act 1997 Principles that refers to services that are to be provided to all residents including Hotel Services, Care and other Services. For example inclusion under Hotel Services included, maintenance of buildings and grounds (1.2), cleaning services (1.6), meals and refreshments (1.10), resident social activities (1.11) and

emergency assistance (1.12) (Commonwealth of Australia, 1997b, p 235-236), which indeed are consistent with a hospitality service. As noted further by Baron (2000):

At present aged care facilities use a medical model that treats a resident as a patient; that is someone in need of physical, mental and emotional assistance – a sense of helplessness. A change in focus from a medical model to a hospitality model would allow many of the problems that now exist to be addressed and a positive atmosphere to be promoted (p 20).

Problems that Baron (2000) may be referring to include incontinence, constipation, urinary tract infections, falls that may be reduced even prevented through health promotion programmes such as exercise and dietary management (Hope, 1983; and Kalache and Keller, 1999).

Improved nutrition may not only prevent falls but may provide the opportunity to stimulate social interaction if there is an “optimal group dining experience” (Bonnell, 1995, p 15). Studies by Bonnell (1995) and Moore (1999) have indicated that residents spend a great deal of their time in the dining areas, yet Moore (1999) questioned whether they are provided adequate stimulation and encouragement to socialise and spend time in activity programmes. However the retirement village that the fieldwork was conducted included a café for residents. This could be recognised as what Fletcher et al (1999) termed a ‘community cafe’, that is one that provides an opportunity for socialisation and also a means to promote healthier food choices, “nutrition education and skills” (p 6) such as having a guest speaker or a food tasting session. As explained further by Fletcher et al (1999):

Meals provided for elderly people in residential or community settings should be assessed for adequate nutritional content and acceptability to elderly people (p 6).

Nevertheless, the Village’s café that was located within the area of independent living does not require formal assessment under the current legislation, apart from the

requirement to meet the criteria of the Food Act 1984, to ensure that food is safe for consumption. But the acceptability of food within aged care facilities are accredited under expected outcome 2.10 – Nutrition and Hydration (Commonwealth Department of Health and Family Services, 1998b), however there is no set guideline on assessing nutritional content of meals. Nonetheless, the Quality of Care Principles 1997 state that meals and refreshments (Item 1.10, Schedule 1, Section 18.6) are to include “adequate variety, quality and quantity” consisting of “3 meals per day plus morning tea, afternoon tea and supper”. Fruit juice is also to be included and meals are to take into consideration dietary requirements for medical, religious or cultural reasons (Commonwealth of Australia, 1997b, p 236).

The Quality of Care Principles 1997 also stipulated that residential aged care services provide buildings and grounds that are ‘adequately maintained’ (Schedule 1, Section 18.6, Commonwealth of Australia, 1997b, p 235). Nevertheless, there are those such as Archibald, (1999), Fletcher et al (1999) and Sutherland (2000) that recommend moving beyond ‘maintenance’ to one whereby buildings are universally designed – homes that are adaptable and functional for all ages thus enabling older people to remain in their own home or unit within a retirement village; promoting ageing in place. As noted by Archibald (1999) the environment is an important aspect in aged care:

Older people deserve the best of what is left of their future and their choice of buildings should reflect the best of what they are used to or aspire to . . . Older people have time to look forward and they should be able to do so in a socially creative environment (p 106).

The provision of social activities for residents living within aged care facilities is in fact a legislated requirement under the Quality of Care Principles 1997

(Commonwealth of Australia, 1997b) and the Standards and Guidelines for Residential Aged Care Services (Commonwealth Department of Health and Family Services, 1998b). Archibald (1999), Levkoff, Berkman, Balsam and Minaker (1996) and NSW Health (1999) also recognised the importance of activities especially those that offer some form of physical activity that can help promote a healthier lifestyle, improve functional ability and even reduce the incidence of falls and fractures that often result in unnecessary institutionalisation.

Aged care facilities are often associated with institutionalisation that has created misconceptions and negative stereotyping of ageing. This stereotyping may be reduced by promoting a health promoting environment that offers older people security, companionship and support services and personnel. Setterlund (1998), Jilek (2000) and Caris-Verhallen, Kerkstra and Bensing (1999) suggested that staff in aged care facilities may be seen as a substitute family for some residents, whilst for others they may be a means for social interaction both of which promote quality of life (Moore, 1999 and Caris-Verhallen et al, 1999).

2.2.1.3 Fostering community action enabling residents and staff to retain networks and build social capital

The Ottawa Charter's action area, strengthening community action, can act as a framework for aged care facilities and retirement communities to work toward. The two could work collaboratively to enhance their services and promote greater participation and learning between age groups and cultures. As noted by Kellehear (1999), "professional work must be work 'with' rather than 'on' others . . . Health promotion should be intersectoral and involve many groups and professions" (p 12). Rakowski (1992) also recognised that health promotion is more beneficial when

aimed at the entire community rather than to those only at high-risk. Community involvement may include local schools and other educational institutions, voluntary action and inclusion of residents' relatives. Community organisations may provide education to staff, residents and their family, as well as assist with screening sessions. Projects by school children such as 'adopting a grandparent' can provide positive outcomes for both the resident and the student. For example the resident has a visitor to whom they can talk, and the student can learn a great deal from a person's lifetime experiences; it may also be an instrumental method of reducing negative stereotyping of the elderly community and a means to foster relationships between young and old.

Cox (2000) recognised that negative stereotypes may be reduced by building social capital. The term social capital is under some debate and scrutiny by health promoters. There are however those who advocate that social capital is relevant as it plays a role in health promotion activities. For example, social capital relates to collaboration and the building of trust, networks and partnerships that is necessary in the promotion of health and well-being. The debates and the concept of social capital will be discussed in greater detail in Chapter 6 – Strengthening Community Action.

Within aged care, the resident can work in collaboration with students from local schools by providing some form of voluntary service. Independent residents living within a retirement village may be able to contribute through activities such as the Learning Assessment Programme discussed by Penhall (1999) whereby people are able to assist students with their learning. Students themselves may help with the activity programme or visit and befriend a resident who may be infrequently visited, thus enabling staff to focus on other work duties (Morellini, 1999).

Cox (2000) suggested that communities with high levels of social capital are able to manage difficulties and change more effectively than communities with low levels of social capital. For example, indicators of high social capital may include effective conflict resolution methods, regular and effective meetings, community activities, participation between people, friendly interactions, safety, acceptance of newcomers (Cox, 2000) as well as participation of residents' family members.

Nevertheless, there does remain some scepticism whether the term social capital should be applied to health promoting settings as suggested by Coleman (1990 cited in Paul, 1998), "[l]ike other forms of capital, social capital is productive" (p 54), which may in fact promote further negative stereotypes of the elderly (Leeder and Dominello, 1999).

There are conflicting views with regard to whether families are adequately involved in retirement village activities, including the care of their relative (that is the resident). Kane (1991 cited in Krothe, 1997, p 221) suggested that there is a myth of family abandonment which was supported in Krothe's (1997) study which revealed frequent communication between the resident and their relative via telephone contact. A further study conducted by Higgins and Cadd (1999) that used the Critical Care Family Needs Inventory (CCFNI) tool showed that relatives wished to be readily informed and that there was a need for effective communication between the carer and the relative as the carer or nursing staff perceived that relatives did not require to be informed of the medical care. Higgins and Cadd (1999) also suggested that "lack of time may also be a significant barrier in the provision of information to the relatives"

(p 21). This latter point was evident in a qualitative study conducted by Tilse (1997) that explored family participation in six residential aged care facilities in Queensland, Australia. This study recognised that family members who act as advocates for their relative are often perceived as ‘difficult’ by staff who have limited time to discuss issues with family members. Tilse (1997) acknowledged that there are “few avenues such as support groups” for families to access (p 22). However, a further qualitative study conducted by Hagen and Gallagher (1997) showed that support groups for family members offer an “important opportunity for caregivers to learn that they are not alone . . . They can also learn specific strategies for coping with stress, anger, and grief” (p 23). Nevertheless, Setterlund’s (1998) qualitative doctoral studies revealed that staff believed families infrequently participate. This may be as a result of being unable to cope with the deteriorating physical health and cognitive ability (dementia) of their ageing relative that indicates the necessity of offering family members support groups as indicated by Tilse (1997) and Hagan and Gallagher (1997). Relatives of course may also be maintaining relationships that staff are unaware of, with communication occurring by telecommunications.

2.2.1.4 Developing personal skills

Health education plays a vital role in health promotion. Health education can include management of pre-existing conditions and preventive methods. Kelly (1989) also recognised that health-promoting programmes require to be well designed and suitable for the particular setting. This can be accomplished through networking with others in the field to identify programmes that are or have been effective. Programmes suitable for the elderly will be investigated below in further detail.

The World Health Organization – Regional Office for the Western Pacific (1996), suggested that to become a health promoting setting, it is necessary to “develop policies, practices and structures” (WHO, WPRO, 1996, p 2) to promote health and wellness within the setting. As noted by Koff (1986) policies need to focus on a wellness approach:

that recognises and pays for the skills that are an essential part of long-term care; namely, the care provided to meet the personal and social needs of the resident (p 129).

Utilising ideas from the World Health Organization – Regional Office for the Western Pacific (1996), a health promoting retirement village could possibly aim to:

- utilise a “holistic model of health which includes the interrelationships between the physical, mental, social, [spiritual] and environmental aspects of health” (p 3);
- provide a means for residents, relatives, friends and the community to be involved in health promoting activities;
- promote a healthy and friendly environment;
- utilise programmes from the local community;
- provide social and spiritual guidance to cater for individual needs;
- provide an environment which helps those that are less mentally astute; and
- provide “a positive and supportive working environment for [retirement village] staff” (p 4).

These aims provide an achievable basis for a retirement village to work toward. They will be investigated further during this thesis, however the second point – “provide health promoting activities”, will be briefly discussed in this section.

2.2.2 Incorporating health promoting programmes for a retirement village

It is necessary to offer the elderly person a multitude of services and health promotion programmes. As noted by Koff (1986) “[t]he typical long-term care services . . . usually include nursing care; rehabilitation or therapeutic services, such as occupational or physical therapy; social work, and nutritional services” (p 123). However, other services to “promote wellness, such as cultural, artistic and spiritual services . . . that might strengthen the whole person” (p 123) can also be tried.

Prior to incorporating health promoting programmes, it is necessary to identify the needs of the residents, staff and relatives and ensure that the programmes are creative for the particular setting. Kimble and Longe (1989) suggested including health promoting classes, a library facility encompassing varied resource material, support groups and group discussions, exercise classes and nutritional counselling. Other ideas could include reminiscence, general counselling, aromatherapy, dancing (as a form of exercise), food tasting, cooking for one/two, smoking cessation, stress management, safe medication usage and gardening. Health promoting programmes can target the community, staff, management and resident family and friends. Inclusion of this latter group can help to foster family relationships.

2.2.2.1 Developing a health promoting programme

Glaros (1997) noted that “[d]etermining specific characteristics of your target population . . . usually increases the appeal of your activity” with greater attendance numbers. Characteristics Glaros (1997) is referring to include “age, sex, job type, education level, income level, and marital status” (p 3). Within aged care, Glaros’ characteristics could be reviewed to be more specific to the setting. For

example characteristics could include level of independence and target specific working areas, for example care staff, domestic staff and administrative staff. Within the village setting, female residents and staff often outnumber the males. In 1996 a study conducted by the Australian Institute of Health and Welfare revealed that more than seventy percent of people living in nursing homes were women (Geriacton, 1998b, p 29). On occasions however programmes specifically for the male minority group could be offered especially programmes that are gender based for example “seminars that address prostate cancer or breast cancer” (Glaros, 1997, p 3) and other topics specific to one sex.

Kimble and Longe (1989) also suggested it may also be worthwhile to conduct market research to assess the “needs and preferences” (p 17) of the community in which the health promoting initiative is to be implemented. This may help toward reducing the risk of limited attendance and help make the health promoting setting a success in meeting the wants and needs of the community.

Prior to conducting the programme, it is always necessary to promote the session, either by “flyers, bulletin boards, e-mail, newsletters articles, banners, and other communication vehicles” (Glaros, 1997, p 11). O’Connor and Parker (1995) also suggested utilisation of health professionals from the community who will help market and promote the programme.

When developing a ‘theme’ for the programme, Glaros (1997) and O’Connor and Parker (1995) considered the use of a ‘catchy title’ to entice participation, however when dealing with topics such as ‘coping with grief’, a clear description is more

appropriate. Some interesting titles Glaros (1997) considered that are relevant in an aged care setting include ‘nuts are not what they’re cracked up to be!’, ‘summer salad celebration’, ‘walktoberfest’, ‘SOS stamp out stress’, ‘care for the caregivers’, ‘vital vitamins’, ‘bone up on osteoporosis’ and many more. Lorig (1991, cited in O’Connor and Parker, 1995, p 240) suggested ‘Growing Younger and Healthier’ compared to the title ‘Self Help for the elderly’. Prior to conducting the session, it is recommended that the topic be researched and consideration given to the timing of the event. For example scheduled events that have been organised by the community or as national events such as National Healthy Bones Week.

Another necessary point to the implementation of a health promoting programme as pointed out by Kimble and Longe (1989) is trying to achieve “the organization’s financial goals” (p 48). The organisation may be content with the programme operating “as a community service and provide no financial return” (Kimble and Longe, 1989, p 48). As has been evident in the health promoting college, a health promoting setting can be highly cost-effective in a competitive market that values high standards and progress (O’Donnell and Gray, 1993, p 33).

A study on older people conducted by Resnick (1998) to determine participation rates of health promoting behaviour revealed “relatively high compliance” with regard to vaccination. Screening activities such as mammography, pap test and prostate examination, and exercise and alcohol reduction were more evident amongst the young elderly compared to a decreased number of older elderly. Residents concluded that: “Many of the residents in the old and old-old age groups reported that they refused testing because they felt that they were too old for preventive health care” (p

151). It could be such that screening tests such as mammography and cholesterol intervention are not appropriate for the older age group due to the intrusive nature. Nevertheless, Resnick (1998) identified the need for educating the elderly as to the benefits of health promoting behaviour and the risks associated with non preventive methods. The older person can then decide on the activities that suit them.

Fiveash (1997) also recognised that programmes could also be offered to new and existing aged care staff about elderly persons perceptions and the consequences for entering aged care facilities, and insight into understanding the importance of recognising resident's individuality including culture, values and beliefs. A further suggestion by Fiveash (1997) was that student nurses "live the life of a resident for a day" (p 35). This could in fact be provided to a variety of aged care practitioners enabling them to gain insight and understanding, thus helping to reduce negative attitudes and stereotypes of the elderly.

SUMMARY

In working toward a health promoting setting, the organisation requires a commitment to the change process, allowing the people within the establishment to work collaboratively as a team to promote health and well-being. This is demonstrated within the health promoting school, hospital and workplace, described above.

The settings approach provides a basis for moving beyond the medical model toward one that is health promoting. It appears that it is even more relevant to offer health promoting programmes with our increasing elderly population to work toward a health promoting retirement village to achieve a healthier stage of life and thus

promotion of healthier ageing. Health promoting programmes such as exercise, accident prevention, education on health dying and death, medication usage, gardening, bowel/bladder management, support groups, food tasting and cooking demonstrations and nutrition, may be implemented within a retirement village allocating the necessary resources and will be investigated further during the research phase.

It is noted however that the limitation or restriction of accomplishing this goal is the pre-existing negative stereotyping of the elderly population that can be reduced or eliminated by introducing 'positive ageing' within the education curriculum both at formal and tertiary levels. The existing subject of home economics incorporates the role of family and the importance of fostering family relationships, however this is dominated by females.

Family participation in health promoting programmes and the care of their elderly parent is a vital component to the health promoting retirement village, helping to ensure wellbeing by all. This approach can be shared by the staff and community empowering each individual in the process of working toward a health promoting setting.

The following section will discuss the methodology phase in which staff and residents were interviewed and asked for their suggestions and ideas, specific to the Ottawa Charter's action areas. It is recognised that there are barriers in accomplishing the goal to move beyond the institutional or medical model of care to one that is health promoting, however by encouraging the community, residents and their family, and

the staff to work together this can, I believe, be accomplished. There appears to be a need for initial recognition of the overall benefits of working toward a health promoting setting, such as reduced depression, lower rates of staff absenteeism, reduced medication usage, increased activity, overall wellbeing by all, and so on. But, it is also recognised that there is limited research and data available, especially within the Australian context and this may be a limiting factor for initiating such programmes.

Chapter Three

Methodology

In this chapter I will describe the qualitative methodological approach used to collect, code, analyse and generate theory from the data collected from a case study of a retirement village, offering all levels of care. Nutbeam (1998) recommended a need to develop a 'national strategy' that is 'population based' or based on the settings approach specific to the elderly community. In Australia there have been a variety of qualitative studies that were discussed in the previous chapter but will also be discussed in the forthcoming chapters pertinent to the themes that emerged through the analysis of data. As a summation of these studies, there has been an objective by researchers to inform policy makers for the need to promote healthier public policy. For example, various studies have indicated a need to promote positive relationships between aged care providers, staff, residents and their relatives (Setterlund, 1998, Fleming, 1998, Tsey, Morrish and Lucas, 1998, Leong, Madjar and Fiveash, 2001 and Tan, Fleming and Ledwidge, 2001). Tilse (1997) completed a study that concluded that there is "limited acceptance" (p 22) by staff working in aged care facilities for families to act as advocates as staff had limited time to listen. Tsey, Morrish and Lucas (1998) completed a review of a 'Trainer's Manual' for the delivery of care to frail aged Aboriginal people. Tsey et al (1998) study reflected the need for policy makers to ensure resources are available and effective for culturally specific groups and ensure health professionals respect the rights of elderly people. Other qualitative

studies have recognised the need to improve social relations and interaction between staff and residents during meal times (Moore, 1999 and Bonnel, 1995).

Studying aged care with the aim of designing a health promoting setting requires some epidemiological evidence showing “disease patterns and factors that cause disease” (Baum, 1998, p 106). The research context incorporated this epidemiology through findings of the Health For All Committee (AHMAC, 1988) the Goals and Targets for Australia’s Health in the Year 2000 and Beyond (Nutbeam et al, 1993) and the general biological patterns associated with the ageing process. As noted by Kellehear (1993) research with the very old has increased partly due to the “epidemiological picture” (p 137) of an ageing society. Baum (1995, 1998) recognised that “epidemiology dominated the public health research” (1998, p 104) from its often male bio-medical paradigm that “had considerable success in developing ways of dealing with disease” (Baum, 1995, p 461) to a shift in social science oriented by females. Baum (1995) suggested that:

the medical science and social science divide is strong . . . many medically trained researchers or practitioners believe their science is the ‘hard’, ‘objective’ one while the social sciences are ‘soft’, imprecise and too subjective to be meaningful (p 460-461).

Aged care appears to be focused primarily on the medical model, however this study has aimed to promote a social perspective of aged care. The reason for this is, as noted by Duhl and Sanchez (1999):

The medical model focuses on the individual and on interventions that are used to treat disease. By contrast, a social model considers health as an outcome of the effects of socioeconomic status, culture, environmental conditions, housing, employment and community influences (p 7).

This has been possible by including not only medical staff, but also incorporating the knowledge and ideas of people associated with the retirement village, for example administrative, grounds, maintenance, domestic and food services staff who are not directly identified within what Kellehear (1999) referred to as the “institutional model of care” (p 6).

It was for this reason that a qualitative methodological approach was utilised to gain a social perspective of an aged care setting and presentation of a case study of a retirement village comprising all levels of care from independent living through to aged care facility living. Data was analysed using Glaser and Strauss’ (1967) constant comparative method of coding with data being compared, analysed, and critically examined against existing policy in aged care, particularly within aged care facilities in the Australian context. It was believed that utilising a qualitative methodological approach, would be a means of generating theory and provide policy makers with the voice of those often marginalised – the residents themselves as well as staff working in an aged care setting. Strauss and Corbin (1994) recognised the creation of theory through “interpretations ‘must’ include the perspectives and voices of the people whom we study” (p 274). Gifford (1994) further stated:

qualitative public health research has the ability to describe in depth the experiences of people’s lives and the social contexts that strengthen, support or diminish health. It has the ability to humanise the research process and to lead to context-specific strategies for individual and collective change (p 58).

3.1 Qualitative research for moving beyond the institutional model of care

This study was not about the quantity of data that could be gained, as would be required in a quantitative study. As recognised by Atkinson and Hammersley (1994) the limitation of quantitative research is its “failing to capture the true nature of human social behavior” (p 251). And it was for this reason that qualitative research was undertaken; to gain a social perspective of those that work and live in an aged care setting that has undergone enormous policy changes especially since 1997. As described by Janesick (1994) qualitative research is similar to dance, both are able to be “adapted, changed, and redesigned” (p 218) and this occurred at one stage of the study when there was an influx of media coverage relating to aged care facility closures. During this stage I was unable to conduct interviews with residents living in the facility (hostel) as they were unwilling, assuming maybe that I would close the facility. I assumed this, as the responses I had from several residents was that they did not wish to be interviewed and that everything in the Village was ‘wonderful’, and they had ‘no complaints’. The staff at this stage were also declining interviews as they were preparing for accreditation and they informed me that they did not have time. Finally, media coverage became lessened and residents within the facility began to feel happy to participate, however there remained some scepticism. It is partly for this reason that I was only able to gain four interviews from residents in the hostel. It could be suggested that this is insufficient data, however, I did interview residents living within independent units who were actively involved in the retirement village while maintaining friendships with residents in the facility. Nevertheless, it was evident that feedback from interviewing residents in the hostel was similar, and therefore the collection of the data in this location of the retirement village was at the point of ‘saturation’.

Denzin and Lincoln (1994) recognised that qualitative research can include “multiple methodologies” with the researcher being viewed as “‘bricoleur’” or “Jack of all trades” (p 2). This is a familiar term being used extensively to define home economists’ however it could be assumed that this is a complimentary term identifying the multiple skills and abilities used by researchers and home economists’ alike. Grbich (1999) identified three methodological approaches to qualitative research – “field-based, action-based and library-based” (p 10). As recognised by Kellehear (1993):

Methodological choices should complement the research questions asked, . . . but furthermore, the methods should also be sensitive to the needs and features of the respondents or social processes being studied (Kellehear, 1993, p 126).

This study was field based in which I observed and interviewed residents and staff, yet, at times, the method was also action based when working collaboratively with some of the staff such as the Catering Manager and Occupational Therapist who asked for my expertise and knowledge, for which I was happy to oblige. Field based research however allowed me to gain thoughts and ideas from those working and living in the aged care environment. It was important that the research was multidisciplinary in nature (Baum, 1998), providing a variety of disciplines to share their knowledge and “skills” (Daly, 1993, p 24) as well as being inquisitive as to the ‘conditions’ in which people work and live (Robottom and Colquhoun, 1993, p 52). The structure of the research was based on the principles of the Ottawa Charter (WHO, 1986), investigating whether aged care promotes health and wellbeing, and if it were possible to move beyond the traditional medical approach toward one that is a health promoting setting, similar to other settings such as schools, cities and hospitals.

This project consisted of a case study of one retirement village. The main methods used were participant observation and individual informal interviews. This is referred to by Fontana and Frey (1994), as a 'multimethod approach' (p 373) providing a more in-depth study.

The method of triangulation is often used in qualitative research to "strengthen" (Gifford, 1996, p 60) the research findings. Throughout the analysis, data was compared between interviews of residents and staff, between information that was collected through observation, and from the literature review. For example, there were general concerns amongst staff that there was inadequate time to complete the work required of them. This information was compared with responses from residents who also commented upon staff having less time to spend with them. For example from a resident living within the hostel: "Sometimes I think they are a bit short staffed. I mean they are running sometimes" (HR3-02.11.00). And from staff, first, an activity staff member commented: "I haven't got enough time to do all of the documentation. I know it has to be done but it is very difficult trying to juggle both" (ACT3-07-12.00). And second, the Physiotherapist made a similar comment with regard to limited time: "I don't have the time now. The Resident Classification Scale have affected this – I just don't have the time" (PHYS1-12.10.00). Literature, for example from Professor Len Gray's 'Two Year Review of aged care reforms' (2001), admitted to voiced concerns by stakeholders that the reforms had seen a decrease in staffing, but data was unable to confirm this information. During the observational stage of the fieldwork, staff were never seen to be sitting idle and always appeared busy, with interviews often taking place during lunch breaks or after work. This is just one example of the method of triangulation which occurred throughout the

analysis of data. I believe, on reflection, that this method was easier to accomplish as I had personally typed up each interview and coded immediately, allowing the interviews to remain focused in my mind. I would suggest for other researchers that are not using a qualitative computer programme to analyse data, that they also are able to transcribe interviews, ensuring greater success with the research findings and analysis.

Fontana and Frey (1994) presented other suggestions for successful research, for example, presenting oneself appropriately to the field and establishing rapport with the respondents. I consider having worked in the field of aged care with a variety of models from those that offer a continuum of care, to those that offer only the one level of care (such as hostel – low level care, or nursing home – high level care), has provided an insight and understanding of this setting prior to the fieldwork, and thus benefited successful progression of the research.

The fieldwork in the retirement village lasted nine months with data being gained and analysed throughout. Prior to commencement however, it was necessary to conduct some preliminary work.

3.2 Preliminary fieldwork

This study was commenced in 1998, a time when there were numerous changes within the aged care sector; the Coalition Government had introduced aged care reforms of 1997, and aged care was highlighted within the media. Nursing homes and hostels had become amalgamated and were to be referred to as aged care facilities and older people living within these residences were categorised according to their level

of care needs as per the Resident Classification Scale. There was also emerging policy to promote ageing in place, whereby older people were being encouraged to remain in their own home – age in place, and utilise community services as required.

At the time and throughout the study, I was working as a consultant for retirement villages and aged care facilities, working with residents, staff and management. I also completed the Aged Care External Assessor Training Programme in 2000, enabling me to gain further insight into the accreditation system. During the latter stage of my research, I transferred from the University of Ballarat to Victoria University to enable continuance with my supervisor, Derek Colquhoun.

Whilst working in aged care, and experiencing the changes at first hand, I became increasingly interested in pursuing research within the Australian context, particularly in aged care that offered a continuum of care and various support services for residents living within independent units through to high level care (nursing home). It was particularly important to listen and gain ideas and comments from those living and working in this setting, as they can remain unheard but may have a great deal of experience and knowledge to share, thus furthering knowledge. As Koch (1998) recognised: “voices of those marginalised [the elderly] in our culture need to be heard” (p 1186). This was further supported by a study conducted by Krothe (1997) which revealed that elderly people are often not consulted with regard to decisions and suggested that “policy should be formulated based on input from those directly affected”. Research processes such as that conducted by Krothe (1997) “allowed their voices to be heard” (p 223) as does grounded theory that has provided a means for

policy developers to hear the “voices of the people” (Strauss and Corbin, 1994, p 274) through a social perspective as was the case with this research.

Prior to conducting the fieldwork, it was necessary to locate a suitable retirement village, and one that was agreeable to having research conducted with its staff and residents. Ethics approval also had to be gained prior to commencement. A set of criteria were established prior to locating this village and these included being within a 50 kilometre radius of the City of Melbourne, a village offering a continuum of care and one that catered for residents’ nutrition and hydration needs. This latter point was important on a more personal note, being a home economist and consultant nutritionist, and recognising the benefit of good nutrition to the overall health benefits of residents. As a home economist I observe the benefits of a home environment including provision of home cooked meals, and the need to maintain family and community relationships. These issues will be discussed throughout the analysis of data.

From the literature review and from my experience working within various models of aged care, I believed that it was advantageous that the Village provide a continuum of care with one that offers elderly people independent units, and a facility offering low and high level care. For an older person the opportunity of maintaining a home for life or continuance of care is a preferred option to the type of care whereby the person is required to move to an outside facility that offers the required service. It is recognised by various researchers (Manning cited in Wilson, 1984, Braithwaite et al, 1993 and Krothe, 1997) that moving residents from one level of care to another is not recommended (discussed further in Chapter 5). Braithwaite et al (1993) for example

suggested that: “moves amongst nursing home residents are associated with increased morbidity and mortality” (p 63), whilst Manning (cited in Wilson, 1984) recognised that moves generally come at a time when residents are unable to cope with changes as they “are ill-equipped, through sickness, mental state, [and] advanced age and frailty” (p 87).

3.2.1 Selection and description of the retirement village

In locating a suitable retirement village, I contacted the Department of Veterans’ Affairs (DVA) via telephone and provided an explanation of the research process. The DVA was chosen as a starting point due to its relationship with elderly persons and its pro-active role in recent health promotion programmes. For example in 1997, the Commonwealth Department of Veterans’ Affairs produced a resource kit ‘The Better Living Package for the Veteran Community’ focusing on the development of health promoting programmes between 1997 and 1999 and utilised the Ottawa Charter in describing methods toward accomplishing the DVA’s goals (Commonwealth Department of Veterans’ Affairs, 1997). A further health promotion project was developed called ‘Choose Health!’ a strategic five year plan for the veteran community (Commonwealth Department of Veterans’ Affairs, 2001).

The Department of Veterans’ Affairs were able to assist in the selection of a setting, which I followed up immediately with a letter of introduction and a brief description of the research. Luckily, the Village accepted my proposal. The retirement village referred to throughout as the ‘Village’ was slightly further than the anticipated 50 kilometres and was in fact within a 60 kilometre radius of the City of Melbourne, Victoria. Nevertheless, the Village provided a continuum of care, with residents

being offered independent units, low level and high level care. Its site encompassed approximately four hundred self-contained units and a one hundred and eighty bed facility (low level and high level care). These buildings were set amidst about sixty acres of parkland and landscaped gardens, including vegetable and flower allotments, greenhouses and workshops. Residents within the self-contained units had their own small garden, amenity buildings that offered the services of a 'Hostess' as well as a kiosk and indoor activities (billiard tables and library). There was also access to lawn bowls, a croquet lawn and a once weekly visiting fruit and vegetable van.

Residents living within the facility also had the man from the fruit and vegetable van visiting the facility and there was also a kiosk. Residents had all meals provided with breakfast delivered to their room and lunch (12 noon) and dinner (5 pm) meals served in the communal dining areas. Residents were also provided laundry and cleaning services, as well as personal care dependent upon their level of care needs. Many of the facility units were surrounded by landscaped gardens including water gardens. Within the facility there was a craft room, library and billiard room, and a physiotherapy room.

Throughout the Village, residents had access to a hairdresser, doctor's surgery, and chapel all of which were located in close proximity to the facility. There was also a café however this was utilised mainly by independent residents, with independent residents also having the ability to order meals from the facility Food Services Department.

The Village also provided a service to the local community offering home care or domestic services and promoted itself as a community and not as an institution. Residents were offered a transport service around the Village and to the local shopping centres. Staff and services were available to all residents, with the Village Nurse service mainly available for residents within the self-contained units. All units had a 24 hour emergency call system.

3.2.2 Ethics approval

It was necessary to protect the privacy of each individual in this study, especially residents' themselves who are often categorised as a vulnerable group within society.

As recognised by Baum (1998):

Since the formation of the Medical Research Ethics Committee of the National Health and Medical Research Council (NH&MRC) in 1982, there has been increased concern with the ethics of medical and public health research (p 113).

I was fully aware of this, yet my experience in this field helped ensure that participant's would not be affected or harmed. In fact, interviews were conducted informally, and appeared to be enjoyed by residents as well as by staff. Residents seemed to enjoy the conversation with some participants thanking me and inviting me back. For staff, it allowed them to speak about issues to somebody that was an outsider and one that was neutral. The Human Research Ethics Committee and the University of Ballarat, provided ethics clearance at meeting number 99/EM13 (Project Number 457). Following ethical approval I gained permission from the General Manager of the retirement village prior to commencing the fieldwork.

3.3 Collection of data by means of a case study

On entering the field, I was asked to attend a meeting between the General Manager, the Director of Nursing, the Catering Manager and the Village Co-ordinator to discuss the research plans in greater detail. During these discussions, it became evident that the 'cost' of gaining access to the Village, was that I acted as a 'free' consultant, nevertheless, the Village was an ideal setting for this study.

On commencement of the fieldwork, I was given a tour of the grounds and then introduced to the Village Nurse/Education Co-ordinator who asked that we plan two education sessions. Sessions were organised in the initial period of the fieldwork, enabling me to meet with prospective interview candidates as well as for the Village to gain further knowledge on issues relating to health and nutrition for the elderly. A number of residents attended including residents from the facility and independent units. All staff were invited to attend, and consisted of activity staff, Food Services staff and Domestic staff, but unfortunately Clinical staff did not attend. I did offer to conduct a further session for Clinical staff, however the Director of Nursing did not respond. These sessions allowed me to feel comfortable within the setting, and gain some further insight and understanding to the organisational structure and I was therefore able to comfortably commence the case study of this retirement village.

A case study of a retirement village setting was used as a means of gathering information on the retirement village community allowing me to "effectively understand" (Berg, 1998, p 212) the operations of this setting. As defined by Berg (1998):

Case studies of communities can be defined as the systematic gathering of enough information about a particular community

to provide the investigator with understanding and awareness of what things go on in that community; why and how these things occur; who among the community members take part in these activities and behaviors, and what social forces may bind together members of this community (p 219).

Throughout data collection it was through these principles that guided the fieldwork. By investigating the interrelationship of the policies, practices and the people, enabled me to gain an ‘understanding’ (Stake, 1994, p 238) of the setting. This case study was what Stake (1994) referred to as ‘unique’ (p 238) as each retirement village has a population of different people as elderly people are all individuals with different cultures and backgrounds, and all have differing needs according to their ability and level of dependency. This study also provided an understanding as to the retirement village setting, the policies that govern it, the limitations, and the practices that are effective, which may be used in further research and for policy developers to consider future development and design of care for our ageing population. This case study was carried out in two main stages, that is participant observation and informal interviewing techniques.

3.3.1 Entering the field

By meeting with the General Manager and some of the Department Heads, as well as through conducting the education sessions, I entered the field as an overt researcher; that is one who is “announced” (Berg, 1998, p 124). After working in this field I understood the importance of being truthful and open with residents, as they are comforted by truth and I also respected that this was their home which I would be visiting for a period of time. I genuinely believed that through working in the field and from the literature review that this research will ultimately benefit the aged care community and those associated with retirement villages. At no stage did I intend to

“abuse the rights and privacy of the research subjects” and in fact gained “rapport” (Berg, 1998, p 125) with many of the participants including both staff and residents. A number of researchers such as Glaser and Strauss (1967), Taylor and Bogdan (1984), Janesick (1994) and Berg (1998) have recognised the importance of gaining rapport with the research participants. For example Janesick (1994) stressed the importance of “establish[ing] trust, rapport, and authentic communication patterns with participants” (p 211) in the initial stages of the study, thus ensuring greater productivity. And as described further by Berg (1998):

[k]nowledge about the people being studied and familiarity with their routines and rituals facilitate entry as well as rapport once entry has been gained (p 130).

Taylor and Bogdan (1984, p 36-38) identified methods to build rapport when entering the setting, for example offering assistance and being involved in daily routines; being interested in what people have to say; being an equal and establishing a common ground. I did this to a certain degree by providing education sessions and providing professional advice to management and staff. Also as an aged care worker myself, I have the advantage of meeting this latter guideline and believe I have some understanding of the daily routines of residents and staff; as an assumption, residents enjoy visitors, and staff are content with a helping hand. Also as noted by Taylor and Bogdan (1984) support is important, however it is also important to not over commit and identify “where to draw the line” (p 38). And this I did when staff began to recognise my ability as a nutritionist, having assessed a couple of their residents, and requests from staff started to escalate. I decided to discontinue assessing residents and reiterated the purpose of the study with the Director of Nursing, which was effective.

On entering the field, I followed Berg's (1998) method, which was to first, orient myself to the surroundings whilst writing notes to "describe the setting" (p 142). I had access to internal policy and procedure manuals and other organisational documentation that helped with this process. The second step was to introduce myself to staff and residents in order to develop relationships with retirement village personnel. And third, once the surroundings and people became familiar, I was able to conduct initial observations asking questions as they arose.

3.3.2 Participant Observation

The qualitative observational paradigm included interaction amongst residents and staff, referred to as participant observation, enabling me to experience the day to day life of residents and staff at work. As noted by Hammersley and Atkinson (1983 cited in Denzin and Lincoln, 1994):

social research is a form of participant observation, because we cannot study the social world without being part of it (p 249).

Adler and Adler (1994) identified that gathering data through observation includes not only sight but also "smell to hearing, touch, and taste" (p 378). For example through working in the field of aged care, one hears comments from visitors of the distinctive odour that permeates some nursing home establishments. This was not evident throughout the entire fieldwork, with the environment either smelling of home cooked meals or smelling fresh when in resident rooms or in communal areas.

During the stage of participant observation, participants were also categorised (Berg, 1998) as to their location or role within the retirement village. This enabled identification of themes that emerged with the various groups, for example, staff from various departments or residents from either independent living or from the facility

(that is the hostel). The following categories were made and were used within the analysis, as per the brackets:

- i) independent residents residing in units (IR)
- ii) residents in hostel (low level care facility) (HR)
- iii) staff:
 - Village Nurse (VN)
 - Personal Care Assistant (PCA)
 - Activity staff (ACT)
 - Registered Nurse (RN)
 - Food Services staff, including Catering Manager and Cook (FS)
 - Gardener (GARD)
 - Maintenance Manager (MAIN)
 - Resident Co-ordinator (ResCo)
 - Occupational Therapist (OT)
 - Physiotherapy Assistant (PHYS)
 - Hostess (HOST)
 - Director of Nursing (DON)

Initial observation of these groups, as well as the surrounding environment were conducted in the initial stages of the study with field notes, usually recorded on a microcassette recorder documenting information relating to the Ottawa Charter's five action areas (WHO, 1986) which were used during the analysis. As noted by Taylor and Bogdan (1984) and Berg (1998) it was necessary to record events immediately, ensuring greater accuracy. These tapes were then transcribed onto the computer. As noted further by Taylor and Bogdan (1984) it is important as an observer to "[w]atch,

listen [and] concentrate” (p 54) to gain accurate notes and recollection of events. Once I felt the observational stage was complete, due to no new information being collected, as well as feeling familiar with the surroundings and people, interviews commenced, however observation and field notes were continued throughout the fieldwork.

3.3.3 ~~Informal~~ ^{Semi-structured} one-to-one interviews

Interviews are a means of “getting information” (Berg, 1998, p 57) through the method of conversation. Easton, McComish and Greenberg (2000) presented three common pitfalls that can occur during the collection of data – equipment failure, environmental distractions and errors occurring during the transcribing of interviews. These pitfalls will be discussed below in context with the method of data collection. Taylor and Bogdan (1984, p 94-96) presented suggestions for successful interviews. First, to be non-judgemental and appreciate each person as an individual. Second, to allow sufficient time to conduct the interview, as there may be instances where a person wants to talk however information may not necessarily be related to the research. Third, for the researcher to show interest and enthusiasm for the responses. Fourth, to be friendly and sensitive whilst clarifying details. And finally, as already noted above, by establishing a rapport between the interviewer and interviewee (Taylor and Bogdan, 1984, Bailey, 1987 cited in Grbich, 1999, p 90-91, Janesick, 1994 and Berg, 1998).

As already discussed above, sampling in qualitative research is not about the ‘size’ of the sample but to gain an understanding of the setting (Gifford, 1996, p 59). Gifford (1996) stressed the importance of identifying “the logic underlying the sampling

strategy employed” (p 59), and it was for this reason that I attempted to gain a variety of perspectives and ideas from a varied sample, and continued the interviews until the information became repetitive. That is, interviews were providing similar feedback, as noted by Morgan (1997), this is the point of “saturation” (p 43), evidence to suggest that adequate data had been gained.

Interview sampling strategies were by both random and snowballing method, for example, when conducting the education session I asked whether participants would like to be interviewed and if so, to inform me, and at other times, staff and residents suggested others that would like to be interviewed.

There are different types of interview structures that can be used in qualitative research – structured (standardised or formal), unstructured (informal or unstandardised), semi-structured and group interviews (Fontana and Frey, 1994 and Berg, 1998). Semi-structured interviews were conducted with all participants, including staff from various disciplines and residents from the low level care facility and residents from independent units, thus hoping to achieve a holistic comparison of ideas. Bernard (1998) recognised that the benefit of semi-structured interviews is that they provide “a written list of questions and topics that need to be covered” (p 205). In this case study, it was necessary to relate the questions to the Ottawa Charter’s five action areas (see Appendix One). Lofland (1976 cited in Bernard (1998, p 207) suggested:

If you can carry on “nonthreatening, self-controlled, supportive, polite and cordial interaction in everyday life” then interviewing will come easy to you, and informants will feel comfortable responding to your questions.

Interviewing did ‘come easy’ to me, having worked in this field, speaking to both older people and staff in aged care. Nonetheless, interviews require a great deal of concentration while showing interest and as Bernard (1998) recognised having to remain focused on the topic being asked.

Broad based informal questions relating to the Ottawa Charter’s five action areas were developed during the observational stage of the fieldwork and were asked to both staff and residents. Other questions were asked to participants specific to the person’s role within the Village and in response to their comments. Prior to commencing interviews, participants were asked to sign a consent form. Hatcher, Macdonald, Bauer, Wilson (1999) experienced difficulty when residents were asked to sign consent forms prior to commencing a study on ‘hope’. Residents required “assurance that their words and thoughts would remain confidential and that they would not suffer any negative consequences as a result of participating in the study” (p 8). This was not evident in this study from residents living within independent units, however, residents living in the facility voiced some concern, especially during the period of media attention relating to aged care facilities facing the prospect of closing down. I reassured residents by talking about my work as a nutritionist, and as a means of “opening up the conversation” (Hatcher et al, 1999, p 8). I commenced the interviews by asking residents how long they had lived in the Village. Similarly for staff, I asked how long they had worked in the Village and their role.

Easton et al (2000) suggested that problems that can occur during interviews are from distractions in the environment. There were no environmental distractions as Easton et al (2000) referred to for example, there were no telephone or other interruptions.

This can be contributed to the fact that all interviews were conducted in an area conducive to the participant, either in the comfort of the residents room or unit, while staff were interviewed in a vacant quiet room. As noted by Lusardi (cited in Hunter et al, 2002): “meaning making in qualitative work is an awareness of one’s own worldview and perspectives while in dialogue with persons in their natural setting” (p 389). Understanding made possible through my own knowledge and experience working within aged care, enabled the interviewee’s to feel comfortable and confident with the interview process, thus yielding richer, reflective data. Hall and Callery (2001) noted further:

Reflexivity, which addresses the influence of investigator-participant interactions on the research process, and relationality, which addresses power and trust relationships between participants and researchers, have the potential to increase the validity of the findings (p 258).

Easton et al (2000) recommended that the interviewer states “the length of time” (p 705) of the interview and I did this when making an appointment to talk with the person. The length of interviews was on average between forty-five to sixty minutes, with a few staff members wishing to talk longer, up to one and a quarter hours. Easton et al (2000) recognised that equipment failure can present immense problems during interviews. All interviews were tape recorded on a microcassette tape recorder. I always carried extra batteries and tapes, however, on one occasion following an interview with a resident living in the hostel, I commenced transcribing the data to find poor sound quality that was so inaudible that I was unable to pursue with this interview data. All interviews were transcribed by myself, which definitely was beneficial as interviews remained clear, making data analysis easier and probably richer. Easton et al (2000) recognised that the final type of error that can occur during

collection of data is during the transcribing of interviews. Easton et al (2000) recognised:

A common type of error involves the misinterpretation of a word, or mishearing of a word, on the part of the person transcribing the tape (p 706).

I had decided to transcribe all interviews to reduce and eliminate the occurrence of such events. I also included the detail that Easton et al (2000) recommended, such as words that were emphasised during interview were underlined and if the person laughed this was indicated within the data.

A total of thirty-one people were interviewed, eight of whom were residents from independent living, four residents from the hostel and nineteen staff. The proportion of residents from the hostel was small as a consequence of their unwillingness to participate, their level of care needs, and it was believed the point of saturation was reached. Staff were interviewed from various work environments and disciplines including clinical staff (Personal Care Assistants, Village Nurses, Registered Nurse) as well as the Director of Nursing, Food Services Staff (Catering Manager, Cook of the café, and Food Services Assistants), and staff from grounds and maintenance, administration, activities, and allied health (Occupational Therapist and Physiotherapy assistant). Once interviews were transcribed, they were returned immediately to the respondent for verification. Only one interview was returned to me for changes, however these were mainly grammatical and not contextual (see Table II for list of persons interviewed). A brief overview of the roles of staff interviewed follows.

Location within Village		Codes used throughout analysis
1.	Independent resident (1)	IR1-17.02.00
2.	Independent resident (2)	IR2-17.02.00
3.	Independent resident (3)	IR3-22.02.00
4.	Independent resident (4)	IR4-26.02.00
5.	Village Nurse (1)	VN1-26.02.00
6.	Hostel Resident (1)	HR1-04.03.00
7.	Independent resident (5)	IR5-11.03.00
8.	Personal Care Assistant	PCA1-04.03.00
9.	Activity staff (1)	ACT1-11.03.00
10.	Registered Nurse	RN1-11.03.00
11.	Food Services Assistant	FS1-01.04.00
12.	Independent resident (6)	IR6-08.04.00
13.	Independent resident (7)	IR7-08.04.00
14.	Hostel resident (2)	HR2-08.04.00
15.	Independent resident (8)	IR8-04.05.00
16.	Catering Manager (Food Services)	FS2-18.05.00
17.	Gardener	GARD1-24.05.00
18.	Maintenance Manager	MAIN1-01-6-00
19.	Resident Coordinator	ResCo1-01-6-00
20.	Village Nurse (2)/education co-ordinator, Occupational Health and Safety rep.	VN2-02-6-00
21.	Occupational Therapist	OT1-02-6-00
22.	Activity staff (2)	ACT2-05-7-00
23.	Chef of facility Food Services	FS3-13-07-00
24.	Cook, village café (Food Services)	FS4-19-07-00
25.	Food Services Assistant	FS5-19-07-00
26.	Physiotherapy assistant	PHYS-12-10-00
27.	Hostel resident (3)	HR3-02-11-00
28.	Hostel resident (4)	HR4-02-11-00
29.	Hostess for independent residents	HOST1-02-11-00
30.	Director of Nursing	DON1-07-12-00
31.	Activity staff (3)	ACT3-07-12-00

TABLE II
List of Interviews conducted during the fieldwork

Director of Nursing

The Director of Nursing had direct responsibility for all residents within the entire Village, including those in the facility and independent living, and to staff. She was provided the support of a Deputy and department heads. She had been working in this role for 12 years and as she explained during interview, she had seen “enormous

changes”. Just prior to the interview, the Director of Nursing had resigned from her position expressing it was time for “somebody younger with fresh blood” to enter the role which had become “much more administrative”, preferring the past role of having people contact.

Occupational Therapists

There were two part time Occupational Therapists employed to work within the facility. They were relatively new to the organisational structure having been recruited 9 months prior to interview. I shared an office with them and in fact helped them with ideas and suggestions, such as with complications associated with dementia and mealtime issues, as well as types of assistive devices that are effective. Their role was one that utilised their Occupational Therapy skills; assisting residents to maintain their independence. However they were also asked to assist with the facility activity programme to ensure residents’ needs were effectively assessed, reviewed and evaluated. They were also developing the volunteer programme and were at the stage of recruitment during the latter stage of my fieldwork.

Activity staff

Three activity staff were interviewed, two having worked in the Village for over 10 years and one who had worked there for 3 years. These staff were responsible for providing residents within the facility with a social programme encompassing craft, games, outings, exercise including Tai Chi, sing-a-longs, entertainment, food tasting and bingo. The majority of the activity programme was funded through fundraising activities. Activity staff were not qualified Diversional Therapists and were therefore overseen by the recently appointed Occupational Therapists who were employed to co-ordinate and organise the activity programme.

Village Nurses

Two Village Nurses were interviewed both having worked in this role for 15 and 16 years, with one of these women having the recent role as education co-ordinator, organising education according to staff needs. I believed after observing these women at work and having heard a number of independent residents' speaking so highly of these staff, that it was necessary to gain their insight. Having analysed the data, the Village Nurse position appears to be one of great importance and one that is unrepresented. The team of Village Nurses were all Registered Nurses and their role was to provide nursing care to residents living within independent units and at times assisting in the facility. Their workload apparently was increasing with the independent resident population ageing and thus becoming increasingly frailer.

