

RELOCATION TO A NURSING HOME: THE SIGNIFICANCE OF CULTURAL DIVERSITY

Submitted by

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A Thesis submitted in total fulfilment of the requirement for the degree of

DOCTOR OF PHILOSOPHY

SCHOOL OF NURSING & MIDWIFERY (VICTORIA)

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February 2009

ATTESTATION OF AUTHORSHIP

I hereby declare that the work contained in this thesis is my own work and that, to the best of my knowledge and belief, it contains no material previously published or submitted for qualification of any other degree or diploma at this university or any other institution of higher learning except where due reference is made.

Signature

Cecilia Akua Yeboah

Date.....

ACKNOWLEDGEMENTS

I wish to thank a number of people who have journeyed with me throughout the course of this study. Their encouragement and support have been very gratefully appreciated, more so than they will ever realise.

To my principal supervisor, Professor Barbara Bowers, my sincere thanks. Through Professor Bowers' excellent supervision and mentoring, I have not only learnt how to conduct research, but also to enjoy doing it. Her outstanding teaching skills have improved my knowledge about Grounded Theory immensely. Although we work kilometres apart, Professor Bowers has always been available when I needed her, regardless of day or time and both in my frustrating and exciting moments in this study. Her dedication to her teaching, her enthusiasm for guiding me to achieve my goals and her knowledge of research, particularly Grounded Theory, has been outstanding. With her never-ending encouragement, Professor Bowers' quality advice and feedback have been very helpful to me.

To my second supervisor, Dr Colleen Rolls, I am very grateful. With her untiring patience and understanding, Dr Rolls' clear guidance kept me on track, as she supported, motivated and inspired me throughout. Her eagle eye for a well-written sentence has been very helpful.

I am also indebted to my mentor, Professor Baffour Kwaku Takyi of University of Akron, Ohio. His encouragement and support saw me through some difficult times and I have much for which to thank him.

To my study mates in New Zealand, the United States of America and here in Melbourne, particularly Barb, Anne and Melanie, I will be forever grateful for your support.

Mr Jerome Winston, thanks for being such a great editor. I am still amazed by how you managed to find all those commas and full stops.

I wish to acknowledge with special thanks the participants who made this study possible. This is for you. Without your willingness to share your experience, there would have been no data to analyse. I sincerely hope that my appropriation and interpretation of your voices both honours you and extends the life of this crucial conversation.

Most thanks must go to my family – my dear husband, Kwame, my children, Kwaku, Amma and Kwabena - to whom I also dedicate this study. Without their loving presence, encouragement and support in so many ways, the long hours of toil that lie behind this thesis would not have been possible. Thank you!

ABSTRACT

Australian society is changing in its composition. People are living longer than previously which has led to increase in older people. Increased immigration during the past few decades has led to a significant increase in the number of older Australia residents who are both culturally and linguistically diverse (CALD). Also families, familial relationships and traditional support structures are altering.

These demographic changes have significant implications for the challenges that Australia faces with its ageing population. The longevity is partially due to advances in preventative and curative health care, as well as to improvements in living standards. Research suggests alterations to the structure of family life are also affecting care relations. As in many parts of the world, kinship-based security and intergenerational reciprocity are disappearing and are being replaced by publicly or privately organised systems of care for the elderly in Australia, thereby leading to an increasing need for Nursing homes.

The increase in the number of older adults from non-English speaking backgrounds, who are placed in nursing homes without giving adequate attention to the consequences of their culture or migrant status, is particularly challenging. Perceiving Australian society and local communities as multicultural and looking upon cultural diversity as important for health care, pose challenges for Australian health professionals. Cultural diversity is a prominent feature of the Australian health system and is impacting significantly on the quality of nursing care that is required, particularly in aged care.

Culture is a way of perceiving, believing, evaluating and behaving. A person's cultural identity is based on traits and values that are learnt during life experience associated with ethnic origin, religion, gender, age, socio-economic level, primary language, geographical region, place of residence and level of abilities and disabilities.