Catering Manager and Food Services staff

The Catering Manager was a qualified Chef and was responsible for the day to day running of the Food Services Department. Her job like that of the Director of Nursing had recently become focused on administrative duties to meet the needs of accreditation. Her role prior to this was working amongst the Food Services staff helping to develop their catering skills. I spent a considerable amount of time interviewing and talking with Food Services staff as this is an area that I have worked in, and enjoy passionately. I was able to provide ideas and advice, for example, regarding dietary management and delivering the inservice on health and nutrition. The Food Services Department catered for all residents living within the facility, and preparing approximately 30 meals for residents living within independent units. This latter number was steadily increasing from an increasing older and dependent population.

Hostess

The Hostess was responsible for general assistance and acted as the receptionist for residents living within independent units. She had been employed for almost 3 years and her duties included organising maintenance/repairs/gardening for the residents through the Maintenance Department, collecting money, answering concerns, sorting mail and other administrative tasks specific to residents within independent living.

Maintenance and Grounds staff

The qualified Gardener was a recent addition to the Village having been with the organisation for only 9 months. She was responsible for the Village grounds around the units and facility and was accountable to the Maintenance Manager. Since her position was within this Department, she was expected to not only maintain and design the gardens, but also to help move furniture and clean gutters for independent residents. She was the youngest staff member interviewed being in her early 20s, with the Maintenance Manager being one of the oldest at around mid 50s. He was also fairly new to the Village having been employed for 2 years. His role was to manage the maintenance and gardening Department and the staff who did building, maintenance and gardening for the facility and independent areas. One of his staff also had the responsibility of driving the Village bus around the grounds and for transporting residents to the local supermarket and shopping centres and taking them on mystery trips.

Physiotherapy Assistant

The physiotherapy assistant referred in the analysis as the Physiotherapist was a State Enrolled Nurse who worked with the physiotherapist. The physiotherapist developed individualised programmes and the physiotherapy assistant conducted the sessions. The 'Physiotherapist' as I have referred to her, had worked for the Village for almost 7 years. A physiotherapy room was available for residents, however this programme was not offered to residents living within independent units, but only to facility residents.

It was felt that qualitative research was the ideal methodological approach in this study as this approach has become increasingly popular in the field of health promotion and public health. Qualitative research as noted by Gifford (1996) "has the ability to humanise the research process and to lead to context-specific strategies for individual and collective change" (p 58). Both these concepts were important as I wanted to provide a voice for the people that work and live in aged care. It is anticipated that some form of change, may eventuate within the retirement village environment from the current medical model to one that works toward being a health promoting setting.

3.4 Data analysis using the constant comparative method

Qualitative research is often labelled "unreliable" (Kellehear, 1993, p 127) as it is not presented by statistics as in quantitative research but is "presented in words" (Daly, 1993, p 30). Easton, et al (2000) also recognised that qualitative research methods can be criticised "for the subjective nature of data collection and analysis. Although qualitative methods. . . [can] yield rich, extensive data" (p 703). As indicated above,

data was collected from a varied sample of those working and living within the retirement village. Glaser and Strauss (1967) noted the importance of ‘comparing’ the data from these groups or sub-groups. Within the retirement village, groups included residents from independent living, residents from low level care (hostel), and a variety of staff.

Qualitative research can be analysed by a variety of approaches, all however having some degree of interpretation. This research utilised Glaser and Strauss’s (1967) concept of grounded theory or building theory through the constant comparative method of data analysis enabling policy makers to hear the ‘voice’ of those living and working in a retirement village, and to generate theory from the data. As stated by Glaser and Strauss (1967):

The purpose of the constant comparative method of joint coding and analysis is to generate theory more systematically. . . theory that is integrated, consistent, plausible, close to the data (p 102-103).

The constant comparative method required that data be analysed on an ongoing process, which allowed the “research design to emerge over time” (Maykut and Morehouse, 1994, 123). The data were coded and then categorised into the Ottawa Charter’s four action areas. It was imperative that interviews and observational notes were transcribed and coded immediately, ensuring that the data were more manageable, as this method of analysis is time consuming and requires a great deal of organisation and concentration. As noted by Marshall and Rossman (1989) the constant comparative method is a:

process of bringing order, structure, and meaning to the mass of collected data . . . Qualitative data analysis is a search for general statements about relationships among categories of data (p 112).

The constant comparative analysis method combines a number of steps or stages from coding raw data through to the finished written product and a sophisticated understanding that hopefully may lead to further research.

3.4.1 Stages of the constant comparative method

Field notes through the observational stage and throughout interviews were coded (see figure 3.1), categorised, compared with other data with themes and sub-themes emerging. Comparative analysis is useful in both large and small scale research (Glaser and Strauss, 1967) and involves a lengthy process of collecting and coding of data, however Berg (1995) justified this by making similarities between coding and a jigsaw puzzle:

As researchers move through the coding process and begin to see the puzzle pieces come together to form a more complete picture, the process can be downright thrilling. Time consuming, tiring, and even laborious as the process is, it is seldom boring (p 180).

Glaser and Strauss (1967) identified four stages of the constant comparative method (See Table III for a brief summation). The first stage is to code each incident of the data which may be done in the margins or “more elaboratively” (p 106). This latter concept was referred to by Lincoln and Guba (1985) as ‘unitizing’ – a process whereby coded data is cut and pasted onto cards, with an indication of where this information has been found. I utilised a similar process with field notes and interviews being transcribed onto the computer with two columns whereby themes and codes could be written. I then cut and pasted coded data from the original documents onto separate files, indicating the source of data, for example ‘DON’ (Director of Nursing) or ‘IR (Independent Resident), allowing comparisons to be made. (See figure 3.2 that demonstrates the document known as ‘documentation’

with data from interviews of the Village Nurse, activity staff, independent resident and Registered Nurse). The original transcripts were kept so that they could be revisited as suggested by Maykut and Morehouse (1994) “should further clarification of meaning be needed” (p 129). As noted further by Maykut and Morehouse (1994):

Careful attention to recording the source of all data pages early in the data collection and analysis process will allow you to return to the original data set when necessary (p 128).

Glaser and Strauss (1967) also explained the “defining rule for the constant comparative method”:

while coding an incident for a category, compare it with the previous incidents in the same and different groups coded in the same category (p 106).

As noted further by Glaser and Strauss (1967): “This constant comparison of the incidents very soon starts to generate theoretical properties of the category” (p 106). At this stage Glaser and Strauss (1967) identified the need to “‘stop coding and record a memo on your ideas’” (p 107). Memo’s or ‘theoretical notes’ as defined by Berg (1995, p 187) provide written ‘ideas’ that may eventuate in development of theories at a later stage of writing up the findings. For example, it became increasingly evident that staff did not have enough time as a result of increasing documentation requirements for both accreditation and funding purposes through the Resident Classification Scale (RCS).

Stage two of the constant comparative method involves ‘integrating’ and ‘refining’ categories. For example, within the Ottawa Charter’s action area – building healthy public policy, data that had been coded as ‘documentation’, ‘accreditation’ ‘time’ and ‘care’ were integrated. Staff discussed the difficulty in balancing resident care with documentation required for funding and accreditation purpose, while residents

themselves recognised that staff appeared to ‘be running’ and that they had other work commitments (see figure 3.3).

INTERVIEW – VN1-26.02.00		
Interview	Theme	Code
Data	No education regarding RCS	Policy / Education
Data	Increasing stress on staff with accreditation	Accreditation
Data	Perceived as part of team	Team
Data	Poor communication between dep'ts	Communication

FIGURE 3.1
Demonstrating coding of individual interviews

DOCUMENTATION	
Interview / obs	Code
Data	VN1-26.2.00
Data	ACT2-5.7.00
Data	IR6-08.04.00
Data	RN1-11.03.00

FIGURE 3.2
Stage One of the Constant Comparative method (Glaser and Strauss, 1967)

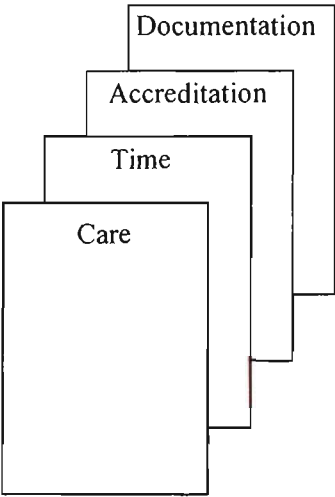


FIGURE 3.3
Stage Two of the Constant Comparative Method (Glaser and Strauss, 1967)

Stage 1	Coding into different categories	30 plus categories: funding, policy, skills, meetings, socialisation, relationships, communication, education, volunteers, school/children, family, gardening, maintenance, meals/diets, community, activity, support, pets, team, frailty/dependency, care, stereotyping, documentation, accreditation, media, time, environment, medication, services
Stage 2	Integrating categories	Building healthy public policy – accreditation, time, documentation, care, Resident Classification Scale, policy, funding, stereotyping
		Creating supportive environments – relationships, gardening, maintenance, meals/diets, activity, support, frailty, services
		Strengthening community action – volunteers, school, family, community
		Developing personal skills – skills, meetings, communication, education, team
Stage 3	Delimiting and further integration	See table IV below
Stage 4	Presented thesis	As per chapters 4-8 and concluding chapter relating to the Ottawa Charter's fifth action area, re-orienting health services

TABLE III
Stages of the constant comparative method
utilising Glaser and Strauss (1967) method, in the formation of:
‘Towards the health promoting retirement village: A case study’

The third stage involved reducing these categories by a method of further ‘integration’, or as Glaser and Strauss refer to as ‘delimiting the theory’ (p 109-113). For example, continuing the example above, led to the development of chapter 4 – Building Health Public Policy in an aged care setting (see Table IV). This stage enabled greater ‘focus’ on the Ottawa Charter and it was evident that a point of saturation had occurred in which similar responses were identified from the data. Data were then organised into chapter headings and sub-headings.

This then led to the fourth and final stage of the constant comparative method allowing for the writing up and completion of the thesis, and integration of the literature through the analysis. As recognised by Glaser and Strauss (1967), generation of theory requires “reflection” and “uninterrupted quiet” (p 72) and will be presented as a discussion within the research findings. Hunter, Lusardi, Zucker, Jacelon and Chandler (2002) recognised the importance of allowing the researcher to be immersed in the data and referred to this stage as the “incubation” phase of qualitative research. This is the stage when the researcher is able to ‘live and breath’ the data, trying to “understand its meanings, find its patterns, and draw legitimate yet novel conclusions” (p 389). As further noted by Glaser and Strauss (1967) grounded theory “is written with the assumption that it is still developing”:

The discussional form of formulating theory gives a feeling of “ever-developing” to the theory, allows it to become quite rich, complex, and dense, and makes its fit and relevance easy to comprehend (p 32).

Discussional grounded theory is often utilised in research that is exploratory in nature, which has been the aim of this research – exploring the settings approach and its utilisation in an aged care or retirement village environment. The method of constant comparative analysis has provided theory from other health promoting settings to be used in combination with data obtained through the case study to generate further theory or to ‘elaborate’ or ‘modify’ existing theory (Strauss and Corbin, 1994, p 273).

Main themes	Sub-themes
Chapter 4: Building healthy public policy in an aged care setting	<ul style="list-style-type: none"> • The accreditation process • The negativity of accreditation • Positive attitudes to accreditation • The RCS and the effect on care time • Time constraints • Diversity amongst staffing • Changes in legislature: what it means to staff and residents • The threat of closure
Chapter 5: Creating a supportive environment through the provision of support services and personnel within the Village	<ul style="list-style-type: none"> • The Villages Food Service for facility and independent residents • Menu development and dietary needs • Food wastage and risk of food contamination • Oral health and the negativity of vitamised meals • On-site café available for meals, socialisation and entertainment in a home like environment • Gardening services • Emergency buzzers • Repairs and maintenance • Village bus – transport service • Activities organised for facility residents • An active social life for independent residents • Positive relationships between residents and staff • Some negativity toward residents • Independent living and the supportive role of the Village Nurse • Staff supportive of each other • A need for greater support toward staff • Relationships between independent living and the facility residents • Relationships within independent living – the ‘Friendly Village’ • A continuum of care that fosters relationships
Chapter 6: Strengthening community action through collaboration, participation and empowerment	<ul style="list-style-type: none"> • Building social capital and the empowerment of people • Collaboration between the Village and Community • Co-ordination of Community and Volunteer Programmes • The invaluable contribution of the volunteer • The local school: a win: win situation? • Difficulties encountered and reasons for limited family participation

Table IV (continued over):

Chapter 7: Developing personal skills and recognition of gerontology as a specialist field	<ul style="list-style-type: none"> • Recognition of staff roles and skills • Staff education but at what expense? • Suggestions for further education • Education and the Community • Education for residents and relatives • Communication practices and skills • Residents and staff meetings
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TABLE IV
Stage Three of the constant comparative method
(Glaser and Strauss, 1967)

SUMMARY

This chapter has described the qualitative methodological paradigm used within a field-based case study of a retirement village. Data was gathered through a review of literature, observation, and semi structured interviews with residents and staff. This was completed at a point of ‘saturation’ when no new information was forthcoming. Data was analysed through Glaser and Strauss’ (1967) constant comparative method in which data was coded and compared with other data from interviews, observation and literature. The forthcoming chapters will provide an analysis of the findings, sorted into the Ottawa Charter’s action areas – developing healthy public policy, creating supportive environments, strengthening community action and developing personal skills, with the last action area – re-orienting health services included in the concluding chapter.

Chapter Four

Building Healthy Public Policy in an aged care setting

As discussed within Chapter One – Research Context, a brief history of the aged care industry including the current system was made. This chapter will continue to discuss issues relating specifically to policy. Within aged care, particularly for those living in residential aged care facilities (nursing home, hostel, dementia specific care), there was an influx of legislature changes; aged care reform of the 1990s. This chapter will concentrate on these reforms particular those pertaining from 1 October 1997, with part of these reforms aiming to promote positive ageing. This chapter is the first of five chapters that will explore concepts of the Ottawa Charter's action areas for health promotion. Data that has been analysed from interviews has been applied according to the Ottawa Charter's action area – Building Healthy Public Policy with a reflection on how these changes have affected the work and life of those in the retirement village case study. The World Health Organisation's (1986) Charter defined this action area as:

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. . . It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments (WHO, 1986, p 2).

It is necessary therefore to decide whether the current system in aged care “goes beyond health care”, whether there is “coordinated action” or “joint action” and whether it is an “enjoyable environment” for residents, relatives and staff. As part of the reforms, the Commonwealth Department of Health and Family Services (1998a) developed the Resident Classification Scale (RCS); staff were required to document resident needs through initial assessment, indicating how these needs were being met, how often intervention was required, and review the care provided demonstrating the effectiveness of the programme or care. The main findings from interviews revealed staff dissatisfaction with regard to time and cost constraints that seemingly have occurred with the introduction of both accreditation and the RCS.

4.1 Accreditation and its similarities with the Ottawa Charter

All Federally funded aged care facilities in Australia are required to be accredited and are audited against the ‘Standards and Guidelines for Residential Aged Care Services Manual’ developed by the Commonwealth Department of Health and Family Services (1998b) comprising four standards - management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems, with an overall 44 outcomes. Kovner, Mezey and Harrington (2000) noted that in the United States ‘quality of care’ is often ‘measured’ by “outcomes defined in federal regulations and identified by state survey agencies that monitor nursing homes” (p 78). This has resulted in some confusion in the term ‘quality of care’. This scenario may be similar to the current Australian Federal Standards and would need further research, however, the reforms are using the same terminology, expressing the need to ensure “quality of care for older Australians” (Commonwealth Department of Health and Family Services, 1998b, p VII).

On analysis of the data, it was discovered that there is some overlap with the Standards and the World Health Organisation's (1986) Ottawa Charter. This will be discussed briefly in this section, but discussed in greater detail in the forthcoming chapters.

As stated firstly by the Standards and secondly by the Guidelines with regard to 'Standard one – Management Systems, Staffing and Organisational Development':

This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself (p S-3)¹.

Quality management encompasses the concept of continuous quality improvement . . . based on the belief that the whole organisation can be improved (Commonwealth Department of Health and Family Services, 1998b, p G-4)².

Standard one relates specifically to the provider ensuring that policies, procedures and other documents such as quality plans, outline the "vision, values, philosophy and objectives" that "provide direction for staff" (Outcome 1.5 – Planning and Leadership) (p G-17). It also enables comments and complaints (Outcome 1.4 – Comments and Complaints) to be made by residents and other stakeholders (relatives, staff, volunteers, community members and management) giving the organisation the opportunity of continuous quality improvement. It is also the responsibility of the organisation to purchase suitable goods and equipment (Outcome 1.7 – Inventory and Equipment) and recruit suitably qualified and skilled staff to meet the needs of the resident with ongoing training and staff development (Outcome 1.6 – Human

¹ S-3 refers to page numbers of the Standards and Guidelines for Residential Aged Care Services Manual. 'S' representing the Standards and 3, the page number.

² G-4 refers to page number of the Standards and Guidelines for Residential Aged Care Services Manual. 'G' representing the Guidelines and 4, the page number (Commonwealth Department of Health and Family Services, 1998b)

Resource Management). Externally sourced services must meet quality standards (Outcome 1.9 – External Services). And finally, Outcome 1.8 – Information Systems reads: “Effective information management systems are in place” (p S-11) to ensure information is collected and stored, and complies with legislation (Commonwealth Department of Health and Family Services, 1998b).

The Ottawa Charter’s action area – building healthy public policy, identified the need for organisations to work within legislative requirements. Each of the four Aged Care Standards provide identical information relating to Regulatory Compliance (Outcomes 1.1, 2.1, 3.1, 4.1). For each of the Standards, the expected outcome under regulatory compliance reads:

The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines (p G-10, G-32, G-56, G-84).

Summarising the preamble, aged care services that are funded by the Commonwealth must operate first and foremost according to the Aged Care Act 1997 (Commonwealth of Australia, 1997a), the Quality of Care Principles (Commonwealth of Australia, 1997b) and Aged Care Standards (Commonwealth Department of Health and Family Services, 1998b). Otherwise, sanctions may be applied. The WHO (1986) recommended that policy makers are “aware of the health consequences of their decisions” (p 2). This is an interesting point, especially with regard to the issue of sanctions that may lead to aged care facility closures. Policy makers may believe they are protecting older people by closing facilities that are not complying with the Standards. However, for an older person, and having to be in a situation where their home and the staff that they often care about is suddenly at risk of collapsing may be daunting, considering they may feel they no longer have a home. This issue will be

discussed in more detail in section 4.4.2 – The threat of closure. But, to continue first on the similarities of the Standards and the Ottawa Charter.

The Ottawa Charter (WHO, 1986) reflects on the need to “take care of each other”, the “environment” with work and living arrangements that are “safe, stimulating, satisfying and enjoyable” (p 2). These ideas are reflected in the Standards, for example Standard One – Management Systems, Staffing and Organisational Development, is intended so that management is responsible for continuously improving services and the skills of staff. Standard Two – Health and Personal Care is to ensure that clinical care issues are being addressed. Standard Three – Resident Lifestyle, aims to promote resident independence, enabling them to retain their lifestyle preferences and community activities. And Standard Four – Physical Environment and Safe Systems offers residents a safe and secure environment “that ensures the quality of life and welfare of residents, staff and visitors” (Commonwealth Department of Health and Family Services, 1998b, p S-42).

The Ottawa Charter promotes community ‘empowerment’ and “public participation” (WHO, 1986) as do the Standards, recognising that residential care services are a communal setting, suggesting family participation and for residents to maintain interests in community life. Nevertheless, there were suggestions throughout the interviews that the community and the families of residents were not involved sufficiently.

Offering education and training may be a means to promote family and community participation and empowerment. The Ottawa Charter’s action area, developing

personal skills as well as the Standards, recognise the importance of education. Education and staff development is an expected outcome under all four standards, however, it neglects to recommend resident, community, volunteer or family participation but does recognise the need for management and staff to be provided “appropriate knowledge and skills” (Outcomes 1.3, 2.3, 3.3 and 4.3) (p S-6, S-16, S-34 and S-45).

Finally, the Ottawa Charter’s action area, re-orienting health services will be discussed within the conclusion, yet it is questionable whether aged care has moved beyond what the World Health Organisation (WHO) refers to as “clinical and curative services” (p 3) under the current aged care Standards and Residents Classification Scale. For example, standard two of the Standards has a pronounced message relating to ‘treatment’ and aged care services appear to benefit through the RCS when residents require a high level of care. Under this current policy, providers may be disadvantaged financially to promote health and well-being.

The relationship between the Ottawa Charter, the Standards and Resident Classification Scale will be analysed throughout, but first, a brief explanation of accreditation and its relation specifically to the Village’s own experiences during the accreditation process.

4.2 Accreditation: what it means to residents and staff

The accreditation system was introduced in “January 1998 as part of the Commonwealth Government’s reforms to the quality of care for older Australians” (Commonwealth Department of Health and Family Services, 1998b, pVII). As

explained by the Commonwealth Department of Health and Family Services (1998b), aged care providers are assessed and accredited against five key elements including the Accreditation Standards, building quality, prudential agreements, concessional and assisted resident ratios, and user rights. It is interesting to note that the Standards and Guidelines Manual state “Accreditation is recognition that rewards the effort involved in implementing a quality service (p IX)”. Yet aged care facilities are unable to continue this service without being accredited and as the Aged Care Standards and Accreditation Agency (1998) stated: “All services must be accredited in order to receive Commonwealth subsidies from 1 January 2001” (p C8). Services that do not meet accreditation standards, may have sanctions applied and face the possibility of closure. Therefore all aged care facilities were required to be accredited by January 2001. This legislation excludes retirement villages for residents living independently.

4.2.1 The accreditation process

The accreditation process involves a number of intricate steps. In summary, first, the residential care service completes and submits an application kit and fee to the Aged Care Standards and Accreditation Agency. The ‘Agency’ is an independent body established under Commonwealth legislation (Aged Care Standards and Accreditation Agency, 2001). The application kit consists of an application form, Form B (includes information pertaining to three of the areas that are assessed – building quality, prudential agreements, and concessional and assisted resident ratios), a rating matrix, a priority action workplan and self assessment worksheets for the 44 accreditation outcomes (Aged Care Standards and Accreditation Agency, 1998a).

The second step involves an assessment team who are registered quality assessors to conduct a desk audit of the services self assessment application. The Agency then decides whether the accreditation process continues or is ceased. The former decision is followed by step three (Subdivision 3 of the Accreditation Grant Principles, 1999) in which a site visit is carried out by the assessment team.

The site audit involves the assessment team meeting with the applicant or department heads/managers on a daily basis to discuss the audit process (Commonwealth of Australia, 1999, p 28) allowing the managers to provide the team with relevant documentation that demonstrates evidence of compliance to the Standards. As explained further in the Accreditation Grant Principles 1999 (Commonwealth of Australia, 1999) the assessors follow up with discussion with staff, and at least ten per cent of residents and or their representatives to discuss the audit. A site audit report is prepared by the assessment team with recommendations “about the service’s compliance . . . [or] non compliance” (Commonwealth of Australia, 1999, p 29-30).

The fourth and final step (if accredited – Subdivision 4) involves the Agency informing the service whether it has been successful in meeting accreditation following which the service will be accredited either for a twelve month or three year period. Services that do not meet the Standards are provided “reasons for the decision . . . [and] have to apply for reconsideration” (Commonwealth of Australia, 1999, p 34).

A study conducted by Grenade and Boldy (2002) reported high stress levels amongst staff during the accreditation process. This was supported with findings from this

study. Staff from the aged care facility who were unable to be present during the accreditation days demonstrated elation at being absent (FS1-01.04.00, ACT2-05.07.00, GARD1-25.05.00, VN2-02.06.00). As stated by an activity staff member:

I was introduced to the gentleman who was very nice. He said “you’re meant to be interviewed tomorrow”, and I said “I’m sorry but it is my day off tomorrow”. Then I said, “no I’m not sorry, I’m quite pleased” (laughing) (ACT2-05.07.00).

Nevertheless, during interviews staff from the retirement villages facility, commented that the accreditation team were obviously impressed with the genuine caring environment (ACT2-05.07.00, MAIN1-01.06.00). An activity staff member commented: “They liked the atmosphere . . . it is very friendly . . . and caring and the staff are wonderful” (ACT2-05.07.00) and this was felt by myself during the fieldwork period. It was an environment in which staff were friendly and residents appeared happy and well cared for. Throughout interviews with residents and staff it was apparent that relationships were positive and that they cared for one another.

The facility successfully met accreditation and were accredited for a three year period. Within the village newsletter there was a notice of thanks to all staff from the General Manager. An independent resident commented on such thoughtfulness, “they listed every member of staff on the front page . . . the only one missing . . . is the General Manager himself” (IR6-08.04.00). During my fieldwork visit, following accreditation, staff showed relief saying that they were happy that it was over. There were also other negative responses with regard to the accreditation process both from staff and a non-direct perspective from residents who were aware that staff had limited time.

4.2.2 The negativity of accreditation

There was much public debate during the accreditation process especially with regard to aged care facility non-compliance and closures. Bronwyn Bishop, the then Minister for Aged Care made a number of speeches and media releases regarding these issues and disclosed complaints and sanctions imposed on aged care providers (Bishop, 2000a, 2000b, 2000c). Under Section 56.4 (Part 4.2 User Rights) of the Aged Care Act (Commonwealth of Australia, 1997a) it is the responsibility of the provider to establish a “complaints resolution mechanism” (p 216). The Commonwealth of Australia’s (1997b) Committee Principles (Section 10) defines how a complainant, that is a resident, resident advocate, relative or staff, are able to make an external complaint whilst maintaining anonymity. These complaints are made through the Complaints Resolution Scheme, also introduced as part of the aged care reforms.

The Complaints Resolution Scheme refers matters of seriousness to the Aged Care Standards and Accreditation Agency who then commence investigations (Gray, 2001). In July 2000 the Minister announced further reform to strengthen the Complaints Resolution Scheme by “the creation of the office of Commissioner of Complaints” (Bishop, 2000c, see also Gray, 2001, p 109). As quoted from the Minister in a media release on 16 February 2000:

Where an immediate or severe risk is confirmed a range of sanctions are available to safeguard residents such as withdrawal of Federal funding, cancellation of bed licences and most severely, revocation of provider status for the facility and relocation of residents to ensure continuity of care (Bishop, 2000a).

In a media release by the Aged Care Standards and Accreditation Agency (2001), aged care providers that did not meet accreditation by 1 January 2001 were working with the Department of Health and Aged Care to “ensure that residents’ best interests

are protected". This was supported by comments made in an interview conducted in September 2000 between Bronwyn Bishop and Vanessa Mills (Media Presenter). Bishop openly acknowledged that in Victoria alone some forty-two aged care facilities had been closed down by the Aged Care Standards and Accreditation Agency as a result of non compliance. Bishop assured the presenter that the contingency plan ensured that residents were provided "continuity of care" and that new beds were made available, through re-allocation of "good facilities and good providers" (Bishop, 2000b).

A recent study to review the accreditation system in Western Australia was conducted by Grenade and Boldy (2002). Similarly to this study, Grenade and Boldy (2002) gained feedback from staff working in aged care facilities. The results were similar to the findings of this study. Staff in Grenade and Boldy's (2002) study identified the benefit of accreditation as one that promotes continuous improvement, however there were also feelings of 'stress' with the increased documentation requirements. The cost to staff was increased stress during the accreditation audit and extra "time spent preparing for accreditation" (p 7) during their own time. With this there was an overall need for staff to spend time on "paperwork [which] meant that they had less time to provide 'hands on' care to residents (p 9). In order for this policy to promote health, it is necessary to alleviate staff, management and resident anxiety levels and ensure care needs are being met. Accreditation should be seen as a supportive and learning experience with residents staff and management having the ability to discuss concerns and recognise the services improvements from the continuous improvement activities.

From the staff of the Village, there were both positive and negative comments regarding the accreditation system during the fieldwork. Staff were aware that from a negative perspective, aged care facilities that are unable to meet the Standards have funding ceased and face the possibility of closure. During interviews there was speculation that several facilities in Victoria would close and a general belief amongst staff that this was for political reasons. Staff also felt concerned for the residents' welfare at these facilities with them having to deal with the fear of closure and therefore the loss of their home (MAIN1-01.06.00, FS2-18.05.00). This publicity did affect the residents as they would not participate in interviews during this stage of the fieldwork. The Maintenance Manager became quite verbal on the issue of closure stating:

How many nursing homes around Australia are shutting down because of the owners? . . . what is going to happen to those people [residents]? There has to be a little common sense in all of this. People that are making the decisions, they are God in a sense, but they have a responsibility to see really what happens. I know it sounds grandiose and maybe naive but we are dealing with people's lives here. I guess that is what makes me angry from an accreditation point of view (MAIN1-01.06.00).

In a study conducted by Harulow (2000) there were suggestions that Registered Nurses are having to complete more administrative duties as a result of accreditation. However according to Professor Irene Stein, Director of Aged Care Research and Education Services this increase in administrative duties to meet accreditation standards has brought about improved standards in the aged care industry (cited in Harulow, 2000).

Within the Village, an increase in administrative duties was also felt amongst the majority of staff and residents. It could be speculated that this increase in the amount

of time spent completing documentation was for both accreditation and funding purposes, that is the Resident Classification Scale (RCS). Grenade and Boldy's (2002) study supported this notion. Harulow's (2000) study in which surveys were completed by Registered Nurses working in aged care reported similar feedback with nurses suggesting this has led to reduced care time. These findings were supported by a further study conducted by Kovner et al (2000) who states that quality of care and staffing issues in American nursing homes have been of concern for some time. According to Kovner et al (2000) American nursing home have poor public opinion, "evidence of poor care" and a "limited number of professional staff" (p 77). The Registered Nurses are spending the majority of time on administrative duties with minimal resident "direct care" time (p 78). This scenario appears consistent with the current system in Australian aged care facilities.

This speculation is further supported by result of the analysed data, with suggestions that increase in documentation has inevitably resulted in reduced time spent with residents; not necessarily 'care' time as stated by staff but reduced intimacy/familiarity. As stated by a Personal Care Assistant:

I feel that they are trying to make us robots and we are not . . . It makes you angry when you are told that you are not allowed to call the residents 'love' or 'sweetheart'. I will be struck off when the accreditation team come around I just say love and darling all the time . . . But everyone will be in the same boat (PCA1-04.03.00).

Also as stated by the Maintenance Manager:

when you have a dedicated person, and I believe this is a bit of a cry around here, that the girls who really are dedicated, say they are being taken away from the tender loving care time because of unscrupulous operators where you have to bring in the paper war (MAIN1-01.06.00).

This is further supported by the Director of Nursing who realised documentation was a required component to resident care:

there was more and more demand from my time . . . I now accept . . . that [the paperwork] is like another slice of the residents overall care and you can't do that without the other (DON1-07.12.00).

However the Village Nurse goes on to say:

the amount of paper work is actually self-defeating and it means that whilst you are so busy writing about what you want to do you haven't got the time to physically do it . . . unless there is more funding to provide more hours [for] actual hands on care (VN2-02.06.00).

These comments made by management and staff confirm that the amount of administrative duties resulting from accreditation and the RCS has created an unhealthy environment with staff concern that they are unable to spend the time on direct care. Staff also experienced increased stress prior to and during the accreditation period. For example, staff felt accountable for ensuring the necessary documentation on resident care was in place (VN1-26.02.00, FS2-18.05.00, and OT1-02.06.00) and that policies and procedures reflected this (FS2-18.05.00-18.05.00). As stated by the Catering Manager:

I think the costs to myself at the start could have been a nervous breakdown . . . To me it was just a nightmare . . . I had improved as much as I could but accreditation for me opened arms. It was a nightmare because I thought "how am I going to do this". It would have been easier to go in there from a brand new kitchen and not have a setup. I suppose it is like renovating a house, it is easier to actually build from the beginning rather than renovate (FS2-18.05.00).

Under the current accreditation system, all aged care facilities undergo Accreditation excluding retirement villages or those that offer an aged care service for older people living within a unit of independent living. It became apparent during the fieldwork that the role of the Village Nurse is an extremely valuable role within aged care

particularly to the ageing population of residents living within independent units. The role of the Village Nurse involves identifying residents at risk, providing clinical care, deciding whether the doctor requires to be called in and communicating information between various personnel, for example, doctor, home care service and allied health team. Overall, the Village Nurse helps to retain the older persons' independence and maintain their health and wellbeing. During the interview with the Village Nurse (VN1-26.02.00), it was apparent that she felt concern for the welfare of independent residents stating the role of Village Nurse has a great deal of responsibility yet the accreditation process neglects to monitor this aspect of aged care. With the current policy on ageing in place, the Village Nurse is caring for an increasing number of ageing residents with higher levels of care needs. The Village Nurse believed that neglecting to incorporate this area into accreditation, demonstrates little "respect" for this increasing population of aged care (VN1-26.02.00). This is supported by another Village Nurse who was interviewed and who also confirmed that this area of aged care does not undergo accreditation, yet she believed accreditation is a necessary component to aged care – "I certainly agree with accreditation and I agree with monitoring and needing regulations" (VN2-02.06.00). These comments made by the Village Nurses are extremely relevant and policy makers should consider monitoring the practices of retirement village providers that offer independent living. These residents who are needing the services of qualified care staff, allied health and domestic services need to be monitored to ensure that health and safety is not being compromised.

4.2.3 Positive attitudes to accreditation

As well as the negative aspects with the accreditation system, there were positive comments. On the 12 August 1999, the then Minister, Bronwyn Bishop (1999b) announced that the aged care accreditation system would ensure “real accountability” and “quality care”. She continued:

The Government will not tolerate, and the community will not tolerate, the continued evidence of homes that take taxpayers’ money yet provide poor care to older Australians who live there (Bishop, 1999b).

Results from interviews regarding the accreditation process, revealed that the majority of staff also felt that the monitoring and continuous improvement cycle helps to ensure facilities are adhering to residential care, and thus ‘quality care’, similar to findings from Grenade and Boldy’s (2002) study. The Personal Care Assistant (PCA1-04.03.00) of the Village described her attitudes toward accreditation during interview:

I definitely think it [accreditation] is a good idea. I think people need to be seen to be putting these policies and strategies into action because they can lack in certain areas. And I don’t see that there is anything wrong in having people to check on you. I think this is sensible, it is a good idea . . . you know you are doing your job properly, but it does pick you up in areas where you need to . . . Because we are dealing with people and they need to have the proper care and attention that they deserve (PCA1-04.03.00).

As identified here, the accreditation process helps to improve overall work practices; staff tend to reflect and follow up on processes that require improvement (FS2-18.05.00, OT1-02.06.00, DON1-07.12.00, PCA1-04.03.00, ResCo-01.06.00). For example the Resident Co-ordinator explained that she was responsible for ensuring the “Welcome Kit” was complete prior to accreditation (ResCo-01.06.00). The Resident Co-ordinator explained that the Welcome Kit provides residents in the facility with “information about what is happening in the hostel, all the activities and

general information” about the Village (ResCo-01.06.00). The Occupational Therapist also commented on the positive nature of accreditation:

I think it is a terrific practice . . . it is very important to . . . demonstrate that what you do is provide a quality service to people. And it is an ideal way for everybody reflecting on what their practices are, whether it be good, bad or indifferent and looking at changing them if that is required (OT1-02.06.00).

The majority of residents interviewed were unable to comment on the accreditation process, stating that they had little understanding of it. They were aware however that the accreditation was taking place. An independent resident did state similar positive feedback to that of staff; that there needed to be a monitoring and compliance system for residents who have become dependent upon others thus ensuring a standard of quality care is achieved:

We are also applying for accreditation. They have to have this to keep it up to standard. You have to have this particularly when people are helpless; they are dependent entirely on you on their welfare. They haven't got any say. They really should be under accreditation (IR3-22.02.00).

One way of summarising both the positive and negative attitudes toward accreditation, is as outlined by the Catering Manager:

I think things are improving . . . with accreditation, I am hoping that a lot of these little places are going to be wiped out and then there will be better, I won't say bigger, but better organisations that have these high standards. You know you hear about how some residents are treated and it is really disgusting (FS2-18.05.00).

4.3 From Care to Documentation: myth or fact?

For aged care facilities to receive commonwealth aged care funding, it is necessary for the facility to be accredited by producing documented evidence of the care provided to residents, including initial assessments, implementation of the programmes, and continual monitoring and review of the system, referred to as the

continuous quality improvement cycle (See figure 4.1). Continuous improvement is the focus of the Standards with standard one, ‘Management Systems, Staffing and Organisational Development’ focusing on ensuring “quality performance”. This standard is reflected in the other three standards – Health and Personal Care, Resident Lifestyle, and Physical Environment and Safe Systems with all having to promote “continuous improvement”, and “education and staff development” (Commonwealth Department of Health and Family Services, 1998b, no page number). (Staff education and personal development will be discussed further in Chapter 7 – Developing Personal Skills).

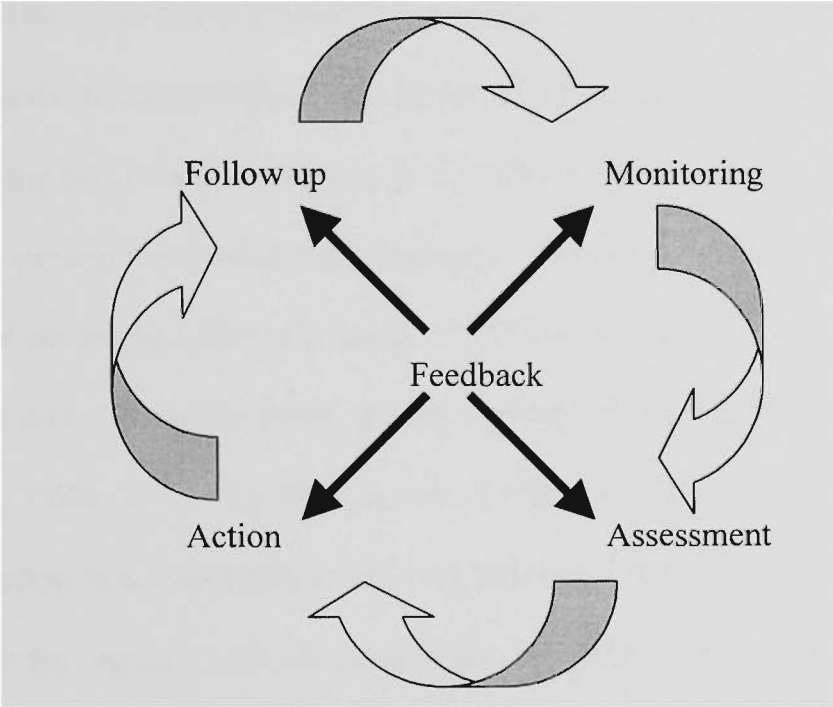


FIGURE 4.1: Continuous quality improvement cycle
(Commonwealth Department of Health and Family Services, 1998b)

There were suggestions from staff and residents that with the introduction of the accreditation system and the Resident Classification Scale, that staff have reduced time to complete their duty of care with what appears to be within tighter budget guidelines. As Kellehear (1999) suggested, industries are having “to do more with less” (p xi) and this appears to be the situation within aged care. For those that work

in aged care there is also the reality that the resident population are ageing and thus becoming frailer which also infringes on the amount of time staff have with each resident.

Nevertheless, aged care providers are provided Commonwealth government funding to compensate for a percentage of care provided to the resident. This percentage is only received when a particular level of care is determined through the Resident Classification Scale (known as the RCS).

The Resident Classification Scale was introduced at the same time as the introduction of the Standards and Guidelines for Residential Care, as part of the reforms. Prior to this, nursing homes were funded by the Commonwealth Government since 1963 with an equal subsidy received for all residents. Between 1969 and 1988, funding was structured according to the care needs of the resident; a “two tiered funding approach (ordinary care / extensive care)” (Commonwealth Department of Health and Family Services, 1998a, p 7). In 1988, a new funding tool was introduced, the Resident Classification Instrument (RCI) however this was reviewed and replaced in October 1997 by the current refined classification system, referred to as the Resident Classification Scale (RCS). Geriaction Incorporated, a national organisation formed in 1967 with a majority of members being gerontological nurses, as well as having “significant involvement in many policy issues related to residential aged care and aged care in general”, carried out a survey as to the appropriateness of the RCS. The survey showed that this “tool [in comparison to the previous instrument] is more comprehensive and attempts to address the holistic and complex care needs of the aged population” (Geriaction, 1998a, p 5). Geriaction Incorporated submitted

recommendations to the Review Panel, for example, suggesting that prior to implementation of the RCS, staff be provided the necessary education and training, that there be refinement and “clarity” in “terminology” and changes made to some of the questions. The RCS was reviewed with some of these issues resolved.

From a personal point of view, and this was also evident in some of the interviews, the RCS does not appear to be an equitable system as it does not necessarily reflect the care needs of the residents. The RCS also incorporates the idea of using allied health professionals, referred to in Question 20 as ‘other therapy’ (podiatrists, dietitian/nutritionist and so on) which often costs more than the received funds and may be seen as non-beneficial or outside of budget guidelines. This may prevent aged care providers from using the services of allied health for their residents. This would then compromise a holistic model of preventive health care being included in the current model of aged care. Policy makers therefore need to consider the benefits of ensuring that allied health and complimentary therapists are used to promote health through health promoting programmes that will ultimately benefit health care expenditure and the health and well-being of residents and staff. To do this though, as the Ottawa Charter (WHO, 1986) suggests, current policy needs to go “beyond its responsibility for providing clinical and curative services” (p 2) to one that promotes health and well-being.

4.3.1 The RCS and the effect on care time

The Resident Classification Scale (RCS) categorises residents according to their care needs, calculated by providing a weighting or score from each of the 21 RCS questions. The resident is classified from category 8 (a total score less than 10.61

referred to as low level care) in which no Commonwealth funding is received to a category 1 (a score greater than 81.01 or high level care) in which funding is received. The Village Nurse made a relevant comment with regard to inequalities of this system:

It is not really fair to say that if someone is what they call a Category 8 which is the lowest category of care and it is pure hostel care, you don't get any funding for them. I just don't think it is fair for the resident (VN2-02.06.00).

This staff member is suggesting that staff are providing residents with care such as provision of hospitality services, that has enabled the residents health to improve. But on doing so, RCS funding is reduced and this would suggest that there is no financial benefit to improve resident independence. To receive this funding the facility must show supported documented evidence of the types of care the resident is receiving such as one on one assistance with personal hygiene, meals and attendance to activities. According to the Commonwealth Department of Health and Family Services (1998a):

the RCS is designed to place residents in order of their care needs, allowing the largest subsidy to be provided to the residents with the greatest overall care needs (p 8).

Staff questioned whether the introduction of the RCS and thus an increase in documentation has led to reduced care time (PCA1-04.03.00, VN1-26.02.00, VN2-02.06.00, PHYS1-12.10.00). As demonstrated first, by a Personal Care Assistant and second, by the Village Nurse:

I did not like the RCS as it put pressure on us and it was taking me away from the care work. If I wanted to do administration and office work I would have gone as an office worker . . . You were saying to the resident "I can't stay" as we had to do the documentation (PCA1-04.03.00).

To tell you the truth we (the village nurses) have discussed that we will keep people out in the village longer because we

do not think they are cared for well enough in here (the facility) (VN1-26.02.00).

The Village Nurses (VN1-26-02.00, VN2-02.06.00) suggested that residents living independently receive an exceptionally high standard of care compared to the care in the facility. This is as a result of the introduction of the RCS and accreditation. Accreditation appears to have taken staff away from care, to concentrate on documentation, while the RCS appears to promote greater amounts of dependence amongst residents. Unfortunately, it is questionable whether this continued level of care can continue. The Village Nurses identified that with an ageing population that is becoming older, frailer and more dependent, residents are thus requiring a higher level of care time. As she described:

with the amount of care that we offer attracts people to come in here. They then expect that level of care but unfortunately their needs are not going to be met to that extent . . . some people have been here for 20 years and they have come to expect a certain standard and a certain number of calls from the village sisters and know that we are concerned for them. So it is very difficult to say “we don’t do that any more” and the time when they need it you know. It’s going to be a very difficult thing. I think really something management are going to have to address is what level of care we can be expected to provide (VN2-02.06.00).

This is reflected in the interviews conducted with the independent residents who all expressed their admiration for the care provided to them by the Village Nurses. Residents as well as the staff also spoke positively about the Village’s structure that offers a continuum of care (IR6-08.04.00, IR4-26.02.00, IR8-04.05.00, FS4-19.07.00, DON1-07.12.00).

The independent residents spoke of their own experiences and the benefits of living in a Village that offers a continuum of care from independent living, hostel care, nursing home care and dementia specific care, and if necessary, day care. They have the

comfort of living and remaining in the Village amongst friends and staff whilst moving into the level of care, as and if required (IR6-08.04.00). Another resident continued expressing that having a partner live in a separate nursing home or facility increases unnecessary anxiety and complication associated with visiting (IR4-26.02.00). A further resident spoke of her husband's deteriorating health and the need for the husband to move into day care and the dementia specific area while she remained living in the unit. She continued by describing the situation:

You get to really know them, the nurses. If you are ill for any length of time they get really involved with them, because of course they are very caring. What I appreciate was they cared for my husband and they cared for me as well without my being aware of it (IR8-04.05.00).

She proceeded to explain that moving into the nursing home is a challenge yet expressed that this situation occurs with all stages of life:

my life I feel is divided into five and each has a challenge. . . You have to drop one thing, kiss it good bye and take on the challenges of new things. And I think when I go into the hostel I will tackle it with a challenge not as a downward step because if you don't tackle it you won't be OK. It's the same of me being on my own, it is completely different. . . Then if I go into the nursing home I will tackle that too (IR8-04.05.00).

From the perspective of staff, they are able to develop an extensive and thorough history of the person from entering the retirement village through to their death, enabling them to provide a more comprehensive continuum of care that is able to be developed more on an individual basis. As demonstrated further first, by the Cook Manager of the café and second, by the Director of Nursing:

I think coming into the village, you know for a fact that when you come into a village the end of line is the nursing home. Having been here I think it is great that you come in living independently and then as you get slower and become more dependent you can move on. I mean it is pretty hard, no one wants to see themselves becoming totally dependent. When you have had your freedom for 70 years or so it is a horrible

thought but as you go along the residents seem to know themselves when they are ready (FS4-19.07.00).

Coming into the nursing home I think we have that history of the resident in the village and I think that is our strength in this village. We are not getting somebody who all we have is a doctor's or resident's next of kin information; we have often 20 years of information on that person. So therefore we are able to build on that (DON1-07.12.00).

Other staff also made general comments regarding the overall caring nature of staff. For example the Catering Manager (FS2-18.05.00) stipulated that when interviewing prospective staff, she chooses people that appear caring and compassionate, whilst the resident coordinator (ResCo-01.06.00) identified that the aged care industry appears to attract a caring personality.

4.3.2 Time constraints

As Gray (2001) identified in his review of the aged care reforms, it is difficult to assess whether there have been changes to staffing levels since the reform as there is no data available prior to the reforms on staffing levels. It is interesting to note that it was questioned whether under the previous funding system of the Care Aggregated Module (CAM), Standard Aggregated Module (SAM) for infrastructure costs, and Other Cost Reimbursed Expenditure (OCRE) funding for staffing costs, that there may have been excess in nursing staff hours not necessarily used for care time (Gray, 2001, p 96). Gray (2001) reported that under this funding system there was “no incentive for providers to achieve efficiencies in their operations” and there was no assurance of “quality of care” (p 84). Gray (2001) however may have been biased in these findings, as he was commissioned by the then coalition government to review the benefits of government reforms.

Prior to the Aged Care Act 1997, providers were required to spend a percentage of funding, for example the Care Aggregated Module (CAM) specifically on direct care based on the care needs of the residents (Gray, 2001, Iliffe, 2000, Harulow, 2000, and Jones and Moran, 1998).

Findings from the Review recognised that there were suggestions from ‘staff, consumers and providers’ “that the reforms had seen a decrease in the overall level of residential aged care staff and the hours they devoted to direct care” (Gray, 2001, p 96).

Residents interviewed in the hostel were aware of staff time constraints (HR1-04.03.00, HR3-02.11.00). Comments included: “the staff are rushed off their feet” (HR1-04.03.00) and from another resident “They are really helpful. Sometimes I think they are a bit short staffed. I mean they are running sometimes” (HR3-02.11.00). The resident went on to express concern with the number of nursing staff leaving, stating that there had been “three sisters” leave in a short period of time – “We are hoping that nobody else leaves” (HR3-02.11.00).

Responses from both staff also reported that there was some form of time constraints in all areas of the Village, including gardening, maintenance, food services, administration, activities and clinical. These time constraints as was evident from responses, have resulted in reduced time with residents. For example, as stated from the Gardener:

Well my objective when I was employed here was to improve the look of the village. And I have started to do that, like we have done so many new things here. And I also tried to start up a gardening club which was like once a month and do some

potting and grow some seeds . . . Well I only did that a couple of times because basically what I was employed to do is so much work that I couldn't do it any more, so I got rid of my own gardening club. But I had something like 40 people come and that is a really good response. I had a meeting and I had something like 60 people there . . . And they loved it and it was really good . . . but I had to trash that because I don't have enough time. (GARD1-25.05.00).

When the Gardener referred to "so much work", she explained to me that her job role included maintenance work as well as the gardening. Independent residents also recognised this, for example from one independent resident, "I couldn't believe it when we saw her doing the spouting . . . it shouldn't be a gardener's job" (IR4-26.02.00). The Physiotherapist also informed me that at one stage she also had a gardening programme for the hostel residents however discontinued this when the RCS was introduced (PHYS1-12.10.00). Other staff such as the Resident Co-ordinator and office staff also explained about how their positions have changed over a period of employment with increased responsibilities but no increase in staffing hours (ResCo-01.06.00). This situation is similar to that of the Village Nurses, whereby residents are becoming older and frailer and their needs are increasing. Staff are also expected to be multi-skilled, for example, the Village Nurse was allocated the role of Education Co-ordinator.

There were other comments from staff such as: "With staff there seems to be frustration on the time constraints that they have" (OT1-02.06.00) and from the Personal Care Assistant, "A lot of the girls are very pressured. They have a lot of heavy work to do and I think more time with the residents is needed" (PCA1-04.03.00). The Personal Care Assistant continued:

I would love to stay with certain residents or see them but you are limited with time and they obviously feel . . . neglected, but we just cannot give that time that we would love to . . .

Time is a major factor in aged care. They want you to do so much in so little time (PCA1-04.03.00).

There were further time constraints on weekends with reduced staffing in all departments. For example, in Food Services during the weekend staff utilised quick methods of food production. They used pre-prepared soups in comparison to homemade soups made during weekdays (FS1-01.04.00). An activity staff member was also aware of residents having no activity programme during the weekend:

I often have relatives and residents say to me that it is quiet around here on the weekend. So I think maybe they could have someone in on the weekend, like a programme for them in the activity department . . . I could do with more hours (ACT3-07.12.00).

The Village also had to rely on agency staff. A Personal Care Assistant confirmed that relief or agency staff do not continue long term and new Personal Care Assistants are provided inadequate time to gain the confidence and skills necessary to perform their role. The PCA and Registered Nurse also stated that often staff will attend work in times of ill health, understanding that they will be short staffed which will ultimately impact on other staff, leading to increasing stress and staff illness (RN1-11.03.00, PCA1-04.03.00). The Registered Nurse explained that she had reduced her working hours to two days, however she believed she worked more than this as the staff “really run” (RN1-11.03.00). As explained further by the Personal Care Assistant:

the girls were getting really uptight because the relievers weren't staying with us and if you phoned in sick, the pressure. You'd get “I can't fill your shift” and some girls are coming in sick. Then they can't give a 100% . . . when you are not feeling well but sometimes that happens (PCA1-04.03.00).

This scenario infringes on the health of staff and residents with staff working when they are unwell. They could pass their illness onto others. Residents for example, are

a vulnerable group who may have reduced immunity. The responses from both residents and staff regarding reduced care time and staffing shortages is evidently a problem in aged care and needs to be addressed by policy makers for a health promoting retirement village. As the Ottawa Charter stipulates: “policy makers . . . [need] to be aware of the health consequences of their decisions” (p 1).

4.3.3 Diversity amongst staffing

As can be seen from the above, there was a genuine feeling amongst the majority of staff that there has been an increase in the amount of documentation since the introduction of accreditation and the Resident Classification Scale (RCS). With the increase in documentation there have also been some positive outcomes. For example, the Standards have provided the opportunity for further education for staff, systems have improved to highlight the need of continuous improvement, and there has been more diversity in staffing with input from allied health staff. This has allowed the nursing staff to work with a variety of staff. As noted by staff working within the Villages aged care facility, the Registered Nurse, Personal Care Assistant or SEN, and domestic staff all meet for a half an hour period to discuss the care needs of residents who are on RCS assessment or review. This ultimately benefits the residents who are provided greater diversity of care in comparison to previous practice of the nurse being the carer and having to identify all care needs. As stated by the Personal Care Assistant:

one good thing that has come out of the documentation and accreditation, the domestic and care workers have input, because they can give us an enormous amount of information about things we don't know, because they can see if the resident is incontinent, they can see things that are happening, they give input and we give input (PCA1-04.03.00).

This team of staff discuss the results of the monthly observations (weight, skin integrity), and evaluate care plans (DON1-07.12.00, PCA1-04.03.00). The staff also make suggestions whether the resident would benefit from the services of the allied health team. Presently the Village utilises a Physiotherapist, Occupational Therapist and Podiatrist. As the Personal Care Assistant explained further:

If we feel that a resident needs something like the occupational therapy team or physiotherapy – these are all things that have improved. These have improved the residents' care (PCA1-04.03.00).

The Occupational Therapists were a recent addition to the facility having been employed six months prior to commencement of my fieldwork. It was obvious whilst interviewing activity staff that the Occupational Therapists had improved working conditions for the activity staff by providing guidance and support. As stated by an activity staff member: “since we have had the Occupational Therapists working with us it has taken some of the pressure off and we have someone to go to if there is a problem” (ACT2-05.07.00). Originally the activity personnel were responsible for developing care plans, however this responsibility was given to the Occupational Therapists while activity staff were able to concentrate on developing and conducting activities for residents. This demonstrates an example of the benefits of using the services of allied health professionals within aged care.

Whilst conducting fieldwork (05.07.00), an education session specifically on documentation was held for all staff members. During the day there was much talk amongst staff who expressed the need to attend as management were concerned about insufficient funding, resulting from inadequate or poor documentation methods. According to the Village Nurse (also Education Co-ordinator) (VN1-26.02.00), there had been previous education on documentation and the RCS. On both occasions, the

Village Nurses were not invited and were disappointed that management would not support Village Nurse attendance. The Village Nurses viewed themselves as separate entities. They did complete documentation, however, the majority of this was for those residents living as independent – Village Nurse work is not accredited or utilised for RCS funding purposes. The activity staff member who was being interviewed on the day (ACT2-05.07.00) also commented that she was unable to attend as it was during working hours and there was nobody to replace her. (See Chapter on 'Education' for further details on staff working as a team and the education programme offered to staff).

4.4 Ageing in place and the provision of a continuum of care

As part of the aged care reforms, there has been a move by the Federal government to endorse 'ageing in place' as part of the aged care reforms, whereby older people are provided support services and systems to retain their independence and health and remain living within the community. This also occurs within a retirement village, whereby the older resident living within the independent unit, remains until they are no longer able and then move into usually low level care. For those in the hostel (low level care) or nursing home (high level of care), under the reforms, these facilities were amalgamated to promote ageing in place. The terms nursing home and hostel were replaced by the amalgamated term 'aged care facility' which aimed to provide ongoing or a continuum of care as well as help reduce the negative stereotyping of the term, 'nursing home', which is often equated with deteriorating health and death (Wilson, 1984).

As Gray (2001) recognised, the Aged Care Act 1997 does not define ageing in place. Stein, Jackson and Mannix (1999) defined ageing in place within the Australian context as “the provision of support services to a level which will enable an older person to remain in the living environment of their choice” (p 34 cited in Stein, Jackson and Mannix, 2000). The Aged Care Act 1997 promoted this concept through the aged care reforms. The reforms removed the division between hostel and nursing homes allowing providers to retain residents in the aged care facility which offers low and high levels of care. The reforms further reinforced this by introducing a single “classification and funding tool” (Gray, 2001, p 194) through the Resident Classification Scale (RCS). As Gray (2001) further noted:

ageing in place . . . creates the opportunity for providers to choose to provide the full continuum of care by removing the legislative and administrative barriers that prevented it in the past (p 195).

Stein, Jackson and Mannix (2000) however proposed that ageing in place “presented a challenge to those who assist older people to age-in-place” (p 13) .For example, low care facilities may not be designed to accommodate high care residents. There may be difference in staffing knowledge, more equipment such as high-low beds and lifting machines are required in high care and structural design may not be appropriate.

Krothe (1997) however suggested that elderly people prefer to remain in their own home and age in place. He suggested this is economically viable and provides greater opportunity for the older person to “maintain control of their lives” (p 219), and live a healthier life than those institutionalised, that is if they are provided the necessary services. Ageing in place also applies to residents living within the retirement village’s independent units in which services are provided according to the provider,

and residents are monitored in some form. For example, the Village Nurse did random checks to ensure residents were well. Residents themselves also tended to keep a watchful eye on their neighbours and reported concerns to Management. Independent residents themselves identified that new residents entering independent living are older and frailer and this appeared to be creating some animosity and concern for residents that had lived in the Village for up to twenty years. Residents informed me that they had been instrumental in making the Village what it is today, a Friendly Village of residents who have been actively involved in fundraising events and providing a voluntary service to the Village and facility. As noted by an independent resident:

People that are now . . . moving in their 80s are not able to join into the village and not participating because they are not capable or interested. So they are missing out on being in the village and the village is losing (IR8-04.05.00).

The Village Nurse also noted that the policy ageing in place is idealistic “but the practice is lacking badly” (VN2-02.06.00):

it is great that people can stay at home where they are happy and have all their valuables rather than move into a little single bed sitter type of environment. It is much nicer to be able to have all your things spread out in your own home, if of course you can do it (VN2-02.06.00).

The Village Nurse is referring to the older person’s health and ability to care for one’s self. Unfortunately it appears that the theory is unrealistic with society’s structure; Australia is a vast country with amenities often accessible only by motor car and families tend to become geographically distant reducing family support mechanisms. The Village Nurse identified that independent residents already have difficulty “with transport getting to and from their appointments” (VN2-02.06.00). The Director of Nursing also had some reservations with regard to this policy:

It would be a wonderful idea if we could all grow old where we want to grow old, however, communities are such these days that young people are working. There are so many more mothers going out to work and so many families are split so you consequently don't have the family unit that can support the older person in their own place (DON1-07.12.00).

The other disadvantage with ageing in place is limited assets to fund an ageing population. As recognised by Ratnaike (1998) with an increasing ageing population, there is the inevitability of increasing health care costs associated with greater utilisation of community and health care services yet “both government and private health care providers are actively seeking and implementing initiatives to decrease expenditure” (p 21). Ratnaike (1998) suggested that with policy decisions to reduce expenditure in aged care that older people's well-being be ‘monitored and evaluated’ through health indicators such as the “measurement of quality of life (QOL)”. QOL as defined by the World Health Organisation is:

an individual's perception of their position in life in the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO, 1993a cited in Ratnaike, 1998, p 21).

A number of staff and residents voiced concern and frustration regarding the limited amount of funds available in the aged care setting including the facility and independent living. As stated by the Village Nurse: “Funding is the biggest problem, I mean it is funding with a capital F” (VN2-02.06.00). The Personal Care Assistant identified the necessity to increase documentation to receive some funding - “You know you have 10 people to write on and if you don't do that you don't get the funding” (PCA1-04.03.00). The Gardener exhibited frustration:

we have to squeeze every cent out of the Finance Manager and gardening is on the bottom rung . . . and yet they want the place looking nice. It does get frustrating (GARD1-25.05.00).

In a country like Australia, we are unable to fund a public transport system whereby all members of the community have access to a safe and extensive system. Transport availability and suitability to the older population would enable the elderly to access community services, however there would then be a need for a greater number of services and staff to cater for our ageing population.

Within independent living in the retirement village, the Village Nurse noted the limitation of funding:

there is not enough funding to . . . back the policy [ageing in place] . . . we are finding . . . in the independent units . . . people have to reach a much higher level of dependence to get into the hostel . . . people cannot get into hostels if they don't get their points [RCS] up (VN2-02.06.00).

Staff were actively attempting to raise funds through Open Day in which I attended noting that different staff and independent residents were involved in selling crafts, and cakes and the General Manager was busy making hotdogs. Staff also had fundraising activities throughout the year, however they were only allocated one raffle per year being a religious organisation. Areas such as diversional therapy (activities) had an allocated budget that was insufficient and therefore they were required to raise further funds through resident craft groups and selling these products on Open Day and at fetes. An activity staff member explained how she funded activities and the Director of Nursing also discussed fundraising issues in greater detail that demonstrated the ageing and increasing frailty amongst residents:

I make the money . . . We have the residents who make things in the craft room, we make heat packs that we sell . . . I keep as much as I can for open day . . . and we normally sell what we have . . . But I get no other funds (ACT1-11.03.00).

Because we have a fair degree of church background to the village, raffles and things like that are frowned upon. So we have to be very diplomatic in how we raise funds.

Consequently each department is allowed about one raffle a year . . . For the nursing home we have things like the auxiliary which is a group of women in the village who devote time and effort to helping the frailer residents. Initially it was just for the nursing home but as residents in the village become increasingly frail some energy and funding is being channelled towards that (DON1-07.12.00).

What is identified in the aged care setting is the need for older people to have intimacy and care; once older people receive care or companionship either physically or emotionally, the older person's health improves (DON1-07.12.00, VN2-02.06.00). An independent resident confirmed this further relating her own situation when she was caring for her mother:

I often wonder if they spend their money and time in the right areas. . . I know that when my mother was quite aged and I would go down there and I would try and do her housekeeping and shopping and she would always say, "are you going so soon" and she would ask "can't you just sit down and talk to me" . . . I mean people can get by without a lot of things, but they can't get by without human contact (IR6-08.04.00).

When residents are assessed from independent living either from the Village or community as having to move into residential care their health often improves. The Director of Nursing identified this as providing residents with "Maslow's³" hierarchy of needs enabling residents to "thrive". The negative effect to this however, is that funding is reduced through the current RCS system (DON1-07.12.00). As the Village Nurse and Physiotherapist explained further:

as soon as they are receiving support that they really need, their health improves and their outlook improves and they go back to being independent really in a safe and secure environment. Then as a result because they are suddenly able to function independently they don't warrant any points but they are only able to function when they are in that type of environment, not out in the world. (VN2-02.06.00).

³ Abraham Maslow (1908-1970) was a humanistic theorist and identified individuals' needs from the most basic or physiological needs (such as food and water), to safety, love and belonging, esteem and finally self-actualisation (Berger, 1988).

We are just aware that we have to write it all down; every little thing and what is relevant. It leaves a bad taste really because you are constantly trying to improve the quality of life for people but you are actually cut off (funding) when you get there; it doesn't seem right. As long as you appear to be improving things but you haven't got to quite get there. When you are there, you get penalised. It is a bit of a nasty taste. You are penalised for improving the resident's quality of life. It seems that you lose the perception of what it is all about and they focus on what is worth most and it isn't as much about the resident as such (PHYS1-12.10.00).

For the managers of aged care facilities there appears to be no financial incentives to improve the resident's quality of life with the current funding system (RCS). This system places the responsibility on the provider to spend money in accordance with their requirements, yet recognising that they are responsible for ensuring quality of care. As recognised by the Village Nurse and Director of Nursing, often the resident's health improves and they then become increasingly independent whilst living in the hostel. This results in government funding being reduced and often ceased as the resident may have entered the facility as a Category 6, however with the care and support systems within the facility, the resident moves to a Category 8. As the Director of Nursing said:

you think that this person is going to get points on the RCS scale and suddenly they don't because they have improved . . . the government does not reward us for improving the resident's quality of life (DON1-07.12.00).

The current RCS tool appears to have been developed to provide facilities funding through a treatment model of care, not necessarily through a preventive programme that would be more advantageous both financially and to the health of residents. The Village Nurse demonstrated an example of the Resident Classification Scale. Older people often become increasingly anxious living in their own home, often leading to ill health. When the anxiety is removed, often on entering an aged care facility, their health improves:

If someone is incontinent you get points [RCS] and if they need a shower you get points, but often someone is quite physically capable of doing those things, but as people get older they get so much more anxious and fearful . . . If they can have that anxiety removed they are quite fine, but while the level of anxiety is there . . . that does not warrant enough points [RCS] to bring them up to a financially viable situation to bring them into the hostel (VN2-02.06.00).

If older people are to age in place, as Krothe (1997) recommended, services and programmes need to be developed in consultation with older people. However they are often based “on providers’ perceptions” (p 211) or policy makers themselves. Nevertheless, ageing in place may contribute to removing the negative stereotyping attributed to aged care facilities, particularly nursing homes in which the notion that moving into aged care is a downhill progression from independence through to dependence and death, which was a reported finding in Krothe’s (1997) study. Overall, Gray’s (2001) ‘Two Year Review’ reported that providers of aged care have generally ‘embraced the concept’ (p 199) however there remains concerns regarding staffing levels and whether staff are adequately trained and skilled.

4.4.1 Changes in legislature: what it means to residents and staff

The Accreditation Standards state that the guidelines are not “prescriptive” (p G1), however they are there to provide guidelines for individual facilities to develop policies and practices for the needs of staff and residents. The Village employed an Accreditation Co-ordinator whose role was to develop the policy and procedure manual. Staff were not actively involved in developing this manual, but were asked for clarification in some cases; for example as stated by the Personal Care Assistant, “she is sort of clarifying it with us” (PCA1-04.03.00). There were feelings amongst staff of being overwhelmed with the amount of change in the aged care system over a

short period of time (PCA1-04.03.00, DON1-07.12.00, MAIN1-01.06.00, VN2-02.06.00). As stated further by the Personal Care Assistant:

There has been a lot of change recently. It is a lot to take in. The pressure is on . . . I know you need Standards and you need to have Guidelines, but with the RCS documentation and all of the Accreditation and everything I think we are overwhelmed by it all (PCA1-04.03.00).

The Village Nurse related the current system in aged care to a pendulum:

It has gone from like the pendulum swinging from nothing to too much hopefully it will drop back into the middle at some stage and then we shall have more common sense but still maintaining the regulatory process (VN2-02.06.00).

There were differing views on legislature from being “excessively pedantic” (VN2-02.06.00) and mandatory (VN2-02.06.00, MAIN1-01.06.00, DON1-07.12.00) but understanding that this system may ensure that those that are vulnerable in our community such as the elderly are not abused. There was also general questioning amongst staff and residents as to whether the government and policy makers have an understanding and relevant experience in the aged care system. For example there were some suggestions that the government were stipulating that residents be provided single rooms in comparison to the traditional shared room (IR6-08.04.00, MAIN1-01.06.00) however as was evident through the study, this is not necessarily beneficial for the resident. As stated further by an independent resident:

We have the strange situation where the government are trying to force single bed units in the nursing home. I see this ideal when you don't know anyone, but in here they probably would not like it because they want to be with their friends (IR6-08.04.00).

I think this latter point is relevant with government policy and society having to realise that as one ages, the older person is still capable of making decisions. Older people, as individuals can be provided choice – like young people, there are those that prefer the company of others whilst others prefer solitude. Jilek (2000) wrote an

interesting paper on the work of sociologist Erving Goffman and utilised concepts of Goffman's theory in examining residents living in nursing homes. In doing so, he recognised that moving a person into a nursing home, as well as moving any older person into a different environment (eg. hostel) "is a major event in a person's life . . . The most common effect is the psychological stress of moving an elderly, and often frail, person from a familiar environment to an unfamiliar environment" (p 16). He further suggested that:

Providers of aged care must consider the impact of long term residential care on the individual and design procedures for admission and every day life that not only minimise the negative effects of being placed into such an environment, but also improve the experience as much as possible (Jilek, 2000, p 20).

Jilek (2000) continued to suggest that when moving an older person it is necessary to maintain a resident's "[i]ndividuality, autonomy, control and self-determination" (p 17) as well as "connectedness" with family, friends and the community and finally the right to "choice, dignity and privacy" (p 19) in areas such as meal times and personal hygiene and comfort. This latter concept relates to the notion that residents are disadvantaged having to share facilities such as bathrooms and bedrooms with other residents. "Shared bedrooms, toilet and bathing areas contribute greatly to the stripping of dignity and the promotion of minimal privacy" (p 19) however as can be seen above this was not necessarily an issue. In developing policy it is important to remain focused on the individual and their ability of as Jilek (2000) has noted 'choice', recognising the difference in people according to ones cultures, standards and attitudes.

4.4.2 The threat of closure

Conducting the fieldwork during the time of the media attention to aged care and the threats of closure, was an interesting time. It seemed that residents were concerned that I was there in an official government capacity and therefore a threat to their home, with comments such as “everything is wonderful here”, or “I wouldn’t be anywhere else”, whilst declining an interview. I attempted on several occasions to conduct interviews with residents from the hostel to no avail and therefore had to pursue interviews with staff, until residents began to feel settled and confident.

The Maintenance Manager spoke about the closure of a nursing home that was at the forefront of media attention. He described it as one that was a political decision, affecting both staff and residents. “The staff will be crucified over that and they shouldn’t be” (MAIN1-01.06.00). An independent resident also stated:

I feel very sympathetic to a lot of the nursing homes with the criticism because I wonder whether the people who are doing a lot of the criticising are grandstanding and whether they have had any experience in it (aged care). . . . I think the nurses do their absolute best with people who are sick, difficult, incontinent, and I wonder if Bronwyn Bishop knows what she is talking about? (IR6-08.04.00).

There was also concern for the wellbeing of the residents who were in the situation of losing their home and being forced to move to other premises, “that is their home. The trauma of moving them” (MAIN1-01.06.00). There was also genuine concern for the welfare of nursing staff (IR4, IR6-08.04.00, MAIN1-01.06.00) working in the nursing home and the media attention to nursing home closures for malpractice or non-compliance of the Standards.

4.5 International Year of Older Persons (1999) and the promotion of positive ageing

There was evidence to suggest through feedback from interviews and the review of the literature (Bishop, 1999, Sargeant, 1999 and Wilkes, LeMiere, Walker, 1998) that the elderly remain negatively stereotyped. However, Sargeant (1999) suggested that there is “rising interest in challenging the negative stereotypes and myths of old age . . . [from] people around 50 as they start to relate to themselves being older” (p 4). Stereotyping of the elderly was also at the forefront during 1999 which was a year that was designated ‘International Year of Older Persons’, with the theme, ‘Towards a Society for all Ages’. It was the aim of the United Nations that International Year of Older Persons (IYOP), 1999 was “to have each country alerted to the substantial social changes which are likely to occur with the universal demography of the increasing ageing of populations” (Sargeant, 1999, p 5). According to the then Minister for Aged Care, Bronwyn Bishop, the Federal Government commissioned research that reported that the media is “partly responsible for narrow perceptions of older people” (Bishop, 1999f). This was supported by reports from IYOP which attempted to address issues relating to ageism with people both young and old viewing ageing negatively (Sargeant, 1999). The Government also provided financial support for the IYOP to be spent on projects, activities and the ‘Australian Coalition ‘99’, with this latter being an IYOP initiative. ‘Australian Coalition ‘99’ provided updates, interviews and projects advertised through its ‘National Update Newsletters’ which were also available through the Internet (Australian Coalition ‘99, 1999).

Sargeant (1999) recognised that IYOP offered “small grants to community groups to promote positive ageing” that helped lead to “the development of strong networks” (p

8). Social capital (discussed in Chapter 6 – Community Action), is a term being used to demonstrate the importance of networks and people working together collaboratively. Nevertheless, the concept of ‘social capital’ has the capacity of also negatively stereotyping the elderly. As noted by Leeder and Dominello (1999):

here is the derivative function of capital – to be productive – which suggests that the primary purpose of society and all individuals is to produce. . . ageist attitudes towards the unproductive elderly might find support, . . . from the messages proclaimed by the advocates of social capital (p 428).

Furthermore, Bishop promoted productivity amongst the older population. This is evident in a speech to Aged Care Australia and the Australian Association of Gerontology, at the 1999 National Conference, in which Bishop stated:

the pension deferment bonus scheme where anyone of pensionable age and entitlement who defers taking the pension for up to five years, registers with Centrelink and continues to work 20 hours a week, can receive a lump sum tax free payment at the end of that period of up to \$21,000, and for a couple, \$36,000. . . We are getting rid of the compulsory retirement age of 65 from the public service (Bishop, 1999c).

Bishop also recognised the importance of the International Year of Older Persons in which positive messages regarding the elderly population could be sent. She suggested that this would be the beginning of “long term cultural change” whereby older people would be “valued for their continuing contribution to the community” and recognised for their “wisdom” and “experience” (Bishop, 1999a).

A study conducted by Wilkes et al (1998) at Nepean Hospital in New South Wales aimed to identify the attitudes and knowledge of nurses working with elderly people. I acknowledge that Wilkes et al (1998) study was hospital based in comparison to an aged care setting, however as noted:

numerous researchers have found that health workers in general have negative attitudes towards older people and literature shows that the attitude of health care professionals to older people affects the quality of care older people receive (Wilkes et al , 1998, p 9).

The results of Wilkes et al (1998) study indicated that nurses have “an overall negative attitude to older people” (p 11) in which they hold stereotypical views such as older people being unable to learn new skills and that they are “inflexible” (p 15). However, these findings were not evident in this study, but I did not ask questions specifically on ‘attitudes toward the elderly’. I did ask what ‘relations’ were like between residents and staff, and this revealed a high regard. The Gardener during her interview did provide her own experience and insight into her change of attitude once entering the field of aged care (my further question in italics):

Families don’t come and visit their relatives . . . But I mean I don’t visit my nanna either and that has only dawned on me since I have worked here. Because you just think of them as old. They are old people but you realise when you work here that they are really nice and interesting and personally I think, “I should go and see my nanna”. But I am disappointed that they don’t come and see their relatives. *Why do you think they don’t?* Because I suppose they also think they are stuck in a retirement village and they are just doddering around (GARD1-25.05.00).

The Maintenance Manager also suggested that people do not want to consider their own inevitable ageing and likens visiting a retirement village to a dentist:

you never want to know about where a dentist is, or retirement or elderly, I’m getting old, you don’t want to know about going into a nursing home and carking it (MAIN1-01.06.00).

There were a few suggestions from staff and residents living within independent units that negative attitudes may be a consequence of inadequate understanding which would suggest a need for further education. As noted by the Physiotherapist:

I find people don't know how to treat older people. I may take someone to x-ray and they don't have a clue how to treat them. The fact that the person might not be able to hear or can't see and they also get confused. People don't have any idea of approaching an elderly person (PHYS-12.10.00).

Other suggestions to reduce negative attitudes, was, for example, to promote interaction and programmes between young and old, however there was some scepticism from independent residents whether this could occur, as a result of recent vandalism and residents being fearful of the school children (IR8-04.05.00, IR6-08.04.00). And an independent resident suggested that understanding about ageing occurs when you become old – “When we get to the same age as our parents, you think, was I that ignorant?” (IR6-08.04.00). This is not necessarily the situation, it is dependent upon individual values, beliefs and knowledge in our attitudes to older people. This latter point leads to comments made by the Gardener and by the Registered Nurse:

You know you have these old guys doddering around the veggie patch and I always think they should get the school kids because they do horticulture at school so they should bring them over here once a week. I told the chicks in admin to start bringing the kids over once a week to help with veggies and it will help break down the barriers between “you cranky old man” and “those mongrel kids”. I think this would help (GARD1-25.05.00).

A few months ago I was talking with a 21 year old girl, who was a lovely girl and she had taken two of the senile ones out, one in the wheelchair and the other walking and she took them over to the little park here and she brought them back and had a cup of tea with them and they both loved it . . . I thought those that are on the dole should be doing that; it would make them feel more worthy of themselves and they could learn things here. You can learn a lot from the elderly (RN1-11.03.00).

SUMMARY

This section has investigated the thoughts and ideas of residents and staff, and findings from researchers with regard to the reforms that occurred in aged care in

1997. As is evident, there are both positive and negative issues with regard to these reforms. It would seem that further change and review of current policy is required, particularly with regard to staffing levels and skills mix. The current funding system may also benefit from further collaborative change, including the thoughts and ideas from those using the 'tool' and those that are understanding of the benefits of a preventive programme using allied health staff. Ageing in place also appears to have its downfalls particularly within the Australian context with the suburban sprawl making community services limited especially for those in rural Australia. However if one thinks about provision of retirement villages that accommodate those that prefer this environment for its social benefits, this has its advantages if developed collaboratively between administrators, staff, residents and relatives. Nevertheless, with the ageing population in this setting, residents would benefit from further support services. This would probably require further investigation by policy makers to decide on allocation of funds. Overall however the reforms did aim to include the community and family members. But we can hope that further changes are made to achieve quality of life for the older population, a healthier work environment for the staff, support services for the residents, community, relatives and staff, and a place where relatives enjoy visiting.

In the next section, I will continue to analyse the Standards and Resident Classification Scale in relation to the Ottawa Charter's action area, creating supportive environments. Creating supportive environments will incorporate issues relating to the provision of support services and personnel within an aged care setting.

Chapter Five

Creating a supportive environment through the provision of support services and personnel within the Village

The Village provided a myriad of support services and personnel. The types of personnel that contributed to a supportive environment included the community; staff and residents. Support services consisted of the provision of the village bus; emergency buzzer in all rooms and units; cleaning, laundry, meals and personal care for facility residents; home care including meals and cleaning for independent living residents; a cafeteria; doctor's surgery; hairdresser; gardener; maintenance; respite; day care; chemist; and a continuum of care from independent living through to nursing home or death. Some of these services were discussed in detail during interviews and will be discussed in this Chapter, together with supportive personnel with reference to the Ottawa Charters action area Creating Supportive Environments.

Cookman (1996) suggested that when working with older people there is a need to assess whether their environment is conducive to well-being. As stated by Cookman (1996) "Attachment theory holds promise as one framework for describing the environment in terms that . . . embrace a more holistic view of environment and aging" (p 228). Environment to Cookman (1996) includes attachment to places, for example, to their 'home', things as "cherished possessions" such as photographs, furniture and jewellery (p 228), companions, such as pets, "ideas, beliefs or

memories” (p 230) and to people. This chapter will include a discussion of the importance on people in creating a supportive environment.

The Ottawa Charters (WHO, 1986) action area creating supportive environments recognises the need for people:

to take care of each other, our communities and our natural environment. . . . Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable (p 1-2).

The environment as defined by the World Health Organisation’s (1986) Ottawa Charter includes the “natural and built environments”. The Charter also acknowledged that “Work and leisure should be a source of health for people” (p 2) and leisure activities will be discussed with reference to the activity programme for residents from the facility and independent living.

The Commonwealth Department of Health and Family Services (1998b) ‘Standards and Guidelines for Residential Aged Care Services’ utilise the term ‘supportive environment’ in the guidelines for Standard Three – Resident Lifestyle, which reads:

Standard 3 addresses the criteria that focuses on providing the resident with a supportive environment that does not limit the rights and responsibilities of the resident to remain an active member of the community in areas of their choice (p G-55).

A previous report from the Commonwealth Department of Health, Housing and Community Services (Nutbeam et al, 1993) - ‘Goals and Targets for Australia’s Health in the Year 2000 and Beyond’ identified four principle areas of action, one of which was fostering healthy environments. As stated by Nutbeam et al (1993):

Creating supportive environments for health is a vital component of any effort to achieve greater equity in health, particularly because the adverse impact of the environment on

health is generally greatest amongst disadvantaged groups (p 175).

The types of supportive environments that were discussed at length by staff and residents included food, dietary, gardening and transport services which relate to the 'living and working environment'; maintenance services including issues of safety and security relating to the 'built environment'; the activity or social programme available for residents which relates to 'leisure'; and to the people themselves (the staff and residents) that relates to caring for each other.

Krothe (1997) conducted a study conducted with older people living in the community facing the prospect of entering aged care. Essential services that the older people saw as helping to maintain independence whilst living in their own home included nursing care, home help, meals, transport, "home maintenance" and the overall socialisation that occurs with the provision of these services (p 221). This is also consistent with services offered by the Home and Community Care (HACC) programme offered to elderly people living in the community. The majority of these services as well as those of the Ottawa Charter relates to Standard Four - Physical Environment and Safe Systems and Standard Three – Resident Lifestyle. Standard Three will be discussed during analysis of feedback from residents and staff with reference to the activity programme. The principle though of Standard Four relates specifically to the physical environment and reads:

Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors (p S-42).

Within Standard Four, the residential care service must be certified according to the providers approved number of aged care places. Certification is considered when the Secretary is satisfied with first, the services standard of "buildings", "equipment" and

“care”, second, a provider’s previous “conduct” and “compliance” and third, any “other matters” pertaining to the “Certification Principles” (Commonwealth Department of Health and Family Services, 1998a, p G-85, and Commonwealth of Australia, 1997a, p 131). Other regulatory requirements are in accordance with each State and Territory and it is the responsibility of the administrator of the service to identify and comply with these regulations. The Standard’s provide examples of regulations that are specific to Standard Four and will be addressed in this chapter, dependent on its relevance. For example the Food Act relates to issues surrounding food and dietary services, and the Building Code of Australia to the Maintenance service.

5.1 Food and dietary services

Meals are an important component to everybody’s life; providing the body with nourishment and hydration, celebrating culture, religion and special events, a means for socialisation and overall enjoyment. Various studies such as Moore (1999) and Blaser (1990 cited in Bonnel, 1995) have identified the large amount of time some residents spend in the dining room. In Moore’s (1999) study which was conducted in a Special Care Unit, residents spent 65% of time in the dining room, with the majority of this time spent with “very little stimulation and little social contact” (p 143). And as noted further by Moore (1999) for some residents particularly those with dementia, inactivity can result in wandering behaviour. For the elderly meals may offer comfort by overcoming hunger as well as providing time to socialise, or sometimes disappointment and frustration if the person has meals that are unappetising or the person is unable to eat for various reasons such as a feeling of fullness from constipated bowels or from sores/ulcers in the mouth from poor fitting dentures. The Dietitians Association of Australia (1998) and Home Economist Bunney (1997)

recognised that “nutrition plays an important role in maintaining independence of older people” (Bunney, 1997, p 69). Lipski (1996) also recognised that if residents have “an inadequate nutrient supply to meet body requirements to maintain health” malnutrition may occur (p 14). Hartz, Russell and Rosenberg (1992), Chapman, Samman and Lilburne (1993), Stuart (1993), Dawson-Hughes (1996) and Holick (1996) all recognised that Vitamin D deficiency which can cause osteomalacia is common amongst the elderly especially those that are housebound or institutionalised. Bowel management, particularly constipation, is also problematic in aged care facilities, as recognised by the Standards and Resident Classification Scale. Nevertheless, there have been a number of positive outcomes from effective bowel management programmes that can lead to cost savings from reduced use of laxatives and suppositories and staff time (Stuart, 1993). An example of this positive outcome was reported in a long-term care facility in Ottawa, Canada in which fluid and dietary fibre were increased gradually, a schedule for toileting and an exercise programme were initiated. Benton, O’Hara, Chen, Harper and Johnston (1997) reported a decrease in urinary tract infections and behavioural problems, improved staff “interaction with patients” and a feeling of “[e]mpowerment” (p 16) following reduced use of, and prescriptions for, laxatives. It is for reasons such as these that Bunney (1997) recommended that “[s]preading a relevant nutrition message that can be integrated in terms of food is essential” (p 69). Good nutrition is also an important factor for promoting quality of life; an important component to the Ottawa Charter (WHO, 1986).

There have been a number of educational and other programmes and resources available to assist those working with the older population and the elderly themselves

to help combat malnutrition. For example, the Food and Nutrition Policy (FNP) (Commonwealth Department of Health, Housing and Community Services, 1994) was developed in 1994 which acknowledged “the importance of good nutrition in reducing ill health in the community” (p 3) thus having a positive indicator on the economy. This policy included the elderly as a group with “special needs” (Objective 3, p 17) and recommended development and implementation of programmes “which support the Australian Dietary Guidelines, and foster community participation” (p 12). It also recognised the importance of ensuring food remains uncontaminated from chemicals and pesticides as per the Food Act 1984 and that quality produce with “acceptable taste and appearance” is produced in preference to the large quantities of unacceptable food (Commonwealth Department of Health, Housing and Community Services, 1994, p 6). Health promoting settings, particularly primary schools and healthy cities in developing countries have incorporated food safety into the implementation of supportive environments (WHO/UNEP, 1993 and WHO/SEARO, 2000).

Since the introduction of the Food and Nutrition Policy, there have been various project developments two of which were aimed at the elderly population – ‘Nutrition for older people project’ and ‘Ethnic aged nutrition project – A world of food manual’. The first “project was conducted by the Australian Pensioners and Superannuants Federation” (Department of Health and Family Services, 1998, p 37) who developed a nutrition resource – ‘The Proof of the Pudding’. The resource kit was evaluated and “received a strong positive endorsement from professionals” (p 38). The second project is specifically oriented to ethnic facilities or those that enjoy celebrating cultural days. Kovesdy (1997) identified that with Australia’s multicultural society there is a need for aged care facilities to take into consideration

services to cater for the ethnic persons dietary and religious needs. Both resources could be advantageously used by educators and food services staff who work in aged care.

With an increasing ageing population including those that live within independent units, as was evident during the study, residents may benefit by being provided with support and education to ensure malnutrition does not occur. Poor nutrition can lead to unnecessary increases in health care expenditure. The Health For All Committee (1988) identified that poor nutrition in the community accounted for six billion dollars in health costs recognising that a percentage of this was from the elderly community (AHMAC, 1988). The Dietitians Association of Australia (Victorian Branch) (1998) explained:

malnutrition can lead to an increased risk of falls and infections, poor wound healing, and poor recovery from surgery. It may lead to decreased appetite, dental problems, depression, apathy, and even dementia. Poor nutrition (sometimes malnutrition) is one of the major reasons why elderly people become frail and dependent. Poor nutrition reduces quality of life and also increases the cost of health care for the individual and the community (p 11).

The joint work of the Victorian Department of Human Services and the Dietitians Association of Australia (Victoria Branch), 1998, developed a Resource Manual 'Identifying and assisting home based frail elderly people who are nutritionally at risk'. This resource was developed to assist the Home and Community Care (HACC) programme to introduce Nutrition Risk Screening as part of the assessment process. The Nutrition Risk Screening programme included a screening tool, both a resource and training manual and a booklet for the client or older person. The booklet 'Good food and health advice for older people who want to help themselves' was written for the older person, and their families and carers in an easy to read large format with

important nutrition messages written in boxes, for example: “Take at least 6 to 8 cups of fluid every day” (p 13).

A further document specific to older people living in the community and those that live within independent units within retirement villages - ‘Eat well for life: A practical guide to the Dietary Guidelines for Older Australians’ was produced by the National Health and Medical Research Council (2000) and contained a revised version of the Australian Dietary Guidelines specific though to the elderly population. As shown in Table V guidelines 3, 4 and 8 were added to the original Dietary Guidelines making the Guidelines for Older Australians specific to the needs of this population.

A programme called ‘Caring Hands’ implemented a number of interventions to combat malnutrition with positive results. These interventions included:

- provision of education for staff in understanding and working with dementia;
- development of relationships between the caregiver and resident thus promoting effective communication;
- reducing the amount of confusion at meal times and providing a relaxing dining atmosphere; and
- providing foods that are appetising, for example, finger foods, and for those with dysphagia, a texture modified diet with sensory appeal. Herne (1995) recognised that food also needs to be familiar to the person, as unfamiliar food will be neglected. It is therefore important to gain a history from the resident’s family and friends as to the residents likes and dislikes, mealtime preferences, cultural

requirements, and medical history that can assist to determine drug/nutrient interactions.

Other steps to combat malnutrition includes review of medication, provision of high energy foods and high protein drink supplements, nasogastric tube feeding, monitoring of height, weight and food intake and provision of eating aids, such as lip plates, feeding cups, angled cutlery and non slip mats. Health education, monitoring, and providing a happy home with nutritious meals to retirement village residents is vital in maintaining health and well being. In doing so, the cost to the community and health care system could be vastly reduced, allowing the elderly the opportunity to remain living independently.

The Ottawa Charter recognises that “[c]hanging patterns of life . . . have a significant impact of life” (WHO, 1986, p 2). The provision of food and fluid that is acceptable to older people will help maintain health and well-being and will therefore assist in preventing malnutrition and deterioration to residents’ independence.

5.1.1 The Village’s Food Service for facility and independent residents

The Village provided a catering service situated in the facility, cooking fresh meals and snacks daily including breakfast, morning and afternoon tea, lunch (12 noon) and dinner (5 pm). The main meal of the day was at lunchtime, and also available at a cost for residents from independent living who either had the meal in the facility or delivered to their unit by Food Services staff. A qualified Chef was employed as the Catering Manager who was supported by a Chef, Food Service Assistants and an

Dietary Guidelines for Australians, 1992	Dietary Guidelines for Older Australians, 2000
1. Enjoy a wide variety of nutritious foods	1. Enjoy a wide variety of nutritious foods
2. Eat plenty of breads and cereals (preferably wholegrain), vegetables (include legumes), and fruits	6. Eat plenty of cereals, breads and pastas
	5. Eat plenty of vegetables (including legumes) and fruit
3. Eat a diet low in fat and, in particular, low in saturated fat	7. Eat a diet low in saturated fat
4. Maintain a healthy body weight by balancing physical activity and food intake	2. Keep active to maintain muscle strength and a healthy body weight
5. If you drink alcohol, limit your intake	9. If you drink alcohol, limit your intake
6. Eat only a moderate amount of sugars and foods containing added sugars	12. Use added sugars in moderation
7. Choose low salt foods and use salt sparingly	10. Choose foods low in salt and use salt sparingly
8. Encourage and support breastfeeding	
9. Eat foods containing calcium. This is particularly important for girls and women	11. Include foods high in calcium
10. Eat foods containing iron. This applies particularly to girls, women, vegetarians and athletes	
	3. Eat at least three meals every day
	4. Care for your food: prepare and store it correctly
	8. Drink adequate amounts of water and / or other fluids

TABLE V
Comparison of the Dietary Guidelines (NHMRC, 1992) with the Dietary Guidelines for Older Australians (NHMRC, 2000)

apprentice Cook. A qualified dietitian or nutritionist is infrequently used, with reliance on nursing staff and general practitioners to assess resident’s dietary and eating ability. An on-site café also offered lunch meals, morning and afternoon tea and catered for special occasions, for all residents, staff, and relatives with the majority of custom from independent residents.

The Food Services Department catered for approximately 180 residents in the nursing home and hostel, and provided a meals-on-wheels service to approximately 20 to 30 independent residents living within the Village. It was identified by Food Services staff that the latter are increasing in numbers, as residents are “getting frailer and they want to keep them in their homes for as long as they can” (FS2-18.05.00). This statement reflects the practice of promoting ageing in place. A further 35 residents (on average) were purchasing meals from the café or from the facility food services.

5.1.2 Menu development and dietary needs

The Standards identify the importance of food and nutrition in a number of outcomes. These Standards are reflected to some extent in the Resident Classification Scale (see table VI). For example, expected outcome 2.11 Skin Care can be classified as technical and complex nursing procedures. This expected outcome suggests consideration of “risk factors such as nutritional and hydration status” (p G-47), and expected outcome 2.16 – Sensory loss reads: “Assessment of a resident’s sensory abilities should include sight . . . smell, taste” and considers use of “assistive devices” (p G-53) such as lip plates that can maintain a residents independence. Cultural awareness and provision of culturally appropriate meals are a necessity under expected outcome 3.8 – Cultural and Spiritual life, which reads, “residents are enabled to maintain their dietary customs according to their religious and cultural beliefs” (Commonwealth Department of Health and Family Services, 1998b, p S-39). Expected outcome 4.8 encompasses a number of support services including laundry, cleaning and catering, under the umbrella of hospitality services. Baron (2000) proposed that there be a focus in aged care to a hospitality model and a shift away

from the current medical model. He suggested that the current model needs “to be explored and exploited if we are truly going to enhance the quality of life” (p 21) for older people. A limitation with the Standards is under expected outcome 2.10 – Nutrition and Hydration that reads: “residents receive adequate nourishment and hydration” (p G-45). This statement can be open to interpretation for staff who have limited knowledge to assess residents’ nutrition and hydration needs. In 1992, the Aged and Community Care Division of the Department of Health, Housing and Community Services “reported a compliance rate of only 40% on this Standard (cited in Hunter and Mahoney, 1997, p 118). Hunter and Mahoney (1997), home economists’ recognised this and suggested the need to develop a clearer nutrition policy. This is particularly important for residents in high level care who are a vulnerable group and as stated by Hunter and Mahoney: “ many [older people] are not in a position to pursue complaints . . . if the provision of that care is somewhat inadequate” (p 119). Yet this Standard does provide a number of “considerations”. Considerations through the Guidelines are not a necessity but are examples for aged care providers to ‘consider’ when developing policies and procedures. These considerations include consultation with residents or their representatives regarding individual preferences including cultural and religious requirements, menu development, “identification” of eating and drinking ability of residents and thus the “identification” of “services and health professionals” in assisting residents with swallowing difficulties or difficulties encountered in meeting their “nutrition and hydration requirements” (p G-45 – G46). In other words, the service would benefit from ‘identifying’ the services of a Speech Pathologist or Dietitian/Nutritionist, but this is not a necessity under the current legislation. Aged care providers can determine their practice of assessing residents’ nutrition and hydration needs and may

consider the use of general practitioners. For this reason it appears that a clearer, more concise nutrition policy as suggested by Hunter and Mahoney (1997) may help protect residents from unnecessary weight loss, malnutrition and other complications associated with a poor diet.

Mealtime and dietary services	
Resident Classification Scale	Standards and Guidelines Manual
3. Meals and drinks	2.10 Nutrition and hydration
4. Personal hygiene	2.15 Oral and dental care
6. Bladder management	2.12 Continence management
7. Bowel management	2.12 Continence management
18. Technical & complex nursing procedures – Blood Sugar Levels, wound healing, suppositories, tube feeding	2.11 Skin care (wound healing)
20. Other services – dietitian	All of the above (eg. dietitian, oral / dental service, continence nurse, medical practitioners)
-	2.16 Sensory loss
-	3.8 Cultural and spiritual life

TABLE VI
Comparison of the Standards with the RCS

Special dietary requirements were prepared by Food Services staff as directed by requests from the General Practitioner or nursing staff (FS2-18.05.00 and FS3-13.07.00). Family involvement in dietary decisions was not evident on analysis of interview data. Also as noted by the Director of Nursing “kitchen staff will often pick up in the hostel that someone is not eating properly” (DON1-07.12.00). This suggests that dietary needs of residents are not effectively being met through the current system and could be rectified with the addition of a qualified nutritionist and speech pathologist. The addition of allied health professionals in a retirement village setting

could offer the opportunity of creating a supporting environment that prevents unnecessary neglect of resident care needs. The Ottawa Charter (WHO, 1986) for example states:

Health promotion focuses on achieving equity in health. Health promotion action aims at . . . ensuring equal opportunities and resources to ‘enable’ all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health (p 1).

The Ottawa Charter also recommends that “health personnel have a major responsibility to ‘mediate’ between differing interests in society for the pursuit of health” (WHO, 1986, p 1). This is not occurring in the Village. If aged care facilities are not using the services of health personnel such as a nutritionist, residents and their relatives are disempowered by not being able to obtain professional advice or ‘information’ and are unable to ‘take control’ of their health unless they are prepared to pay for such services.

One of the activity staff suggested during interview that the diet for residents with chewing and/or swallowing difficulty required attention, suggesting modification to the menus with appropriate foods (ACT3-07.12.00). The omission of a nutritionist and speech pathologist concerned staff including the Catering Manager (FS2-18.05.00), Occupational Therapist (OT1-02.06.00) an activity staff member (ACT3-07.12.00) and Personal Care Assistant (PCA1-04.03.00) as well as myself. As is noted by the Dietary Guidelines for Older Australians (NHMRC, 1999), and other studies (Hope, 1983, Hope and Down, 1986, Kalache and Keller, 1999, and NHMRC,

1999), episodes of bowel disorders such as constipation are prevalent amongst the elderly population:

Many factors contribute to the development of constipation . . . among them the effects of medication; a reduction in physical activity, . . . and a decline in bowel motility. These problems are likely to be greater for residents of aged care accommodation than for older people who are living independently (NHMRC, 1999, p 73).

Often a diet high in fibre and fluid will promote regular bowels thus providing a healthier lifestyle. Hope (1983) expressed concern for the continuance of the treatment method; particularly for residents who are incontinent:

Drugs often produce unpleasant or even embarrassing conditions particularly if incontinence is involved. Procedures like suppositories, enemas, and manual removals are always undignified and potentially dangerous (p 45).