For this purpose, this study was set out to explore CALD elderly residents' experience of nursing home relocation.

Using a Grounded Theory and interpretive methodology, data was collected through progressive, semi-structured, repeated, in-person, individual interviews from residents of four nursing homes in the northern suburbs of Melbourne, Australia. Employing theoretical sampling, data was collected from 20 participants, five from each participating nursing home. The initial objective of exploring the participants' nursing home relocation experience shifted during the study to participants' experience from the beginning of the pathway to nursing home relocation. Four major categories emerged from the data: (i) losses experienced by participants, (ii) participants' responses to losses that they experienced, (iii) participants' experience on deciding to move and moving to a nursing home and (iv) how participants dealt with settling in and adjustment to the nursing homes.

This study found that it is not just the culturally specific things that allow people to feel connected to their old cultures but also those things, which all cultures believe are important. The study findings also indicate that whilst some residents found the nursing home relocation experience acceptable, many reported that things are done differently in their culture and that their expectations about old age have, for the most part, been influenced by their own cultural upbringing, making it somewhat difficult at times for them to accept the realities of their situation - that they live in a different culture.

The four nursing homes in the northern suburbs of Melbourne and the twenty participants studied constitute only a small proportion of all CALD elderly nursing home residents in Australia and therefore the findings could not be claimed as pertinent to all members of this group. Nonetheless, this study makes an important contribution to future discussions regarding cultural diversity in nursing home relocation of CALD elderly in Australia. The study findings provide some insight into the conditions and contexts that impact on nursing home relocation.

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1. CHAPTER ONE: INTRODUCTION

The focus of this study was on the significance of cultural diversity in the experience of overseas-born culturally and linguistically diverse (CALD) elderly persons in nursing homes. The term CALD was described by Jowett, (2008) and will be used extensively in this thesis to describe persons from culturally and linguistically diverse background. The literature on relocation of CALD people identifies three aspects of the experiences of these people in the process of relocating to a nursing home.

- The first is the general lack of understanding on the experiences of minority ethnic groups toward nursing home relocation experiences (Homan et al (2004).
- Secondly, the available literature on the nursing home relocation identifies elderly people's experiences in long-term residential placement and suggests that cultural differences exist in how ethnic groups view their nursing home relocation. (Nay, 1995).
- Thirdly, although there is a body of knowledge relating to the different challenges residents encounter after nursing home placement, there is a lack of in-depth knowledge about how minority ethnic groups experience life in long-term care, in particular, the meanings that members of these groups associate with their experience of relocation (Denermark & Ekstorm, 1990).

Understanding the meaning given to these relocations is important because understanding the “contextual realities and subjective meanings that shape people's interactions with their world” as Davis (1994) notes, is essential to effectively addressing the human dimensions of relocation to a nursing home. As will be developed in Chapter 3, there is a growing need in Australia for all health care providers to understanding how elderly and – in particular, CALD elderly – experience relocation to nursing homes.

Chapter 2 provides a review of significant research and theory development concerned with the provision of health care for elderly people who have special needs because of

their cultural backgrounds. None of the research that was located focussed specifically on the needs of CALD people who have relocated to a nursing home.

Extensive research will be needed to provide a basis for improving, monitoring and evaluating the relocation of CALD elderly to a nursing home. This thesis begins to fill this gap in knowledge by reporting the results of an exploratory study carried out in the Northern suburbs of Melbourne, Victoria, Australia, between June 2006 and November 2008. As discussed in Chapter 4, this exploratory study employs a specific research methodology – Grounded Theory Methodology (GTM) – to identify concepts and generate hypotheses about the meaning that CALD elderly give to their experiences – and the experiences of their caregivers – to their relocation to a nursing home. Additional research will be needed to confirm the extent to which the findings of this exploratory study, adequately and sympathetically, describe the meaning that CALD elderly give to their transition from more-or-less independent living to living in an Australian nursing home.