Hope's (1983) study involved consultation with "residents, relatives, medical officers, and staff" (p 46) including Food Services staff who were involved in preparing high fibre foods. In the interim staff were anxious about increased workload until they began to see positive outcomes after a 4 week period with residents improved well-being.

From the Village, the Catering Manager was concerned regarding resident diet and fluid supplements. In this conversation below, she refers to the use of high protein drinks that I recommended in combination with the sustagen, particularly for residents who were losing weight:

We are aware that a dietitian should have a look at it [the menu]. The drinks are something that we haven't entered into 100% . . . We have sustagen. But it is through yourself that we are more aware of the high protein shakes . . . It is probably nicer for them as well (FS2-18.05.00).

This was consistent with the views of the Personal Care Assistant (PCA1-04.03.00) who commented on the inadequate consumption of fluid intake by residents particularly during the summer months and by cognitively impaired residents. The PCA explained that it is difficult to deliver drinks to residents with the present staff resident ratio's. The National Health and Medical Research Council (1999) reported that fluid intake is often reduced in "frail older people and residents of aged care facilities" (p 91), particularly those with dementia who may require prompting to consume fluids. This highlights the need for staff to be supported by allied health professionals such as nutritionists to discuss recommendations on an effective fluid intake programme.

The Occupational Therapist also provided feedback from residents who felt their diet may be amiss, especially those with diabetes. Comments from the residents to the Occupational Therapist included:

"I get gravy and I don't think I should", and "I never used to eat butter" and "I didn't have any eggs and I feel as if I'm eating lots" and "I'm really worried about it" [diabetes] (OT1-02.06.00).

This issue of diabetes was supported by concern voiced by the Catering Manager with a resident who had fluctuating blood sugar levels relating to diabetes. During the course of the fieldwork there were situations whereby staff who knew that I was a nutritionist, asked me to assess residents. The Director of Nursing also tended to refer to me as their nutritionist. I did assist on a few occasions from concern about resident welfare. For example, I interviewed a resident in the hostel who had been placed on a low fat diet for medical reasons, however the lady was identifiably underweight.

Within the Food Services Department, staff did have access to a resource manual that contained details on diets, and the Catering Manager encouraged staff to attend education sessions relating to diabetes and other diets (FS1-01.04.00, FS2-18.05.00).

The Catering Manager proposed that the four-week rotating menu provided sufficient choice for residents. A six-week menu had been trialed but residents did not enjoy many items so the Catering Manager opted to return to the four-week cycle. The Catering Manager (FS2-18.05.00) and Chef (FS3-13.07.00) implied that the residents enjoyed the traditional style meals:

They [residents] could eat a roast dinner every day if they could. They get corned silverside that is their favourite. Chicken tenderloins they tend to like and they like their fish and chips. They like steamed puddings in the wintertime, they love their icecream – jelly and icecream. They would eat that every day too (FS2-18.05.00).

This comment was refuted by activity personnel who conducted food tasting sessions with the residents with the outcome that residents enjoy new food tastes. One could surmise that comments made by Food Services staff are for their benefit. For example not having to learn new skills and the ease of preparing similar meals, in preference to trialing of new dishes. As described by an activity staff member:

We [residents and staff] will often talk about food and I find out what their favourite food was or what they would like to try. A lot of them are quite adventurous and they like to try something a little different. At the moment they are mad on ribbon sandwiches with different types of filling in them (ACT3-07.12.00).

The Catering Manager admitted that new resident admissions were expecting greater choice and variety being a slightly younger generation that enjoy restaurant food. This is supported by findings from the interview conducted by the Cook Manager of the café. The café catered for slightly younger people, the majority of which were those living in independent units. This was also supported by an independent resident

who was having meals in the facility however found them monotonous, stating: “you would get sick of them; you wouldn’t like them for long” (IR5-11.03.00).

From analysing the above, it would appear that the Village would indeed benefit from having a nutritionist to work with staff. A nutritionist could help staff to accurately identify and promote issues relating to dietary management, improve communication between clinical and food services staff and residents and offer educational assistance to incorporate a varied diet. Stewart and Newton (1998) provided a valuable resource ‘Cooking for elderly people’, and suggested that nursing, personal care and Food Services staff conduct regular meetings to discuss menus and means to provide “variety”, “creativity” and have an overall philosophy that food “promotes wellness” (p 47). Bonnel (1995) also recognised the need for nursing and Food Services or dietetic staff to work “collaboratively” in meeting “resident dietary needs” and meal time issues (p 24). The nutritionist could also assist staff in recognising the important role of dietary interventions that has been discussed and developed with the resident, discussing and alleviating concerns and developing individualised dietary programmes in preference to diets from text books. Food tasting sessions such as those organised by the activity staff are also a means to trial new tastes and promote cultural awareness that can be included in revised menus.

5.1.3 Food wastage and risk of food contamination

Residents and staff commented upon the amount of food produced, residents gaining or losing weight and the amount of food wastage. This reiterates the necessity of resident nutrition assessments including individual preferences such as meal serving size being completed by allied health professionals. There were also suggestions that

residents particularly those who have meals delivered to their units may consume a proportion of the meal and then reheat the leftovers for later consumption. This could lead to food contamination, food poisoning and more seriously to death. Food safety issues need to be addressed to promote supportive environments specifically for residents. Food safety issues in aged care food services are addressed by legislation through the Food Act. The Ottawa Charter (WHO, 1986) also recognises the importance of ensuring the “health of the public” (p 2) is maintained. The Dietary Guidelines for Older Australians (NHMRC, 1999) identified the importance of food safety for this generation under guideline – ‘Care for your food, prepare and store it correctly’ with the ageing process contributing to a “decline in immune system function, altered gastrointestinal tract function, and decreased sensory function” (p 48). The majority of residents living within the Village’s facility had a bar refrigerator and often had extra food in their room either purchased by themselves or their relatives (HR1-04.03.00, HR3-02.11.00). It is therefore vital that staff or relatives randomly check residents refrigerators, and provide education on food safety issues in accordance with the Food Act 1984 and ensure unnecessary food wastage from inadequate food serving size.

The following quotes demonstrate the situation with excessive food wastage. Comments include those from the Catering Manager (FS2-18.05.00) and residents both from independent living (IR2-17.02.00 IR5-11.03.00), and the hostel (HR1-04.03.00):

We have a three-course meal at lunchtime [soup, main, and sweet] and I have never been used to all of that. It doesn’t matter if I leave things but I think it is such a waste (HR1-04.03.00).

I don't know how they eat it all. We have tried to take it [food] away from them. They have soup at lunch and teatime . . . They are well fed (FS2-18.05.00).

A lot of them [the residents] go from here [independent living] and they go into the hostel and get so fat because they eat everything that is put in front of them (IR5-11.03.00).

There was too much, I couldn't eat it all. Most people can't eat it all so they save a bit and eat it for tea (IR2-17.02.00).

These incidents of food wastage may also be a result of other complications, such as resident preferences not being considered, or food that is unfamiliar to residents including texture modified diets, or problems associated with oral health.

5.1.4 Oral health and the negativity of vitamised meals

Cluskey (1989) conducted a study to examine the reasons why residents are placed on texture modified diets, that is pureed or vitamised diets. Unfortunately results indicated that these diets are “relatively common” (p 13) amongst institutionalised elderly, and that there is “limited involvement of physician and dietitian” (p 16) consultation. She also acknowledged that loss of teeth, dysphagia or residents with behavioural problems such as those with dementia do not necessarily require this diet. Vitamised diets often lack sensory and textural appeal and for those with dementia, residents are unable to recognise food, which is an important aspect for stimulating appetite. During interviews with residents in the hostel, it was apparent that they had negative attitudes to what they referred to as ‘baby food’.

At one point during an interview with a resident from the hostel, the resident apologised for her speech, “sorry I have terrible teeth” (HR3-02.11.00) which led to a conversation regarding meals. The resident informed me that she had difficulty chewing meat, however when asked if she would opt for vitamised meat, the response

was negative, “I couldn’t bare that . . . It’s awful, like baby food” (HR3-02.11.00). As noted by Hunter and Mahoney (1997) residents with swallowing or chewing difficulty are frequently provided with “pureed food [that] often lacks sensory appeal as it lacks shape and texture, form or visual stimulation and it may result in some food items being eliminated from the diet”. The result is often “high wastage costs”, residents losing interest in the food and thus weight loss and malnutrition (Hunter and Mahoney, 1997, p 122). A similar incident occurred with another resident reiterating this difficulty with their teeth:

I have dentures and the bottom ones are really crook. I can’t bite. I have had the darn things for 35 years I reckon . . . I reckon they are worn out (HR4-02.11.00).

Once again, I asked the question regarding the alternative of vitamised meals and the response was similar to that above (my comment is in italics):

I’m not lowering myself to that. *Lowering yourself?* I’m very independent and I have seen vitamised food up there for different ones [residents]. I don’t like the look of it and I don’t see why I should have this. I can manage all right (HR4-02.11.00).

This gentleman indicated to me that he not only has difficulty with chewing but also with speech, which demonstrates that the facility is not sufficiently addressing the issue of oral and dental health relating to Outcome 2.15 – Oral and dental care. For example the preamble reads that staff have an awareness of oral health and that “dental management assists [residents] as far as possible to eat and talk comfortably” (Commonwealth Department of Health and Family Service, 1998b, p G-52). This outcome also recognises the importance of good oral and dental health on “residents’ quality of life” thus reducing unnecessary “distress or challenging behaviour” as a result of “dental problems” (p G-52). Short (1998) also acknowledged that oral health is an important factor in the health and wellbeing of older people. Poor oral hygiene

like that mentioned above can lead to inadequate food intake either due to inability to chew the food or with meals that appear unacceptable from being vitamised. Short (1998) however identified that unfortunately, people in aged care facilities are among those that have decreased services with limiting factors of accessibility and finances. Short (1998) further recommended that there is the need for States and Territories to follow the South Australian path of providing dental hygienists in the aged care setting in accordance with ensuring effective compliance with Outcome 2.15. This is a positive means of promoting a supportive environment for residents, that has been initiated successfully in South Australia.

Staff working in aged care would benefit from being provided education, both practical and theory based and thus gain an understanding as to what food means to people and also how to prepare the types of food that is enjoyed and easily eaten by this generation. This can sometimes be difficult with Australia having an ageing multicultural society, however as identified above, resources are available. As recognised by the Food and Nutrition Policy “[e]ating is a social activity and a sensual experience, and food and diet are the subject of many deep seated beliefs and practices” (Commonwealth Department of Health, Housing and Community Services, 1994, p 8). The Aged Care Standards also acknowledge to a certain extent the importance of food, for example meal and drink preferences must be considered when residents enter an aged care facility, as well as identifying that diet may play a role in the overall health of the resident. This Village not only provided residents with meals prepared and delivered on the premises, but also offered the invaluable service of an on-site café, discussed below. This service no doubt provides nourishment and thus

reduces the incidence of malnutrition to many of the residents living in independent units.

5.1.5 On-site café available for meals, socialisation and entertainment in a home like environment

The Village provided an extra service of an on-site café which was originally a family home and had the warmth of a home environment with a log fire burning in the open plan kitchen/dining area during winter months with an outlook to gardens, a barbecue area of tables and chairs and a bird table. All residents, relatives, friends and staff were welcome however the majority of custom was from independent living residents. I gained insight into the services of the on-site Village café through interviewing the Cook Manager, visiting on several occasions and having a meal.

Costs in the café were kept to a minimum covering expenses and promoting family participation to celebrate special occasions. The Catering Manager of the facility described the café as “cosy”, “not institutionalised”, a place to go for an affordable meal and friendly atmosphere (FS2-18.05.00). She attributed success to the atmosphere, to the Cook Manager who promoted enthusiasm, and to providing staff access to the service as a means of escapism from work (FS2-18.05.00).

The Cook Manager planned the menu as well as cooking, serving and cleaning with the support of a part time person who helped with waitressing and cleaning. The lunch meal comprised three courses, soup, main and dessert with the main meal and dessert prepared fresh. The main meal consisted of either a roast dinner or an alternative such as a curry. At least bimonthly the café provided something a little different such as a barbecue “to break the monotony” (FS4-19.07.00).

The Cook Manager introduced new styles and flavours of cooking using various herbs and spices, stating that residents “love it” (FS4-19.07.00). Feedback from residents

and staff on the service of the café was positive with comments such as “residents just love going in there” (FS1-01.04.00) and “I am a great believer in that place” (IR6-08.04.00).

This was evident from the amount of residents the café catered for, with an average 35 with numbers up to 50, 16 of whom were regulars. Some of the residents were reliant on the café for socialisation (IR6-08.04.00) whilst others relied on the service for providing nourishment. As recognised by independent residents:

It helps people that are in independent living who have trouble with shopping or cooking (IR3-22.02.00).

I can see the difference in the men particularly who go in there now and get one good meal a day . . . goodness knows what they were eating before . . . I can see the difference in the people that go there. A lot of them have filled out (IR6-08.04.00).

The men in the Village particularly relied heavily on the meal service either from the hostel or café as they had previously relied on their spouse to cook. A health promoting retirement village could offer cooking classes for the men as well as for the women who wish to gain new skills or become adventurous in cooking. This would be in accordance with recommendations of the Ottawa Charter (WHO, 1986) that recognised the importance of ‘enabling’ “women and men” to access “skills” to reduce “differences in current health status” (p 1). As noted by the facility Catering Manager (FS2-18.05.00) some residents from independent living had meals in the facility. However the Catering Manager (FS2-18.05.00) and café Cook Manager (FS4-19.07.00) recognised that residents often felt reluctant to have meals in the hostel as this was the “next step” (FS2-18.05.00) in the continuum of care. Whereas the café provided an ideal opportunity for residents to remain living independently within the Village and therefore fostered the policy of ageing in place. This was an

exceptional service offered by the Village and would be an ideal service for other retirement villages to provide, creating a continuum of care and allowing older people to retain their independence. Projects like 'Proof of the Pudding' and 'Eat well for life' and overseen by qualified educators and dietitians/nutritionist provide a holistic basis for meeting residents nutrition and hydration needs and promote a supportive environment.

The Village café could be recognised as what Fletcher et al (1999) termed a 'community cafe', one that provides an opportunity for socialisation and also a means to promote healthier food choices, "nutrition education and skills" (p 6) such as having a guest speaker or a food tasting session. As stated further by Fletcher et al (1999):

Meals provided for elderly people in residential or community settings should be assessed for adequate nutritional content and acceptability to elderly people (p 6).

Providing comprehensive policies, education training for Food Services staff and thus fresh home made meals on the premises is a vital component to a health promoting retirement village. Meals do not only provide the nutritional needs of the residents but also play a valuable role in socialisation and celebration. As noted by Kovesdy (1997):

Food is more than just something to eat, it has social as well as nutritional functions . . . Food also provides a focus for communal activity and it defines our belonging to or separateness from a group . . . [it] reflect[s] a strong cultural identity (p 131).

This section has discussed the Food Services Department within the Village, as well as issues raised by residents such as oral health and the non-acceptance of vitamised meals. Fortunately, this Village provided a café, utilised mainly by those living

within independent units, thus providing a greater opportunity of maintaining their independence. In the following section I will investigate issues relating to a further service offered by the Village - the Gardening Service.

5.2 Gardening services

The Village grounds comprised approximately 75 acres and were maintained by one qualified Gardener. Residents from independent living queried the plausibility of one qualified Gardener with the amount of land area and responsibility (IR3-26.02.00, IR7-08.04.00), however she was supported by Maintenance staff and contractors. Independent residents also assisted in gardening maintenance, being responsible for their own garden beds, vegetable plots or allotments and the 10 acres of parkland. For those residents who were unable to maintain their garden, they were able to pay for the service which was then carried out by the Gardener or Maintenance staff. As stated by an independent resident: "If we are unable to do our section of the garden we can pay the gardeners to do it" (IR2-17.02.00).

Otherwise, independent residents grew flowers and vegetables on 60 or more vegetable plots/allotments and in the 2 hothouses. They were then responsible for maintaining the plot to grow flowers and or vegetables for their own personal needs or by supporting each other through donating excess to the kiosk for other residents to purchase. This money was then contributed to the maintenance of garden machinery:

The vegetables are taken to the kiosk on Friday and people can take them for a small donation and the money goes toward keeping the equipment maintained (IR4-26.02.00).

The Gardener was relatively new to the Village, however she was evidently optimistic and knowledgeable with her future landscaping plans. She commented:

Over the last 25 years since this place has been built there were people that thought “I’m going to dig a tree there” and it grew 30 foot high and they wonder why their unit is falling apart and when I do chop it down they go “you can’t do that”. . . My main aim here is to have avenues of trees with proper landscaping (GARD1-25.05.00).

This supports the notion of retirement villages having a qualified Gardener to design safe and visually stimulating gardens.

5.2.1 Tension between the gardener and independent residents

At commencement of interviews with independent residents, it was evident that there was tension amongst residents and the relatively new Gardener. A supportive environment though is one that promotes positive relationships. This section has been included to highlight the necessity of good communication skills and working in partnership to fulfil the health goals of individuals. In this case, it was the goal of the Gardener to prevent unnecessary finances spent on reactive maintenance that could be spent on health promoting programmes that will ultimately benefit the resident. The Gardener though had not effectively communicated her plans to residents. The residents spoke about the amount of trees that had been cut down and other plants that had been removed (IR4-26.02.00, IR7-08.04.00). Unfortunately, this tension was being exacerbated by inadequate and seemingly poor communication between the Gardener and residents. As stated by a resident:

I have been a little upset with the look of the Village. The new gardener took out a lot of trees leaving a lot of empty space – disgraceful . . . the garden is a disgrace. It is dreadful (IR4-26.02.00).

This was supported by information gained from interviewing the Hostess. Nevertheless the Hostess was interviewed at the latter stage of interviews and she

recognised that residents had begun to see the benefits and were no longer complaining:

We have the new gardener and she pulled out a lot of plants. They [residents] were really complaining about that but within 6 months they had forgotten because it is now absolutely beautiful (HOST1-02.11.00).

Another resident, during the middle stage of interviews described a resident meeting and demonstrated the lack of initial communication between the Gardener and residents:

There were a lot of complaints about the garden . . . They had dug it all up and left it . . . but they are getting it nice now . . . I think it is going to be a Japanese garden . . . so that was the most negative [meeting] we have been to (IR7-08.04.00).

This resident went on to explain the reason for the garden being “left”; the Gardener was spending the time on ensuring the facility gardens were complete for accreditation (IR7-08.04.00).

Overall on analysis it was apparent that the Gardener neglected to discuss ideas and long term gardening plans with residents. The Gardener was fully qualified and it was clearly recognised by residents and myself that the garden landscape was improving, however if communicated successfully from the initial period of undertaking such a venture, relationships may have been improved. If this had occurred, the Gardener may have had more enjoyable working relations with both residents and Management; providing Management with positive feedback from resident meetings with long term goals including landscaping ideas and ongoing consultation with residents and a successful gardening programme for both facility and independent residents. This example provides a real life example of the importance of communication.

Communicating change to stakeholders of aged care will create a more supportive environment for those that visit, live and work in retirement villages.

5.2.2 Limiting factors to commencement of gardening programmes

The Village's facility incorporated a visually stimulating garden accessible to the majority of residents which is in accordance with expected outcome 4.4 – Living Environment. This outcome stresses that the “grounds of the service are safe, well-maintained and easily accessible” (p S-46). These gardens were fairly well maintained and as Krothe (1997) concluded in her study the elderly admitted that a well maintained garden promotes “well-being” (p 219). The Villages facility gardens incorporated a number of different water fountains and ponds with an occasional park bench. During observation, I felt that there could have been more places for residents to sit as I noticed a number of residents standing admiring the garden. The garden was a walkway through to the facility dining and activity areas for the majority of residents. This path however was built of cobblestones which caused some difficulty with wheelchair and walking frame access as was acknowledged at interview with the Personal Care Assistant:

With all the wheelie walkers, sticks and everything. It is undulating as well, so whoever thought to put this in an old people's home, there is just absolutely no thought put into it. It looks pretty but it is horrendous for the residents. It should be a smooth surface. When you are wheeling someone in a wheelchair you can see the resident bopping up and down (PCA1-04.03.00).

Apart from this, gardening provides residents with “a good social time” (IR4-26.02.00, IR6-08.04.00 and IR7-08.04.00) and residents within the hostel did comment on how they enjoyed their gardening whilst in the Village: “I had to give up my gardening when I came into the hostel and I miss it” (HR1-04.03.00). As stated

by two other residents living in the hostel who enjoyed the gardens surrounding the facility:

I loved the garden. When I was over there (in independent living) I had the vegetable garden – they have vegetable gardens out there. I had one and I also had a flower garden. The bit of garden outside here, I used to look after that, but it got to a stage that I couldn't do it any longer and it has now gone wild. There is a little concrete path down the centre of it and you can't see it as it is covered with leaves and rubbish (HR4-02.11.00).

I've got some pots . . . I water once a week. I mainly sit out in the gardens out the back quite a bit; it is lovely in the afternoon . . . In the beginning I used to go to the gardening sessions. I love gardening (HR3-02.11.00).

The gardening sessions this resident refers to were conducted by the physiotherapy group (PHYS1-12.10.00 and GARD1-25.05.00). The physiotherapist informed me that these sessions were discontinued as a result of time constraints relating to documentation for the purpose of the Resident Classification Scale (PHYS1-12.10.00). The Gardener was not involved in this programme, yet, as indicated above, this programme could benefit relationships and resident enjoyment, if there were sufficient resident interest.

Unfortunately, there were no gardening programmes available to residents in the facility however some residents had their own pot plants that they either kept in their room or in the majority of cases, on their porch in the garden grounds. One resident informed me that prior to entering the facility she did request a north facing unit as she enjoyed growing tropical plants (HR3-02.11.00). Pot plants enabled residents to continue their interest with plants and planting. Accessibility to gardening is impossible for many with deteriorating health, however there are often methods such as raised garden beds that make accessibility to gardening a possibility.

Raised garden beds are a means for elderly residents, including those in wheelchairs to have access to gardening. As noted by the Horticultural Therapy Association of Victoria (1996), there are a variety of advantages to this type of gardening, especially for the elderly. “Raised beds bring soil to an accessible height” and are extremely useful for those with impaired sight. Gardening at this height allows for greater “social contact . . . as people are able to garden from both sides in a group and maintain eye contact more easily than gardening at ground level” (p 3).

The Horticultural Therapy Association of Victoria (1996) recognised that there are a variety of plants and gardens that can be considered to “stimulate interest and have a purpose such as for culinary use, crafts, decoration and sensory stimulation” (p 13). For example a sensory garden “stimulates the use of the five senses” (Horticultural Therapy Association of Victoria, 1997, p 3) – smell, touch, sight, taste, and hearing. A “garden which is visually stimulating arouses a sense of curiosity, encouraging exploration and activity” (p 4) whilst touch and smell may “stimulate memory” (HTAV, 1997, p 4-5) especially important for those who are visually impaired. “Tasting and comparing herbs, or other fruit and vegetables creates interaction and discussion [and is] . . . a valuable socialisation activity”. The Horticultural Therapy Association of Victoria (1997) also recognised that a variety of sounds in the garden such as those identified during the fieldwork included singing of birds, running water from the fountains, rustling of leaves, as well as wind chimes that were not evident can all “evoke memories” (p 6).

As discussed at interview, an activity staff member (ACT3-07.12.00) did suggest to facility residents the idea of raised garden beds, however the residents at this stage were disinterested but admitted to enjoying the look of the gardens. The activity staff member did admit that a 98 year old resident was growing her own tomatoes and a recently admitted resident had pot plants and there may be a need for a programme of raised garden beds in the future. The activity person also advised that the men were even less interested due to their higher frailty levels to that of the women:

They like to go out into the garden but they don't want to do the garden themselves, although one of our residents has got two tomatoes that she is growing in a pot and she is 98 . . . And another resident who has recently come in has her own flowers and pot plants . . . this is it, things change and their needs change . . . most of our men are frailer and less interested than the women (ACT3-07.12.00).

There was also the question of future gardening for independent residents and the period they would be able to maintain their own garden, parkland and vegetable allotments as a result of the ageing population and thus increasing frailty amongst residents (MAIN1-01.06.00, GARD1-25.05.00, IR5-11.03.00). As stated by the Gardener:

There is a high turnover [of independent residents] . . . so when someone you know, moves on . . . we then have to take on the responsibility. Like . . . when they get too old we [the staff] are going to get that park [the parkland] (GARD1-25.05.00).

According to a resident from independent living (IR6-08.04.00), the number of females gardening had increased over the past 7 years; it could be speculated that this relates to the ageing population with the women taking on the responsibility of gardening when their husbands become ill or die. This was supported by an interview with a husband and wife in which the wife stated: "the vegetable patch has been a disaster this year with Mr G not being well" (IR4-26.03.00).

It would appear that the constraints of time and money prevent incentives such as gardening yet it is apparent that residents both in the facility and within independent living enjoy the garden and gardening. Activity staff did suggest that facility residents had shown little interest in a gardening programme, however this could be construed as a result of staff inexperience with gardening. A gardening programme could indeed be collaboratively organised with the professional advice of the Gardener, co-ordinated by activity staff and the life skills of residents utilised in designing a gardening plan and building of raised garden beds. The Gardener reiterated that she was unable to organise an area of raised garden beds as this is the land of the independent residents. "This really isn't our territory as it belongs to the residents" (GARD1-25.05.00). And an independent resident supported this by stating that if they were to have raised garden beds that they would have to pay and, or, do the work to create the gardens as "management sort of leaves you on your own" (IR4-26.02.00). To minimise costs, original building plans need to take into account issues such as raised garden beds. As architect, Paul Archibald (1999) identified, building plans can incorporate raised gardens:

Building planning should be adjustable and expandable and raised garden walls throughout landscaped areas should be high enough to be used as benches by residents and for growing flowers and vegetables if this is desired (p 107).

From analysing interviews, there is no doubt that the population of both independent and facility residents are ageing and thus becoming frailer. It would therefore warrant the administrators commencing implementation of a gardening action plan for the future, including the role of the Gardener, Physiotherapist and activity staff in developing various gardening programmes. It would appear from resident and staff feedback that gardens and plants are therapeutic. For example, as stated by the

Horticultural Therapy Association of Victoria (1997) the sensory gardens may be a source of “validation, orientation, remembrance, cultural identity, warning, awakening, enjoyment and invitation” (p 3). Yet gardening programmes play little role in facility resident’s life and this is supported from the limited amount of references on gardening in aged care facilities. Unfortunately, there is the issue of finance with options such as raised garden beds having an initial outlay cost for construction. However residents especially those living independently and who are presently involved in the woodwork room may be able to assist in the building of raised garden beds. If the issue of increasing age and frailty is not considered, the future garden area for independent residents is going to become an enormous responsibility for the Gardener. It would therefore be advantageous to look toward the future of promoting gardening for these residents in preference to greater responsibility and workload for the Gardener. These gardening programmes would also promote positive relationships between staff and residents and between residents from both independent living and the facility.

5.3 Maintenance Services

The Commonwealth Department of Health and Aged Care (2000) developed an extensive resource document – ‘The Guide: Implementing Occupational Health and Safety in Residential Aged Care’ or ‘The Guide’ as a support document to the Accreditation Standards. This resource assists aged care providers to develop occupational health and safety policies and procedures specific to resident and staff requirements in accordance with the Standards.

5.3.1 A safe and secure environment

Graycar (1999) from the Australian Institute of Criminology suggested that older people (those over the age of 65) “are the least likely to be victims” of crime (p 107) and that a study by the Criminology Research Council (1998 cited in Graycar, 1999, p 108) suggested that “older people are no more fearful than younger people” of crime.

There are a variety of support mechanisms that help to ensure the safety and security of residents and staff living within the Village. For staff, there was, for example, a male Village Nurse employed to do night duty. A resident from independent living commented on the amount of support services available within the entire Village enabled residents to have that “feeling of security” (IR4-26.02.00). This was supported by the Director of Nursing:

Because of the caring environment we work . . . They [residents] already feel secure. . . we had the police come in and talk to us and they told us we have the best neighbourhood watch in here because they look out for each other. . . They feel that they are amongst the security of the staff (DON1-07.12.00).

The practice of ‘neighbourhood watch’ was evident from observation and comments during interview with a resident from the facility. He was aware of resident movement throughout the entire interview, watching through the window or looking in the mirror at the reflection from outside:

I see [residents] going down to catch the bus and I know who is going shopping and who’s not. If I’m not looking out this window, I can see them in the mirror (HR4-02.11.00).

The Maintenance Manager recognised his role in fostering a secure environment for residents:

we are a little town; this is their home, they feel secure and we are trying to preserve that security and that is important (MAIN1-01.06.00).

Unfortunately, during the course of the fieldwork, there had been a spate of vandalism that was attributed to the local school children (also discussed in Chapter 6), yet it would appear from comments made by residents and the Hostess that the children were playing what they thought were harmless practical jokes, while others were vandalising cars and committing robberies. With these episodes of vandalism and from concern voiced at resident meetings, the Administrators had decided to install outdoor surveillance cameras:

Even at the resident's meeting, . . . [residents] were complaining about the number of robberies we have had around here. We have security guys here and now we are putting cameras in . . . A few of the cars were being damaged. But that is being followed up and the cameras should be installed shortly (HOST1-02.11.00).

Nevertheless, an independent resident commented upon the security of the Village compared to living within the community, and suggested that the majority of problems are trivial:

the security here is good. . . things got a bit grim with older people, you know the bashings, I think you get a bit nervous when you are on your own and getting older. . . We have a security door but we are not too worried living here. The worst thing that has happened here is with someone stealing all the hose fittings from the entire village (IR4-26.02.00).

Residents from independent units also had a sense of security with services of the Village Nurses with generalised resident comments such as "if you need help [the Village Nurses] are there for you" (IR4-26.02.00). The Village Nurses themselves were protected to some degree with male staff being employed to do night duty:

Actually to some extent having the male at night is probably better particularly in light with the recent episodes of vandalism (VN2-02.06.00).

The Village Nurses also had the added comfort with the future installation of the surveillance cameras. Cameras were also installed within the facility however with some annoyance from staff, regarding issues of confidentiality and privacy:

I am also not happy about the security cameras that are around. It is particularly those that pick up conversation. We have one outside our office and if we have the door open and people come to discuss something personal and this is being recorded . . . I do not think anybody should have a voice recording (VN1-26.02.00).

Apart from the staff themselves, residents were provided a number of support mechanisms that help maintain a resident's feeling of security including emergency buzzers, fire alarms, building renovations, and repairs and maintenance of equipment, all of which was the responsibility of the Maintenance Department. These are requirements under the Accreditation Standards, specific to expected outcome 4.4 – Living Environment and 4.6 – Fire, Security and other Emergencies, and will be discussed briefly.

5.3.1.1 Emergency buzzers

The majority of staff and residents recognised the importance of residents having access to the emergency buzzer. For residents living within the facility, the emergency button was located behind their bed and also in the bathroom, whereas for residents living within independent units, they had the option of a portable button that they could either place near the bed or for those that were frailer, wearing the button around the neck (IR2-17.02.00). The emergency call was then transferred to the pager system and was received either by the nursing staff within the facility or by the Village Nurses.

There were limitations to this service, for example the emergency button only worked within the Village grounds. For residents living in the facility, it was apparent that the button was inaccessible at times, as an accident does not always occur when in bed or in the bathroom. This matter was broached at a resident meeting with the resident suggesting that independent residents had an improved system, having lived there previously:

The emergency situation down in the village is much better in my opinion. Now if you fall over there and broke your leg, how would I get to the buzzer? It's fine if you're in bed . . . I have mentioned it but apparently it is too difficult to change . . . I can't see that they will allow it if it means a tremendous amount of expense (HR3-02.11.00).

This was supported by another resident living within the hostel who commented similarly:

There is one in the bathroom but it is hard to get at but they say they can't alter it. There have been a lot of complaints about it. It is over the toilet and there have been complaints from different meetings, but they say that nothing can be done about it (HR4-02.11.00).

It would appear that within the Village, independent residents had an improved emergency system to that of facility residents. Nevertheless, falls and accidents are supposedly reduced within aged care facilities and residents have the staff to monitor their whereabouts, yet it may be advantageous for facilities to rethink the current system to a system that is transferable such as that used within independent living as well as through improved building solutions.

5.3.1.2 Building renovations

Maintenance staff had the responsibility of ensuring that independent units and facility buildings were safe, secure and maintained. The safety and security of facility buildings is a requirement under the Standards. During the initial observational stage

of fieldwork, the Village grounds appeared impressive. There were wide paths leading to the units enabling access by motorised scooter, wheelchairs and walking frames. The majority of paths had lights for evening illumination, however there were some areas with no lighting. Ramps were readily accessible from road to path. The concept of Universal Design, that is buildings that are designed to be “accessible or adaptable” for all ages may be advantageous in an aged care setting (Fletcher et al, 1999, p 5). Bridget Sutherland (2000) of Mondo Furniture presented an interesting paper at the Australian Association of Gerontology 2000 National Conference. She acknowledged the benefit of Universal Design and was optimistic that Australia would follow in this direction as there will not only be a long term cost benefit but also safety for the entire community. She accepted the fact that aged care facilities are to be “home-like in character” but also need to be “functional, easily cleaned, maintained and safe” for the residents, their relatives and the staff. For example Sutherland (2000) queried whether the Aged Care Standards Agency inspect the safety issues with regard to fire hazards and the type of furniture materials used in aged care facilities. Aged care assessors are responsible for ensuring that fire equipment is regularly tested and maintained. The Standards recommend that management provide a safe environment that minimises fire and other emergencies (expected outcomes 4.4 and 4.6) but do not contain specific requirements.

Paul Archibald of Paul Archibald Pty Ltd Architects (1999) also identified the advantages of building homes that are adaptable for all ages which therefore promotes ageing in place. In fact in 1998, the Australian Building Codes Board (1999) began review of the Building Code of Australia 1996 (BCA96) and the current classification of buildings. For example, facilities were classified either as low level care (class 3)

or high level care (class 9a) (ABCB, 1999) which was in accordance with the aged care system prior to the aged care reforms. The Australian Building Codes Board (2000) recognised “that many residents progress through a continuum of care from low to high” (p 5). Therefore a further classification to promote aging in place in accordance with the Aged Care Act 1997 was included in the reviewed Building Code of Australia, as classification 9c whereby the facility building provides a multi-care level of care offering both low and high level of care (ABCB, 2001). This concept along with Universal Design architecture would indeed benefit aged care providers who are renovating or building as well as promoting the concept of ageing in place.

Archibald (1999) provided features of Universal Design homes:

wide doorways, level floors, handrails, non-slip floor finishes, correct bench heights, outdoor and indoor living floor surfaces, finishes and levels, alarm systems, security lighting, passages (if any), natural light and ventilation, heating and cooling, solar power, alternative low energy construction and correct building orientation (p 106).

The majority of residents and staff spoke highly of the Maintenance Service with residents from independent living (IR2-17.02.00, IR5-11.03.00) recognising the difficulty and restrictions encountered as an older person living within the community has to organise a tradesman who is unknown by the person. By moving into a retirement village whereby Maintenance Services are available, with its own maintenance staff they become easily recognisable to residents and thus provide a feeling of security (IR2-17.02.00). As stated by another independent resident:

I would be quite prepared to let them [maintenance] come in here and do any sort of repair whether I was home or not (IR6-08.04.00).

5.3.1.3 Repairs and Maintenance

Requests from independent residents for repairs and maintenance on their units were co-ordinated by the Hostess who submitted the request to the Maintenance Manager

who then organised his team including the Gardener to complete the work from changing a light bulb to cleaning the guttering. Costs were covered by monthly maintenance fees payable by independent residents. As explained further by the following quotations from firstly the Hostess, secondly by an activity staff member and lastly by two independent residents:

If they need something doing like the guttering, then the boys from maintenance will go over and fix it to no cost because that is all included in their maintenance (HOST1-02.11.00).

Maintenance is wonderful if something is wrong we let them know and they fix it straight away (ACT2-05.07.00).

if anything goes wrong here, like my toilet here, it gets fixed (IR5-11.03.00).

If you need anything done, like I had grass growing in my gutter, I told the hostess and the next day it was cleaned out (IR2-17.02.00).

The Village units and the facility were all equipped with fire alarms and on a yearly basis Maintenance staff replaced the batteries (IR2-17.02.00). The Maintenance Manager recognised that menial tasks such as this were completed by Maintenance staff thus reducing unnecessary accidents. As quoted from the Maintenance Manager:

We do anything literally from changing a light globe. . I would rather do that because there are a lot of people . . . who have been tradesmen . . . they might be 80 years old and they still feel they can wrestle the world and they fall off the ladder and break their hip. I have to nicely tell them that they can't do that . . . You . . . have to be very diplomatic (MAIN1-01.06.00).

This is supported by an independent resident's comments recognising the need to allow Maintenance staff to make the necessary repairs. "Most of us, if we have a light globe go or anything like that, most of us are quite prepared to let them come in and fix it" (IR6-08.04.00).

There were some negative aspects and suggestions for improvement of the Maintenance Service. For example a Personal Care Assistant was concerned regarding maintenance schedules for facility equipment. An example of this was the wheelchairs that had flat tyres or were generally “horrendous”, with staff having to transfer the residents from one chair to another prior to moving them (PCA1-04.03.00). All facility equipment could be included within a maintenance of equipment schedule thus reducing overall costs in renewing longterm equipment damage. This in fact is a necessity under Outcome 4.5 – Occupational Health and Safety in which facilities have “an equipment maintenance system to ensure routine and preventive maintenance is recorded and undertaken” (Commonwealth Department of Health and Family Services, 1998b, p G-91).

5.4 Transport services

In recent years there has been some speculation whether older people should be driving and whether they indeed cause accidents from deteriorating health such as reduced sight, hearing and reflexes, and even dementia. Geriatrician, Dr Peter Lipski suggested that statistics reveal that “there may be 80,000 drivers over 70 years of age with dementia on Australian roads (Lipski, 2000, p 23).

The New South Wales Roads and Traffic Authority (RTA, 2000) and the Alzheimer’s Association developed a resource booklet ‘Driving with Dementia’ to help families of drivers who have dementia (RTA, 2000). Handbooks have also been produced for different road users, such as the elderly and specific to the State or Territory. For example in Victoria, VicRoads and the Tasmanian Department of Infrastructure, Energy and Resources jointly produced ‘The Victorian Older Drivers’ Handbook’. This book was directed to the older driver and contains a self-assessment

questionnaire to assess their driving ability and practical advice for safe driving (VicRoads, 1999). It would be beneficial if these booklets were made readily available in retirement villages for residents that continue to drive.

Residents living within aged care facilities often have discontinued driving and become reliant on others, whilst residents that live within the Villages independent units may have access to their own car. The Village had a number of car parking spaces within close proximity to the units and I did observe residents driving in and out of the Village. It was apparent that residents often do not drive at night with recognition by residents themselves that they have difficulty driving in poor light. This in fact is a question asked within the self-assessment questionnaire and suggests that older drivers “avoid driving at night or at dusk or dawn” (VicRoads, 1999, p 19).

5.4.1 The Village’s bus service

The Village provided all residents with a bus service however this service is almost non existent during weekends and in the evening. Kalache and Keller (1999) recommended the provision of a transport service to help maintain an older person’s independence. The aged care Standards also has the expectation that residents are able to retain “maximum independence” (p G-67) yet does not stipulate that a transport service is a necessity. Nevertheless it does recommend that residents are encouraged to maintain community contact and that the facility has identified options “other than staff, to assist a resident to have contact with life outside the service” (Commonwealth Department of Health and Family Services, 1998b, p G-68).

The Village's bus travelled around the Village picking up or dropping off residents from the units and from the facility. This service not only provides the resident with greater independence but also helps to maintain and build relationships. For example the bus stop at the facility enabled independent residents to visit friends in the facility and then return to the unit on the bus (IR8-04.05.00). The bus also travelled to and from the local shops including a supermarket and major shopping centres (IR2-17.02.00, IR8-04.05.00, IR5-11.03.00, HR3-02.11.00) allowing all residents to buy necessary commodities such as food. The bus driver also conducted monthly mystery trips for independent and facility residents. During the fieldwork the bus was exchanged for a larger bus as a result of the frequency and overall extensive use of the service. Comments from residents regarding the service included: "The bus is marvellous" (IR2-17.02.00), "We have a good bus service" (IR5-11.03.00), and "We have the best bus service" (IR6-08.04.00).

There were however suggestions for improvement of the bus service. For example the Cook Manager of the café explained that the location of the café is at the far end of the Village inaccessible for some residents who live at the other end of the Village or for those that are frailer. As explained in detail by the Cook Manager of the café:

I have asked the general manager for the bus to stop here so that the ones that can't walk, even for the residents living at the other end who by the time they get here are pooped (FS4-19.07.00).

The Cook Manager of the café also acknowledged that the café meal times coincided with the bus drivers lunch break. She continued to express concern for the wellbeing of residents some of whom become reliant on meals:

[During] summertime there are a couple who come from the other end and by the time she gets here she is pooped and on hot days . . . I think . . . she will one day collapse . . . It's the

same in the cold weather. I don't think she came up today and I think what will she do for a meal. She comes seven days a week and therefore obviously she is not cooking (FS4-19.07.00).

This statement further suggests that residents well-being is sometimes compromised and could be prevented by improved communication between residents, staff and management. This is supported by further comments made by residents and activity staff from the hostel who suggested that there are some limitations to the accessibility to the bus. For example as stated by a resident in the hostel: "It's a bit of a struggle sometimes . . . with the wheeley" (HR3-02.11.00). This was also supported by an activity staff member noting that some of the residents in the facility:

are very frail . . and the steps on the bus frighten them; some of them are so frightened that they won't try even though there is myself and a volunteer and the driver that will help them (ACT2-05.07.00).

During an interview with another activity staff member there was also the comment that "They did have lifts on the bus at one stage but they took it off which I can't understand why when there are so many frail residents (ACT3-07.12.00). The new bus was only recently purchased and there has not been consideration of either hydraulic steps or provision for wheelchairs. This is an omission on the part of management and may have been prevented by consulting staff and residents prior to purchasing new equipment including the bus.

There were also occasions when residents experienced difficulty in attending appointment such as doctors, pathology, radiology and so on (VN2-02.06.00, ResCo-01.06.00, PHYS1-12.10.00). As noted by the physiotherapist and village nurse, it is too expensive for residents to pay for a taxi (VN2-02.06.00, PHYS1-12.10.00) as well as being able to access a person "to go with them" (VN2.02.06.00). As noted by the

facilities Resident Co-ordinator who on occasions attempted to organise “a more able resident to accompany them”, the limitation with this is that residents “are getting frail so that is a bit hard to find somebody that is able” (ResCo-01.06.00). She suggested this could be rectified to some degree with community and volunteer services. The Physiotherapist also recommended access to a Village car for staff to escort residents, with the Physiotherapist often resorting to using her own car (PHYS1-12.10.00).

The residents within the Village were fortunate to already have access to a bus service that provided access to local shopping centres as well as for recreational use. Nevertheless, this service could indeed be improved. First, greater access with provision of hydraulic steps for all residents especially those that have reduced physical ability. Second, offering a reduced service during weekends and at night recognising that aged care accommodation should offer continued services throughout in line with ‘a home environment’. Third, improved communication between residents, staff and management prior to making decisions. And fourth, an improved service for residents who require access to appointments and to the Village café. All of which help to maintain a resident’s independence and well-being in accordance with expected outcome 3.5 – Independence of the Standards.

5.5 Activity services

There are a variety of social programmes and activities for residents living within the Retirement Village. Independent living residents organise their own social programme, often planned through various committees and funded by residents themselves. In comparison, activities for residents living in the facility are organised by activity staff with fairly recent co-ordinated involvement from the Occupational Therapists. The majority of these activities are funded through fundraising events.

Within the Standards and Guidelines for Residential Care Services, activities are covered under Standard Three – Resident Lifestyle with activities emphasised in Standard 3.7 – Leisure interests and activities which reads, “Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them” (S-38, G-70). Pirotta (2000) recognised that for many, activities are defined as:

A group of people [who] gather together to engage in doing something productive, such as physical exercises, singing, playing games or craft work (p 21).

Yet, Pirotta (2000) recommended that there is a need to move beyond this narrow definition to one that includes “occupational or industrious” (p 21) activities and those relating to activities of daily living such as dressing and grooming.

Baron (2000) queried “How do we meet the needs of residents and still stay within budgets and other limitations?” (p 20). Baron (2000), also implied that residents within aged care facilities are provided with an inadequate choice of activities, often with one event to choose at a period of time. He suggested a need to offer a variety of activities at the one time. The Health Services (Residential Care) Regulations 1991 also stipulated that a range of activities should be made available to all residents that are “designed to maintain a reasonable quality of life” (p 14). Schaller (1996) and Isaksson and Pohjolainen (1994) both recognised that inactivity can create “loss of strength, mobility, balance”, with an increased risk of falls, fractures, “coronary heart disease, non-insulin dependent diabetes, osteoporosis, and depression” (Schaller, 1996, p 12-13 and Isaksson and Pohjolainen, 1994, p 15). NSW Health (1999) also reported that osteoporosis, fractures and falls are common amongst the elderly population and often deprives people of independence and is often the cause of

institutionalisation. Osteoporosis affects thirty to fifty percent of women (Nutbeam et al, 1993) therefore concerted efforts to reduce this need to be implemented. Physical activity is one means to help prevent and reduce the incidence of osteoporosis, falls and fractures (Campbell, 1993, NSW Health, 1999) and concerted efforts could be made to implement health promoting programmes for all residents, including those living within independent units to help maintain their independence.

According to NSW Health (1999) only forty to sixty percent of older people (defined as those over the age of 55 years), participate in regular exercise. These figures would undoubtedly be lower for the older elderly.

5.5.1 Activities organised for facility residents

Due to the number of residents living within the facility, there were a number of staff employed to organise activities for both low and high level care residents. Three of these staff members were interviewed (ACT1-11.03.00, ACT2-05.07.00, ACT3-07.12.00), allowing me to gain insight into the activity programme offered in the facility. From working in other aged care facilities, there appeared similarities in the type of programmes offered. Activities included reading, happy hour, bus trips, celebration of occasions, Tai Chi (recent addition in preference to the exercise programme that was being offered prior to commencement of the Occupational Therapists), sing-a-longs and entertainers, games, craft and concerts held by students of the local school (the latter discussed in detail in following chapter – Strengthening Community Action).

Activity staff all recognised that there were restrictions to the type of activities offered for several reasons, including the increasing frailty amongst residents, a need for supportive personnel such as volunteers and funding restrictions.

5.5.1.1 Increasing frailty

Residents who are old and even frail can continue to participate in activities, including exercise however may require encouragement from staff, family, friends or through counselling. For example, Sobczak (1997) suggested that enabling staff to be included in exercise programmes may encourage residents to participate. Physical activity can also be integrated into the residents' "daily life" (p 49) by encouraging the resident to maintain independence with activities of daily living. They may also need motivating which can occur by informing them of the benefits of exercise. McMurdo and Rennie (1992) stipulated that it is never too late to commence exercise, even for the older or frail elderly. This is supported by NSW Health (1999):

Being frail and elderly need not exclude a person from participating in physical activity. On the contrary, exercise may be beneficial and evidence from clinical trials found no increase in the risk of injury while exercising. However, some modifications to exercise programs may be necessary to accommodate specific needs (NSW Health, 1999, p 8).

NSW Health (1997 and 1999) and McMurdo and Rennie (1992), recommended that an exercise programme is commenced at 'low intensity', and slowly increased. Types of exercise may include swimming particularly for those who suffer arthritis, golf, walking, bowling, relaxation, deep breathing, stretching, sitting and moving arms, shoulders and legs, and use of props such as throwing a ball and even Tai Chi which is becoming increasingly popular for all age groups.

Schaller (1996) suggested that Tai Chi is “a safe and enjoyable form of exercise that can be learned in a short period of time, . . . it does not require any special clothing or equipment and therefore is less expensive” (p 16) than other forms of exercise. Kessenich (1998) further claimed that modern day Tai Chi is “designed to enhance well-being and health” (p 27). Tai Chi can also be conducted either indoors or outdoors. This latter option should be encouraged enabling the resident to obtain fresh air and help promote Vitamin D absorption. There have been a number of positive results from research into Tai Chi. Results of a ten week programme of Tai Chi Chih (a modified form of Tai Chi) to a group of people with an average age of 70 years revealed improvement in balance and a slight reduction in blood pressure (Schaller, 1996). Schaller’s (1996) study did not reveal improvement in flexibility however other studies such as that conducted by Fletcher et al (1999) have reported similar results including improvement in flexibility. Kessenich (1998) believed it is necessary to:

investigate some nontraditional options . . . to promote optimal health for . . . [the elderly]. . . Western societies are just beginning to recognise the potential benefits of Tai Chi as a useful exercise and meditation for the elderly. It may also lead to an increased endurance, calm, serenity, and improvement in quality of life...Tai Chi is an ancient Chinese art form that may help seniors improve their balance and reduce the incidence of falls and fall-related injuries (p 27-29).

Tai Chi was introduced into the Retirement Village’s social programme from recommendations by the Occupational Therapists. From the four hostel residents interviewed, only one attended Tai Chi but the other residents were not actively involved in the existing activity programme. During interviews with these residents, there was the inference that some residents do not attend activities not from limited choice, but as a result of other residents’ increasing frailty (HR1-04.03.00, HR4-02.11.00). As stated from a resident in the hostel:

There is something [activities] most days; it may be in the morning or in the afternoon. There is no reason for anybody to feel out of it. I just don't go because it is inclined to depress me a bit, sitting there and they [residents] haven't got a clue as to what is happening. When I get like that I will be glad to go (HR1-04.03.00).

If residents are being affected by the sight of other resident's frailty, it may be worthwhile in a supportive environment to introduce smaller activity groups. These groups could be formed according to resident's level of frailty and ability thus individualising the activity programme to support resident needs. Staff also made similar comments to that of the hostel resident, for example from one of the activity staff members:

I have been here for 12 years doing the activity programme with the residents. I think it has changed . . . since I first started . . . the residents have gone down. . . They are a lot frailer now than what they used to be. I think mentally they are as good. . . They are just so frail (ACT3-07.12.00).

This staff member also identified that even with the bus service, accessibility for many residents is restricted with residents unable to step up onto the bus (ACT3-07.12.00). One of the hostel residents interviewed provided evidence of this:

Since I damaged my leg I can't get about . . . I go on a few trips but I don't like shall we say, holding people up. Because I know when I was alright we used to go out on trips and there would always be someone with one of these (walkers) and hold the whole lot up and I feel if I don't watch myself I will do the same, so I don't go much (HR4-02.11.00).

Another activity staff member also recognised that day trips are becoming increasingly difficult and that there is a need for supportive personnel to be actively involved:

Probably the only thing that would restrict me from doing certain things is the residents themselves. One of the residents asked me if we could go to the Crown Casino. I am prepared to do that but there are only a certain few that I could take. It could only be residents that are 100% . . . unless I had other members of staff going with me (ACT1-11.03.00).

In the past and at present, independent residents had been actively involved in providing a number of services for the Village including voluntary assistance with the activity programme. However as noted by staff including activity staff, independent residents themselves were becoming “older” (ACT3-07.12.00) and it was therefore difficult to expect them to take on this type of responsibility.

5.5.1.2 A need for supportive personnel

The Director of Nursing and the Occupational Therapist both identified the need for the activity programme to be developed according to individual needs (DON1-07.12.00, OT1-02.06.00) in line with the Standards. The Director of Nursing suggested that there were some residents who attended activities whilst others did not, preferring solitude and their own company in their private room (DON1-07.12.00). This latter suggestion was supported by a resident in the hostel who informed me that he preferred to read and spend time alone in his unit (HR4-02.11.00). Residents declining inclusion in the activity programme may also be a response to residents increasing frailty, as previously discussed as well as individual preferences and not wanting to intrude on other residents enjoyment believing they are too frail and slow. The Occupational Therapist explained her role in developing this individualised activity programme which was in accordance with the requirements of the Resident Classification Scale. For example, the Occupational Therapists were fully qualified, they assessed the resident, developed individualised programmes which were being implemented by the activity staff, and regularly evaluated the programme. The Occupational Therapist demonstrated her understanding of the RCS as follows:

we don't have hands on activities, but I am involved in looking at some of the programmes including setting up of the Golden-oldies club which is for those with significant or mild

memory loss and mild dementia. My role in activities is also to look at linking the resident's identified needs with the activity programme that is offered in the hostel which is run by the activities programme staff. So it is an assessment process, with review and evaluation and looking at change. So it is all part of quality assurance, reviewing, modifying and changing as the needs of the residents change (OT1-02.06.00).

This "Golden-oldies club" which is a dementia specific programme was being developed during my fieldwork. I provided advice regarding difficulties that are often encountered during meal times as residents can become easily distracted and often will not eat. In a study conducted by Bonnel (1995) results indicated there were concerns regarding dining areas that are large and noisy which can "impact other residents' eating abilities and enjoyment" (p 20) and there was a suggestion that bifold doors be used "to create more intimate dining areas" (p 21). Noise and distraction was occurring in the Villages' facility's extremely large open dining room in which the majority of residents ate. Fortunately, the facility had the necessary resource of a vacant room, providing those with dementia the quiet surrounding and personalised attention required to cater for their individualised needs. The Occupational Therapist continued to explain the programme in detail:

The golden oldies programme operates generally once a week and we set it up to provide social and mental stimulation for residents primarily who have significant problems related to dementia and problems with wandering and that type of thing. The group has developed into a social group. We also try to help their communication skills . . . we found that there is a number of residents who feel that they are lonely and like to come up and have a cup of tea and some attention and participate. So we have 20-25 people who contribute. This programme is supported by volunteers . . . we set up the dining room for dementia residents. Because it is such a big place and it is quite a difficult environment for residents with dementia. Some of them still have trouble becoming orientated to the hostel (OT1-02.06.00).

This type of programme is an example of offering residents a supportive environment that promotes independence and social interaction according to residents care needs.

As noted above, this programme was being developed during the fieldwork, so it was only during the latter part of the fieldwork that staff and residents revealed they were aware of this programme as one that was dementia specific and one that relied on the help of volunteers (HR3-02.11.00, ResCo-01.06.00, PHYS-12.10.00, ACT3-07.12.00). Volunteers play a valuable role in aged care including assisting activity staff with the activities programme. As noted by a Food Services Assistant:

We have the volunteers who are great. I guess because it is a village and you have the ones that are capable of coming in whereas if you have a nursing home on its own you wouldn't get that many volunteers. *You mean you get people from independent living?* Yes. When I say quite a lot I mean we could always do with more but you get your regulars, which I think is great (FS5-19.07.00).

An independent resident also commented upon being actively involved in the University of the Third Age (IR8-04.05.00), which is a voluntary organisation offering education. As noted by Swindell and Vassella (1999): "The concept of 'productive ageing' has emerged over the past few years" (p 19) with a number of older people such as those living within the independent living units of the Retirement Village offering voluntary services. Swindell and Vassella (1999) recognised the importance for older people to be socially active as "social isolation has been reported to be as great a risk to health as smoking" (p 22). Social activity is another means to improve health and well-being in a supportive environment.

A resident in the hostel informed me that mystery bus trips are offered yet are often full to capacity (HR3-02.11.00). A further hostel resident explained that she had not been asked to attend the last trip and queried whether this was as a result of being fully booked (HR1-04.03.00). And this was supported further by the Personal Care Assistant who suggested that the bus always appeared full with the same residents

which would either suggest that there are inadequate bus trips with this being popular amongst residents, or as stipulated by the Personal Care Assistant, residents are being persuaded to attend (PCA1-04.03.00). The initial reason appears the most likely, and was supported by one of the activity staff:

Even though the encouragement is given to everyone, the announcements are made, it is always the same people that are involved. You get the others that are quite happy to go and sit in their room after lunch, have a sleep watch the television (ACT1-11.03.00).

5.5.1.3 Limitation of funds

All activity staff attempted to raise money to offer greater diversity with the activity programme. There were suggestions from staff however that there were insufficient activities (FS5-19.07.00, ResCo-01.06.00). The Resident Co-ordinator whose role it was to announce daily activities over the intercom system suggested that the activity programme was becoming monotonous and she spoke to me during the interview about the difficulty in reading the same announcement daily:

We (Administration staff) were thinking that our activities needed a bit of a lift because you tend to get into a rut and you find that year after year it is the same boring routine. I just feel that it is nice to have a change; frequently change the activities. I think resident's life becomes very routine and very boring as they sort of do the same thing day in day out. . . I just think sometimes it would be nice to change things around a little bit and make it varied a bit more. It then makes life a bit more interesting. I mean even when I do the announcements sometimes I think how can I start these announcements, same day, same time you know. You say the same thing and I think "here she goes again" and I think how can I start announcing these announcements to make them more interesting but it is difficult (ResCo-01.06.00).

The Resident Co-ordinator continued to suggest that if the activity programme remains routine or as described as "regimented and repetitive" that both staff and residents may become "bored" (ResCo-01.06.00). The Gardener also suggested that

many of the residents were inactive from boredom – “those in the hostel . . . they’re bored and you think “they’re not that frail”. It takes a while for them to go down hill” (GARD1-25.05.00). The Resident Co-ordinator however continued to indicate that she had never had a resident complain about activities, only comments of praise for staff (ResCo-01.06.00).

An activity staff member commented on attending diversional therapy meetings held in the community. Attending these meetings provided an opportunity to discuss ideas through brainstorming sessions with other activity staff. She recognised that all facility residents differ according to cultural and socioeconomic backgrounds and therefore these ideas were discussed with residents prior to commencement (ACT3-07.12.00). Restriction of funds may also be a deciding factor in determining the type of activities offered. For example, activity staff had the idea of introducing happy hour, but were unsure how this could be funded. With the commencement of the Occupational Therapists and further discussion, a request was made to Management and a compromise enabled happy hour to be offered to residents. As explained further by one of the activity staff:

When we decided to do happy hour, we decided to do this when the OT started. It had been an idea that we had thought about but nobody had implemented and we approached management . . . I asked the residents what they thought about paying . . . \$2 . . . the money we [activities] had went for food So I go in and buy them pate and dip, cheezels and twisties and biscuits and we have a lovely time. We have sherry and light beer, lemonade (ACT2-05.07.00).

The major source of funding for activities was through fundraising and the sale of goods made by the residents within the activity programme (ACT1-11.03.00, ACT2-05.07.00, ACT3-07.12.00, DON1-07.12.00), particularly through the craft group. The activity programme emphasised the component of craft, with the Registered Nurse

making the comment: “They [residents] do a lot of craft” (RN1-11.03.00). When one of the activity staff members was asked how the programme is funded the response was as follows (with a prompt by myself, indicated in italics):

I make the money. *How?* In the craft room. . . We have the residents who make things in the craft room, we make heat packs that we sell (ACT1-11.03.00).

This comment is negated to a degree by another activity staff member who did suggest that when Management are approached, monies are made available. As illustrated further by this staff member:

We are having our winter dance at the end of the month and we are having a competition and we went to the chemist and asked them for a donation. I asked our restaurant here for a donation, so we will raffle those. We have no money and if you actually look in my diary I left a note for my co-worker because I job share for some suggestions on how we can raise some money. We have no money at the moment, none at all . . . if I went and asked for money I would probably be given a small amount (ACT2-05.07.00).

Open Day was also recognised by myself as an important event for the whole Village as residents from both the facility and independent living were exhibiting and selling paintings, pottery and craft work. This was apparently one of the largest fundraising events for the facility activity programme in which all craft and goods were exhibited and sold to the general public and others who attend:

open day . . . is our big day . . . and we have hundreds of people come through and we normally sell what we have. This year we made about \$900 so that has to last me a year to pay for concerts, videos and whatever . . . But I get no other funds whatsoever (11.03.00).

There is the indirect provision of funding through the Resident Classification Scale, yet this relates to all questions of the RCS according to resident’s individualised care needs, and not just those that relate to activities. There is no doubt that independent residents play a valuable role in providing voluntary work including support of the

activity programme, yet due to their increasing age and frailty there remains a question of how long this voluntary help will continue. Nonetheless, it was apparent that a large number of independent residents continue to have an active social programme themselves.

5.5.2 An active social life for independent residents

Feedback from independent residents and staff that liaise frequently with them, such as the Hostess, Maintenance Manager and Gardener all provided insight into the social programme for residents living within independent units. Activities consisted of bus trips, cards, exercise including a walking group and Tai Chi, pottery, art, craft, information sessions, lawn bowls, computer classes, a group who play music together (music makers) and concerts. There was a snooker room in the Amenity building and I observed this to always be full of men, however no one was observed on the croquet lawn. Lawn bowls was observed to be frequently used both inside and out on the lawn. Independent residents also had their own garden and the option of a vegetable or flower plot and residents were often seen gardening. Some of the residents also had a car with car parking facilities available within the Village.

There were comments made by the Maintenance Manager (MAIN1-01.06.00), Hostess (HOST1-02.11.00), and by residents (IR2-17.02.00, IR4-26.02.00, IR3-22.02.00, IR6-08.04.00) that residents living within independent units had an extremely busy social life if they wished, with no excuse for loneliness or boredom. For example, one resident suggested that she found it difficult to find time to have her “hair permed” as she was “too busy” (IR2-17.02.00). Another resident contributed the extensive recreational life to the overall size of the Village (IR6-08.04.00) and from another independent resident:

It is very busy here, you don't sit around doing nothing. It is very difficult when we are trying to arrange things in one of the Amenities, they have to be booked ahead a year before because there are so many things that happen (IR4-26.02.00).

And supported from the Maintenance Manager:

They have a club for everything and there is no excuse for any resident not to be involved in about ten different things . . . It would be annoying if you want to be alone (MAIN1-01.06.00).

As noted above, residents are able to keep themselves active with what appears to be a social programme that is organised by numerous social clubs and committees. For example there is a social club that is responsible for organising bus trips in consultation with the bus driver. The Hostess explained that the social club secretary may make a suggestion to the bus driver for future ideas on mystery trips (HOST1-02.11.00). Bus outings and dates were advertised in the Amenity building for residents to indicate if they were interested. These trips consisted of the monthly day trip and there were holiday trips whereby residents could go away for three to four days (MAIN1-01.06.00, IR2-17.02.00, IR3-22.02.00, IR5-11.03.00, IR6-08.04.00).

As explained further by two residents:

There is also a social club for independent residents. They organise one day every month to go somewhere – on day trips, like Geelong and we went to Smorgys for lunch. Mr H organises the holiday trips that are 3-4 days holiday twice a year. They put a list up in the amenity buildings and we put our names down (IR2-17.02.00).

Up until recently I went on all the trips and this is a great way of getting together and going out on the coach for the day. They went out yesterday to the winery. We get the same coach all the time and the driver spoils us. We go to the concert hall once a year. We also go to the City lights at Christmas time. We also go out for a Christmas dinner. They are going away for a 3-4 day trip and this happens all the time. They do something every month and then in the winter we go to the cinema and lunch (IR3-22.02.00).

The Maintenance Manager commented upon the fact that as a result of the number of bus trips, the Village recently purchased a further bus. This has affected the Maintenance department, reducing Maintenance staff by half a day per week. Their multiskilled position required Maintenance staff to have a bus licence and to be responsible to drive the bus for both facility and independent residents for their day trips or daily round trips to the local supermarket or shopping centre (MAIN1-01.06.00).

The Hostess commented upon the Maintenance staff as bus drivers who often took residents on trips “outside of working” hours (HOST1-02.11.00) and this was supported by comments made by residents, for example:

The maintenance men go out of their way, like every so often, like the other night we had fish and chips at night at the kiosk down the beach. Now they are not paid to do that . . . we are very grateful . . . They don’t have to do that, they are just doing it out of the goodness of their heart. I think they both love driving but it is a big responsibility . . . they have a licence for driving the bus, but they are maintenance (IR7-08.04.00).

It appears that these staff are dedicated, however the Village relies on this type of commitment; a type of voluntary service in one respect that future staff may not be prepared to do.

It is evident that residents living within independent units had an extensive social programme organised by the numerous social committees and funded by themselves. This was partly assisted by Administration and dedicated staff such as the bus drivers and residents themselves who possessed a car, both of which provided a relatively good transport service helping to promote independence and continued involvement with the community.

5.5.3 Similarities and differences with the activities programme

The social programme available to independent residents is extensive, varied and is both active and relaxed compared with the facility resident's inactive programme. To explain this further, comparisons will be made. All residents within the Village have craft groups in which items are made suitable for sale, however the independent residents also have groups that paint, draw, make pottery and for the men of the Village woodwork.

The men living within independent living have their billiards, lawn bowls, woodwork and gardening, whereas the men within the facility have limited choice of recreation apart from billiards. As noted by one of the activity staff members, the majority of staff and residents are women and the men appeared to be neglected and may enjoy male companionship. An activity staff member recognised a need for male volunteers to assist male residents (ACT3-07.12.00). As explained further by two activity staff members (my question is in italics):

It would also be wonderful to have some men come in and visit our men . . . we do have 2 male nurses which is great but mostly our men are dealt with all day every day with women. It would be really good if we could get someone . . . who could just chat with them . . . *So how many men do you have here?* At the moment not many, the women outlive the men. . . If we had some men who would come in to do something with our men would be wonderful. Have a yarn and talk over old times (ACT2-05.07.00).

I have tried to get a men's group going but I haven't been able to . . . but I would really like to do that. . . it is also finding a volunteer who will come in and run it, that is the other thing (ACT3-07.12.00).

The Physiotherapist also admitted to the need for male oriented programmes. The men are offered a monthly bus trip and within the facility there was a billiard room.

The Physiotherapist continued:

Men have their lunch out once a month. They go out to a different hotel, just for men. Men seem to be excluded. We have a lot of lady orientated programmes (PHYS-12.10.00).

When the Physiotherapist refers to “lady oriented programmes”, I assume she is referring to the concerts offered by the school children and other sing-a-longs, bingo, and craft. Men may also feel some reservation about doing Tai Chi as opposed to exercise. On analysing the data, it also became apparent that relatives and family are seldom involved in the Village’s activity programme, however an activity staff member did comment that on occasions friends of residents may offer some of their time and this is always greatly appreciated (ACT2-05.07.00). Whilst another activity staff member commented upon relative feedback regarding limited activities on the weekend:

I often have relatives and residents say to me that it is quiet around here on the weekend. So I think maybe they could have someone in on the weekend, like a programme for them in the activity department (ACT3-07.12.00).

There were also differences with regard to entertainment. Within the facility, residents had children from the local school or other entertainers or people playing instruments to old-fashioned songs. As stated by a hostel resident:

They have a sing song . . . I don’t go to that. They sing all the old songs and I don’t like them. I don’t care for those nostalgic things (HR3-02.11.00).

Independent residents have their own group known as the music makers, who may entertain Village residents or people in the community. As described in further detail by an independent resident:

They also have music makers – we have a lot of talented people in here. They have formed a music maker group – anybody who plays or has any idea about music at all can join this music maker group. They have a rehearsal every week . . . they . . . have a concert once a week . . . We also have a concert group who go out to other nursing homes/hostels and senior citizens groups (IR3-22.02.00).

Independent residents had exercise classes and Tai Chi however residents in the facility were only provided Tai Chi as a result of the Occupational Therapist suggesting Tai Chi is less strenuous. A hostel resident commented on the enjoyment of the programme:

I do Tai Chi . . . I love it, I wish we did it more often. We do it twice a week. I don't know why more don't do it . . . Well I mean it is so easy and the ones that don't do it, they are just sitting up in the lounge not doing anything or just watching the TV (HR3-02.11.00).

Exercise including Tai Chi can improve functional capacity including reduction in falls and injury, increase range of motion, improve sleep patterns, reduce constipation, lower cholesterol levels and blood pressure, aid in digestion, reduce weight in those that are overweight, reduce effects of osteoporosis, decrease resting blood pressure, increase socialisation (Sobczak, 1997 and Wallace, et al, 1998: 645) and thus “be an effective approach to preventing disease . . . and rehabilitating acute or chronic illness” (Levkoff et al, 1996, p 98). As also noted by NSW Health (1999):

Most of the frail elderly live in environments and among caregivers for whom exercise is still an unfamiliar and perhaps frightening concept. There is a need to address the physical surroundings, recreational programming options, and staff training to instil appropriate physical activity in private homes, retirement villages and residential aged care facilities. By eliminating unnecessary barriers to optimal mobility and physical activity among the oldest adults, substantial health benefits may be realised both through the prevention of new disabilities as well as through the rehabilitation of chronic conditions (NSW Health, 1999, p 8).

However, as noted by Levkoff et al (1996) the limitation in providing health promoting physical activity programmes is that staff often “do not have sufficient training to establish safe and effective” (p 98) sessions for residents. Pirotta (2000) recommended provision of education to staff and to relatives (p 22) and this is also relevant to residents.

It appears that independent residents have an active social life one that provides as little or as much socialisation, enjoyment and activity as possible. Their bus outings appear to be greater in number with facility residents having reduced ability with increased frailty. This is apparent with the type of inactive social programme offered to residents in the facility. The other probable influencing factor with reduced activity services for facility residents would be from limited funds, in comparison to independent residents funding their own social agenda. Facility residents are more dependent upon staff to provide a social programme.

5.6 Resident and staff relations

As well as the various types of services mentioned above, there were also various people who were seen as contributing to a supportive environment. The following will continue analysis of a supportive environment but from the perspective of social support mechanisms. This will include identifying the importance of resident relations, particularly ongoing friendships that occur through the continuum of care, and the contribution that residents from independent living make to village life.

The Standards attempt to promote relationships between residents and staff, for example, staff are encouraged to act professionally in their role, whilst maintaining residents' independence. As stated in the guidelines preamble of Standard Three, residents:

require support at various levels in order to maintain their physical, social, cultural and mental well-being. In providing the necessary support for an individual, the service encourages the resident to maintain their independence, cultural preferences and chosen lifestyle as much as possible

(Commonwealth Department of Health and Family Services, 1998b, p G-55).

The idea of promoting independence is interesting, as a study conducted by Krothe (1997) concluded that health professionals working with older people often provide too much service. As she stated, offering too much service results in:

learned helplessness which fostered dependence . . .
Repeatedly the participants [older people interviewed] indicated that they would prefer being asked what they needed, rather than providers and family members assuming that they know their needs (Krothe, 1997, p 219).

The Standards nevertheless recognise the importance of preventing resident dependence, as per Outcome 3.5 – Independence, in which the role of staff is to actively work to “overcome any loss of independence arising from inappropriate acceptance of control by other people (staff or families)” (Commonwealth Department of Health and Family Services, 1998b, p G-67). Staff working in aged care facilities are expected to provide residents with ‘emotional support’ as per Quality of Care Principles (Commonwealth of Australia, 1997b, p 237) and Outcome 3.4. Residents may require support in dealing with aspects of grief and loss, orientation to a new environment and ongoing ‘support’ “for living in a communal environment” (p G-66). As noted by Setterlund (1998) and others (Forsyth, 1998, and Gardner, 1995 cited in Setterlund, 1998) “care staff are likely to experience tensions and contradictions surrounding their attempts to provide both physical and emotional care” (p 135) as a result from the influence of “economic rationalism, involving financial accountability and proven effectiveness of care strategies” (Setterlund, 1998, p 135). This was also evident in this study and discussed in greater detail in Chapter 4 – Policy.

5.6.1 Positive relationships between residents and staff

The majority of comments relating to relationships between residents and staff were extremely positive with suggestions of familiarity, friendliness and the notion of the Village as a family environment. On occasions however there were some negative situations whereby relationships could be improved. During interviews specific staff were mentioned as providing a supportive environment including the Hostess for independent residents, the Chaplains, Doctors and the Village Nurse who will be discussed below. Overall, staff recognised that it was their responsibility to encourage good relationships with residents and that they believed residents were well cared for both medically and also socially, with all staff acknowledging residents with a friendly “hello”. For some residents, there were suggestions that they may become reliant on staff for social wellbeing having lost friends and family.

Caris-Verhallen et al (1999) recognised the importance of socialisation throughout the lifespan, but as one ages, there may be “little social contact” from reduced health and loss of friendships through death (p 809) or by moving into aged care. Caris-Verhallen et al, 1999 continued to note that:

People are social beings. Interacting with other people provides support, comfort, love and affection, which are needs we all have (p 808).

Nevertheless, “to create good interpersonal relationships in which there is reason for socializing, affection and empathy” (Caris-Verhallen et al, 1999, p 809), there is a need for effective verbal and non-verbal communication between residents and staff. In the study conducted by Caris-Verhallen et al (1999) there was more non-verbal behaviour such as touch and eye contact from nurses working with residents in aged

care facilities than nurses working in the community. This was reiterated by findings from this study, for example a Food Services Assistant described both verbal and non-verbal behaviour when describing relationships between the residents and staff:

We have a joke with them and we care for them, you know we will give them a kiss that type of thing. You are there to try and make them happy and as comfortable as possible (FS5-19.07.00).

An activities staff member (ACT2-05.07.00) also recognised the importance for residents to discuss issues with staff; issues that may appear menial to some however for the resident may create anxiety and thus ill health or tragically as noted by Kissane (2001) that “intense anxiety” in the elderly can lead to increased “risk of suicide” (p 110).

An activity staff member informed me that there were positive comments made from a group of women from the community who were entertaining in the facility who exclaimed “out of all the nursing homes that they go to, if they had to come to one, they would choose this, because of how our residents are treated” (ACT3-07.12.00). The Director of Nursing attributed positive feedback with the provision of a continuum of care in which staff and residents are able to form longterm relationships (DON1-07.12.00). As noted by the Occupational Therapist (OT1-02.06.00) and an activity staff member (ACT2-05.07.00), the Village provided a varied group of personnel for resident social and professional contact. As explained further by the Occupational Therapist:

My perception with residents is that they are happy with their relationship with staff. I also feel that there is a variety of staff too, so if they don't get satisfaction from somebody they will get somebody else . . . The general manager makes it clear quite well I think through resident meetings (OT1-02.06.00).

The residents and staff both spoke fondly of each other including residents from independent living who were able to demonstrate their appreciation of staff. The Cook Manager of the café explained how independent residents had organised a surprise birthday party for her. She related the story to me:

I was really pleased as there were about 50 and there were regulars as well as other residents. Then I realised that all my hard work had been given back to me. It was just beautiful (FS4-19.07.00).

On another occasion, as discussed at interview by the Hostess, residents become “very attached to staff”. She described a couple of incidents. The first of a staff member who was retiring and the residents were organising a collection and a farewell party. On another occasion, the independent residents “put up a petition” when the bus driver was leaving “because they didn’t want him to go” and “he was well liked”, as he often included extra bus stops to accommodate residents (HOST1-02.11.00).

Residents from the facility may have less opportunity for demonstrating their appreciation of staff, however, overall comments were positive, such as:

You know they are very friendly and nice (HR1-04.03.00).

The girls are really wonderful . . . I can’t find a fault with them . . . I think all the girls are obliging, they’ll do anything for you as far as I can see (HR4-02.11.00).

The staff are really lovely here. They are really helpful (HR3-02.11.00).

There were similar findings in another study conducted in a residential care facility by Hatcher et al (1999) in which residents described staff in positive terms such as being “caring, nice, talkative with the residents” (p 10).

Comments from staff regarding their relationships with residents were also positive but demonstrated even greater closeness. Setterlund (1998) suggested that care staff “see themselves as providing a substitute family and home for residents” (p 138) similar with other researchers who describe resident staff relationships as “mimicking a family bond (Sumaya-Smith 1995, Nyström and Segesten 1996)” (cited in Caris-Verhallen et al, 1998, p 810) which is evident from the following quotes from interviews conducted with staff:

You become so close to them [residents] they're like part of the family and no matter what you say there are always some that tug at the heart more than others. Not that you necessarily treat one better than the other (PCA1-04.03.00).

Some of the residents you get to be really good friends with them and you find out about their life. Some of us [staff] even go and ask them for advice (GARD1-25.05.00).

Between the residents and the staff I would say relationships in almost all cases are very warm and caring (ACT2-05.07.00).

We [staff and residents] get really fond of each other. A lot of people [residents] come to me for cuddles, they expect it. If I don't do it they are most put out (PHYS1-12.10.00).

This is reiterated by staff using familiar names for residents. The Physiotherapist explained that during accreditation, Management requested that staff discontinue using ‘pet names’ for residents and to call them by their name. This situation frustrated the Physiotherapist who continued to explain:

They [accreditation team] are not realising that this is a form of endearment. They [residents] say it [love or sweetheart] to us too; it is their home and I think they forget that this isn't an institution it is their home and this is what people call each other at home (PHYS1-12.10.00).

A number of other staff commented upon the importance of non-verbal communication and familiarity with residents. A Food Services staff member commented on staff fondness toward residents – “she was treating her like her

grandmother, with compassion” (FS2-18.05.00). As explained by the Registered Nurse, each resident is treated individually as there are a percentage of residents who in fact prefer to be called by their surname. “They are all different personalities and all want different things” (RN1-11.03.00). The Registered Nurse is showing compliance with the Standards for example Outcome 3.5 Independence states:

This Expected Outcome is concerned with autonomy and the encouragement and support necessary for residents’ reasonable expectations of self-determination and individuality within a residential setting (Commonwealth Department of Health and Family Services, 1998b, p G-67).

The idea of individuality is also an interesting concept, as staff in this study appeared to recognise the importance of treating residents as individuals and with respect. In a study conducted in a nursing unit by Waters and Easton (1999) there was little evidence of individualised care. Waters and Easton (1999) explained that this is exacerbated by the types of routine that occur such as meal times or getting the person to bed before a shift ends. Individualised care as defined by Waters and Easton (1999) includes:

Recogniz[ing] the uniqueness of a human being, their individuality, personality and human frailty . . . offer[ing] patients different ways of meeting their needs, allow[ing] choice, and involv[ing] the nurse in listening rather than telling (p 83).

There is also some contradiction in policy regarding the issue of individuality. For example, the Standards promote the notion of supporting residents ‘independence’ whilst the Resident Classification Scale labels or categorises residents according to their level of care needs (ie. Category 1 to 8). Forsyth (1998) recognised that classifying people “ignores the ideals of primary health care and preventive medicine” acknowledging that people are individuals who should be ‘treated with compassion’ (p 20).

Forsyth (1998) recognised that Florence Nightingale “set up a tradition of nursing that was disciplined in its compassion”, that ensured that patients’ needs were individually assessed and met (p 18) however Forsyth (1998) suggested that in recent years, there has been an “emphasis on professionalism in nursing” (p 19) and a reflection on economic rationalism with the advent of classification. The Standards also promote the notion of staff “fostering” “professional and respectful relationships” (Commonwealth Department of Health and Family Services, 1998b, p G-69, S-37). Professionalism is an important aspect of a workplace environment, yet so is the notion of treating residents with compassion and as individuals.

The notion of familiarity is also interesting, as staff identified that they often call residents by ‘pet names’ with suggestions that Management felt this unsuitable at the time of Accreditation. Yet Outcome 3.6 Privacy and Dignity states “Residents are addressed according to their wishes” (G-69) and like all relationships, people may be called a variety of names which is not necessarily derogatory but a form of endearment. Jilek (2000) and others (Setterlund, 1998, Ronalds, 1989) however suggested that there are “often power struggles between residents and staff members”, when staff “rarely” refer to residents “by their surnames” and residents often become “parented” by nursing staff (Jilek, 2000, p 18). It is difficult to make an assumption on either principle as both arguments appear to have some credibility; Jilek’s (2000) argument that ‘pet names’ may create power struggles may be true, yet aged care is supposedly promoting a home environment whereby ‘pet names’ are used. Further research on this issue is required and would be interesting. To overcome inappropriate use of verbal and non verbal communication between residents and staff

or between residents themselves, it may be appropriate for aged care providers to offer training on effective communication techniques as well as on issues relating to sexual awareness and sexual needs including the importance of touch. This is in accordance with Outcome 3.6 Privacy and Dignity that suggests that residential care services provide residents with privacy and allow residents to “maintain personal relationships” (p G-69) and “promote an appropriately tolerant environment that fosters sexual freedom for residents” (Lyder, 1994, p 62, and Wallace et al, 1998).

5.6.2 Some negativity toward residents

As well as the many positive aspects toward residents and staff, there were also some negative attitudes, unfortunately from the staff toward residents. Prior to the aged care reforms, residents or their representatives were able to make complaints, nevertheless, as Gray (2001) acknowledged “internal complaints resolution mechanisms within aged care homes was . . . not a requirement” and under the reforms, the Aged Care Act 1997 requires providers to “ensure that residents are aware of their rights” (Gray, 2001, p 106). This was reiterated in a media release by the then Minister for Aged Care, Bronwyn Bishop who made a statement asking:

all people including television stations, newspapers and health professionals including doctors, as well as individuals to notify us of any bad practice as soon as they become aware of it (Bishop, 2000c).

Staff and Management have the responsibility of ensuring that residents physical, social, emotional and cultural needs are met as well and to comply with State and Federal regulations. It is also the responsibility of staff and Management to achieve quality of care through continuous improvement systems that can be gained from feedback such as through comments and complaints procedures. A Food Services staff member acknowledged the relevance for residents and their representatives to be

able to make comments and complaints to assist in the improvement of living conditions for the elderly in aged care. She also believed information relating to neglect should be made public to help ensure residents who are sometimes vulnerable are treated with compassion and that staff be reminded that the “residents could be your parents, and you just don’t treat your parents like that . . . so I hope they will fix it before we get there” (FS1-01.04.00). The Food Services Manager also supported the suggestion that staff have a responsibility to the resident:

this place is very much on what the residents feel or say, they have a big influence so it is a matter of the staff fitting in with them, not them fitting in with the staff. That is why I call this place The Voice. I think this is great because I know for a fact that you go to some places and the residents have to fit in with the staff and that is sad and is not right because we are doing them a service; they’re paying us so we should be at their beck and call. . At the end of the day, they are paying our wages (FS-2-18.05.00).

There was however a general feeling of animosity from some staff toward residents being able to vocalise their complaints. An activity staff member for example commented that residents are “spoilt” and that the staff are always available to accommodate the resident (ACT1-11.03.00). Several other staff also had strong feelings on this:

Occasionally I feel that the staff are not represented enough and given the opportunity to air their say. It is always the resident. It doesn’t matter how you feel. There is no particular person you can go to. It can be really stressful (PCA1-04.03.00).

residents go and bitch to admin and then admin come to us and the story then changes. I also think admin put a barrier between us [staff] and the residents (GARD1-25.05.00).

in this place the people [residents] have a voice . . they really do. You can’t keep everybody happy but they do have a voice. If they have a grumble about anything it’s almost like the staff bend over backwards and in a way are frightened (FS2-18.05.00).

From analysing the data, there is evidence to suggest that overall relationships between residents and staff are generally positive, but relationships could be improved. For example, it is evident that staff may feel unrepresented with residents able to communicate their grievances through complaints mechanisms made possible through the Aged Care Act 1997. Staff may benefit with the provision of discussion groups to enable them to consider the types of complaints being made and the benefits of the complaints system. For example, giving residents a voice suggests that improvements can be made to the service. In identifying the positive nature of complaints mechanisms staff and residents are being provided a supportive environment and relationships will be fostered. Another means to improve relationships as suggested by the Gardener (GARD1-25.05.00) is the provision of “more social functions” between the residents and staff. As noted by Moore (1999), “social relationships are an essential component in one’s quality of life” (p 135). In the past, Management held entertainment performances for residents. As described by two independent residents:

they had a New Years Eve party and the place was packed. They put on a wonderful party (IR4-26.02.00).

We used to have a concert where all the staff joined in. The maintenance man had his top hat and tails on and he was the compare for the night. It was so funny. The nurses joined and they all acted. The manager was a pussycat and the finance manager was a dog. You should have seen it we roared with laughter (IR2-17.02.00).

5.6.3 Independent living and the supportive role of the Village Nurse

The Village Nurse service was provided to independent residents over a 24-hour period with qualified ambulance men covering the evening shift to encourage greater safety and security (VN1-26.02.00, HR3-02.11.00, IR2-17.02.00). From all of the interviews with independent residents, the majority spoke highly of the Village Nurse

and indicated that she was a valuable resource in providing a supportive environment (IR2-17.02.00, IR3-22.2.00, IR4-26.02.00, IR6-08.04.00, IR7-08.04.00, IR8-04.05.00). The Village Nurses themselves were aware of the respect for them held by independent residents (VN1-26.02.00). As noted by a Village Nurse:

some people have been here for 20 years and they have come to expect a certain standard and a certain number of calls from the village sisters and know that we are concerned for them. They become almost like your friends and if you don't call in well they begin to get anxious and wonder what is going on (VN2-02.06.00).

Unfortunately, staff excluding the Gardener (GARD1-25.05.00) neglected to recognise the role of the Village Nurse as part of the supportive environment. This would suggest the need for the Village Nurse to promote her valuable services as demonstrated during interviews with independent residents.

The Village Nurse provided residents within independent living with various support, not solely medical nursing care but also social and emotional support. For example a resident discussed the period when her husband became ill eventuating in his death. The Village Nurse provided the husband with nursing care whilst also caring for the wife and children, allowing the children to feel comforted by the realisation that their father was dying but was being well cared for, whilst providing their mother with emotional support. As expressed by the resident:

My sons knew when my husband was ill that they didn't have to rush over or do anything. They kept in touch and the nurses were marvellous. They took the worry away, I could cope. My sons didn't have to worry in the care, and that is as it should be (IR8-04.05.00).

And she continued to explain the care provided to her:

they are very caring. What I appreciate was they cared for my husband and they cared for me as well without my being aware of it (IR8-04.05.00).

In another case, a resident explained an incident whereby she fell and sprained her ankle. The Village Nurse provided the resident with a walking frame and organised with the facility's Food Services Department for meals to be delivered to the resident (IR2-17.02.00). She responded to the resident's emergency call within "5 minutes" and the Village Nurse:

telephoned the doctor from my phone and he then came around – it was an all round excellent service. She then called in every day to see how I was for a fortnight, and bandaged it up or told me what to do with the ankle (IR2-17.02.00).

Other positive comments made by independent residents included, "Village Nurses are very supportive and we always know they are there" (IR4-26.02.00), "If anyone has been ill the sisters are marvellous; they come and give you a shower" (IR2-17.02.00) and "We have a great deal of care and support. You telephone the sisters and they come around very quick" (R2-17.02.00). An interview with a resident from the hostel that had previously lived within independent living acknowledged the services of the Village Nurse as "marvellous". She noted that the Village Nurse was able to respond immediately with the system of the emergency buzzer being mobile. Whereas in the hostel if the resident is unable to access the buzzer that is secured, the nurse would most probably not respond until staff recognised that the resident was missing (HR3-02.11.00). This resident who has moved through the continuum of care, provides a valuable insight into the different emergency call systems to alert care staff. This is an important recommendation that would create a safer environment and improve the health and well-being of residents in the Village.

As can be seen above, the Village Nurse provided a valuable service for residents living within independent units. They provide residents with a medical service, as

well as emotional support. The Village Nurses were also instrumental in helping to maintain residents' quality of life and independence. Yet this service appeared to have little recognition by other staff or Management working in the Village. It appears though that the position of Village Nurse will become increasingly important for an ageing population of residents living within independent units. Residents would therefore benefit with the provision of other support services and personnel such as those offered by the facility (physiotherapist, diversional therapist and occupational therapist) and others that would be valuable in both the facility and independent living such as nutritionist and other complimentary therapists (eg. aromatherapist). This may alleviate the growing need for aged care facilities to provide the service within a smaller compact community, that is, independent residents living within retirement villages.

5.7 Support mechanisms for staff

Unlike the residents who are provided support by other residents and the staff, the staff themselves may on occasions feel unrepresented, over worked, poorly paid, and at times saddened by the loss of residents who have become part of their family. This study was carried out in a Village that is particularly large which may hinder relationships between staff, particularly those that work different shifts or through staff shortage and the use of agency staff, or changes in staffing qualifications and skills.

Under the Aged Care Act 1997, aged care providers are responsible for “maintain[ing] an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met” (Commonwealth of Australia, 1997a, Part 4.1, Division 54-1, p 207). It is therefore the responsibility of management to determine the required skills

mix and their definition of ‘appropriately skilled staff’. A number of surveys were conducted by the New South Wales Nurses’ Association in 1999 which reported that over a third of care staff reported a significant reduction in Registered Nurses employed in aged care. The survey also reported that over half the respondents believed there was a reduction in the standard of care because of reduced staffing levels, higher care needs amongst the residents and ‘budget cuts’ (Harulow, 2000). Some of these issues are evident in the forthcoming section on staffing issues and relationships.

5.7.1 Staff supportive of each other

Generally staff relationships in the Village were positive, with staff comments including, “staff are very friendly” (PCA1-04.03.00), “it is like a big family” (GARD1-25.05.00), and “you all have to get on” (ResCo-01.06.00). There were also general comments made by the majority of staff that they provide support to each other. However, from analysing the data, there were feelings of animosity between Departments and divisions within Clinical Services. This appeared to be exacerbated by the size of the Village, changes in nursing from use of qualified Registered Nurses to staff who were trained as Personal Care Assistants, as well as the familiar occurrence of personality differences that occur in working establishments particularly those that are so large and diverse.

The Village Nurse recognised that “certainly you will always get a personality difference . . . with any sort of organisation” (VN2-02.06.00). This was supported by the facility’s Resident Co-ordinator who stated: “you are going to get your personality where people sort of clash” (ResCo-01.06.00). Unfortunately, apart from personality

differences, there were also negative attitudes between staff and the various Departments. For example, the Village Nurse suggested there was little respect from the Personal Care Assistants, SEN's and Village Nurses toward the Registered Nurses working in the facility. "Some have been here a long time so they are entrenched in whatever they do or the lack of what they do" (VN1-26.02.00). However this was refuted by a Personal Care Assistant who acknowledged the role of the Registered Nurse (RN) – "we have RNs that we can call on if there is an emergency. I am not qualified to cope with an emergency" (PCA1-04.03.00). This was supported by an RN who informed me that there is an increasing number of PCAs working in aged care with insufficient training with "patients" and their overall inadequate knowledge:

We have a lot of Personal Care Attendants here now and I have nothing against these girls, they do short courses, but unfortunately they haven't had the patient contact before they come in. They do a few essays and things like that but they don't have a really good understanding of what the elderly really want from you (RN1-11.03.00).

It is interesting to note the use of the word 'patient' which would suggest that this staff member considers her role as a nurse and the residents as her patients. This along with the comment of the Village Nurse confirms that aged care is dominated by the medical model. Providing residents with services other than treatment, that is hospitality services, diversional therapists, complimentary therapists and allied health professionals in an environment that promotes health and well-being may create a more supportive environment for older people. This would assist the current shortage of RNs in the hospital sector.

The overall size of the Village also created some alienation between staff working different shifts and also especially toward staff working outside the facility such as the café Cook Manager (FS4-19.07.00), Gardening and Maintenance staff (GARD1-

25.05.00) and the Hostess (HOST1-02.11.00) who had minimal contact with staff working in the facility. The café Cook Manager expressed her concern:

I don't have any social interaction . . . I wouldn't know half the staff that work in the hostel or nursing home. It's disgusting but there is nothing I can do about it . . . I am so far away from everything (FS4-19.07.00).

This is supported by the Gardener who explained that the Maintenance and Gardening Department are often detached, infrequently asked to attend education programmes and believes the Department is given little credibility within the organisational structure. As quoted:

We are right down the bottom [of the organisation] . . . the biggest thing we did was a CPR course . . . Doing that is a novelty for us. I mean . . . maintenance are involved . . . there is like this line . . . we are not really involved but we probably should be . . . they have a Christmas party and the guys [from maintenance] never go because they are maintenance (GARD1-25.05.00).

There was also friction between the various Departments. For example, a Food Services staff member indicated that Clinical staff have in the past repeatedly reported Food Service staff for having extended tea or lunch breaks (FS3-13.07.00). This could have been exacerbated by the fact that, as stated by the Occupational Therapist and Physiotherapist staff have lunch or tea breaks with staff from the same Departments (OT1-02.06.00, PHYS1-12.10.00). These factors of staff not integrating exacerbate poor staffing relationships.

A Food Services staff member suggested that the Clinical Services Department regard themselves as superior (FS3-13.07.00) and that Management tended to provide positive feedback and praise to Clinical staff (GARD1-25.05.00). It is interesting to note that in Setterlund's (1998) study which was conducted in a number of dementia specific facilities, care staff perceived themselves and "their approach to care" as

“devalued within the organisation” (p 136). This was to a degree consistent with findings from this study, yet relevant to a broad spectrum of staff, including Maintenance, Gardening, Food Services, activities and Clinical Services who spoke fondly of Management but acknowledged the need for recognition of their role and dedication. For example, during interview, the Gardener became frustrated with issues relating to staff inequalities believing this was contributed to by Management. She explained that the Maintenance and Gardening Department:

don't get any feedback about how good everything is going,
but only the sisters get a pat on the back from administration
(GARD1-25.05.00).

The Maintenance Manager also suggested that all staff need to be thanked for their work recognising that the General Manager sent out birthday cards to all staff however a thank you would be welcomed (MAIN1-01.06.00). This was supported by an activity staff member who identified that staff often work extra hours without remuneration:

You don't get appreciated for what you do here from up top. A
thank you would be nice . . . The manager does not say
anything . . . None of us mind putting in the time and not
getting paid for it, but I put in a lot of time (ACT1-11.03.00).

There were other negative comments toward the General Manager made by the Village Nurse suggesting that staff are shown little respect for the work they do. As she expressed:

There is a dreadful relationship with management. I think if
there was a little respect this could improve relationships. I
have already in the last 12 months had to sign an agreement
for a pay cut, even though I have been here for 15 years. Now
this does not give someone respect . . . It makes you . . . feel
that there is a lack of respect and understanding of our abilities
(VN1-26.02.00).

Conversely, a number of staff provided positive feedback regarding the General Manager, and his support for staff expressing that “he will help out” (GARD1-

25.05.00), he is “very caring” (ResCo-01.06.00) and “always available” (ACT2-05.07.00). The Chef also discussed with the General Manager her wish to train as a nurse and the General Manager suggested that she spend time with the nurses as a trial prior to making the commitment (FS3-13.07.00).

Overall it is difficult to make an assumption regarding Management and staff relations as there were a number of varied reports, some of which were extremely appreciative whilst others show annoyance to inappropriate acknowledgment toward staff. Yet some of this negativity may be as a consequence to the overall size of the Village. In a retirement village that promotes health, it is necessary for staff to recognise the role of others and be provided assistance on means to improve relationship.

5.7.2 A need for greater support toward staff

It was evident that staff generally are supportive of each other however relationships may be improved between Management and staff and between Departments. Staff were asked during interviews whether relationships could be improved and if so how. The Village Nurse also recognised the need for improved team work but stated, “How you change peoples’ attitudes and perspectives and that we are all on the same team, I really do not know” (VN1-26.02.00). All staff who provided feedback recommended that relationships between staff might be improved and fostered through promoting social activities (FS4-19.07.00, GARD1-25.05.00, PHYS1-12.10.00, ACT3-07.12.00) which would indeed enable staff to meet with each other. As stated by a Food Services staff member: “If we had social times and we had to mix it would be lovely” (FS4-19.07.00). Rotation of staff between shifts may also assist in this process.

Staff also suggested a need for debriefing sessions (VN1-26.02.00, ACT2-05.07.00, PCA1-04.03.00, PHYS-12.10.00). It is interesting to note the wording of outcome 3.4 Emotional Support which is resident focused: "Each resident receives support in adjusting to life in the new environment and on an ongoing basis". The criteria of this states: "residents and their families are helped to adjust to . . . cope with grief and loss" (Commonwealth Department of Health and Family Services, 1998b, p S-35). Staff are not considered as requiring emotional support. Yet feedback from staff suggested that emotional support and debriefing are necessary when working with older people, illness and death. An activity staff member explained:

It is very important in this sort of work. I mean if someone dies here; its OK saying this is a job and you don't get fond of residents, but you do. There are some people that you get particularly fond of. I mean if someone dies, you are quite likely to need counselling of some sort; debriefing. (ACT2-05.07.00).

The Physiotherapist, Personal Care Assistant and Village Nurse also believed that there was a need for 'debriefing' or for a better word 'counselling' especially at times when a resident died. The Personal Care Assistant expressed the fact that when a resident is injured or dies, the PCA notifies the Registered Nurse who then organises subsequent action. As she explained further:

We have CPR training and things like that but when you have someone there unconscious and the only thing you can do is to call an RN or an ambulance. There have been situations when we are the first on the scene and then we are forgotten about. I feel that staff could have some opportunity to talk about it to someone, just get the people concerned to sit in a room for 10 minutes and you can say, I tried to do this. Just to alleviate the pain and help you to come to terms with what has happened, say if the person has died afterwards. I suppose it is the way of life because they are elderly (PCA1-04.03.00).

There is no doubt from comments above that staff require support services. Nevertheless, at no point did staff suggest that residents may also require this service.