In this study, the Grounded Theory Methodology provided a conceptual framework that was used to plan, conduct and interpret the results of 57 individual interviews with a sample population of twenty CALD elderly residents in four nursing homes in Melbourne.

1.1 Contextual Background of the Study

According to the Australian Institute of Health and Welfare (AIHW, 2003), the demography of Australian communities is changing dramatically. People in Australia are living longer than previously, partially due to advances in preventative and curative health care, as well as to improvements in living standards. As more people live to an older age, there is a growing need for both formal and informal residential aged care facilities (RACF). Increased immigration in the past few decades has led to a significant increase in the number of older Australia residents who are both culturally and linguistically diverse (CALD) (ABS, 2004). These demographic changes have significant implications for the challenges that Australia faces with its ageing population. Many of the nation's institutions have been unable to keep pace with the need for increased services resulting from the demographic increase in both Australian and foreign born older Australian residents (AIHW, 2003). One consequence is that many older adults from non-English speaking backgrounds have been moved into nursing homes without careful consideration being given to the impact that their transition will have upon them, given their culture or migrant status (AIHW, 2003). This study was designed to explore the experience of a selected sample of elderly CALD people relocating to a nursing home.

1.1.1 CALD Elderly in Australia

Today, nearly one in four Australian residents is foreign born. In addition to being foreign born, many originate from non-English speaking countries. According to the Australian Bureau of Statistics (ABS, 2004), the proportion of Australian residents from non-English speaking backgrounds in the 70+ age group has more than doubled in the past twenty years from 11% to nearly 25%.

One change that we are seeing with respect to the elderly foreign-born Australian residents is related to their care and support. Over the next twenty years, the Australian Institute of Health and Welfare (AIHW, 2003) predicts that the residential and community aged care services sectors are set to experience unprecedented levels of demand for culturally appropriate services due to the increasing number of elderly CALD people.

The number of both Australian and foreign-born elderly requiring nursing home care is increasing. Overall, in just one year, between 30 June 2001 and 30 June 2002, the number of Australian residents in residential homes increased from 136,608 to 138,929. Of those, AIHW (2003) found, 52% (47,345) were for permanent care. Just over half of the residents in aged care services as of 30 June 2002 were aged 85 years and over (AIHW, 2003), while 68% were aged 80 years and over with the vast majority (73%) being female (AIHW, 2003). The population of people from non-English speaking backgrounds receiving permanent care as at June 2002 was found to be quite high: 53.0 per 1,000 non-English speakers were aged 75-84 and as high as 214.1 per 1,000 for those over 85 years old (AIHW, 2003).

Even though the representation of the CALD elderly in nursing homes is lower than that for Australian-born older adults in the same age cohort (AIHW, 2003), there is evidence that this trend may be changing due to social pressures experienced by families from non-English speaking backgrounds. For example, it has been observed that as a result of economic and other pressures on families, there are fewer women available in the home to care for these CALD elderly. Not surprisingly, AIHW (2003) reports that there has been a growing need for ethno-specific nursing homes for foreign-born older adults whose families can no longer look after aged relatives at home. While these facilities sometimes meet the needs of older adults from the larger ethnic communities they do not meet the needs of ageing people from smaller and dispersed ethnic groups (AIHW, 2003).

In recognition of the need for culturally appropriate residential care, many larger ethnic communities (Dutch, German, Italian and Chinese) have funded or raised funds to establish ethno-specific facilities and home based services in Victoria (AIHW, 2003). In order to meet the health care needs of these new residents from CALD backgrounds, Rice (1999) and Pauwels (1995) have stressed that it is important for policy makers to understand how the backgrounds and beliefs of these new Australian residents are reflected in the implementation of residential aged care services and how their needs differ from what 'mainstream' residential aged care has to offer.

There are several compelling reasons for health care providers and policy makers to focus research efforts on Australia's CALD population.

- Firstly, meeting the needs of increasing numbers of foreign-born elderly Australian residents will require careful policy planning and development. Effective aged care policies require reliable and relevant information about these 'new' citizens.
- Secondly, the number and backgrounds of the CALD elderly people have implications for both residential and community based care giving services and caregiver support. For example, variations in cultural and ethnic backgrounds may preclude the application of findings from one group to other groups. Indeed, there is currently recognition in the literature that aged care services needed by older people from culturally and linguistically diverse backgrounds may be different than those needed by Australian born older adults (Allotey & Reidpath, 2002).
- Thirdly, there may be needs for services that are specific to those at more advanced ages (particularly those 80 and over), when older people have a higher level of need for informal and formal care services. Of significance, is the finding that most aged people from non-English speaking countries find great comfort and security in their own cultural traditions, music, language, food, and religious observances (Pesenti, 1990).

Thus, to effectively address the needs of CALD people in Australia, policy makers, service organisations and health care providers need to understand the social context and backgrounds of CALD people and how their cultural backgrounds influence their needs for services and their experiences with relocation to residential aged care.

In response to this growing cultural diversity of the Australian population, the Commonwealth Government promoted an "Access and Equity Strategy" (A&E, 1997) was designed to ensure people from non-English speaking communities, Aboriginal and Torres Strait Islanders and all groups who may face barriers of race, religion, language and culture, benefit equally from Government funded programs and services.

Some nursing homes have established clusters of three or more aged residents from the same language and cultural background, recognising that the more residents there are from the same language group, the easier it is to justify employing bilingual professional and domestic staff (AIHW, 2003).

1.1.2 My Own Background

...experience and knowledge are what sensitize the researcher to significant problems and issues in the data and allows him or her to see alternative explanations and to recognize properties and dimensions of emerging concepts (Strauss & Corbin, 1998, p 205).

The impetus of study came from my own migrant and professional backgrounds. I migrated to Australia from Ghana about 18 years ago as a young nurse with postgraduate qualifications in Midwifery and in Psychiatric nursing.

Since my arrival to this lucky country, I have achieved a lot in both my social life and career, thanks to pioneers (nurses and migrants). Socially, I have been married and have had three beautiful children. Although the children are being brought up under the values of both the culture of my home country and that of Australia, they are mainly exposed to what happens or what they see happening in Australia, as they have only been to Ghana twice. Professionally, I have added a few important areas to my list of qualifications such as health management, education, and aged care nursing.

My professional achievements and my experience as an aged care nurse and educator have been the major influences of this study, which, I hope, will enable me to contribute to and continue the good work that I have so much benefited from and which has brought me this far.

Another benefit that I bring to this study is how I see myself as an older person in the near future. My children have adjusted well to the Australian culture and way of life. My husband and I have not planned on returning to our home country when we get older.

Knowing the difficulties and the responsibilities involved in bringing up a family and working to support them, I can easily see the difficulties my children may face when my husband and I need to be looked after in our old age. Consequently, I anticipate that our relocating to a nursing home will be the most appropriate choice. This study might help prepare aged care services for both of us, as well as the rest of the migrant population in Australia, when our time comes.

In a Grounded Theory study, Strauss and Corbin (1998) acknowledge that the researcher brings a considerable background in professional and disciplinary knowledge to an inquiry. Thus, according to GTM, the extent to which I, as the sole interviewer-researcher for this study, am able to understand and interpret the content of my 'discussions' with the participants, may be influenced by how I have experienced my own 'cultural diversity' and my own 'relocations'. My ability may have also been limited by the extent to which my understanding of my experience was different from how participants reported that they had reacted to a similar experience. Throughout the process of data collection I was conscious that I would have been regarded by research participants as someone who is a member of a minority culture within the Australian context, just as they are. Hopefully, my training and extensive experience in nursing prepared me to identify these differences and avoid projecting my personal understanding into the stories that I was hearing.

1.2 Problem Formulation and Research Questions

1.2.1 Study purpose

To develop knowledge that is perceived as relevant and useful to policy advisers and service providers who seek to improve the quality of life of CALD elderly residents of Australia who require some form of aged care.