Analysing results indicated like staff, residents living in the hostel also require some form of support particularly effective communication from staff regarding the well-being of other residents. A resident living within the hostel explained a situation with reference to the loss of fellow residents. (My comment is in italics):

I eat at the small dining room. I think there are only half of them there at the moment . . . One of them has disappeared, so has another one . . . You have to ask the sister if she comes in. We might say, “where has Mavis gone?” and the sister will say, “she’s in hospital or she’s gone to the nursing home” or whatever. *It would be nice if you were told?* It doesn’t matter, we can always ask them . . . My best friend sits in my dining room and if anything happened to her, I’d want to know. But otherwise, you find out eventually (HR3-02.11.00).

This demonstrates poor and ineffective communication between staff and residents. Residents interviewed in Hatcher et al’s (1999) study also revealed concern for other resident who had died. Hatcher et al suggested:

that there is a need for recognition and ritual in residential care facilities surrounding the event of death. If there is no time put aside to remember the person who has died through recognised rituals like funeral services, in which other members of this community can engage, then the residents might realise that in the event of their own death, a similar lack of recognition and ritual may also ensue (p 11-12).

Kellehear (1999) also recommended provision of “education and information for health, dying, and death” for people who “might die soon” as well as for “older people” (p 27). However from analysing data above, this type of education would also benefit staff. The guidelines in the Standards do recommend that staff are provided education “that addresses grief and loss” (as per Outcome 3.4, p G-66) that would enable staff to respond effectively to resident bereavement. This is however only a recommendation and not a requirement and is therefore determined by the aged care provider. Kellehear (1999) noted that all of us are facing death. Support sessions that address grief and loss would therefore be beneficial to residents, relatives and

staff including the necessity of debriefing sessions. The Health Services (Residential Care) Regulation 1991 recognised that staff need to be aware of the procedures for notifying the next of kin when a resident dies or is showing signs of deterioration. Kellehear (1999) stated: "The incorporation of death-awareness and education programs can easily help partly to convert conventional health promotion programs into health promoting palliative care services for older people" (p 28).

Kellehear (1999) also recommended inclusion of support groups whereby the group which could include residents, staff or family and relatives of residents can encourage each other to be involved thereby empowering individuals to take control of their lives:

Support groups . . . provide motivation and encouragement . . . provide a forum for joint problem-solving [and] . . . provide a wider pool of people to share information (p 34).

It is evident above that in times when a resident dies or is transferred to hospital, there is a need for improved communication between staff and with residents, allowing staff and residents to be informed. In the case when a resident death occurs, counselling may be appropriate. It is evident that this service would be worthwhile within the facility in preference to calling on outside resources that may help an individual but not the team and the Village as a whole. Staff would also benefit from this support enabling them to achieve best practice of care as well as peace of mind. Counselling may also be beneficial for residents who are losing a friend and who may also be questioning their own mortality. This Village nevertheless did provide a chaplain service and I would assume that they provide residents and staff with some form of counselling and recognition of a resident death through a church service. Aged care

policy does recognise the necessity of providing emotional support and education but how the service provides this support is determined by management.

5.8 Friendships amongst residents

This chapter has examined the relationships between the residents and staff, and the relationships between staff themselves. This section will investigate the third type of relationships that occur between residents themselves, both within independent living and the facility. For example the relationships between independent residents as well as the supportive role independent residents play within the facility. Unfortunately, I am unable to shed much light on relationships between residents living in the facility as residents were not forthcoming in discussing this issue, apart from some generalised comments that suggest positive relationships.

5.8.1 Relationships between independent living and the facility residents

It was apparent during interview that residents that live within independent living provide support to each other as well as to residents in the aged care facility (hostel and nursing home). As the Director of Nursing suggested, the Villages' "greatest resources are other residents" (DON1-07.12.00). For example, independent residents organise in the facility "church group services twice a week" (DON1-07.12.00, IR3-22.02.00). An independent resident acknowledges that the church service is a means of "bringing the Village together" and found it surprising that the nursing home residents who appear so frail and cognitively impaired, appear to respond during the service - "you can see their lips moving and they are responding" (IR3-22.02.00). This would appear to indicate that residents who are cognitively impaired can converse if they are provided suitable programmes that stimulate their mental capacity.

Residents from independent living also offered a varied voluntary service. This service consisted of entertainment, visiting residents some of whom they once knew when living independently themselves, whilst others are visited because the facility resident has no family, they helped feed residents in the nursing home and they were involved in fundraising activities. (Discussed further in the following chapter Strengthening Community Action and volunteer services). As stated by the Maintenance Manager:

there is a good feeling about this place, amongst the residents.
... everyone is helping each other – a lot of residents go over to
the nursing home and feed [facility residents] everyday
(MAIN1-01.06.00).

During an interview with a resident living within the hostel, she indicated that she “keeps in touch with people from the Village” (HR-1.04.03.00). The Director of Nursing also confirmed that independent residents are involved in providing support for facility residents, stipulating:

Oh they are [involved]. I would like to use them a bit more
than I can but they do have a very busy life . . . And I have
never been a person who likes asking for help (DON1-
07.12.00).

One of the residents in the hostel informed me during interview that she had told her neighbouring resident to “knock on the wall” if she was unable to access her emergency buzzer (HR1-04.03.00). Staff encouraged friendships between residents which is an expected outcome under Standard Three. For example the guidelines for outcome 3.5 – Independence, suggests that “Residents are assisted to . . . maintain friendships” (p G-67, S-36) and that strategies should be in place to foster “friendship and social networks” (p S-36). Friendships may be fostered through activity programmes such as craft whereby residents meet with people who have “common

interests” (PHYS1-12.10.00) and on occasions, this has resulted in marriages within the facility (PHYS1-12.10.00, FS2-18.05.00).

Friendships are indeed fostered within this Village, with residents from independent living maintaining their friendships with residents from the facility. Independent residents also offered a great deal of support through church services, voluntary services, feeding and reading to residents, assisting in fundraising activities all of which support the staff in meeting their role in providing care to residents living in the aged care facility. These social relations will be discussed in the following chapter that will consider the issue of social capital and its meaning to health promotion.

5.8.2 Relationships within independent living – the ‘Friendly Village’

Relationships within independent living were promoted by Management. Residents were provided effective communication between administration with monthly meetings, a Village newsletter and provision of a list of all the residents living in the entire Village from independent living, the hostel and nursing home. This list was regularly updated and if mislaid, a copy could be purchased from administration (IR2-17.02.00). Residents living within independent units identified their own contribution to Village life, providing support with fundraising activities and offering voluntary services, as well as fostering friendships. Results of a study conducted by McDonald (1996) in a retirement village in Victoria indicated that “It is unknown for two residents [in a retirement village] to pass without at least greeting one another” (p 169). This study supported McDonald’s (1996) findings with residents also acknowledging each other either verbally or non-verbally while walking through the Village. . As quoted from a resident from independent living:

There is always someone to meet. You go from here to get your mail in the amenity building and you very seldom go over without meeting someone and having a chat. It is like a family. If you need anything, you only have to ask. Some people have a car and they always offer a lift (IR3-22.02.00).

The Hostess noted that residents always say “hello” and if a resident becomes ill or a spouse dies, residents will provide meals or offer assistance as required (HOST1-02.11.00). Other general comments made by independent residents that demonstrated a supportive environment include:

The residents give each other support (IR5-11.03.00).

I think we support one another. This is very much a big family place. We support one another. We are not intrusive. I know that if I need anything, the lady next door is there. But in general this is a very supportive place, between the residents themselves (IR6-08.04.00).

The other residents in the village are all very helpful. I have a good neighbour . . . We are a Friendly Village (IR2-17.02.00).

This latter assertion was evident throughout the field study with a number of residents and staff referring to the Village as a ‘Friendly Village’. These findings are consistent with similar results from McDonald’s (1996) study with residents also referring to the village as a “friendly village” (p 169). This may be as a response from residents helping each other. Friendships were also fostered through the various activities and outings that were organised in the Village helping ensure resident’s social life is maintained. There were suggestions during the fieldwork by staff and residents that residents are so active that they would be happy to have some time to spare (IR6-08.04.00). The Maintenance Manager noted that residents:

have a club for everything and there is no excuse for any resident not to be involved in about ten different things . . . It would be annoying if you want to be alone (MAIN1-01.06.00).

Residents were able to attend various meetings or clubs either between Management or each other. For example, there was the recent development of the 'friendly club' allowing residents to socialise together helping to reduce isolation that may occur when living in the community. As explained by an independent resident, the friendly club commenced with approximately 60 people attending the first meeting in which ideas were discussed. The aim of the club was "to allow people to meet and talk" and for people "who were lonely or who had no friends . . .to get together and have a chat and cup of tea [and] discuss their problems" (IR4-26.02.00). As noted by independent residents, within the Village, "there should not be lonely people" (IR6-08.04.00, IR3-22.02.00) however some residents choose to enjoy their own company or "are too shy to do anything" (IR4-26.02.00). The friendly club is a good example of how a retirement village can create a supportive environment for residents. Residents also acknowledged and recognised that individual preferences are respected.

The men living within independent units were inclined to have their own hobbies and activities. For example they had formed a social club for men only, and often attended the café for meals (IR8-04.05.00). They also had access to vegetable plots enabling them to grow fruit, vegetables and flowers not solely for themselves but also to share with other residents. There were also two workshops that the men exclusively used. I visited the workshops and spoke with some of the gentleman who were happy to show me their work. I later attended the Open Day and was further impressed by the work of these talented men who produce a range of toys and home ware for sale as a fundraising activity. As explained further by one of these residents:

They [the men in the workshop] do a lot of work for the village, such as library shelves, they make furniture and little jobs for people. They make things for themselves. It is a very active workshop. The top workshop used to make mainly toys

which they sold on open day. I think the ones that were running that have got too old to do it, but ours is very active (IR6-08.04.00).

Provision of these types of services enables older people to remain actively independent and contribute to retirement village living, such as through fundraising events. It was apparent during the course of the fieldwork that residents from independent living were becoming less active. This was confirmed by residents and the Director of Nursing who stated that residents: “are all ageing at around the same time” (DON1-07.12.00). The Village may need to consider providing men in the facility with a similar hobby workshop. The men from independent living could assist in the development of small projects. This would foster relationships between the men of the Village and provide a means for socialisation and physical activity, thus promoting health and well-being.

Fortunately, this Village provided residents with the opportunity of having a home for life within the same Village that offered a continuum of care. This continuum of care helps to promote relationships throughout the Village that will be discussed below to conclude this chapter. As can be seen above however, relationships between residents living within independent units are positive with feelings of caring and friendships and again the notion of a family unit. This appears to be attributed through effective communication between Management and residents and between residents themselves and by the numerous social activities that are available, and the common theme of the Village as ‘a Friendly Village’ that helps to promote and instil positive relationships. These are all aspects that are invaluable in a health promoting retirement village.

5.9 A continuum of care that fosters relationships

Residents were not only supportive of each other, but were also complemented by the continuum of care offered in a retirement village that provides all levels of care. This system has its limitations such as not always being able to accommodate residents in the facility until a room is available, yet the limitations appear to be outweighed by the benefits. It offers residents greater choice with increased assurance of a home for life compared with other villages that may offer limited services and facilities. Relationships are also fostered by providing extensive networks between residents at all levels of care, thus enabling residents a chance of maintaining independence with provision of readily available support services as identified earlier in the chapter, with the Village operating as a community in its own right. By offering a continuum of care, there is often an extensive history of a person, helping to assure that the resident is acknowledged and treated as an individual.

The Director of Nursing explained that there were occasions when residents may be required to find temporary nursing home accommodation until a vacancy became available within the Village's own nursing home or hostel (DON1-07.12.00). Fortunately, the nursing home was being extended at the time of completing the fieldwork to accommodate the Village's ageing population. As expressed by an independent resident and the Director of Nursing respectively:

A resident from here has had to put his wife into a nursing home – he couldn't get her in here. It is extremely disappointing. A lot of the people here have to go out to an outside nursing home, as they only have a 30 bed nursing home, so when there is an extra 15 (building in progress), it should be better, but they have to take outsiders because they are able to get subsidies. I know I could name a number of our friends who have had to or will need to send their partners to outside nursing homes (IR4-26.02.00).

We endeavour to maintain . . . that family cohort. We are not always able to do it. We certainly endeavour to get couples back together. Whereas with the community at large when somebody is put in the nursing home they are often quite a far distance away. We nurture our relationships here (DON1-07.12.00).

Relationships are indeed fostered when residents are able to reside in a Village from independent living through to the nursing home. Friendships are able to be maintained with the aid of the Village bus enabling residents to visit each other in the different areas or facilities of the Village. As was noted by independent residents and the Director of Nursing, residents are generally the same age which promotes a better understanding of each other, being born in the same era – “we are at an age where we went through the same period and you come in here but you meet people who you went through school with . . . It is like a family type of atmosphere” (IR3-22.02.00).

I asked some of the residents from independent living how they felt with regard to moving from independent living through to the hostel and nursing home and was surprised with the response; as summed up by a resident:

You know that has to happen. You can continue to live in the village, as we have a lot of 90 year olds, but they get their rooms done, meals and also help from the nursing staff. You know that you cannot be independent forever but that varies with each person with your health, your family and your attitude to life. I hope I am here for another 10 years, I don't know where 10 years has gone. During this time you lose people and friends, but you make new ones (IR3-22.02.00).

This highlights the necessity of providing the services of the Village Nurse, home help and meals to residents living within independent units. This comment made by a resident also acknowledges that there is some reservation toward entering an aged care facility. For this reason I think it is important for Villages that offer a continuum of care, that residents are provided support and encouragement by staff, doctors and

relatives when making decisions about moving between levels of care, and that the resident feels the time is right. Krothe (1997) who talked with older people who were living independently but at the stage of having to consider entering a nursing home found that they: “feared losing control over the very decision of whether to go to a nursing home” believing this was the final stage of life prior to death. So what is the right time? From my observations and interviews, residents do seem to be provided the opportunity of moving into the facility at a time that they felt was ‘right’. If a group were asked this question, the answers would probably be answered differently. For example, the resident may begin to feel that they are increasingly dependent on their family and the services of the village. Relatives may look at the person that they love but suggest from a protective perspective that the resident enters care. Whilst the medical profession may observe the residents deteriorating health and recommend moving the person. These are assumptions that would be interesting to follow up in a further study. However below are some comments made by a resident from the hostel who begins explaining the assessment stage and later in the interview, she continued to explain her decision to move. She spoke about “Nicky” who is her cat, and fortunately, she was able to move into the facility with Nicky:

Well you get assessed. You see I have a balance problem and they assess you and they say if I wanted to come to the hostel they would sign the form because I was ready for it. And then the doctor said to me one day “would you like to go into the hostel”, I was getting worse and couldn’t shop very well and I had meals on wheels for a while because I couldn’t get to the shop on some days and I said “I don’t think so, I won’t be able to take Nicky”. He said, “yes you will”, so then I decided there and then to come up because I was finding it difficult down in the village. Down there (in the unit), I got to the stage of thinking “oh I have to do my washing today”, whereas here you get that done. In the end I had to have someone help in the house and then shopping got difficult, gardening almost got impossible. So that is all eliminated by coming in here (HR3-02.11.00).

And from the perspective of staff, firstly the Village Nurse and secondly a Food Services staff member:

we don't bring them in if they don't want to by all means encourage them to stay at home. But if their quality of life will improve by bringing them into a secure environment, it's not everyone's cup of tea, but there are so many of them that want that support and security. We encourage them to get all the additional help before they think about moving, so they have the meals on wheels, they have assistance with cleaning. But that is not the problem, I mean that helps, but that is not what the problem is. There is the insecurity and knowing that someone is there and that they are safe and they are all under the one roof and they are not vulnerable and someone is going to come. They see staff walking past, and even just that is reassuring; they know that they can reach out and grab someone if they need some assistance and the fact that they've got it keeps them happier and healthier (VN2-02.06.00).

I think it is great that you come in living independently and then as you get slower and become more dependent you can move on [into the nursing home or hostel] (FS4-19.07.00).

And as a concluding remark, the Director of Nursing expressed the "ideal situation" of providing a continuum of care and the importance of maintaining resident's independence through the provision of support services.

I think essentially in the village here we have an ideal situation, which is supportive, because we have ideally people come in as independent people and living through the different levels of care. We support them in the independent living units when needed, but try and back off readily so that they retain that independence. As they move through the different levels we put into place different levels of support that we are always endeavouring to make them independent or maximise their independence (DON1-07.12.00).

As is evident the provision of support services to independent residents is a necessity and is most likely to become increasingly vital with an ageing population. As noted by Krothe (1997) it is not economically viable for an ageing population to rely on aged care facilities whereas the provision of a continuum of care whereby health promoting services and personnel are available to maintain and promote the older person's

independence and quality of life while living within independent living appears to be more viable.

SUMMARY

This Chapter has investigated albeit briefly, the various types of services relationships that occur within a retirement village; the relationships between residents and staff in the facility, between staff themselves, between Management and independent living residents, between these residents themselves and the Village Nurse and residents. These relationships are fostered with the provision of a continuum of care and effective verbal and non-verbal communication. Communication skills however could be improved between Management and staff and from analysing findings in this study, I feel it is appropriate to have representation for the rights of staff to investigate the issue of the complaints resolution mechanism and gain staff feedback on their experience of this system. Staff and even residents and relatives could also be provided further support through the provision of education and counselling on issues relating to death and dying. At times, relationships could also be improved between Departments. Yet throughout this section there is evidence of friendships and a tendency toward measuring relationships in terms of a family network. As can be seen, this action area provided an extensive analysis and identification of the important role of providing both support services and personnel into an aged care setting.

The support services that were available within the Village, included food services, gardening, maintenance and security, transport and the activity programme. All of

these services contribute to residents wellbeing; providing a means to promote ongoing long-term relationships and an active social life.

Meal times are one means to reduce isolation and promote socialisation between residents, their families and even community groups, and food promotes good health. However, the elderly are at risk of malnutrition and it is therefore necessary to promote nutrition services from qualified personnel within aged care settings to review the use of vitamised diets and provide guidance to Food Services staff with regard to meal serving size and resident dietary requirements. This needs immediate attention by policy makers, as mealtimes are an important time for residents and to their overall health and well-being.

Gardening and the garden service was also an important aspect to both residents in the facility and those living within independent units. Unfortunately, on entering the facility, residents were unable to continue gardening, and it seemed that residents in the independent units were becoming older and less able to manage the gardening. It would seem appropriate for the qualified gardener, if time permitted, to organise raised gardening beds and a gardening programme. Nevertheless, the gardener had time constraints as a result of other commitments, including assisting in the Maintenance Department.

The maintenance service was particularly important to residents within independent units who experienced feelings of safety and security with staff who could carry out various household repairs. The maintenance staff also had the responsibility for transporting residents in the Village bus to shopping centres as well as on mystery trips.

Residents within independent living had an active and varied social life compared with residents living within the facility. This may have been a response to limited funding and time of the activity staff, however, with the commencement of the Occupational Therapists, activities had become a little more varied and co-ordinated in the facility.

The following chapter will continue analysing the Ottawa Charter specifically though to the action area, strengthening community action. This chapter will discuss issues of family and relative participation, and to the overall importance of community partnerships and social capital within a retirement village that offers a continuum of care.

Chapter Six

Strengthening community action through collaboration, participation and empowerment

The Ottawa Charter's action area, Strengthening Community Action will be investigated in this chapter encompassing issues of family/relative/friend participation in aged care, volunteer action and partnerships with the school community. As was noted in the previous chapter, residents and staff tend to use the words such as 'community' and 'family' when describing Village life. The Ottawa Charter (WHO, 1986) recognises the invaluable contribution of the community in 'planning' and 'implementing' health promotion 'strategies' to "achieve better health. At the heart of this process is the empowerment [and participation] of communities" (p 2). A community as defined by The Oxford Dictionary is a group or 'body of people forming' 'social unity' (Johnston, 1976). Or Davey, Emery and Milne (1980) described community as a group of people working together, sharing 'skills' and 'ideas', "to make their lives and surroundings better" with each person feeling they 'belong' and have "an important part to play" (p 1). A retirement village such as the Village could therefore be described as a community. For example, residents living within independent units who produce and exchange goods as well as offering their skills and abilities to other residents and to the children in the local school shows that the residents are working together, being supportive and are building partnerships with the local community. Within the Standard, outcome 3.4 – Emotional Support, volunteer participation is recommended. Throughout the Standards, family

participation, use of advocacy services and community involvement are encouraged as the organisation is expected to 'consult with each resident or their representative'. Standard 3 – Resident Lifestyle recommends that residents are encouraged to “remain an active member of the community” (p G-55) and that programmes and strategies are in place to foster family and community involvement.

Throughout the fieldwork staff and residents from the Village referred to the fact that community living is promoted. In fact prior to entering the Village residents are provided with an information pack including an explanation on 'community living'.

As stated by a resident:

you have to have the type of people in the establishment who are community minded. . . I think some people are and others are not, but most of the people in here are community people, they don't come in here otherwise. This is definitely a community-based place, everybody does a bit (IR6-08.04.00).

When this resident refers to 'everybody doing a bit', she is describing the various activities and voluntary contributions of residents and the processes available that enables residents, particularly those living within independent units, to be empowered in an aged care setting.

The Ottawa Charter (WHO, 1986) and the Jakarta Declaration (WHO, 1997) recognises the importance of empowerment in the process of strengthening community action. The Jakarta Declaration which was developed a decade after the Ottawa Charter and during the 4th International Conference on Health Promotion acknowledged that health promoting activities needed to challenge the determinants in health such as issues relating to globalisation and an ageing population. The Declaration also recommended there was a need to 'build social capital' (WHO,

1997). Issues relating to social capital will be discussed briefly in this chapter, but not in its entirety as this issue remains debatable in health promotion and was not a component to the Ottawa Charter which is at the forefront of this study. Yet the Charter does recognise that “[c]ommunity development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation” (WHO, 1986). Within the retirement village, it could be assumed that human resources include individuals and community organisations offering emotional and social support through the sharing of skills and the building of relationships. Material resources on the other hand include monetary funds contributed by government or through fundraising activities. These issues as well as the valuable contribution and partnerships that occur between the Village, volunteers and school community and the need to promote family participation through means such as empowerment will be discussed below. But first, it appears relevant at this stage to provide a brief overview of social capital which has been attributed to the processes that occur between people and the community to establish networks, co-operation and trust.

6.1 Building social capital and the empowerment of people

Glenn Loury introduced the term social capital in 1977 followed by recent works of Robert Putnam in Italy and in Australia, Eva Cox (Leeder and Dominello, 1999, p 426). There are various thoughts with regard to the concept of social capital. For example, Ronald Labonte (1999) and Stephen Leeder and Amanda Dominello (1999) believed there needs to be some caution with the use of social capital. But firstly, what is social capital? There are differing definitions but for the purpose of this study, I shall use social capital as defined by Cox (1995):

the processes between people which establish networks, norms, social trust and facilitate coordination and cooperation for mutual benefit (p 15).

Within a retirement village setting, the concept of social capital appears relevant. For example, there are a number of social networks that occur between residents in the facility and independent living. Residents from independent living play a valuable role in offering volunteer services within the facility that is of mutual benefit – residents are able to maintain friendships and their co-ordinated action of offering volunteer services assists the staff. Eva Cox's (2000) theory on social capital is that 'social cohesion' "enables people, organisations, communities and nations" to 'work together collaboratively', 'resolve disputes civilly', to build 'trust' (p 103) and establish networks. Colquhoun (2000) also suggested that social capital may see "a resurfacing of terms and concepts" such as 'social justice', 'empowerment' and 'community capacity' within health promotion (p 171). He utilised the strategies of the Ottawa Charter in health promotion activities, that is, 'advocating', 'enabling' and 'mediating' to explain the association of social capital in health promotion as follows:

Health promoters would be able to enable, mediate or advocate very little without networking, trust, partnerships, coordination, cooperation and community involvement (p 170).

The residents within the Village worked in partnership, helping each other in a number of ways, such as through the sharing of seasonal vegetables that have been grown in the vegetable plots, or independent residents helping to feed residents in the facility whilst maintaining friendships. It could be suggested that residents have built up trust and social networks. According to Cox (2000) trust enables individuals and groups to communicate effectively "and makes it possible for people to work co-operatively and collaboratively" (p 104). As was evident from previous chapters (Chapter 5), networks are prevalent in the retirement village, for example between

independent residents, between residents living in the facility, between volunteers, staff and residents, between staff and residents, and between residents and the children from the local school. These networks could be expanded to include other community organisations and the fostering of family participation. These networks will be discussed within this chapter from the analysed data on strengthening community action.

One could suggest that social capital is vital within a retirement village setting in which staff network and create partnerships with other organisations, learning from each other to create harmonious living for residents and working conditions for staff. It may also be a means of empowering all people within the retirement village and community to participate in decisions and activities. As noted by Baum (1998):

Community empowerment results in a community in which individuals and organisations work together to meet their respective needs. They provide support for each other, deal with conflicts constructively and establish control over the quality of life of the community” (p 328).

These processes are a “means of strengthening [retirement village] communities” (Baum, 1998, p 95) and one that is healthier and happier for residents to live in, staff to work in and community and family to visit. Baum (1998) referred to “self-empowered healthy behaviour” (p 96) that is, individuals taking responsibility for their own health and well-being. Isaksson and Pohjolainen (1994) suggested this is vital in ensuring dignity, privacy and individualism is adhered. Within aged care it may be necessary to provide residents with encouragement and assistance in this ‘empowerment process’. Empowerment as described by Green et al (2000) is:

a cardinal principle of health promotion . . . That is, health promotion seeks to ensure that individuals and communities can exercise their rightful power in making decisions that can improve or damage their health (p 7).

The Standards have attempted to promote the empowerment of residents by enabling them to be involved in decisions, suggestions and complaints through management systems. These systems may include resident meetings and internal and external complaints mechanisms. Nevertheless, to be empowered means enabling individuals to exercise control in making healthy informed choices. Residents would therefore be empowered further with the provision of knowledge, skills and resources. Nystrom and Segesten (1994) suggested that this “could be directed towards supporting the individual in strengthening self-concept and improving the understanding of the situation, and towards facilitating patient influence by refraining from control, providing resources and advocating at different levels” (p 127). The residents sense of belonging may also play an important role in empowering the individual to retain “memories of the past” (Nystrom and Segesten, 1994, p 127). Therefore, on entering the retirement village, the resident may benefit from being encouraged to keep their most treasured belongings including photographs. It may also be relevant to attempt to empower the relatives allowing them greater control and involvement in aged care decisions and the decisions made regarding their parent’s (the residents) wellbeing.

On a negative note with regard to social capital, there are those such as Labonte (1999), Leeder and Dominello (1999) and Paul (1998) who are concerned that the idea of social capital may be used or co-opted by vested interests. Leeder and Dominello (1999) for example suggested:

social capital is flavoured by an economic essence, and its potential exploitation to push already laden individuals into assuming more responsibilities, such as the care of the aged . . . with a view to saving taxes, is worrying (p 427-428).

Eva Cox (2000) also recognised that the concept of social capital has been used for political benefit, “for example, promoting the idea that the voluntary/community sector can replace government services” (p 103). And Putnam (cited in Leeder and Dominello, p 426) noted that social capital may be used “for socially perverse purposes” such as by the World Bank. In fact, in 1995 the World Bank estimated the ‘world’s wealth’ in terms of human, natural/environmental, social and economic capital. Hancock (2001) and Edgar (1999) considered challenging the changing face of society with Edgar (1999) suggesting:

that business, local government, education, voluntary, non-government organisations and other social services will have to work more together in mutual support, instead of relying on paternalistic government authorities to ‘deliver’ what they decide is needed, or affordable. This new form of ‘tribalisation’, as I have called it, . . . might engender more sharing, cooperation and better quality of life for more people than we have at present. And voluntary work will become more, not less central to the processes of everyday living (p 12).

Whilst Hancock (2001) proposed:

What communities require is a new form of capitalism: one that will simultaneously increase all four forms of capital. This can be considered to be the creation of community capital (p 277).

Hancock (2001) is suggesting that healthy communities such as a health promoting retirement village can be created through the building of social, economic, environmental and human capital, simultaneously. Nevertheless, I agree with Labonte (1999) and Leeder and Dominello (1999) that we should tread cautiously with issues surrounding social capital. Social capital though appears to be an important health promotion concept whereby networks are established and the community work together collaboratively, building partnerships, thus empowering individuals. Empowerment is an important aspect in health promotion enabling people,

particularly important for older people and their relatives as well as the retirement village as a whole, to take responsibility and ownership of their health with support from volunteers and the community. Nevertheless this needs to be in partnership with government and policy developers through provision of health promoting policies and financial assistance, including financial incentives that may be accomplished through accreditation that recognises facilities that are working in partnership with the community and offering health promoting incentives.

6.2 Limited Partnerships between the Community and the Village

The community including volunteers, the local school, relatives and friends of the residents, community groups and so on play a variety of roles in the Village. There are several benefits to both the Village and community including maintaining relationships through networks, partnerships and the empowerment of residents. Nevertheless, due to the size of, and extensive services that the Village offers, residents may be disadvantaged by the community reducing the amount of support services offered and the Village offering their own services such as home care, to the community. Sherman (1975) described this dual role:

retirement housing can serve a dual function by offering services not only to residents but to other members of the community, who are able to and choose to remain in age-integrated housing (p 231).

Offering services between the retirement village and community is a means to foster and promote relations and improve allocation of resources. In the past the Village utilised services of the community such as the Royal District Nursing Service and Open Door. At the time of the study, these services were infrequently used with suggestions from staff that these services were overwhelmed with the sheer number of residents from the Village whilst having to continue the service to the community at

large (VN2-02.06.00, ResCo-01.06.00, DON1-07.12.00). As noted by the Village Nurse:

“Open Door” is a church service that has volunteers that offer driving support and that sort of thing and we were using them at one stage; helping to transport our residents. But . . . our requirements were sort of sucking up all of “Open Door’s” resources (laughing) and that is where we miss out a lot (VN2-02.06.00).

This staff member continued, elaborating on the size of the Village that prevents residents from obtaining community services thus prohibiting community and resident relations: “It would be good if we could utilise more of the community services without sucking them dry” (VN2-02.06.00). Residents therefore become reliant on Village services such as meals and home care with the latter being offered to the outside community. As noted by a number of staff (MAIN1-01.06.00, DON1-07.12.00, RN1-11.03.00, ResCo-01.06.00, FS2-18.05.00), the General Manager had attempted to provide various services to the outside community, one of which was home care. As explained by the Resident Co-ordinator:

we at the village actually liaise with people in the community through our home care service. We provide a very extensive home care service, which is for residents in the village as well as people in the community. . . We offer cleaning, gardening and meals on wheels (ResCo-01.06.00).

Staff who remarked on the home care service were not aware that the meals on wheels component was no longer available. Home care services however still continued to be offered to the outside community. As explained by the Catering Manager, the food services to the community ceased as it was inappropriately resourced – there were inadequate staff to deliver meals within limited time constraints. She did admit that the Village may endeavour to trial this service in the future when the Food Services Department was expected to expand with building upgrades planned in the near future. She also realised that there would be a need to purchase a food transport

vehicle and suitably qualified staff to transport meals to people in the community (FS2-18.05.00). It could be hypothesised that residents in the Village are disadvantaged with not being able to access community services whilst services such as Home and Community Care (HACC) is being supported from the provision of home care offered by the Village. In other words residents in the Village are entirely reliant on the Village services, whilst the community, is compensated or reduced through provision of services offered by the Village.

6.2.1 Collaboration between the Village and Community

There are a number of opportunities for the residents of the Village to liaise with those in the community, especially through the invaluable contribution of volunteers and the social activity programme. Activity staff approached various community groups, but admitted that the results are “mainly looking for donations”, often to no avail (ACT2-05.07.00). The Director of Nursing also commented that people from the community tend to donate goods in preference to monetary funds which then does not allow the facility to spend accordingly (DON1-07.12.00). Nevertheless, it could be presumed that donations of goods could contribute to the life of residents as this enables funds to be redirected in other areas. As stated further by the Director of Nursing:

we have people even out in the community who usually donate something. I mean somebody dropped in three crocheted rugs yesterday, which isn't going to raise any funds for us, but it means that we don't have to buy extra rugs for residents so essentially that helps us a lot (DON1-07.12.00).

Personnel that were involved in the Village's social programme include a variety of entertainers such as the Community Women's Group (ACT2-05.07.00, ACT3-07.12.00) and the Elderly Citizen's Group that enabled residents to maintain and build relationships with the community whilst maintaining involvement in social functions

(VN2-02.06.00). There were various activity and interest groups from both the hostel and independent areas who participate in competition tournaments with community groups. Expected outcome 3.7 – Leisure Interests and Activities, encourages aged care organisations to consider:

Strategies to develop and foster a community among residents, enabling them to identify others with whom they have common interests and to build social networks (p G-70).

This outcome is suggesting residents within the aged care facility are provided the opportunity of socialising with each other, identifying ‘common interests’ and building networks, consistent with the process of social capital. Within the Village, there remained some concern especially from the Occupational Therapist and Cook Manager of the café whether residents living in the facility maintain adequate association with the community. The Cook Manager for example spoke about residents from the facility “missing out” on continuing relationships with the community. She explained that some residents from the facility go to the café just so they can talk with residents from independent living or with the Cook Manager herself. As demonstrated below, the Occupational Therapist first, relates the situation of residents moving from independent living through to the hostel and second, the Cook Manager illustrates the importance for residents to talk with people outside the hostel:

It is interesting talking to some of the residents who have come from independent living to the hostel. For a lot of them it is quite a culture shock because they are going from whole independence even if they have had the village sisters and home care service, to what they see as a dependent environment in comparison. They feel that their world has closed in . . . because their choices have been taken away. It is also regimental in particular with mealtimes. So I think there would be a lot of people who would really benefit from maintaining contact with the community (OT1-02.06.00).

They [residents] say they want a break. But they want to sit and talk and ask me 101 questions about my family and things like that. And then the next week she'll come in and say "did you ever go on that holiday?" Then I go through the whole process; I mean that is fine. I feel pleased that they are able to come here and do something. They need to belong. They walk away much happier in themselves (FS4-19.07.00).

One means to foster community relationships and for the community to have a greater understanding of retirement village living is provided when the Village has its yearly Open Day, which I attended. This is a fundraising event with people from the community having the opportunity to walk through the grounds and inspect units both at the hostel and independent living. The Village also organised a stagecoach for people who wanted to sit back and relax while taking in the Village grounds and environment. During the day both staff and residents offered the community a variety of entertainment both within the facility and outside including line dancing, singers/choirs, concerts and bands. Residents were able to show and sell their art and craft work including paintings and woodwork. As the Catering Manager noted, "they always have fun things on" (FS2-18.05.00) with the year that I attended, celebrating Australia's bicentennial offering residents the opportunity of reading poems, singing and sharing their knowledge through an exceptional show for all participants to share. During the day, food was being sold and prepared by staff and Management with the Director of Nursing admitting that staff offer their own time as volunteers (DON1-07.12.00). Open Day appeared to be instrumental in a number of ways as discussed in previous chapters, such as through its fundraising ability, and was also an effective means to promote community awareness of life in aged care. Activities such as these could help reduce the negative stereotyping of aged care, with people from the community being made aware of the knowledge and skills within this setting.

Other means to collaborate between the community and the Village, may include provision of education. The Village Nurse whose multiple roles included Education Co-ordinator, in fact suggested the development of an education programme that was accessible to the community (VN2-02.06.00). The present education programme utilised specialists and educators from the community to talk with residents and / or educate staff (VN1-26.02.00, DON1-07.12.00) however could easily be developed further through collaboration. (Discussed in greater detail in the following Chapter on Developing Personal Skills).

Another role of the Village Nurse was acting as the Department of Veteran's Affairs Nursing Care Provider. This role allowed her and another Village Nurse to provide nursing care to "residents that are in Veteran's Affairs" with the apparent ultimate aim of the Village to provide this service "to the broader community" (VN2-02.06.00). The Village Nurse however queried the plausibility of this, again similar to the Food Services situation, considering the need for staffing, time and organisation to ensure a successful joint venture between the community and the Village.

On analysis, there appears to be a need to ensure that future services between the Village and the community offer a level of service maintained for both the residents within the Village and to the community. Networking with community health centres, libraries and health promotion agencies can provide valuable research material, knowledge, skills, assist in staff professional development, reduce negative stereotypes and assist in fundraising events. Kellehear (1999) recognised that the media may "help publicise the health promoting service and its philosophy, thereby assisting the service with self-referrals" (p 36-37, 41-42). The community, such as

the local Council, could also be involved in collaboration with the Village to discuss implementation of programmes such as meals on wheels, home care, nursing care, gardening/maintenance services and education, ensuring that resources are effectively utilised for the benefit of the community and the Village. Nevertheless this needs to be a win: win situation for both parties, recognising the potential for both to share their resources and knowledge of aged care and service provision.

6.2.2 Co-ordination of Community and Volunteer Programmes

As is apparent above, there would appear to be a need to increase community participation with the Village. But there were conflicting opinions with regard to whether the community is promoted adequately. This may be attributed to the fact that staff and residents liken the Village to a community within its own right (HOST1-0211.00, MAIN1-01.06.00) as a result of the supportive activities of independent residents, and the various support services available for all residents (Discussed in Chapter 5 – Support Services). For example comments made by residents themselves suggested residents “like to keep to themselves” (IR5-11.03.00) and that the Village “is pretty well an amenity by itself” (IR6-08.04.00). Another independent resident suggested that within the local community “people perhaps think that we are a community of its own” (IR8-04.05.00). Interestingly enough however, the Village Nurses who liaise daily with independent residents negated this, suggesting the community are inadequately promoted (VN1-26.02.00) and that the community could be utilised more (VN2-02.06.00). When the activity staff member was asked whether the community is involved the response was “Wouldn’t that be nice” (ACT2-05.07.00).

The Occupational Therapist also acknowledged the need for community participation however considered its implication, with regard to whose role it would be to co-ordinate the association, having already taken on the responsibility of volunteer coordinator. As she expressed when discussing ideas on present community involvement:

It is a thought provoking aspect to have more community involvement, etc. and the thing that I am thinking is, whose job is it to do that, whose job is it to organise it? I mean all the things we have talked about is the voluntary programme and residents going out to concerts or whatever. They are all done by little people here and there. Sometimes I feel that we need a person to draw it all together . . . But sometimes, I just feel that even with the voluntary programme there is too much for us two OT's to take on and we can't really take on the time as it is taking us away from the specific job we are doing, although it is related and it is important. I don't know whose role it could be (OT1-02.06.00).

As is noted by the Occupational Therapist the volunteer programme was not co-ordinated efficiently, as the programme had not been considered a priority. The Occupational Therapists were asked to develop the programme but in combination with their existing role as Occupational Therapists.

Organisations, such as aged care will probably call upon volunteers as a result of economic rationalism, but there is a need, as recommended by the Ottawa Charter, for 'coordinated action' including the provision of skills that will help maintain volunteer interest. Hallahan (2000) recognised though that:

Volunteer programs are often considered peripheral to the core activities of the organisation, regardless of the contributions that volunteers might make to the organisation's operations (p 10).

This may be the situation within aged care, and appeared to be the situation within the Village in which the volunteer programme was not co-ordinated until the recent

addition of the Occupational Therapists who were developing the programme during my fieldwork. During the interview with the Occupational Therapist I suggested whether there could be a position such as ‘volunteer co-ordinator’ who would be responsible for co-ordinating both the volunteer and community programmes. This would then allow the Occupational Therapists to concentrate on their own role and the activity staff to benefit with increased community action. This is part of the conversation that followed:

I think we need to provide a voluntary service to people because there are a lot of residents who are not interested in group activity but they would like someone just to come and have a chat with them. To organise for a volunteer it needs more than just finding someone. You are putting someone in a position of providing a service to someone who is vulnerable and it can open up a whole can of worms; you need someone that is trustworthy. People need a set of ground rules; they also need to be supported or they won't continue to come. They have to get something out of it as much as the resident. To provide all of that and give the instructions and training and everything is a really big job. I really think it would be great if we had a volunteer co-ordinator with being such a big facility (OT1-02.06.00).

As was noted by the Occupational Therapist, “It is difficult to juggle the time as OT and volunteer co-ordinator” (OT1-02.06.00). The two Occupational Therapist's had developed guidelines for “an orientation session” and “a volunteers’ rights and responsibility brochure” (OT1-02.06.00). They also advertised for volunteers through the Village newsletter (IR2-17.02.00, ACT2-05.07.00, OT1-02.06.00) and were happy with the response (ACT2-05.07.00, OT1-02.06.00). Prior to this, volunteer numbers had reduced considerably which may have been a contributing factor for Management to decide that the Occupational Therapists were to develop a programme including recruitment. An activity staff member commented on the difficulty in maintaining and recruiting volunteers, with people not being forthcoming to volunteer in this field (ACT2-05.07.00). This may have been as a response to a lack of co-ordination and

support toward these volunteers. Studies such as that conducted by Hallahan (2000) and Battaglia and Metzger (2000) have reported that the majority of volunteers traditionally have been women and that as a consequence volunteer numbers are falling with an increasing number of women moving into paid work and others working longer hours. Nevertheless, older people, or those that are retired “are being considered as a rich resource from which to recruit volunteers” (Battaglia and Metzger, 2000, p 6). However there were some younger people who have recently joined the Village as volunteers (OT1-2.06.00, ACT2-05.07.00, ACT3-07.12.00), some of whom may be considering it a means to gain employment, with one young lady applying to do a Personal Care Assistant course (ACT2-05.07.00). This situation however benefits both parties; the volunteer is able to increase their knowledge and skills while the Village is able to utilise the service.

6.3 The invaluable contribution of the volunteer

Volunteers play a contributing factor in building social capital and as noted by Baum, Modra, Bush, Cox, Cooke and Potter (1999), the activities of volunteers “should build the trust, coordination and cooperation which is at the heart of social capital” (p 13). Volunteers from independent living and to a much lesser extent from the local community offer a range of services to Village life with the main activities including fundraising, assisting with the social programme and resident care within the facility. It should be noted at this stage that like the concept of social capital, there are also varying thoughts and definitions about volunteers and volunteering. Paull (1999) for example recognised that there has been “a lack of clarity about the terminology” (p 19). However for the purpose of this study, I am utilising the thoughts and views of the people that I interviewed, that is, the residents and staff associated with the

retirement village who believe they are offering such a service. Generally, volunteering comprises an activity carried out that has no financial incentive, but is of benefit to the individual, organisation and/or community and to the volunteer themselves.

The majority of volunteers within this Village were elderly which was recognised by both residents and staff. Watson and Hall (2001) noted that volunteering probably benefits the older person as well as the community:

The potential value of social capital to older adults is substantial, but it is worth noting that older adults can contribute significantly to overall social capital in a community. This is because they have more discretionary time to devote to building social capital than younger adults do (p 25).

As noted by Sargeant (1999), Deputy President of the Council on the Ageing (Australia) International Year of Older Persons, 1999 showed “that those who volunteer usually find that it contributes to their own personal well-being and their happiness” (p 8). This is supported by Hendricks (1999 cited in Watson and Hall, 2001, p 24) and Battaglia and Metzger (2000), who recognised that for older people, voluntary work offers psychological and physical well-being and is a means to remain active community members. Interestingly, Baum et al’s (1999) study conducted in Adelaide revealed that “[v]olunteers are more active socially than non-volunteers” (p 20) which is supported from findings from this study that revealed the active social life of independent residents, a number of whom were active volunteers.

There were both positive and negative comments with regard to the ageing volunteers. Independent residents informed me that there were a “team of volunteers” from independent living “but now they are too old” and that residents moving into the

Village are often not prepared to provide voluntary assistance as they expect a service for which they are paying (IR8-04.05.00). The activity staff member commented:

Sometimes we have old people visit very old people; although that is wonderful and quite valuable it's sometimes not terribly useful because they are old and frail themselves. They just haven't got the stamina (ACT2-05.07.00).

There were however a number of independent residents who continue to provide a form of voluntary service. These services included fundraising, assisting with activities within independent living such as helping in the kiosk, working in the library (IR6-08.04.00, IR7-08.04.00), maintaining village equipment, growing vegetables (IR4-26.02.00), videoing special events such as Open Day to "go into their archives" (IR7-08.04.00) and assisting in the facility such as with feeding residents.

An independent resident remarked:

We provide our own buddy system in the hostel and nursing home who volunteer and sit with one person and sit and read or talk with them (IR6-08.04.00).

The Standards (expected outcome 3.4 Emotional Support) in fact recommend that organisations develop "strategies to support participation in a range of activities" providing examples such as a buddy system and volunteer programme (p G-65). An independent resident explained the process of voluntary activities which was co-ordinated by residents themselves:

You are put on a kiosk volunteer list, but you are not conscripted. I was put on the volunteer list and I was terrified, but the lady I was on with was older and she had worked in a kiosk for many years and she was excellent. She was patient with me so that was good. Then if you volunteer you are on library duty, just to put books away. A meeting was called about that and your duties were explained (IR7-08.04.00).

One of the ladies that I interviewed from independent living was an active volunteer, helping with feeding residents and admitted that volunteer resident numbers tend to fluctuate; "they tend to come and go" (IR8-04.05.00). She identified the bus service

as the means to maintaining relationships as well as provision of voluntary assistance.

An activity staff member was also grateful for voluntary activity support provided by the independent residents. She explained:

We have one lady who comes in but she is on holiday at the moment and we miss her. She is the most outgoing wonderful person and she comes and she helps in the hostel and here [nursing home]. There is a particular resident that she comes to visit but not only that she is great with everybody. She joins in the games and the music and she gets them up dancing (ACT2-05.07.00).

Volunteers assisted activity staff during outings, providing that extra security for residents. As indicated by a staff member: "I wouldn't feel secure without the volunteer" (ACT2-05.07.00). Morellini (1999) recognised that:

Volunteers are able to devote a significant amount of time to one person or activity, which for a staff member may be impractical. Thus the paid worker is able to concentrate on tasks more central to his/her duties (p 44).

This was supported by comments from activity staff, who explained that volunteers help and contribute to the activity programme whilst staff are able to concentrate on other aspects of work such as relevant documentation that demonstrates the suitability of the activity programme offered to residents. As explained further by an activity staff member:

My volunteer is coming in today so that is excellent. Yesterday I would normally have done a reading group for the visually impaired but because of this new documentation I didn't do it. So I will ask her when she comes if she will go to my small group; they're not all visually impaired, some of them just like to hear the story so I will get her to do that for me today. That will help allow me to finish my documentation that I haven't finished (ACT2-05.07.00).

It is apparent that the voluntary service provided by independent residents is appreciated by staff, as well as by independent residents themselves. For example, those that provide voluntary assistance are sent a letter of appreciation from the

volunteer committee organisers, that is, independent residents. Volunteers are a valuable resource to the Village helping to build 'social capital', being involved in a range of activities and helping to build community life (Baum et al, 1999). They provide not only residents with support but also the staff, particularly activity staff enabling them to concentrate on documentation needs whilst the volunteer is able to concentrate on resident needs. For the residents living in the facility, volunteers are able to read or take them for a walk, as well as provide companionship and a means to maintain relationships with the community. As was noted in Chapter 5 (Support Services), volunteers had also been recruited in the Golden Oldies, dementia specific programme organised by the Occupational Therapist's (OT1-02.06.00, ACT1-11.03.00, ACT3-07.12.00) to promote quality of care. As well as the volunteer programme, the local school also provided a means to build social capital between the community and the Village.

6.4 The local school: a win: win situation?

The Village was situated close to a local primary school. The children had walk through or bicycle access to get to and from the school and provided entertainment to residents either at the school or in the facility. The residents from independent living also offered remedial reading lessons to the students. A number of staff suggested that children of all ages would be a welcome sight for residents, as well as for the children themselves who sometimes do not have grandparents of their own. As stated by an independent resident "this is the trend these days, getting the grandparents which the children are missing out on" (IR3-22.02.00).

Staff and residents acknowledged that the school children offered a variety of entertainment such as school concerts to all residents which was organised by activity staff. On one occasion when the nursing home was originally opened, the school band was asked to perform (IR7.08.04.00) and the students have continued to perform at various events such as Christmas (ACT3-07.12.00). An independent resident made reference to evening events held by the school, but residents infrequently socialised in the evening with feelings of vulnerability and limited access to transport (IR8-04.05.00). Another independent resident stressed upon the fact that often their social life is so active that occasionally they cannot attend, however “it is good to have the young people” (IR4-26.02.00). And from another resident “we have a good rapport with the school children” (IR3-22.02.00). Others also identified the importance of young people and their contribution to aged care. For example as noted by a Personal Care Assistant “children . . . bring them [residents] to life” (PCA1-04.03.00). This was supported by an activity staff member who related an occasion when the school children performed for residents in the facility:

The residents love children . . . and the kids sing to them and they actually talk to the residents which is wonderful . . . They are wonderful, they sing well, they play musical instruments . . . We don’t have enough of that sort of thing (ACT2-05.07.00).