1.2.2 Study Objective

The main objective of this study is to discover the extent to which relevant and useful information can be obtained using Grounded Theory Methodology to explore how Australia's overseas born CALD elderly experience relocation to a nursing home.

1.2.3 Research Questions

The broad research question that provided the overall focus for data collection and analysis was:

What has been the significance of cultural diversity in experiences of a selected panel of CALD elderly in their relocation to a nursing home?

This broad research question was divided into four more narrowly focussed questions:

- How do selected older CALD Australian residents experience relocation in selected locations in Melbourne?
- How, if at all, did these residents and the researcher perceive their cultural heritage as influencing to their experience?
- How do older CALD adults respond to their experience of relocation?
- To what extent can exploratory research using the Grounded Theory Methodology contribute to the development of relevant and useful conceptual frameworks and hypotheses that can inform the development of policies and practices associated with the relocation to a nursing home (or other aged-care services) of overseas-born (and other) CALD elderly.

1.3 Application of Grounded Theory Methodology to Answering Research Questions

As exploratory research, by definition, the problem under study is not fully conceptualised prior to data collection. Rather, one objective of exploratory research is to clarify the conceptual frameworks that enable a researcher to describe the problem under study. Creswell (2003) identifies three approaches to exploratory research, one of which involves identifying the extent to which a chosen methodology contributes to clarifying conceptual frameworks and generating hypotheses for further study. In this exploratory study, Grounded Theory Methodology (GTM) has been employed to answer three specific research questions (see above) regarding the relocation of CALD elderly to a nursing home.

In GTM the researcher does not attempt to define the research problem too narrowly in advance, as the GTM approach to data collection and analysis requires that the focus of each cycle of research – as much as possible – emerge from ‘discussions’ that are held between the researcher-interviewer and the interview subjects, who are known in this study as ‘participants’ in order to emphasise the inter-personal nature of the interviews. A more detailed formulation of the research problem emerges as one of the results of applying the GTM, rather than being more specified at the commencement of the research. In other words, the focus of this research was deliberately broad at the start of the research process, as the researcher could not know in advance how interview participants would attribute meaning to their self-reported experience.

The interviewer-participant remained open to the data provided by the “participants” (Strauss & Corbin, 1990). It is hoped that by having the interviewer remain open to the structure and content of the interviews, participants will feel more able to direct the course of the discussion-interviews and express thoughts and feelings that they might otherwise have withheld.

1.4 Significance of this Research

The literature reports on the cultural difficulties women experience in the institutional maternity care system in Australia. Women have reported experiencing insensitive care, cultural misunderstanding, particularly related to food, hot/cold beliefs and the cultural care a post natal woman should receive (Small et al, 1997).

It is not known if these same difficulties arise for elderly CALD persons in nursing homes as the existing research has not addressed the significance of residential cultural care. Culture as defined by Bodley (1994) is a way of perceiving, believing, evaluating and behaving. A person's cultural identity is based on traits and values that are learnt as part of ethnic origin, religion, gender, age, socio-economic level, primary language, geographical region, place of residence and disabilities. Perceiving society and local communities as multicultural and looking upon cultural diversity as important for health care pose a challenge for Australian health professionals.

Bodley (1994) points to the notion that culture is constituted by, and in turn constitutes, local worlds of everyday experience. Thus, the locus of culture is not to be the mind of the isolated person, but the interconnected body/self of groups: families work settings, networks and whole communities. In local worlds, experience is an interpersonal flow of communication, interaction and negotiation that is social and not individual (Bodley 1994). The goal of the Australian health care system is to provide optimal care for all patients (Australian Institute of Health and Welfare (AIHW, 2003). In a multicultural society like Australia, this can be accomplished only if health care providers understand why people from CALD backgrounds behave differently to a diversity of experience. When cultural beliefs and practices are not appropriately identified, the significance of behaviour may confuse the nurse and result in the delivery of inappropriate care. These cultural behaviours are a result of adaptation to both the physical and the social environment. Providing high quality care for older people of diverse cultural and linguistic backgrounds in nursing homes; the role of cultural differences including language, social roles, spiritual beliefs and practices and expressive ways of dealing with experience related to loss of objects, relationships, persons and identity due to relocation into a nursing home, must be understood.

1.5 Structure of the Thesis

The thesis comprises eight chapters:

- Chapter One opens with an introduction to the research focus, the contextual background, significance and nature of the study.
- Chapter Two reviews the literature of the subject areas, which have Impact on relocation to residential aged care in both Australian and international contexts. Additionally, I present the definition and classification of relocation and a review of Cultural Impact of Ageing; the role of family caring for CALD elderly persons, and the consequences of relocation into long-term care in the chapter.
- Chapter Three, describes the Grounded Theory Methodology; the philosophy behind it and discusses its application to the research process.
- Chapters Four to Seven provide the findings of this study as organised in emergent categories, which are presented corresponding with the pathway to nursing home relocation.
 - Chapter Four explores the losses the CALD elderly experience that lead them to considering options and offers of care.
 - Chapter Five explores the processes of the search and selection.
 - Chapter Six explores the experience of moving into a nursing home.
 - Chapter Seven describes strategies, which the CALD elderly nursing home residents use to adjust and settle into the nursing homes.
- Chapter Eight discusses the findings of the study and provides an outline of the conclusion that I have reached. Options for future research, the implications for aged care nursing practice and education are considered and limitations of the study's conclusions, together with recommendations, are reviewed.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

While it was considered that Grounded Theory study should be based exclusively on data collected from the research (Glaser & Strauss, 1967), Strauss & Corbin (1998) acknowledge that a prior understanding of the literature can be used effectively in developing theory. The authors identified that, concepts derived from literature may provide a source for comparing data at a dimensional level enabling the researcher to identify and compare in terms of their properties and dimensions. Familiarity with relevant literature enables an enhanced sensitivity to subtle nuances of data and increases the awareness of the researcher as to what to look for, including which questions to ask participants (Strauss & Corbin, 1998). The literature can also be used to confirm findings and determine situations where the literature may be incorrect, over simplistic and only partially explaining the phenomena (Strauss and Corbin, 1998).

This chapter provides a review of (and identifies gaps in) published literature regarding relocation of older people into various types of aged care in Australia and else where.

A literature search using MEDLINE, CINAHL (Cumulative Index for Nursing and Allied Health Literature), Psychological Abstracts, Google Scholar, Yahoo, Pub med was conducted with a combination of keywords: “relocation”, elderly”, “nursing home” “ethnic elderly” and “Australia”. Limiting the search to the elderly produced 121 publications. The “short-abstracts” for each of these publications were subsequently examined to determine their applicability for review in this study. Relevant studies were defined as those that included any discussion about the relocation of the elderly. Studies did not have to include relocation as their main focus, although with relatively few exceptions, this was the case. The issue of relocation was found to have been addressed in the mental health literature, but most of these publications did not particularly examine elders only as they tended to concentrate on dementia sufferers; therefore, they were not included in this review. After excluding these, I was left with 78 publications that were deemed relevant to my study. In addition, I also examined the citations used in each of these 78 publications for the period of interest; 1980-2006. In 2008, another literature search was done but I came out with no new articles.

The review gives particular attention to the experience of relocation, including the extent of changes involved and the consequences of these changes. The review concludes with a summary of strategies in place for relocation for CALD elderly people in Australia and elsewhere.

The main themes in this review are summarised below with a focus on the definition, types and causes for relocation. Furthermore, I reported on what the literature said about relocation experience, its extent and consequences and current strategies in place for relocation of CALD elderly persons.

It needs to be noted that a number of interchangeable terms are used in this review of the literature to describe CALD persons. Terms used include overseas, foreign born and non-English speaking persons. The terms used are reflective of the literature reviewed for this study.