There were suggestions that a childcare service would be ideal for the staff, residents and their family. For example as noted by a Food Services staff member:

I am sure there would be grandmothers here who would like to support their grandchildren while their daughters are working. I would believe that if the residents see children it would make it more homely . . . Even the residents can . . go and play with them (FS1-01.04.00).

The Village Nurse and activity staff member (VN1-26.02.00 and ACT3-03.12.00) could remember when there was a kindergarten adjoining the Village with residents

able to “see little children playing and the parents coming and going” and commented upon how residents “like younger people around” (VN1-26.02.00).

A further suggestion was made by the Registered Nurse (RN1-11.03.00) who recommended that young people who are on the work for the dole scheme could contribute to the life of facility residents, particularly those that have few visitors. She explained and provided an example of a resident who was in the situation of having few visitors and went on to express that there were others:

There are a lot of lonely people who love company . . . There are heaps of these residents who would love to go for a walk or have someone to sit down and talk with them and make them a cup of tea; just a bit of company. . . If a group of teenagers walked in here now who are on the dole I could give each one a job in the afternoon that would really please the residents. There are a lot of lonely people who love company (RN1-11.03.00).

The Gardener also suggested that the students could be involved in a gardening programme assisting residents whilst learning about horticulture. This would also assist in building relationships:

I always think they should get the school kids because they do horticulture at school . . . and it will help break down the barriers between “you cranky old man” and “those mongrel kids” (GARD1-25.05.00).

Morellini (1999) discussed a Student Community Involvement Program (SCIP) that has been operating in a number of States in Australia. For example in Western Australia students in “Year 9 upwards, including university students, . . . learn about volunteering and then . . . get involved in their communities through volunteer efforts” (p 42). As identified by Morellini (1999) a programme such as SCIP can offer benefits to both parties. For the young volunteer, volunteering offers the opportunity to “explore career opportunities”, gain knowledge, skills and experience

and understand the role of volunteers within the community (Morellini, 1999, p 43). And for an organisation such as an aged care facility, it can offer ‘youthfulness’, ‘fresh approaches’ and overall ‘lasting relationships’ (Morellini, 1999, p 44-45). This dual relationship was evident from comments made by independent residents and the Village Nurse, although I did not meet or interview the school children to confirm responses.

Apparently though, the children from the school are provided a variety of learning skills through the Village, mainly from independent residents. For example, as I learned from discussion with the lawn bowls group, they have on occasions taught the children how to play lawn bowls (IR4-26.02.00). Residents also provided what they referred to as remedial support services to the school children (VN1-26.02.0, IR3-22.02.00, IR6-08.04.00, IR7-08.04.00). Independent residents may be referring to the Learning Assessment Program (LAP). The LAP test identifies student with learning difficulties. In Australia there are approximately one thousand schools with students being provided assistance. The volunteers are offered training sessions and in some cases become “friend and mentor” (Penhall, 1999, p 47) to the student. Penhall (1999) explained that the volunteers may help students with reading, writing, organisational skills, gardening, mathematical skills and so. Comments made by an independent resident demonstrated evidence of this:

The school encourages us to become involved like in the reading programme. I go over and help students . . . it is only one on one, you are not with a group. I enjoy this. They [the children] are very appreciative (IR7.08.04.00).

This appreciation is demonstrated by the students who organised morning and afternoon tea and a speech thanking the residents for “a wonderful job” (IR7-

08.04.00). This independent resident continued to explain that the school provided the residents with training prior to commencing the remedial classes:

They [the school] did put on a short training programme at one stage, a video demonstrating hearing and reading. They gave us a folder and leaflet explaining everything and after the three sessions we got presented with a certificate which they had done on their computer (IR7-08.04.00).

The remedial classes offer students with greater skills than just reading alone. For example independent residents (IR6-08.04.00 and IR7-08.04.00) described occasions whereby students confide in the residents. This resident describes the experiences of another resident who provided remedial tutoring:

The poor kid looked worried . . . and the kid said, “I haven’t done the homework” . . . so she didn’t help him read but helped him do his homework (IR7-08.04.00).

And from another resident:

This is one thing they [children] didn’t have – someone to talk with. They would tell an old lady things that they would not tell anybody else. My friend over here who is a teacher thought she had not taught them [children] anything. But I said “if I come out of the year with them understanding more about old people and having more respect for them [elderly] I think I have had a successful year (IR6-08.04.00).

In the situation whereby students are trusting of the older person in sharing concerns or asking for advice, levels of social capital are produced. As noted by Cox (2000) “social capital requires opportunities to get to know and trust people who are ‘unlike us’” (p 105) which may be a means of reducing negative stereotyping. (Issues relating to negative stereotyping are discussed in Chapter 4 – Policy). Unfortunately, there were negative attitudes toward the school children by some of the residents with recent episodes of vandalism. As described by an independent resident:

One night the kids came in here and switched all of the pot plants and jammed a door shut with a verandah chair . . . it caused a lot of distress [particularly from the lady] who couldn’t get out of her front door and when she did, she found

that all her pot plants weren't there, she had somebody else's.
They [children] probably had a lovely time (IR6-08.04.00).

This resident however suggested that the children require an understanding that residents themselves, even though elderly also have a sense of humour as well as becoming frightened and vulnerable with such events. Another independent resident described actions at a resident meeting whereby residents were suggesting that it was their "property and they [children] have no right to come through" (IR8-04.08.00). This resident as well as others and administration staff defended the actions of the children, probably noting the benefits outweigh the negative events, as discussed above. Prior to me completing the fieldwork, there were rumours that management were planning to increase security surveillance. It may have also been worthwhile to organise a meeting between the school and the Village to discuss this matter in detail and attempt to promote improved relationships and understanding.

It would seem sensible to maintain these relationships between old and young through the activities of the school children and the aid of independent residents. Yet there remains the question whether with an ageing population these joint activities could be maintained, nevertheless, the younger people could continue to provide entertainment whilst the residents offer their life experience and mutual friendships. These types of associations with the community could help reduce negative stereotypes and foster improved relationships and increase learning across the generations too. The Ottawa Charter (WHO, 1986) also recommends drawing on 'existing human resources' "to enhance self-help and social support . . . for strengthening public participation" (p 2)

6.5 Difficulties encountered and reasons for limited family participation

The Standards promote family and relative inclusion thus enabling residents to maintain networks with the community and to promote supportive and continuing relationships between family members. A study was conducted by Hatcher et al (1999) in which residents were asked what 'hope' meant to them revealing the necessity for older people to 'improve' or 'maintain' "relationships with friends or family" (p 9). Kane (1991 cited in Krothe, 1997, p 221) suggested that there is a myth of "family abandonment", which influences policy decisions, yet there is evidence that relatives do maintain close relationships when the older person moves into aged care. This was supported by a study conducted by Krothe (1997) which revealed that telephone contact by family members was frequent and important to the elderly respondents, and in fact many older people are asked to move in with their children, but decline the offer preferring to maintain their independence. I am unable to substantiate this from this study which did not confirm or negate these findings. Unfortunately though there were suggestions by staff that there was limited family participation in the Village. This may have resulted from poor communication practices by staff with relatives, or, staff that offer too much assistance to residents as a consequence of the RCS that promotes dependence. The family may then feel that they are 'intruding' on staff practices.

Within the Village there was a percentage of residents who had minimal contact with the outside community as a result of either having no relatives or relatives that no longer visited (IR6-08.04.00, IR8-04.05.00) and therefore had to rely on the staff to access community groups. There were also situations in which the resident has had no children or the resident had "outlived their children" (ACT2-05.07.00).

Unfortunately, there were a number of negative comments from both staff and residents regarding the involvement or lack of involvement from relatives or family. Residents themselves making these comments were not necessarily relating it to their own situation, with many of them speaking positively about their own family (HR1-04.03.00). A Personal Care Assistant commented upon residents and the importance of staff acting as family and providing a link with the community. As described in detail:

Certain families take responsibility. Some though feel that once their parent or family is in the hostel . . . it is the end of their job basically and a lot of the residents consider us as their family because they do not see their family members. They (the resident) love to see us because they get feedback on what is happening in the outside world (PCA1-04.03.00).

With all the support and services that are available to residents, there are situations when the resident requires the support and love from their own family as well as to help with tasks such as shopping. For example, a resident from the hostel spoke thankfully of her children who either purchased items or took her shopping (HR1-04.03.00). The residents within the Village had the availability of a small kiosk, weekly visits by a fruiterer and on occasions, activity staff organised clothes sales (RN1-11.03.00, ACT2-05.07.00). Nevertheless, a hostel resident described difficulties encountered by other residents who are alone, for example being able to purchase presents or attending appointments. She described these two scenarios:

I think most people here, if they want to get out, they get the relatives to take them . . . the problem is that people here that don't have anyone, it's hard for them to buy for Christmas. . . I think sometimes when you have to go to x-ray or something like that, it can be difficult. I know my friend had to go without much warning, she was able to get her niece to take her, but this can be difficult when you can't get anyone to take you (HR3-02.11.00).

An activity staff member also recognised that there still remained occasions when the resident needs to purchase “new clothes” or just go shopping (ACT2-05.07.00).

Residents and staff both provided a variety of reasons for the limitation of family involvement. For example an independent resident commented upon the existing commitment that one’s family has (IR5-11.03.00) such as looking after their own children (IR2-17.02.00) or work (HOST1-02.11.00). This was supported in a study conducted by Krothe (1997) in which participants “acknowledge the multiple time demands on their adult children’s lives, including work and family responsibilities” (p 221).

There were also suggestions made by staff that there may be occasions that relatives do not visit as a result of grievances within the family. The Resident Co-ordinator explained: “Some of us might think that they [relatives] are treating their parents so cold, but you really don’t know . . . there may have been big problems in the past” (ResCo-01.06.00). As reiterated earlier, the Director of Nursing recognised that in some cases family systems are changing, and as Battaglia and Metzger (2000) recognised volunteer numbers are tending to reduce as a consequence of increasing numbers of women in paid employment. The Director of Nursing continued:

communities are such these days that young people are working. There are so many more mothers going out to work and so many more families are split so you consequently don’t have the family unit that can support the older person in their place (DON1-07.12.00).

There were also thoughts from staff that at times relatives are unable to cope with the deterioration of a loved one. Care staff from Setterlund’s (1998) study suggested that family “non-involvement” may be as a result of “their inability to cope with the

emotional impact of dementia” (p 137). This issue was discussed by the Village Nurse and activity staff as follows:

When I first started to work in the nursing home I used to get very angry at relatives. I thought – you don’t care I never see you here. As I have grown a little older I do recognise that there are times that family cannot cope with dementia or the deterioration of an aged person and how decrepit and how awful it is. I recognise that people may not be able to deal with that and I recognise that this is why we are here (VN1-26.02.00).

You have had your mum all your life and your mum was the figure that you went to and all of a sudden your mum has . . dementia, she’s not your mum any more. She is not the same. Some people with dementia have personalities that change completely, some people don’t. . . But the person they are now seeing is not this mother figure that was always strong and there for them and affectionate. And all of a sudden this mother figure is no longer a mother figure and she is not the same any more. And some families can’t cope with the change (ACT2-05.07.00).

In this situation, Kellehear (1999) there is a need to develop policies in which family and friends are involved in support groups. Internal support services are not promoted through the Standards, yet expected outcome 2.9 – Palliative Care, does recommend that the organisation is able to refer staff, relatives and residents to external support services. Glaros (1997) provided an example of a health promotion programme targeted at residents’ family to “address issues of concern such as elder care” (p 3). This type of support group can encourage issues such as the loss of the parent they once remembered or a means of identifying how they can be involved in the care of their loved ones. The family of the resident for example can be involved in feeding the resident during mealtimes. Support groups provide an opportunity for relatives who do not wish to discuss particular issues amongst those they care for. Effective well-run support groups are “highly participatory” in nature (Parkinson, 1979 cited in Kellehear, 1999, p 108-109), allowing people to “come together for the purposes of

providing mutual aid, addressing common need, and facilitating personal and social exchange” (Kellehear, 1999, p 106).

Residents and staff suggested that relatives acknowledge the amount of services that are available to the resident and therefore may believe that they no longer are required to support their parent or relative (that is the resident). This is supported by an independent resident and the Gardener who acknowledged that “families tend to opt out a bit because they know that we have such good support systems in here” (IR6-08.04.00). And as quoted from the Gardener:

Its just weird that families don't come and visit. And there are a lot of lonely people in here as well. In a way the village is very community minded but also its not. . . You can be lonely with 100 people around them and I think they are lonely because they have been shoved aside by their families. . . It doesn't matter how much support you have but you can still be lonely. You can see it in a lot of them (GARD1-25.05.00).

The Gardener who is a young woman admitted that prior to working with the elderly, she had very little contact with her own grandmother, believing that they are ‘old’ and ‘dodderly’. But, after working with the elderly, she had come to realise from her own experience that residents though old in years, “are really nice and interesting” (GARD1-25.05.00). The Village Nurse and Personal Care Assistant suggested that families may visit rarely because of the impression they are given during pre-admission interviews. During these interviews, the resident with their relatives are provided a tour of the facility and grounds. Staff tend to overemphasise the amount of support and services that are available, neglecting to suggest the need to encourage family participation and the valuable contribution that they could offer to Village life. As explained further first, by the Village Nurse and second, by the Personal Care Assistant:

I think sometimes the relatives get the impression . . . and . . . latch on to that phrase ‘total care’ . . . and the expectation is unrealistic. . . others too are inclined to sort of think, “we have put them [residents] in care so now it has absolved our responsibility” and I think that can be a bit difficult because when we have to involve the relatives in requiring their assistance for whatever reason, they get quite cranky with us. . . But at other times due to the misinterpretation of that original phrase leads to some problems (VN2-02.06.00).

I think in the very beginning . . . they [management] dress it up and make it sound so fantastic that when you come in here there is nothing else you [relatives] need to do – they are selling it. I think they could be encouraged to put some input in and maybe find out. You know one of the resident’s sons comes in and plays the piano. If they know they are able to do that, the children and grandchildren and everything could come in and mix with the other residents that don’t actually see their family (PCA1-04.03.00).

There seems to be a need to foster relationships that include relatives in the care of the residents. There were suggestions that the families could indeed be utilised and welcomed into Village and facility life (HR1-04.03.00, PCA1-04.08.00, VN1-26.02.00, OT1-02.06.00), however there were few suggestions on means to foster relationships between residents and their relatives. An independent resident did comment on the effectiveness of maintaining links with her family through electronic mail (IR8-04.05.00), and it may therefore be advantageous for aged care facilities to have computer and electronic mail access to its residents. A computer not only provides access to family members but also to the broader community through the Internet. Relatives also on occasions have lunch provided either by the facility Food Service or at the café (FS1-01.04.00, FS2-18.05.00). Food provides a means to celebrate special events and it may be appropriate to have days where the family are invited, or as suggested by the Occupational Therapist, offer “family evenings” (OT1-02.06.00) which may be in the form of entertainment, activities or a happy hour. Expected outcome 3.7 – Leisure Interests and Activities, does recommend that

families and community members participate in “regular and special events” (p G-71). The Gardener also suggested utilisation of the parkland for residents and their relatives to have a sing-a-long around a bushfire (GARD1-25.05.00). There were also occasions when the relatives are able to attend meetings (ACT3-07.12.00) but infrequently participated, maybe requiring support themselves. For example, as discussed above, if the family are experiencing difficulty coming to terms with the loss of their parent through dementia, it may be advisable to offer support or counselling sessions. Staff did admit that relatives are always able to discuss issues with various staff including the Resident Co-ordinator, Director of Nursing, Registered Nurses and other care staff (ACT2-05.07.00, ACT3-07.12.00, OT1-02.06.00, ResCo-01.06.00), however, relatives may not be aware of this, especially if it has not been communicated effectively to them.

I believe retirement villages can promote family and friend ‘participation’ which may appear difficult or impossible to organise with the resources of time and finance in shortage. This is an essential element if a retirement village is to be one that is health promoting in nature. Family and community participation is an integral part in aged care, helping strengthen community action and for the resident to retain association with the outside world. As Koff (1986) acknowledged: “for any individual to whom family has been significant, wellness is not possible in the absence of family” (p 125). Koff (1986) further suggested that family members can be instrumental within a retirement village’s activities and decisions, and maintain a portion of the “responsibility of caring” for the resident (p 126). This could occur through family involvement in committees thereby enabling them to exercise greater control over the residents environment, voicing opinions and being involved in retirement village decisions as a group. An example of this could be what Glaros (1997) termed a

‘wellness committee’ that can be developed in the retirement village as a whole having representatives from residents at all levels, their family and friends, staff from different departments, and a representative from the community. The wellness committee could have some initial training into health promotion and programme development and could be involved in ‘brainstorming sessions’ and speaking with other staff/residents to gain further ideas (p 5). Koff (1998) also recommended that residents as well as their families be involved in the “selection and evaluation of personnel, including the administrator” (p 129). Yet the Standards do not propose that residents or relatives are included in the process of staff recruitment. Staff are selected according to skills, qualifications, knowledge and the cultural needs of the residents (expected outcome – 1.6 Human Resource Management, p G-19). Yet family participation could help reduce loneliness, isolation and improve family relations as well as relationships between staff and relatives, and maintain resident’s “sense of wholeness” and wellbeing (Koff, 1986, p 126).

SUMMARY

This chapter has recognised the contribution that residents living within independent units make to the Village’s community and relatively high levels of social capital through the volunteer programme, fundraising and helping children at the local school. Yet it remains questionable whether this level of contribution can continue with a population that appears to be ageing. Through policy such as ageing in place there may be the potential for older people to be discouraged from entering retirement villages independent living until they are older and frailer. This scenario may be both problematic or a means to allow older people to remain in their own home with greater support from the community. The community though would need to build

‘social capital’ and empower individuals and communities to work toward preventive programmes thus promoting health and wellness to an ageing population. As the findings have demonstrated, when independent living residents have entered the Village in relatively good health, they have been able to be instrumental in their supportive role in the retirement villages operations including voluntary involvement and development of a supportive community environment. Nevertheless, if the trend continues that older people enter retirement living accommodation at a later stage, that is, older and frailer, then there is the question whether this environment can continue to promote community participation amongst its own population and with the school community. Presently, residents are able to build social capital through social networking with the community, school and between residents, as well as in the production of economic capital through fundraising activities, and finally, human capital through teaching children from the local school. It is unfortunate that there appears limited participation from residents’ family members with staff attempts to fulfil this role. Family participation indeed could be promoted to encourage greater participation in Village activities and foster relationships between residents and their families as well as between staff and the relatives. Relationships could be similar to that of activity staff and volunteers in which staff recognised the important contributing factors such as allowing others to care or support the resident whilst staff are able to fulfil their work requirements including documentation.

It therefore seems relevant to introduce health promoting initiatives and increase in support services and personnel to help maintain residents quality of life, independence and level of activity. Family and community participation may be fostered through provision of education and support groups.

In the following section I will continue analysis of the Ottawa Charter's action area, developing personal skills. This chapter will illustrate the Commonwealth Department of Health and Family Services (1998b) promotion of education and continuous quality improvement systems through the 'Standards and Guidelines for Residential Aged Care Services', and the need to offer education that is specifically gerontological based.

Chapter Seven

Developing personal skills and recognition of gerontology as a specialist field

This chapter will specifically look at a further action area of the Ottawa Charter; developing personal skills. 'Education and staff development' was one of the objectives of the aged care reforms, particularly within the Standards, with an emphasis on those working in aged care. Nutbeam et al (1993) included health literacy and life skills within the Health Goals and Targets report. Health literacy is important for the entire population as it allows people "to gain access to, understand, and use information in ways which promote and maintain good health" (Nutbeam et al, 1993, p 151). Nevertheless, Nutbeam (2000) recognised that 'health literacy' was not a concept used within the Ottawa Charter as it "is a relatively new concept in health promotion" (p 259). The World Health Organisation (1997 cited in Nutbeam, 2000, p 264) defined health literacy as follows:

Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. . . health literacy is critical to empowerment.

The Ottawa Charter effectively demonstrated the commitment to enabling people to gain or access information to maintain good health. As stated:

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own

health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential (WHO, 1986, p 3).

The Ottawa Charter (WHO, 1986) and Jakarta Declaration (WHO, 1997) also recognised that education is a 'pre-requisite for health', and to 'enable' individuals to "achieve their fullest health potential", "access to information", "life skills" and the ability to make "healthy choices" is necessary (WHO, 1986, p 1).

O'Donnell and Gray (1993) recognised though that health education is a vast subject but it "is the most important process by which health promotion objectives can be achieved" (p 6). In the past it has concentrated on changing people's behaviour. Kellehear (1999) referred to this model of health education as "the individualist model" (also referred to by others as healthism, conservative, medical and preventive models). Kellehear (1999) strongly recommended a participatory model of health education involving a number of processes - listening to others, identification of the problem and how it can be prevented in the future, review and reflection of information, clarification of needs and values and ways in which the problem can be solved (p 60-62). O'Donnell and Gray (1993) proposed that the aim of health education is to improve individual "health skills" and "develop the capacity to value health" (p 31). The following section will investigate issues relating specifically to staff skills within the aged care industry particularly following the reforms and the views held by the staff working in the Village.

7.1 Recognition of staff roles and skills

Reviewing the various policy and legislative documents, that is the Aged Care Act 1997, Quality of Care Principles, Accreditation Standards and the Resident Classification Scale (RCS), as well as Gray's (2001) review of the reforms will provide an overview with regard to staffing, educational requirements and skills mix for staff working in an aged care facility. This will be followed with an analysis of issues relating to the Village's staffing skills and roles.

As a result of Gray's (2001) review, there were suggestions "by staff, consumers, providers, and . . . governments that reforms had seen . . . a negative change in the skills mix, with many staff not having the necessary training or qualifications" (p 96). This may have occurred either as a result of providers cutting costs, or employing unqualified staff, or through qualified nursing staff shortages. As noted by Gray (2001) prior to the reforms, aged care providers were accountable for staffing levels under the Care Aggregated Module (CAM) funding system. Nursing homes were required to employ registered nurses 24 hours a day whilst hostels were not, instead relying on personal care staff. However, as discussed in Chapter 4 – Policy, the reforms deregulated staffing ratios. Nevertheless, the Aged Care Act 1997, Part 4.1, Division 54 – Quality of Care, stated that the provider must:

maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met
(Commonwealth of Australia, 1997a, p 207)

and that other responsibilities are carried out in accordance with the Quality of Care Principles. The Quality of Care Principles were amended in 1998 to omit the nurse resident ratio. Some procedures which will be discussed below, must be carried out by qualified nursing staff, with other requirements such as administering of

medication, to be carried out in accordance with State and Territory legislation (Commonwealth of Australia, 2000).

Gray (2001) concluded that there was “limited data” (p 96) available to establish certainty with regard to staffing and skills mix, but suggested that the system which is based on quality of care and “linked to outcomes” is an “appropriate indicator” (p 96), and continued:

The quality of care outcomes that the system promotes are central to the accreditation process and are assessed by the Agency [The Aged Care Standards and Accreditation Agency]. The Agency is required to assess provider compliance against the standards, or outcomes . . . In theory, it is not possible for a home to be assessed as compliant against the standards if staffing is inadequate . . . or deficient in relevant knowledge and skills (Gray, 2001, p 97).

As stated further by the Standards which promote education, staff development and appropriately skilled staff under all four Standards (Outcomes 1.3, 2.3, 3.3, 4.3):

The standards require that residential care services are staffed with appropriately skilled and qualified people sufficient to ensure that services are delivered in accordance with these standards. The standards do not set out the skills and qualifications required to perform different duties, rather, the appropriate response to a resident’s needs will always be dictated by those particular needs (Commonwealth Department of Health and Family Services, 1998b, p x).

Whilst Outcome 1.6 – Human Resource Management recommends that “training and education is conducted” with an expected outcome that reads:

There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives (Commonwealth Department of Health and Family Services, 1998b, p S-9).

The Standards further recommend that there is an appraisal system for staff, and skills assessment with ongoing training by internal and external means thus enabling staff to

“perform their roles effectively” and deliver “quality of care” (Commonwealth Department of Health and Family Services, 1998b, p G-13, G-35, G-63, G-86).

Lastly, the Commonwealth Department of Health and Family Services (1998a) Resident Classification Scale (RCS) is purely for funding purposes and does not “set out standards of care or prescribe an overall staffing mix” (p 26). When classifying residents and appointing a rating of A, B, C, or D, toward each of the 20 questions, there is a generalisation made to ‘staff’, for example, Question 1 – Communication reads:

Where a care recipient requires assistance with communication from facility staff on almost all occasions to communicate by translating or interpreting, or non-verbally . . . record D (Commonwealth Department of Health and Family Services, 1998a, p iii).

But within the Resident Classification Scale there are specific questions that relate to staffing requirements, for example, under Question 18 of the RCS – Technical and Complex Nursing Procedures, some of these procedures “will be carried out by a registered nurse or other health professional appropriate to the particular procedure” (Commonwealth Department of Health and Family Services, 1998a, p xxxiv). Interestingly, this question provides comparable information to Outcome 2.5 – Specialised Nursing Care Needs of the Standards stating that treatment is to be “carried out by appropriately qualified nursing staff” (Commonwealth Department of Health and Family Services, 1998b, p G-39). As well as question 18 that relates specifically to staffing qualifications, question 19 – Therapy, recommends that the therapist, such as physiotherapist or occupational therapist “should meet the requirements for full membership” of their professional body, or, “be a registered nurse for physical therapy”, nevertheless, after initial assessment and ‘regular

evaluation', the programme can then be "implemented by a staff member" (Commonwealth Department of Health and Family Services, 1998a, p xxxvi). This does not necessarily mean a qualified staff member, but a staff member who is assessed as competent by the aged care provider. The above legislation shows that staff working in aged care must only be 'appropriately qualified' and ensure that they meet the Standards.

It could be suggested from analysing these documents that there could indeed be some discrepancy with regard to staffing levels and skills mix, with some generalisations being made and a deregulation to staffing ratios and funding. Further research in the use of unqualified staff is required to identify the limitations that this may cause. Within the Village, there did appear to be qualified staff. For example Registered Nurses were employed, but this could be a response to residents ageing in place and the Village providing a continuum of care from low to high care that requires a registered nurse to conduct specialised nursing care needs.

Overall, there was concern amongst some staff that their role and/or skills are not recognised either by management or other staff. For example, the Occupational Therapist suggested during an informal discussion with me her concern that staff did not fully understand the role of the Occupational Therapist and to a certain extent were categorised as Diversional Therapist's as was evident in Chapter 5 – Support Services, on discussion of the activity programme. As noted by the Occupational Therapist, on commencement of their positions, there were no clear guidelines and "clarity in regard to what we were here to do" (OT1-02.06.00) nevertheless she continued to explain that this had been positive in some aspects allowing them to

develop their own role. I did suggest to the Occupational Therapist that they place an article in the Village newsletter introducing themselves and explaining their role and this they did with positive outcomes. Both the Director of Nursing (DON1-07.12.00) and an activity staff member (ACT3-07.12.00), acknowledged this article with the Director of Nursing stating that the Occupational Therapist's "put articles in the Village and staff newsletter about their role" (DON1-07.12.00). Following this, the OT's services were used by the DON, other staff and by residents themselves who were asking for advice on use of assistive devices.

When asked if there were any barriers or limitations to acquiring skills, the Village Nurse suggested that skills are not recognised:

For example the village paid for a legal course and I had to write a report on what I had learned. Then I mentioned that we should not be doing certain things but nobody would listen or showed interest, so things just continued as they were (VN1-26.02.00).

The Village Nurse was also a qualified clinical masseur and was not being utilised by the organisation. Use of a clinical masseur could be funded to a certain extent through the Resident Classification Scale (RCS), under Question 20 - Other Services. Unfortunately though, this question has little weighting (0.71 to 2.93) and includes services that are expensive to the institution for example, psychologist, dietitian/nutritionist, podiatrist, social worker, music therapist, aromatherapist and so on (Commonwealth Department of Health and Family Services, 1998a). As stated further by the Village Nurse:

I am a clinical masseur as well as an RN but the company has not embraced my qualification. I do massage with residents here but it is totally private and they have to contact me at home. Whereas if the company embraced our qualifications we could help residents. I find that it is narrow for these skills not to be used. I have worked in aged care for many years and

I am probably the most skilled for soft tissue injury and relaxation and it is not being used . . . By not allowing us freely to use our knowledge in that respect deprives our residents (VN1-26.02.00).

This latter point of depriving residents is a relevant issue and the services of a massage therapist in a health promoting setting would surely benefit residents and even others, such as staff. During interviews with the staff, there were suggestions that there was inadequate appreciation from senior staff and management (PCA1-04.03.00, MAIN1-01.06.00). For example the Maintenance Manager suggested that managers need to recognise the qualifications and skills of the staff and on occasions either “pat their staff on the back” or say “thank you”. As expressed by the Maintenance Manager:

If someone does a good job, pat them on the back. I will go in and say “thanks troops” . . . So if someone does something, thank them for it. They will walk on broken glass for you (MAIN1-01.06.00).

This was confirmed by the Catering Manager who explained that she encouraged ideas from the Food Services staff. She commented that on commencement of her role that the staff were working singularly - “one person’s cooking skills, one person’s ideas and it was really limited and nobody had any input”. She encouraged team participation. This is an important facet in a health promoting setting as the Ottawa Charter recommends “enabling people to learn” (p1) while at work.

Comments made by a Food Services Assistant implied that teamwork was lacking, explaining that on occasions if staff complete their work, they will invariably “talk” or “bitch” in preference to helping another staff member to complete their work. She suggested that inclusion of male staff may help combat this situation but stated: “the boys wouldn’t want the job” (FS3-13.07.00).

The Registered Nurse admitted that: “Teamwork is vital and this is one thing that is lacking” (RN1-11.03.00). Whilst teamwork may be lacking in some departments, this was not evident in the administration area. For example, the Resident Co-ordinator explained her role within the Village, which provided evidence to suggest a team approach. She provided insight into the organisation of the office comprising three staff members, all of whom worked part time. They only worked together two days per week with the remaining days with two staff. It appeared because they had a great deal of responsibility having to work with residents and their relatives as well as looking after resident finances that administrative staff worked with each other in the various roles and responsibilities and as quoted: “it is a big job. We all try and support each other” (ResCo-01.06.00). The Director of Nursing also suggested that staff attempted to work as a team and that there was a need to be respectful of each other’s duties, and as she so well demonstrated:

as far as I am concerned every role is important and if you can respect every role as being as important be it the general manager, be it the cleaner, be it the maintenance, whoever, nobody is more important than anyone else. I think essentially we are a team and I think that is the way we have to be viewed and that is the only way you empower everybody that way. You make them feel good about what they are doing and that rubs off on the residents (DON1-07.12.00).

Discussion with the Village Nurses also indicated that they attempted to work as a team within their own Department but “the teams change all the time” from staff working different shifts (VN1-26.02.00) and unfortunately, they did not tend to work with other staff from the facility. Apparently in the past there were good working relations and “good rapport with other staff [in the facility] and a great deal of respect” (VN1-26.02.00). As explained further by the Village Nurse:

I think from the village sister's point of view we look as if we are part of the hostel, but it is an optical illusion, designed for whatever reason. Our office is in the front foyer – it appears this is where I work but in fact I work in the village as a whole (VN1-26.02.00).

The Village Nurse is referring to the fact that their office is situated in the facility. This would suggest the Village Nurses are part of the team, but in fact other staff working in the facility do not consider this to be the case. If staff and management were to recognise each other's roles and skills this may be a means for promoting staff relationships and improved team participation. Staff suggested that on occasions there was uncertainty as to the role of other staff (OT1-02.06.00, PHYS1-12.10.00, FS3-13.07.00) and the Physiotherapist suggested "we are quite separated when it comes to kitchen staff, office staff, nursing staff. Probably we don't understand each other's role" (PHYS1-12.10.00). There was also a comment by an activity staff member that the Occupational Therapists were employed as they were qualified and that activity staff are not qualified to do the documentation necessary for accreditation and the Resident Classification Scale (ACT3-11.03.00) until they had their certificate as Diversional Therapists. This staff member also told me that she did not know what an Occupational Therapist's role was (This interview was conducted prior to the newsletter detailing the OT role). These relationships between the activity staff and Occupational Therapist had not started off positively, with some feelings of animosity from the activity staff toward the Occupational Therapists. This may have been improved if activity staff and the Occupational Therapist's had recognised and understood each other's role and abilities. Activity staff were beginning to recognise the contribution that the Occupational Therapists were making with comments that they had taken "some of the pressure off" (ACT1-11.03.00) and a similar comment from another staff member: "Since we have had the OT working with us it has taken

some of the pressure off and we have someone to go to if there is a problem” (ACT2-05.07.00).

It appears that there is some confusion with regard to staff roles and skills, as well as some animosity toward Management with suggestions that they do not recognise staff skills. This will be discussed further in the forthcoming section with discussion on issues relating to education for staff, residents and their relatives.

7.2 Education and staff development and compliance with the Standards

A number of researchers (Wilkinson and Sainsbury, 1998, Wilkes et al, 1998, McKinna and Conners, 1999 and Gething, 1999) identified the negativity of careers and attitudes in aged care. For example, Wilkinson and Sainsbury (1998) stated: “geriatric medicine is not widely regarded as a glamour speciality” (p 115) whilst McKinna and Conners (1999) implied that caring for the elderly is “often devalued” (p 26). It may therefore be beneficial to provide staff and those associated with aged care, and those entering the field with education specifically specialised in gerontology. Gething (1999) recognised the need to “[p]rovide information about healthy ageing” as well as education to reduce negative stereotypes of the elderly, and continued:

Ongoing education must be readily accessible for practicing professionals entering aged care and for ensuring those already working in this area have the skills, knowledge and attitudes necessary to provide effective care (p 2).

Various studies have indicated positive outcomes and attitudes following education and training. For example, first, Wilkes and LeMiere (2001) conducted a qualitative study in an aged care facility in Western Sydney. The sample comprised of 23 staff who provided direct care, for example, registered nurses, state enrolled nurses,

personal care assistants, and 24 staff who provided indirect care (maintenance, administration, Food Services, laundry and pastoral care). Results indicated that staff providing direct care, had a significant increase in knowledge following twelve months attending education specific to aged care. Both groups also showed a significant increase in positive attitudes towards older people.

The second study that was conducted by Wilkinson and Sainsbury (1998) reported improved attitudes toward the elderly by medical students at the Christchurch School of Medicine, New Zealand, having participated in programmes specific to geriatric medicine. Feedback regarding the programme by those attending the course revealed positive results. Wilkinson and Sainsbury (1998) reported the following reasons for the effectiveness of the programme – teaching by multidisciplinary professions, community focused enabling students to review older people in their home, patients being seen in a “therapeutic environment”, having a “‘mentor’ scheme” (p 118), and lastly:

Geriatric medicine is a growing field and increasing in importance to medical practice. Effective teaching which engenders positive attitudes towards the elderly is an important component of any undergraduate medical curriculum (Wilkinson and Sainsbury, 1998, p 119).

As noted by Wilkes and LeMiere’s (2001) study, as well as previous studies conducted by Retsas and Wilson (1997) and Nay (1998) (cited in Wilkes and LeMiere (2001, p 20), there remains “a lack of appropriate specialist education” (Wilkes and LeMiere, 2001, p 20) for those working with the elderly. Nevertheless, education plays a vital role in the Continuous Quality Improvement Cycle with aged care facilities expected to provide ongoing education and training to staff.

For those working in the Village's aged care facility, the necessity of providing education in accordance with legislative compliance, the education programme had recently been developed. Prior to this the Village's Food Services offered educational schemes to young people. The first was for those seeking apprenticeship positions as a Chef, which on occasions led to a permanent position (FS1-01.04.00, FS2-18.05.00) as was the case for the existing Chef (FS3-13.07.00). Second, a work experience programme was also offered to students from the local secondary school. This appears to be a positive way to provide young people with skills and experience in aged care. However, the Chef suggested from a negative perspective that the work experience students restricted staff who already had limited time to complete their own tasks (FS3-13.07.00).

The provision of staff training and education is a legislated requirement across the four Standards (1.3, 2.3, 3.3 and 4.3 – Education and staff development). The expected outcome reads:

Management and staff have appropriate knowledge and skills to perform their roles effectively (p S-6, S-16, S-34, S-45)

Within the Village, education sessions were conducted by qualified personnel from various community and educational organisations (PCA1-04.03.00, DON1-07.12.00, VN2-02.06.00). As noted by the Education Co-ordinator: "if we can actually offer something with qualified people to give the information the people are more likely to attend" (VN2-02.06.00). The Village Nurse was asked by the General Manager to organise some in-service sessions. However, the Village Nurse was not confident in this role, recognising that qualified educators are trained specifically to educate others. The provision of qualified educators would ensure greater understanding by staff working in aged care. She stated that if she were to offer such an in-service it

would be promoted as a “workshop rather than a real training programme” (VN2-02.06.00). The Village Nurse has a valid point here. This suggestion reflects the need for policy makers to recognise the importance of training qualified educators in the area of gerontology across all facets of aged care.

Under the four Standards, staff training is required to encompass management systems, personal care, resident lifestyle and safe systems. The Village’s facility provided a varied education programme, but there were suggestions that the focus was on nursing care. Staff attendance was restricted by the limitations of cost and time. The majority of costs were covered by the facility but staff were expected to attend in their own time. Unfortunately, there was limited education for residents within the facility or for their relatives, but a number of staff recommended that relatives and residents be included in the education programme. The Education Co-ordinator also proposed in the near future to invite the outside community to attend education organised by the Village.

The majority of staff were able to recognise that the Village Nurse was responsible for developing and co-ordinating the education programme (VN1-26.02.00, FS2-18.05.00, PCA1-4.03.00, DON1-07.12.00, OT1-02.06.00). There were also those that were able to recognise the multiple roles of the Village Nurse: “We have an Education Co-ordinator who has a number of roles” (VN1-26.02.00) including Village Nurse, Education Co-ordinator and the Health and Safety Representative (PCA1-04.03.00).

The Village Nurse had the responsibility and role to co-ordinate the education programme. During interview, I asked how she was developing this relatively new

programme. At the beginning of the year (2000), a circular was distributed to all staff with a proposed programme and staff were asked to consider subject areas that they were interested in and for further suggestions. The Village Nurse informed me that there was little feedback, although those that did respond provided invaluable information. The types of education that had already been offered to staff included Cardiac Pulmonary Resuscitation (CPR) being well attended by staff from various departments and discussed by the majority of staff interviewed. There were numerous comments made regarding the CPR course, mainly positive however with a couple of concerns. For example, some of the non medical staff including the Catering Manager, and Gardener who spoke on behalf of the Maintenance staff, implied they should have “failed” the CPR course (GARD1-25.05.00) and “wasn’t happy about getting a certificate . . . as I didn’t feel really confident about doing it” (FS2-18.05.00). But the Education Co-ordinator was extremely happy with the response to the CPR course and stated:

I was really happy with the CPR, we had representatives from every single facet of the village and that was the whole lot from the chaplains right through to maintenance and to the nursing home and every single area and administration. (VN2-02.06.00).

There had been courses on “no lifting techniques” (VN2-02.06.00, DON1-07.12.00) and when residents were admitted say on tube feeding, nursing staff were asked to attend whilst the sales representative demonstrated its use (DON1-07.12.00). There had been a Food Handling and Hygiene Level One course (FS2-18.05.00, FS1-01.04.00, FS3-13.07.00, ACT3-07.12.00) which was compulsory for all food handlers in accordance with the Food Act. Other sessions included diabetes with the majority attending from nursing staff (FS3-13.07.00). I held a session on nutrition and hydration that was attended by staff from the Food Services Department and activity

staff but there was no representation from clinical services staff. As stated by an activity staff member, who attended this session: “I can’t explain why no nurses went at all, they knew it was on. The notice was up . . . Normally there is a smattering of nurses” (ACT2-05.07.00). According to the Catering Manager a previous event held by a Dietitian was also attended by non-nursing staff. This concerned the Catering Manager who informed me that nurses were providing all the dietary advice and that nurses “don’t know everything” to make informed decisions regarding dietary and swallowing advice (FS2-18.05.00). This issue was discussed in Chapter 5 – Supportive Environments, and needs to be addressed by policy makers. Within the Village, clinical staff who are not qualified in dietary and swallowing advice are also not increasing their knowledge and skills by attending education in these areas. This suggests that they are not making informed decisions on the lives of older people.

From analysing the interviews, as well as gathering information during the fieldwork through observation, it appeared that the education programme had a focus on nursing care, excluding those courses that are compulsory, such as food handling and hygiene. As stated by the Hostess: “there is a lot more [education] for the nursing staff”, implying that the majority of staff were care staff and that education was required to be “relevant to the job” (HOST1-02.11.00). But it does seem relevant to provide specialist knowledge to all staff working with the elderly, specific to their role. The Catering Manager remarked on the necessity for staff to be multiskilled when working with the elderly, illustrating that the Food Services staff:

are dealing with the residents, they might not be bathing them but when you are feeding them you need to know some of the signs for things to look for (FS2-18.05.00).

As per compliance with the Standards, the Village's education programme was also being developed alongside staff appraisals (VN2-02.06.00, DON1-07.12.00, PCA1-04.03.00, FS2-18.05.00), including a skills audit identifying "deficits" in staff skills.

As explained further by the Village Nurse / Education Co-ordinator:

we are doing staff appraisals . . . and the idea initially was if the skill audit showed a bit of a deficit in something, [or staff such as] . . . PCA's . . . wanted to do blood pressure or something like that, we could incorporate that into the programme . . . That would then give us a bit of an idea and also it allows us to have a base. I mean if we find there is a deficit in a particular area, rather than saying [to staff] "pull your socks up", there is somewhere that they can go [to attain the skills]. And that is the aim of it . . . It has been a fairly new innovation. But that is the aim of it (VN2-02.06.00).

The Education Co-ordinator referred to this as a 'new innovation' as staff appraisals and skills audits are recommended as per Outcomes 1.3, 2.3, 3.3 and 4.3 – Education and Staff Development, as well as Outcome 1.6 – Human Resource Management. The Standards relating to 'education and staff development' recommend that providers consider an "appraisal system that identifies individual education needs" and that a "Skills and knowledge assessment [is] carried out for all staff (Commonwealth Department of Health and Family Services, 1998b, p G-13). Whilst the criteria for Outcome 1.6 reads:

all staff have their performance formally reviewed on a regular basis, giving consideration to performance, training, education and other developmental issues (Commonwealth Department of Health and Family Services, 1998b, p S-9).

7.2.1 Staff education but at what expense?

The Standards particularly those relating to education and staff development, recommend the following:

Management has the responsibility to ensure all staff have access to relevant education, training and ongoing development.

Staff likewise have a responsibility to ensure their skills and knowledge base enables them to perform their roles effectively and comply with duty of care and other relevant requirements.

A learning environment is a growing environment, and education and training together underpin improved quality of care (Commonwealth Department of Health and Family Services, 1998b, p G-13).

Staff in the Village were encouraged to attend education with the Village Nurse suggesting that staff “are frowned upon if they do not attend” (VN1-26.02.00). The education programme was organised by the Education Co-ordinator and conducted within the Village often at no financial expense to staff. The Maintenance Manager and Director of Nursing stated that funding continues to be a “challenge” and the Village was not in a position to fully fund education (DON1-07.12.00). The Director of Nursing explained: “we are not always able to fund totally but if we feel that education is appropriate to the role . . . then we will subsidise the cost” (DON1-07.12.00). The Maintenance Manager also expressed an interest for his staff to attend education but suggested “where do you draw the line” with regard to education and a limited budget. He recognised that there were staff that “would like to do some qualification”, however he concluded: “I should push these guys but I end up thinking about all the other things that need doing [with the budget] so I forget about it” (MAIN1-01.06.00).

To reduce costs further by the Village, staff were expected to attend education in their own time and not during working hours (VN1-26.02.00, PCA1-04.03.00, FS1-01.04.00, PHYS1-12.10.00, ACT3-07.12.00). This would suggest that management is not making a full commitment to the education programme. Similar comments were made by various staff, such as by the Village Nurse: “All of the education I attend is in my own time” (VN1-26.02.00). There were insinuations mainly from nursing staff

that people from the Office and Maintenance Departments are able to attend education during their working hours, whilst “Nursing staff are not paid for attending education” (VN1-26.02.00). As stated further by the Village Nurse:

We have just done a CPR course that was 4 hours on a Wednesday. I have actually worked the last 5 Wednesdays for which the courses were held and I asked if I could go during my working hours, still take my pager. The answer was no. Yet there were 4-5 other staff at the course from maintenance and office who are at work and being paid (VN1-26.02.00).

This is probably not entirely correct and shows again some animosity between Departments. For example the Food Services Assistant did mention that occasionally if they are able to complete their work, they are able to attend education during working hours (FS1-01.04.00). The Maintenance Manager suggested that “when you are working there is not the time and a lot of people don’t want to do [education] after hours” (MAIN1-01.06.00). This was again confirmed by the Resident Co-ordinator stipulating that they can only attend if “time will permit in the office” (ResCo-01.06.00). On the other hand, the Physiotherapist suggested that she is “one of the lucky ones” who is able to “reschedule the physio programme” enabling her to attend education during working hours (PHYS-1.12.10.00). From analysing the responses, I would surmise that nursing staff are less able to attend education during working hours as they are attending to residents direct care needs, whereas other staff who provide indirect care may have greater opportunity to complete their work duties and thus attend education during working hours. Nevertheless, nursing staff are making an assumption, that other staff are attending in working hours, not recognising that they may have completed work which may have been in their own time as a means of attending education. These suppositions may lead to poor working relationships with other Departments, and need to be rectified by management.

A further limitation for staff attendance to education is the availability of other staff to cover shifts. As explained by an activity staff member who described her own situation:

usually your shift happens on the day that the education is on. It is difficult to get somebody to cover you . . . I work weekends and it is very difficult to get somebody . . . they still have to replace you (ACT2-05.07.00).

7.2.2 Suggestions for further education

There were a number of suggestions by staff in the Village regarding further education, yet they did speak positively about the present education programme. The main concerns held by staff were that the majority of education was nurse oriented as well as having to attend in one's own time. The Personal Care Assistant dismissed this latter point wanting to attend any type of education that was available. She surmised that it was a means to:

improve . . . skills, and if someone is offering you a free opportunity I think it is well worth taking (PCA1-04.03.00).

There were a number of recommendations made with regard to education, however training specifically on dementia care and other topics specific to aged care were considered paramount by the majority of staff interviewed. There were suggestions that these sessions be held also for relatives. The activity staff member also suggested a need for the residents "Welcome Kit" to include information specific to dementia. The Welcome Kit contained information regarding the Village, important telephone numbers, the process of the complaints and comments system, and so on. As she explained during our conversation (my extra question is in italics):

Some people don't understand about dementia. It would be lovely if we could provide an education session for families of residents with dementia, because I think a lot of them just don't understand . . . I think an essential part of aged care is

just to let the families understand the actual processes from a medical, nursing, activities and so on side of it. Just to help people understand more. I'm sure a lot of people don't understand how . . . dementia starts and how it progresses. . . I would even like to see printed up sheets with some information given out as part of the welcome kit. *Do residents get a welcome kit?* Yes residents and families. It just tells them what we offer. Not everybody that comes in has dementia, but those that do really need to understand dementia. They don't understand why people wander into other people's rooms and just help themselves. They don't mean any harm, but the resident's family will occasionally say they don't want them in a secure unit. They just don't understand why they should be in there but they don't understand how it puts out other residents when they go into their room and touch things. They need to understand how dementia works. We all need to understand it (ACT2-05.07.00).

These findings regarding the need to offer dementia training and those specifically on ageing, were similar to other studies. For example, as recognised by Chang and Daly (2000) and McKinna and Conners (1999) aged care or gerontological nursing care is a specialty field. McKinna and Conners (1999), both with a background as registered nurses and part of the Collaborative Health, Education and Research Centre of the Bendigo Health Care Group, Bendigo, Victoria identified the importance of providing specialist gerontological nursing care, including hospital based training. As stated:

It is essential that all older adults, both those groups in residential care and in the community, have access to quality, specialised gerontological nursing care which meets national standards and benchmarks. To achieve this aim, there needs to be an appropriately educated nursing workforce (p 27).

Chang and Daly (2000) suggested that for nurses, there has not been a "consensus on essential and urgent research topics" (p 8). They conducted a study consisting of Clinical Nurse Consultants in New South Wales to obtain a consensus and research questions and priorities in aged care nursing. Findings revealed that there is a need to offer education regarding dementia care, along with "ongoing education and support"

(p 11) for the carers. Overall, this is consistent with other findings, since the incidence of “mental health problems” (Maguire, 1999, p 12) is going to increase with an ageing population. As noted by Maguire (1999): “Dementia is disabling not just to patients but to families, carers, communities and national healthcare systems” (p 12). She continued:

The impact of dementia on a family is incalculable . . . In addition, the psychological frustration of seeing a loved one, particularly a parent, unable to accomplish the simplest actions of toileting, eating and dressing can cause serious depression. Research confirms that carers are at high risk for physical and mental ill health (Maguire, 1999, p 13).

Maguire (1999) acknowledged that the European Institute of Women’s Health (Dublin) provided a number of recommendations including a need for further research, the development of training and education programmes for volunteers, policy makers, families, and the provision of counselling “services to help carers” (p 15). These recommendations are conducive to the health and well-being of older people living in aged care.

Further suggestions for education by staff in the Village included first aid (PCA1-04.03.00, GARD1-25.05.00) which was being promoted but at staff cost. There was wound management (VN1-26.02.00) and stress management (MAIN1-01.06.00, OT1-02.06.00, FS2-18.05.00) both of which had been organised for later in the year according to the Education Co-ordinator (VN2-02.06.00). There were also expressions of interest relating to various allied health services such as podiatry and foot care (OT1-02.06.00), or a speech pathologist to discuss issues relating to swallowing and textured foods (OT1-02.06.00). The Occupational Therapist and Physiotherapist also suggested information relating to special tools and equipment

that residents can use to promote independence, all relating to Activities of Daily Living (ADL) (OT1-02.06.00, PHYS1-12.10.00).

Other suggestions from staff included improvement in personal skills, for example the Hostess had organised and completed a computer course at her own expense and time, understanding that in the near future, she would be required to use a computer. Some staff from the Food Services Department were contemplating pursuing a career. For example the Chef had an ambition to pursue a career in nursing and had discussed this with the General Manager who was prepared to discuss and support this (FS3-13.07.00). The Gardener also spoke on behalf of Maintenance staff suggesting the importance for the men to be supported and encouraged to pursue further skills and trades such as carpentry or use of equipment (GARD1-25.05.00). As expressed by the Gardener in two instances during the interview:

I am qualified but the 4 guys I have working with me have no skills . . . They are handymen and they know how to do a bit of stuff but that is it . . . [One of the men] is 27 and I can't see him staying here for a long time as this is the beginning of his working career. They should give them skills because they will then think, "we are learning stuff with this job".

I think everyone should do something at least once a year, even if it isn't in your own field. It would be great to have carpentry courses. Even though we have nurses here, we should still know first aid. We just don't do it and I suppose admin don't really care. I think the main interest is to provide the nurses with courses and refreshment courses as they have more hands-on type of job than we do (GARD1-25.05.00).

The Village Nurse and Director of Nursing both said that education needed to be repetitive and ongoing as "staff sometimes fall back into their old ways" (VN1-26.02.00). Also as noted by the Director of Nursing, if education is not implemented regularly the skills "become superseded by other information" (DON1-07.12.00). The Director of Nursing suggested the difficulty in providing continuing education when

there is resistance by staff (DON1-07.12.00). This resistance included “resistance to change” (DON1-07.12.00) and at the time of conducting the fieldwork, staff had undergone numerous changes as a result of the aged care reforms. As explained further by the Director of Nursing:

I think limitations, as the first thing that comes to my mind is the basic resistance to change. I think you are dealing with people that are protective of their role; they think they are doing a good job . . . They think they provide a good job and suddenly somebody comes in and says you must do it differently. I think a lot of people are threatened from that situation . . . It is very . . . much an educative situation but I do believe a lot of staff still resist that education and that makes the process longer (DON1-07.12.00).

It appears that the education programme could be improved offering a larger range of courses such as those mentioned above and beyond. Yet as the Gardener and other staff pointed out, there is a priority on improving nursing care skills which would suggest either the Education Co-ordinator who is a nurse has not considered other staff needs, or aged care is indeed dominated by the medical model. This latter idea is supported by the fact that nursing staff are providing dietary advice but are not attending the few courses offered on diets and nutrition for the elderly, however they did attend the session on diabetes. It could be surmised that this was attended with the assumption that diabetes is clinically oriented. As noted by the Catering Manager, there is a need for staff to be multiskilled when working with the elderly. This was evident with all staff attending the CPR course, which benefits them, as they all have involvement with people. Education, may indeed become more extensive and varied if management were more committed to the programme and if the education co-ordinator collaborated more with the wider community.

7.2.3 Education and the Community

The Village had various outside community organisations provide either speakers or training, and a recent initiative was to enable community groups to access a meeting room in which staff were able to attend. The Standards do recommend that education is provided both internally, “based on training needs”, and through external services (Commonwealth Department of Health and Family Services, 1998b, p G-14). Education sessions for staff were mainly from external services held within the Village but staff could also access outside education held by various community organisations, advertised and organised by the Education Co-ordinator.

Staff including the Occupational Therapist and a Food Services Assistant (OT1-02.06.00, FS1-01.04.00) recognised they were able to attend other education sessions available from the Community. Notices for availability of education in the community were advertised on the staff notice board. During the fieldwork I observed advertisements from Health Training Education Services held at the Kingston Centre, eg. Basic Palliative Care, Angina and Heart Attack, Medications, Dementia Care, Advanced Skills for PCA's, Caring for People with Dementia, Wound Management, and Documentation for PCA's. There was also an advertisement from the Alzheimer's Association, Dementia Care announcing the commencement of a 30-hour accredited course. A notice from the Education Co-ordinator requested that staff write down their name if they were interested or had not attended a previous session on Food Handling, yet no staff member had completed this. This may have been as a consequence of the overall expense to the staff member for example, as stated by the Occupational Therapist these courses “are restrictive as they are costly” to attend (OT1-02.06.00). This was supported by an activity staff

member who was aware that a first aid course was being promoted, and explained - “[I]t is very expensive as it is not totally funded” (ACT2-05.07.00).

The Community Groups who conducted education sessions in the Village’s meeting room invited staff to participate. These sessions were mainly organised for the community’s own benefit, however, on occasions staff did attend these sessions (VN1-26.02.00, DON1-07.12.00, OT1-02.06.00, MAIN1-01.06.00). For example the Director of Nursing (DON1-07.12.00) and Occupational Therapist (OT1-02.06.00) informed me that the local hospital’s Psychiatric services held an education session, on “behaviour management” (DON1-07.12.00). As noted by the Occupational Therapist, offering the community an education venue is advantageous to both the Village and Community, providing the opportunity for people to find out more about retirement villages and aged care (OT1-02.06.00) and for staff to have access to a wider range of education. Community participation in the provision of education is an important step forward in promoting partnerships between aged care providers and the local community. In the future, the Education Co-ordinator hoped that the Village could extend the education programme and offer educational services to the Community. As stated:

We haven’t really opened a lot of things up to the community as such. But it is something I have thought of recently as far as the education programme is concerned. I thought if we ever had something on in the future . . . maybe, if we were having a talk, we could actually advertise in the local paper (VN2-02.06.00).

There were also some questions regarding the practicality of courses offered in the community such as Personal Care Assistant Training and Certificate courses for Diversional Therapist’s. Activity staff within the aged care facility were being encouraged to complete a Diversional Therapy course, enabling them to do a

Certificate course by a certain period (ACT3-07.12.00). The advantage for staff to be trained as Diversional Therapist's is that it enables them to complete documentation and development of individualised care plans. The organisation can thus score against Question 19 – Therapy, of the Resident Classification Scale that provides fairly high weighting of up to 7.01 (Commonwealth Department of Health and Family Services, 1998a, p 25) which may aid in extra funding. An activity staff member who attended the Diversional Therapy course made the comment: “most of what they told me was not relevant to anything I have encountered so I really didn't get enough out of it” (ACT2-05.07.00). A further comment from another activity person: “There was a lot of craft work even though you don't use it” (ACT3-07.12.00). This latter staff member though spoke highly of the course explaining that they: “learn about different medical things, like medical terminology, complaints, first aid . . . Parkinson's, . . . movement to music, exercise” and so on (ACT3-07.12.00). She also informed me that the course had included “documentation” techniques, but during the course of the interview when asked if there was any further education that she would be interested in, her reply was: “I need to be educated on documentation because I really feel that this is a big area and I haven't got the confidence. I am not really sure how to word properly” (ACT3-07.12.00). Further similar comments were made by a Personal Care Assistant regarding the PCA course:

Staff need to have more training time in the hostel even though they have a certificate in personal care. It is a whole new ball game putting it into practice, organising yourself during the night or day – that is definitely lacking and a problem here (PCA1-04.03.00).

This was further supported by the Registered Nurse who identified that there was an increasing number of PCA's utilised in the aged care industry, but “they don't know

the basics” which could be taught within the course (RN1-11.03.00). The Registered Nurse continued to suggest that the Personal Care Assistants:

haven’t had the patient contact before they come in. They do a few essays and things like that but they don’t have a really good understanding of what the elderly really want from you (RN1-11.03.00).

These comments support the above findings that courses specifically aimed toward gerontology are advantageous. Personally from experience working with staff especially within Food Services, I have identified the need to offer courses that are relevant specifically to the aged care industry, such as Catering for the Elderly or Food Handling Techniques for those working in aged care facilities. I attended a course on food handling and recognised that it was generalised and how this course would be increasingly beneficial if discussed from a gerontological perspective. These courses could teach people the types of food this generation grew up on and methods to modify textures to suit the needs of the resident. Safety and dignity with respect to swallowing and chewing ability is also important, as is the recognition of food safety and hygiene for a high risk group, as per stringent food regulations, as per the amended Food Act 1984.

7.2.4 Education for residents and relatives

The above has discussed issues relating to education for staff and community participation. This section concludes discussion relating to education from the perspective of residents and their relatives. As discussed in Chapter 4 – Policy, government policy is directed toward keeping older Australians in their home as opposed to residential care, (that is, promoting ageing in place), but as noted by Nutbeam (1998) there remains limited health promotion strategies. Health promotion initiatives may be advantageous as, “older people are substantial users of health and

community services” (p 121) and health expenditure is likely to increase as a result of an ageing population (Nutbeam, 1998, McKinna and Connors, 1999). Heidrich (1998) also recognised that “there is little research [on health promotion initiatives] involving nursing home residents or the institutionalized elderly” (p 175). Also, there have been very few health promotion studies that have considered the cost and more importantly, the “important issues of quality of life in old age” (p 191). As Heidrich (1998) continued:

Theoretical work examining the links between health promotion activities or a health-promoting lifestyle and important quality of life and other health outcomes is lacking (p 191).

Nonetheless, an example of a study specifically on health promotion – ‘Healthy Endings’ was developed by graduate nurses and members of a senior centre, and consisted of education for individuals and groups. These programmes included “diabetes, hypertension, congestive heart failure, arthritis . . . stroke[,] . . . hygiene, incontinence, . . . safety, . . . medication compliance, exercise, and depression” (Slaninka and Galbraith, 1998, p 39-40). For those who were unable to attend, a newsletter providing relevant information was made available. This project concluded that:

health promotion for older adults . . . can significantly affect health status and quality of life . . . Community agencies such as retirement communities . . . provide excellent opportunities for health promotion . . . allow[ing] older adults to live longer and healthier lives (Slaninka and Galbraith, 1998, p 43).

Furthermore, Kellehear (1999) identified “two kinds of strategies in health education” and recommended to “[p]ick, choose, experiment, disregard, dispose, and invent strategies as you need to” (p 75). The first is social strategies which includes audio-visual aids, behaviour modification, individual tutoring, lecture and discussion, role play and case studies, professional speakers and a directory of services (Kellehear,

1999, p 63-69). But there is a need to provide speakers that are proficient in aged care services who have an understanding of working with the elderly. Secondly, personal strategies include writing of journals or diary, memory work, letter writing, tape recording, pictorials, and telling life stories (Kellehear, 1999, p 70-74). This latter point, telling life stories is valuable within a retirement village. For example, residents could be provided the opportunity of attending reminiscence sessions. Life stories could also be a learning opportunity for many, including school students. The NSW Department of Health (1996) reported on a case study at Casula Public School in Sydney in which older people visited the school and “share[d] their expertise in art, craft and lapidary and their knowledge of local history in a sensitive, caring manner” (p 72).

Nutbeam (1998) and Kovner et al (2000) both recognised that the health system, including aged care remains dominated by ‘health outcomes’. This is supported by the fact that the Standards are outcome based, with there being 44 outcomes from the designated four standards (Commonwealth Department of Health and Family Services, 1998b). Nutbeam (1998) proposed that in preference to the current system, a health promotion outcome model be used. Nutbeam’s (1998) model utilised concepts from the Ottawa Charter with one of these outcomes focused on health promotion with ‘health literacy’ as an important goal, as well as ‘healthy public policy and organisational practices’ and ‘social action and influence’. Within the outcome model for health promotion, Nutbeam (1998) linked health promotion actions – ‘education’, ‘social mobilisation’ and ‘advocacy’.

Unfortunately, the Standards do not appear to promote education for residents or their relatives, limiting the guidelines for staff and management to be pro-active in education activities. Nevertheless, during interviews there were suggestions from the Catering Manager, Village Nurses, a Food Services Assistant, activity staff and Occupational Therapist (FS2-18.05.00, VN1-26.02.00, VN2-02.06.00, FS3-13.07.00, ACT3-07.12.00, OT1-02.06.00), that residents or relatives would benefit from the provision of an education programme. Relevant and interesting points were discussed. For example, the Occupational Therapist (OT1-02.06.00) noted that there is no formal education programme available to facility residents and that if there were, residents from independent living could also be invited along. As she continued:

I think because you're an old person doesn't mean that you don't need to keep learning and you can't help yourself. I think it [education] would be really interesting in the hostel (OT1-02.06.00).

The Occupational Therapist did organise a couple of sessions for residents. For example there was a speaker who discussed Parkinson's disease (PHYS1-12.10.00). There was also a session held by Vision Australia (OT1-02.06.00, PHYS1-12.10.00) who spoke about adaptive equipment and this was well attended by both hostel and independent residents. As stated by the Occupational Therapist: "people are interested and want to know what is happening and what is available" (OT1-02.06.00). The Occupational Therapist continued to express the concerns of residents that the staff attempt to do "everything", occasionally making it difficult for the residents to maintain independence. She continued to relate an incident with a resident asking to know more about the role of an Occupational Therapist:

I spoke to a resident just before who said "they just want to do everything for you, what do you do"? So I told her that we look at maintaining independence and safety and activity opportunity. And she said "but they don't like you to do too

much for yourself, they like to help you all the time”. So I said, “of course the help is there but it is also important to be able to continue doing everything you want to do, whether that be looking after your own personal hygiene or making decisions about what you are going to eat” (OT1-02.06.00).

The Education Co-ordinator/Village Nurse, as well as another Village Nurse also believed education was important for residents, identifying that residents often “have no knowledge of their bodies [or], their health”. This was supported by an activity staff member who recognised that the session conducted for staff on ‘Nutrition and Hydration’ was just as important for residents as often they do not drink sufficient fluids (ACT3-07.12.00). The Education Co-ordinator also suggested that residents: “are not in the habit of asking for help. So more educational services and more demonstrations are needed” (VN2-02.06.00). However, she acknowledged that if this service was offered it would need to be conducted on the premises to encourage participation by a group where accessibility is paramount: “If it isn’t on their back door they won’t go” (VN2-02.06.00).

This latter point was supported by the fact that residents from independent living attend sessions when they have guest speakers. Speakers are invited to their monthly meetings and provide an informative session on various topics (IR2-17.02.00, IR5-11.03.00). For example, they had a person “talk about hearing aids” (IR4-26.02.00) and residents were encouraged to have their hearing tested (IR7-08.04.00). One of the residents was a member of Better Hearing Australia and she had been taught “lip reading” and suggested this would be invaluable to other residents who had hearing problems. She explained further:

another thing I have learned is that sometimes you haven’t heard and you are scared to say yes or no because you might say the wrong thing, so don’t say anything (IR7-08.04.00).

Independent residents also had a physiotherapist talk about arthritis and the types of exercise that may be beneficial (IR5-11.03.00, IR3-22.02.00). The fire brigade kept residents up to date with fire evacuation procedures (IR2-17.02.00, IR3-22.02.00). As stated by a resident:

We had the fire brigade who showed us how to put a fire out.
They had an old car and set it alight and how they put it out.
It was very interesting (IR2-17.02.00).

Other speakers included those from the ambulance and immigration (IR2-17.02.00). Another independent resident spoke about the talents of residents within the Village who could provide knowledge and discussion groups, however her concern was, how the sessions and speakers could be organised (IR8-04.05.00). Residents only informed me of one external education event, with residents being provided the opportunity of attending a computer course that was well attended (IR3-22.20.00).

It would appear that education sessions, including various speakers are well attended by residents living within independent units and therefore one could query why this type of service is not provided to residents living within the facility. One could speculate that the current policy in aged care, promotes dependence of the elderly, and the provision of education to this clientele may be seen as a waste of resources. The current education programme for staff and the limited or non-existent programme for residents in the facility and for their relatives could indeed be developed and improved. The next section concludes this chapter by discussing issues relating to the various types of communication including the availability and effectiveness of meetings.

7.3 Communication practices and skills

Standard One – Management systems, staffing and organisational development, particularly promotes effective communication practices between all “stakeholders throughout the [continuous quality improvement] cycle of monitoring, assessment, action and follow-up” (p G-5) (This was demonstrated in Figure 4.1). For example, the Standards stipulate that ‘action’ in the form of education programmes are available and that ‘feedback’ mechanisms by means of newsletters and staff and resident and or representative meetings (Commonwealth Department of Health and Family Services, 1998b, p G-4, G-5).

Meetings within the Village were held for both staff and residents from the hostel and independent living, on a regular basis. There appeared to be no meetings especially for relatives but they were invited to resident meetings. Staff were also offered the opportunity to discuss resident needs, in the form of staff ‘handover’. There appeared to be occasions though when communication tended to breakdown either from the immense size of the Village or from communication practices that could be improved. This is an interesting point as Craney (2001) described a case study of her own experiences with an ageing parent and stated this about communication and aged care promoting continuous quality improvement systems:

All the institutions Dad spent time in advertised their program as ‘quality’. But one essential ‘quality’ was missing – an ability to communicate and act on feedback from ‘customers’ (p 360).

Unfortunately, during the course of the interviews there were a number of comments made regarding poor communication mainly between Departments. As noted by the Village Nurse: “Communication is the essence of good free flowing all round care for our residents and that doesn’t really happen” (VN1-26.02.00). She identified that on

occasions when the Village Nurse is asked to help in the facility. She observed that poor communication has resulted in mismanagement of resident care. The Village Nurse demonstrated this when discussing care staff documentation for the purpose of the Resident Classification Scale. The Village Nurse stated that:

writing the same lot of nonsense and the essence of the care is missing. All you have to do is look back in the notes and you see beautiful documentation but no one communicated the problem with the doctor. The woman had abdominal pains for a month or so, she had lost 5 kilograms weight in about 3 weeks and she in fact ended up being diabetic. Why do they not tell the doctor? (VN1-26.02.00).

This quote is an indication that appropriate care is not being provided and that further education, including improved communication skills is necessary. Staff were aware that effective communication skills are a pre-requisite for helping to ensure the best care is provided to residents. The Village Nurse commented: “communication and respect is the key for trying to provide the best care for our residents” (VN1-26.02.00). According to staff comments, effective communication practices appeared to occur through staff handover (PCA1-04.03.00, DON1-07.12.00, OT1-02.06.00). But on analysing the interviews, it would appear that the people involved in staff handover are the nursing and care staff with the Personal Care Assistant and the Director of Nursing only referring to the Registered Nurse, State Enrolled Nurse and Personal Care Assistant as attending these sessions. There were recommendations that the domestic staff be invited to staff handover as they often have a great deal of insight into residents as a result of cleaning their rooms and so on. The Director of Nursing noted: “I think frequently the domestics; people who are walking in and are doing the cleaning, often get information that the nursing staff don’t” (DON1-2.06.00). The Occupational Therapist also explained to me that unfortunately, she

infrequently attended staff handover because the Occupational Therapists work part time. As the OT explained further:

From a professional point of view the only thing I sometimes find difficult is communication in terms of catching up with people because a lot of us are working part time. Or getting together as a team . . . like special care staff, activities staff, physiotherapy and myself. Maybe we could do a better job talking about who is doing what (OT1-02.06.00).

From analysing this information, it would seem beneficial if there was a time whereby a representative from all areas was given the opportunity to discuss resident needs in comparison to the present situation of being nurse/care oriented with informal information being gathered from other staff. It would appear that information from the domestic staff is filtered through from general 'chatter'. Handover could include a team with the present nurse/care staff as well as Food Services and domestic staff, allied health such as Occupational Therapist, Podiatrist, Physiotherapist, Continence Nurse, Diversional Therapist/activity staff and a Nutritionist/Dietitian. The Village infrequently used the services of a nutritionist but it did seem that there was a need from the amount of queries that I had and the amount of feedback from residents and staff with regard to their own dietary dilemmas. From my own work in this field, on a personal note, I feel that a nutrition service is a pre-requisite for holistic professional care.

7.3.1 Residents and staff meetings

There was little feedback regarding resident meetings held in the facility by the General Manager, but they were observed during the fieldwork, and took place on a monthly basis. The Food Services Assistant mentioned that there is often feedback from these meetings regarding meals and this is followed up with changes made to the menu (FS3-13.07.00). Activity staff also held bimonthly meetings with residents to

discuss plans and gain ideas and suggestions for the activity programme (ACT3-07.12.00).

Residents living within independent units as well as the Hostess were fully aware that meetings were held between residents and administration, with these meetings being pro-active (IR2-17.02.00, IR6-08.04.00, IR3-22.02.00, IR7-08.04.00, IR8-04.05.00, HOST1-02.11.00). Residents were fully aware that they were able to discuss ideas, complaints, the gardens, provide reports from the various clubs, and on a yearly basis the Finance Manager would attend to discuss the financial report. An independent resident was surprised at the openness of information, exclaiming: “we are told what monies go toward salary. They are quite open about everything in the Village; they don’t hide anything” (IR2-17.02.00). And as a summation from another independent resident:

We have a resident meeting every month and this gives people the opportunity to get up and if they want to say anything or have a grizzle or ask questions, we have the minutes and finances. The clubs give their reports. They report on trips and all that. Every . . . month . . . management are represented (IR6-08.04.00).

According to a resident these meetings were always well attended and they had a microphone and speaker enabling all to hear, including questions from residents (IR7-08.04.00). The Gardener did attend one of these meetings with independent residents to discuss ideas on future landscaping as well as gardening programmes but due to time constraints, discontinued against the wishes of Administration (GARD1-25.05.00).

Residents gave the impression that they were given every opportunity to discuss freely and that Management attempted to answer questions, nevertheless it was often

the same residents that spoke at these meetings. Unfortunately, relatives were also not involved in these meetings but minutes of the meeting were accessible by relatives if requested (IR8-04.05.00). Changes did appear to result from these meetings. For example the Hostess explained that she was present when residents were discussing concerns with the number of robberies and vandalism that was occurring within the Village and this was actioned immediately following the meeting. As stated by the Hostess:

Even at the resident's meeting, I don't always sit on it, but they were complaining about the number of robberies we have had around here. We have security guys here and now we are putting cameras in . . . A few of the cars were being damaged. But that is being followed up and the cameras should be installed shortly (HOST1-02.11.00).

In comparison, for residents living within the facility, staff indicated that meetings did not provide the opportunity for change or action. Staff also spoke negatively about their own meetings, excluding the time spent during staff handover. The majority of meetings were held with staff from their own individual departments for example there were nurses meetings and Food Services meetings excluding meetings on specific issues such as Occupational Health and Safety (VN1-26.02.00). Activity staff also attended external professional association meetings with the Diversional Therapy Association, held monthly, allowing staff to 'brainstorm' ideas (ACT2-05.07.00, ACT3-07.12.00). A number of staff were concerned with the increasing number of meetings with existing time constraints (VN1-26.02.00, FS1-01.04.00) and the fact that attendance to all meetings were outside working hours (PCA1-04.03.00, VN1-26.02.00). As quoted from the Personal Care Assistant and also from the Village Nurse:

We have a nurse meeting . . . They are not paid for and we have to come in our own time and this irritates me sometimes. You have a day off and you have to come in for an hour . . .

when you have to make a special trip and it breaks your day in half, you get a little irritated, especially when they say “you must attend” (PCA1-04.03.00).

They do not pay for you to come to meetings and then you are criticised if you do not go. I work after hours most of the time, I would say that none of the meetings I have attended have I been paid. If you do not go to meetings you are frowned upon (VN1-26.02.00).

There was also the question of whether meetings were beneficial with staff suggesting that ideas and or concerns are not followed up or actioned and as stated by the Registered Nurse “on rare occasions I have spoken up, but nothing has been done. You realise you’re up against a brick wall” (RN1-11.03.00). These findings relating to staff and facility resident meetings are very different to those meetings held for residents living within independent units, and there would need to be further research to understand the reason for this. It could be assumed that residents that live within independent units are given the opportunity to maintain autonomy. Whereas for those associated with aged care or institutionalisation, that is, the residents and staff, who are living and working in a poorly stereotyped area are treated as such.

SUMMARY

It appears necessary that by offering staff education that the courses need to be specifically in the field of gerontology, providing the opportunity of reducing negative attitudes and stereotypes as well as providing them with information that is not only relevant to the skills being learned but also relevant specific to aged care.

The Ottawa Charter recognised the need for “people to learn throughout life”, and as noted by Nutbeam et al (1993), teaching health literacy at all stages of life, enables individuals a better understanding of the “physical and psychological changes”

(Nutbeam et al, 1993, p 153) associated with age. There has been insufficient research on the benefits of health promotion for the older population, yet health promotion initiatives may be economically viable by reducing the overall health care costs associated with disease and treatment of the elderly as well as by a population that is ageing.

The introduction of gerontological studies incorporating health promotion would be valuable. Gerontology is a specialised area and requires promoting to capture a greater section of society to work in this field. Incorporating health promotion into this field may be a positive step toward achieving this goal by encouraging greater interest. Teaching life skills also enable individuals “to cope with, and adapt to the inevitability of life stresses – to achieve mental wellbeing”. Unfortunately, the elderly population “suffer from negative stereotyping which may lead to reduced self esteem, limited life decisions, . . . limited relationships with others . . . [and] limit[ed] . . . independence and ability to care for themselves” (Nutbeam et al, 1993, p 158). Positive stereotyping of this age group is also required and can commence to be taught to the young generation in schools, as well as by inviting older people into the classroom to tell their tales, enabling the younger person to learn, through incentives that offer intergenerational learning.

Working toward a health promoting retirement village requires change of attitude and commitment by the organisation. As noted by Wilkes et al (1998) the problem associated with negative attitudes by care staff is that staff may “become impatient” (p 12) and consider that older people are unable to learn new skills. This can be accomplished to some extent by encompassing within our education system

knowledge and training into preventive health care, lifetime health and wellness practices, and elimination of negative stereotyping of the elderly. It may be necessary for educators to promote a more interesting perspective or have incentives for young people to want to learn about our elderly population. For example incorporating the wonders of our older generations with the knowledge and experiences that they can share, as occurs in indigenous cultures who respect their elders. Family relationships is an important module of the school curriculum which can aid in a society that identifies the importance of the extended family and the family as a whole.

Conclusion

Reorienting health services

This chapter will focus on the World Health Organisations (1986) Ottawa Charter's action areas – developing healthy public policy, creating supportive environments, strengthening community action and developing personal skills with an emphasis on the fifth action area – a reorientation of health services. This action area states:

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components (p 2).

Nutbeam (1991) recognised the importance of this action area in strengthening and 'supporting' the Ottawa Charter's health promotion actions to promote health and well-being:

One of the cornerstones of the Ottawa Charter on Health Promotion was the re-orientation of health services. This emphasis on health services was partly in recognition of the critical role that the health professions can play in supporting the other major themes of the Charter (p 169).

Retirement villages that offer all levels of care are currently negatively stereotyped in a structural downhill medical model. This thesis has proposed that this model be reoriented to a settings approach that promotes health and well-being for residents, staff and visitors who can all work in collaboration and partnership with the community. This chapter will also provide an overview of what limitations exist with

the current model of aged care, the relevance of the settings approach to aged care and a critique on the use of a qualitative methodological framework in designing, implementing and evaluating the research.

This study has demonstrated the immense changes that have occurred within both the public health and aged care systems. The public health movement moved from a curative approach to one that incorporates health promotion, however, mainly from the perspective of behavioural change. As a consequence of the 1997 aged care reforms, aged care providers have been made more accountable for their actions, having to comply with legislation such as the 'Aged Care Act 1997', the 'Quality of Care Principles' and the 'Standards and Guidelines for Residential Aged Care Services'. The aged care reforms and the new public health movement have promoted education and developing personal skills, however it remains questionable whether aged care particularly within an 'institutional' setting, has fostered health promotion initiatives or whether it remains focused on the curative medical model. The limitation to the medical paradigm is its exclusion of a social environment and the promotion of healthy public policy.

There are those such as the Australian Health Ministers' Council (1988), the then Minister for Aged Care, Bronwyn Bishop (1999, 2000), Campbell (1993), O'Donnell and Gray (1993), and others, who have identified the benefits of providing health promotion initiatives. Inclusion of health promotion programmes are likely to enhance quality of life and offer cost savings, both of which are important indicators for an ageing society. Nevertheless, a number of researchers such as Wilson (1984), Koff (1986), Nutbeam et al (1993), Braithwaite et al (1993) as well as Bronwyn

Bishop, recognised that the elderly and aged care models that represent a downhill progression, are negatively stereotyped. The aged care reforms as well as International Year of Older Persons, 1999, attempted to reduce this negativity by promoting positive and active ageing, and ageing in place.

Methodology

The methodology incorporated some aspects of the epidemiological patterns associated with the ageing process and the difficulty this presents on researching the benefits of health promoting programmes. Nevertheless, this thesis of a retirement village case study utilised a qualitative methodological approach that aimed to provide a social perspective of an aged care setting that offered a continuum of care. Strauss and Corbin (1994), Krothe (1997) and Koch (1998) all recognised that qualitative research provides the opportunity for the voices to be heard of those often marginalised. It was for this reason that data was gathered from the perspective of residents both living within independent units and those in low level care accommodation, as well as staff from a variety of disciplines

Limitations

It is recognised that there are limitations to the research findings. For example data were analysed utilising Glaser and Strauss' (1967) constant comparative method. Coding of data was completed manually in preference to use of a computer programme. It could be suggested that the coding might have been prejudiced according to own personal views and interpretations. In order to gain entry in the retirement village, I provided a 'free' consultancy that may have also biased the findings, as staff may not have been entirely open and transparent during interviews,

but this was not evident. A further disadvantage may have occurred as a result of my own experience and preconceived ideas having worked in the aged care industry. I already believed that care of the elderly was limited and that it is not an environment that is conducive to a holistic approach to health and well-being. I was also aware that staff were having to concentrate on administrative work that reduced one on one time with residents and relatives.

From a positive perspective, a method of triangulation was used to strengthen the research findings with a variety of data being gained from interviews with residents and staff, observation during the fieldwork and through an extensive literature review. It was for this reason that the chapters have been structured to incorporate as many quotes as possible as supportive evidence and hope that this has enabled the voices of the participants to be heard. I also believe my experience and skills in aged care enabled me to gain access to a Village that offered all levels of care and a variety of support services that contributed to gaining quality, valid data with the recipients.

The health promoting setting and its relevance to aged care

It would appear from analysis that the Ottawa Charter (WHO, 1986) which has been applied in other health promoting settings such as schools and cities, can also be applied to an aged care setting. The Ottawa Charter however has only been used as an analytical tool and would need to be trialed and translated into a retirement village, dependent upon the needs of residents, staff and the community. A brief analysis and concluding remarks under each of these action areas is included below. As noted by Baum (1998) and Johnson and Baum (2001), organisations must be committed to change to work successfully toward a health promoting setting. Aged care continues

to change and 'improve' through its 1997 and beyond reforms. These reforms have promoted education and continuous quality improvement systems that are excellent incentives. However it is believed through analysis that current policy such as the Standards and Resident Classification Scale, and other legislation including the Aged Care Act 1997, require further development and review. The RCS and Standards in particular could complement each other and therefore reduce the amount of time staff spend on documentation. Aged care legislation that promotes health and wellness in comparison to the curative or treatment model may promote positive stereotypes. Implementation of health promotion programmes requires staff and even relatives to be provided with education and training specifically from a gerontological perspective that promotes positive ageing and understanding, thus helping to reduce negative attitudes.

It is recognised though that the aged care reforms have promoted staff education and training, but it may be worthwhile to incorporate the community, relatives and residents into these to increase participation, collaboration and empowerment. Empowerment is important for all, however the thesis has demonstrated that residents, particularly those in aged care facilities, remain voiceless and powerless, even with the Complaints Resolution Scheme, compared with residents living within independent units who do remain active and participate in community life.

The difficulty in implementing a health promoting setting is the limited data and research that has occurred within aged care, particularly within the Australian context and within an aged care setting. This may therefore inhibit the initiation of change to one that promotes health. Nevertheless, the health promoting hospital was developed

as a response to the need for cost-effective methods and consumers increasingly being interested in alternative medicine and health promotion. This indeed may also occur with a population that is ageing, who will have greater expectations to improved services and amenities. The following provides a demonstration of the application of the Ottawa Charter's action areas to a retirement village and the types of theory that generated through analysis, but specifically focusing on the reorientation of health services.

Developing healthy public policy

It is evident that there is some comparison between the World Health Organisation's (1986) Ottawa Charter and the Commonwealth Department of Health and Family Services (1998b) Standards. For example, both promote the importance of developing personal skills and community participation. Yet the Standards are focused on the treatment model compared with the Ottawa Charter that promotes health in a broad social and cultural context.

It is also apparent that with the introduction of aged care reforms including the Aged Care Act 1997, that necessitated aged care providers to be accredited under the Standards, as well as the introduction of the Resident Classification Scale, staff have increased documentation, thus reduced care time. This was evident from the findings from interviewing residents and staff. This finding was supported by a recent study conducted by Grenade and Boldy (2002) which reported:

one of the comments often made in relation to the demands on staff time was that these were not necessarily associated with accreditation per se, but the fact that these demands came on top of other existing demands, for example those of the Resident Classification System – in other words, it is the

combination of these demands that has created stress and exhaustion amongst staff (p 9).

Under the current system, aged care providers would probably experience difficulty in promoting continuous quality improvement and there is also the problem of residents missing out on care time whilst staff are overwhelmed with attempting to meet legislative requirements. This then may exacerbate staff stress, absenteeism, reduced morale and high staff turnover rates. It would therefore be advisable to review the current systems. For example the Standards and RCS could be reviewed to complement each other, and aged care providers may be able to organise and co-ordinate their responsibilities effectively as well as maintaining the funding. This suggestion is supported by Grenade and Boldy (2002) who commented upon the “need for accreditation to be structured and implemented in a way that operates in conjunction with other components of the aged care service provision system” (p 9).

Nevertheless, accreditation with its focus on continuous quality improvement and education, appears to be an improved system compared to that in place prior to the reforms. On reflection, it would appear beneficial for providers of residential care offering independent living with supported services to be included in an accreditation system, especially with an ageing population. This would also complement policy on ageing in place, especially if services were increased with a focus on promoting health and wellness.

For staff of the Village, the RCS funding tool appeared unjust, particularly when residents enter the facility often frail. Once residents received the services and care, they gained independence, but this resulted in reduced funding. It may be appropriate for the RCS to be reviewed for providers who offer health promotion programmes that

maintain older peoples' independence and quality of life to receive funding for such incentives in comparison to funding being allocated to facilities that focus on treatment.

It was also clear that a Village that offers a continuum of care from independent living through to high level care appears advantageous for all stakeholders. For residents, there was an increased likelihood of a home for life within familiar surroundings and personnel such as residents and staff, whilst maintaining friendships. For staff, there is the benefit of gaining a social history of the person thus promoting quality of care if the person becomes incoherent.

Ageing in place whereby residents remain living in the community or in a retirement village's independent area, whilst others may age in place within an aged care facility, appears to be an ideal system however in practice unrealistic. Providing support services and personnel in remote areas or even in their own home may create some difficulties. Residents may feel isolated from reduced socialisation and inaccessible transport that may increase anxiety levels. For those residing in a retirement village that offer all levels of care, there is the opportunity of providing health promoting programmes, support services and personnel and an ability to maintain an active social life, however, a system to help fund such an initiative would need to be considered. Also, to have high and low level care residents within the one facility requires adequate staffing, appropriate buildings and equipment, and legislation that is complementary, thus reducing time spent with documentation, and increase care time with residents and their relatives.

Creating supportive environments

A number of services and personnel were extensively discussed by staff and residents, as a means to create a supportive environment. Services included food and dietary services, gardening, maintenance and security, transport and the activity programme.

In 1988, the Health For All Committee identified that malnutrition accounted for 6 billion dollars in health costs. The provision of nutritious and enjoyable meals and professional dietary services in a retirement village helps to maintain residents independence, overall health and wellbeing, promote socialisation and contribute to their cultural and religious beliefs. Meal times may also contribute to family and community inclusion if the services were promoted. The Village café effectively provided this type of service and was recognised as important by both staff and residents. A number of staff at the Village were concerned with regard to dietary advice that was limited to nurses and not provided by a professional nutritionist. This could be overcome with specific nutrition and hydration guidelines being made available within aged care facilities, including review of the Standards that incorporate the need for services to comply with these guidelines. The RCS could also be reviewed to demonstrate the importance of dietetic advice and inclusion into residential care.

The gardening service by a qualified gardener also seemed beneficial, with the gardener having expertise in understanding design that prevents structural damage to buildings. The majority of residents reported the importance of having a garden but with an ageing population, it may appear beneficial for the gardener to commence

implementation of a programme that incorporates raised garden beds and sensory gardens as part of a therapeutic programme.

The Village also provided its residents with an excellent bus service, that helped maintain relationships between residents, although frailer residents were unable to use this service. The aged care provider had not discussed residents needs and abilities with staff or residents prior to purchasing a bus that has hydraulic steps and a storage area for wheelchairs and walking frames. This demonstrates poor communication processes and collaboration between stakeholders; communication processes are an important component to a health promoting setting. Transport services are important to maintain resident independence, maintain relationships and continue access to community services and groups.

The Standards appear to effectively recognise the importance of maintaining resident independence, nevertheless, there were suggestions in the Village that staff attempt to help residents too much. This may be as a consequence of the current Resident Classification Scale with providers considering that funding will be gained when services are provided to residents. Once again, there needs to be a reorientation from the current treatment model to one that focuses on preventive methods.

There is also some contradiction with regard to recognition of residents' individuality, with the Standards promoting individualised care whilst the RCS categorises residents as per their level of care needs. Categorisation further reinforces the negative attitudes and as acknowledged by Forsyth (1998) categorisation ignores preventive methods and individualised compassion.

Within the Village, there was enormous respect from residents for the services of the Village Nurses who provided both nursing care and emotional support. Nevertheless, one could hypothesise that with an ageing population, it would be ideal to offer a service similar to that offered by aged care facilities, whereby services and personnel are offered to residents in the retirement villages independent units. This may help maintain resident's independence whilst promoting ageing in place and reduce the strain on aged care facilities. Services however in both the facility and independent living areas need to be oriented toward complimentary therapies that will promote and foster positive ageing and quality of life.

Staff and residents also recognised the need for a counsellor to provide debriefing sessions, particularly at times of a resident death. This may also be a beneficial service to relatives. This service could be combined with educational sessions that teach staff effective communication skills and education for all stakeholders regarding death, dying and palliative care.

The provision of a continuum of care enabled residents to maintain friendships and contributed to positive relationships between residents and staff with staff likening residents to their family, using terms of endearment. These relationships were made possible by encouraging independent residents in their capacity as volunteers and also by the Village bus that transported residents to the facility and to all areas of the Village including the café, that offered residents the opportunity for socialisation as well as by maintaining their independence. The bus service also enabled residents within independent units to maintain an active social life that promoted relationships

both within the Village and within the community. It was however important for residents to move within the continuum of care at the time that they felt was right, thus increasing autonomy.

Strengthening community action

It could be said that the Village's level of social capital is high, particularly with the contribution made by the residents living within independent units. These residents are extensively involved in the volunteer programme, fundraising activities as well as contributing time to maintain relationships between each other and with residents in the facility. There were however few community groups involved within the Village, apart from those that were involved in the activity programme. It would therefore seem appropriate to foster both community and family participation. The Village's open day which only occurred on a yearly basis did provide the opportunity for the community to gain some understanding and insight into aged care, as well as being able to witness the residents contribution through the sale of their craftwork and so on. There is a need for co-ordinated action between aged care providers and the community to foster and promote community action that helps build social capital that is rewarding and participatory in nature for all to benefit. From the perspective of the Village, volunteers and the children from the local school were instrumental in this, but once again contact was initiated mainly by residents living within independent units.

The relationship between the local school and the Village provided a win: win situation whereby intergenerational learning was evident. There were some problems between the two groups such as blame being placed on the children for recent bouts of

vandalism. However, if education was available for both the children and the residents, this may have reduced the tension, highlighting the need to understand each other's weaknesses such as fear and anxiety as well as their strengths such as lifetime knowledge.

There were suggestions during the fieldwork and at various interviews that family inclusion is limited. There is a need for aged care to promote family participation including decision making and being kept involved and informed in the care of their parent. A number of actions could be undertaken to strengthen community and family action. Kellehear (1999) for example recognised the need for incorporation of support groups, and maybe this could be incorporated within the Standards. Offering education and training to staff, residents and their relatives, volunteers, community organisations and to the school children could also foster relationships and promote positive ageing and increase understanding and awareness. Social events could also be promoted to celebrate special occasions and to increase interaction and socialisation. Costs could be incurred through small donations.

Developing personal skills

The Ottawa Charter (WHO, 1986) recognises that:

Reorienting health services also requires a stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the needs of the individual as a whole person (p 2)

The Standards promote education and staff development throughout the four standards encompassing staff appraisals, staff orientation, an education programme that involves internal and external service providers and allocation of resources.

Nevertheless, aged care legislation neglects to include the importance of education for residents, relatives and volunteers. Within the Village, education was oriented toward clinical staff which supports the notion that aged care is medically focused. On review of the data, it is questionable whether the resources of time and money are sufficient to offer a varied programme for staff, residents and relatives.

The World Health Organisation's (1986) Ottawa Charter recommends that learning is important throughout life, enabling people to prepare themselves during illness or for life changes. One could suggest that for an older person moving from one's home to a retirement village's independent units or into an aged care facility is indeed another stage in one's life. Therefore the provision of education and health promoting programmes such as healthy ageing, nutrition, food safety and physical activity would be beneficial. Also with an ageing population, promotion of ageing in place, and the inevitable increase in dementia and decreased independence, health care expenditure is likely to increase, unless there is a refocus on the current system and further research into aged care, including dementia care. Kellehear (1999) recognised that "education, research and policy development" are key elements to reorient health "services towards a health promoting philosophy and service (p 40).

Offering specialised gerontology courses both within the community and in the education curriculum may promote positive attitudes toward the elderly and aged care and provide staff with specialist knowledge that would contribute to improved care and services.

Re-orienting health services

Sindall (2001) Kickbusch (2001) and Ziglio, Hagard and Griffith (2000) recognised that there has been a great deal of progress in health promotion since the development of the Ottawa Charter (WHO, 1986) some fifteen years ago, however there has been little progress on the notion of reorienting health services (Sindall, 2001 and Lopez-Acuna et al, 2000). With an ageing population and increasing health care expenditure, Lopez-Acuna et al (2000) provided a strong argument at the Fifth Global Conference on Health Promotion in Mexico for the reorientation of health systems and services. Lopez-Acuna et al (2000) recommended that the ‘element’ of the Ottawa Charter’s reorienting health services:

need[s] to be translated into a comprehensive framework and into a body of knowledge that guides and supports the implementation of change. . . Such an operational framework is vital for both the advocacy efforts in favor of the reorientation of health systems and services with health promotion criteria and for the incorporation of these areas of transformation into the country’s health sector reform agenda (p 2).

Various researchers such as Moore (1999) and Baron (2000) recommended moving beyond the medical model to one that offers a social environment or even a focus on hospitality. As acknowledged by Krothe (1997):

The traditional approach to the health care needs of elderly people is to define them within the confines of a medical problem and to offer services on that basis, a phenomena referred to as “medicalization of the life cycle” (Reinhard, 1986 cited in Krothe, 1997, p 217).

These issues described by Lopez-Acuna et al (2000) and Reinhard (1986) are important, however it is questionable under the current aged care legislation, including the Standards and the Resident Classification Scale, whether aged care can move beyond the current treatment model to one that is a health promoting setting. As noted by residents and staff at the Village, governments need to consider the views

and ideas from those working and living in aged care when reviewing and developing policy. It is acknowledged though that the Standards do promote education and staff development, and a supportive environment but does not necessarily promote healthy public policy or community participation. Although education is promoted, it is questionable whether staff have the time to participate and whether providers have the funding to offer an effective programme.

As noted by Kimble and Longe (1989), one goal of providing health promotion within a retirement village is to prevent “the development of disease and disability” for those residents who are living independently and for those who are living in an aged care facility to help prevent “further deterioration” (p 3). Offering health promoting programmes would require support both financially and from policy makers. This may be a more economically viable option than the current treatment model. This requires a reorientation of health care expenditure from the current curative model to one that provides holistic health promotion programmes as recognised by the Ottawa Charter’s action area reorienting health services that states:

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health (p 2).

Levi (1992) also stated:

Governmental action against social, environmental, and health problems is often of a troubleshooting and crisis-oriented nature and addresses only one problem or just a few specific problems at a time (e.g., providing meals, or housing, or medical care). . . More often than not, social and/or behavioral determinants of health problems are left unattended (p 282).

Overall, it is evident that aged care has undergone and continues to undergo profound change since the reforms, but documents such as the Resident Classification Scale and Standards require review since implementation in 1998. Policy could promote health promotion for residents, their relatives, staff and the community. These stakeholders could work in partnership with policy makers to promote wellness, foster relationships and reorient aged care services from a treatment model to one that promotes health and thus reduce the negative stereotyping attributed to aged care, reduce staff turnover, provide improved and increased services and promote education through school curriculum's as well as to the community and within aged care, but from a gerontological perspective.

I conclude with a quote from Moore (1999), whose philosophy I share:

As an advocate and practitioner as well as a researcher, . . . [I am] compelled to acknowledge a sense of social responsibility in creating and advocating the best therapeutic milieus possible, particularly for those who otherwise would have no voice in what can often be a cruel and unfair society (Moore, 1999, p 138).

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INTERVIEWS

Fieldwork guided by developing matrix – 3 areas – POLICIES, PRACTICES, and PEOPLE

Can you tell me about how long you have worked here and what your job/role is? How long have you lived in the Village?

Building healthy public policy	Creating supportive environment	Strengthening community action	Developing personal skills	Reorienting health services
What people are involved in policy development?	Are policies evident that demonstrate a supportive environment?	Are policies evident that suggests the community be involved in the rv?	What people are involved in developing and implementing education programmes?	What are relationships like between residents, staff, relatives and the community?
Do you consider there are limitations to current policy in aged care? → ageing in place → Accreditation → Standards/RCS	If so, what policies exist, and how best can they be implemented according to the various people (staff, residents, relatives, community) in the rv?	Is the community involved in the rv? If so, what organisations? How are they involved? (local council, NGOs)	Who attends education sessions?	Can relationships be improved? If so how best can this occur?
What are the strengths of current policy?	What practices exist to provide a supportive environment for all members of the rv?	What practices currently exist to promote community involvement?	Are the programmes suitable for your needs?	What type of people are involved in resident care and care planning?
Do policies reflect the needs of the whole rv community?	What people are involved in developing a supportive environment?	How can these practices be developed further?	What other type of education programmes would you see as beneficial?	
Are staff/residents involved in decision making activities?		Are there any type of support groups offered? Are staff encouraged to network?	Are there limitations or barriers that exist to prevent new skills to be achieved?	