The literature accessed for this study relating to cultural attitudes of caring for CALD elderly persons is diverse. Owing to minimal literature in the Australian context being available relating to the aims of the study, literature accessed is global in perspective. Consequently, the literature reviewed reflects European, Asian and African elderly persons' cultural aspects of care.

2.2 Relocation

According to Johnson (1996), relocation involves the movement from one location to another. Borup (1983) identified four types of relocation of the elderly person: (1) Inter-institutional; (2) Intra-institutional; (3) Residential and (4) Residential or institutional. Inter-institutional relocation involves the movement from one institution to another. Examples include transfers to and from hospitals, psychiatric facilities, rehabilitation facilities and continuing care retirement communities (Willcocks et al, 1987; Johnson, 1996). In contrast to inter-institutional relocation, intra-institutional relocation involves movement within a facility, for example, movement from one room to another, from one unit to another, or from one floor to another. The third type of residential relocation, involves movement from one residence to another or from one home to another. The fourth type of residential or institutional relocation involves some combination of the first three types and often involves movement from residence to an institution or vice versa. Examples of the latter include the movement from a home to a long-term care facility, such as a nursing home.

Of the four types of relocation identified in the literature, Pesenti (1990) indicates that the one that has a greater significance culturally involves a move from a culturally relevant home setting to a less culturally relevant institution. Of interest to this study is the fourth type as most residents in nursing homes in Victoria enter the facility from home (Nay, 1995). Relocation from home to aged care residence, as described by Rosswurm (1983), is often preceded by declining health, financial problems or death of a spouse and has been widely studied. Among the causes of this type of relocation, it has been found that residential aged care placement usually occurs at a time of distress and crisis, such as following an acute illness or hospitalisation (Chenitz, 1983; Willcocks et al, 1987; Johnson, 1990; Retsinas, 1991).

The Australian aged care system provides a cohesive framework of community, residential and family care that makes available high-quality and cost-effective services appropriate to assessed need.

The Australian aged care system involves unique partnerships among government, private and non-profit enterprises and among medical, health and welfare services (Australian Commonwealth Government Department of Health and Aged Care, 2005).

Many types of government and privately funded RACF exist in Victoria. They operate under Federal and State Government accreditation standards of care (AIHW, 2004). Government funding provides older Australian residents access to care services that are appropriate to their diverse needs and both public and private contributions are required to meet the needs and aspirations of elderly people. However, the standard of care provided in mainstream nursing homes is already considered to have insufficient funding to be able to include cultural aspects of care such as food, music, religious observances, etc., thereby resulting in a lack of funding specifically for cultural care in nursing homes (Lyll, 1989). Although government policy supports cultural nursing home, the reality is that, the support does not happen because of funding shortfalls.

2.3 The Consequences of Relocation into Long Term Care

As Garrett (1987) found, some elderly people experiencing major life changes relive past distressing experience such as war, persecution and separation, while others will retrieve happier memories of other lands and places where they were born.

Both of these findings have important implications for care of non-Australian born older adults. While many older adults who relocate to residential aged care may experience distress, Garrett (1987) argues that such challenges may be exacerbated for immigrants, as they may have fewer ties to their new communities so that their relocation distress may be compounded by their earlier experiences of being uprooted from their country of origin. Similarly, McKinney & Melby (2002) have suggested that each additional relocation after migration to Australia may be particularly problematic for those who are less fluent in English or who have little social support from family members.

Many researchers have found that the relocation of older people into long-term residential aged care is often accompanied by multiple losses (Gibson et al, 2001).

Holman et al (2004) contend that entry into a nursing home involves many losses, in particular those created by separation from community such as loss of identity, role and familiar environment.

While such losses are important for their own sake, Holman et al (2004) suggest that relocation is among a complex set of losses that has implications for the older persons' health, attachment to others and their perception of proximity to their own mortality. Indeed, while some have argued that the loss of a loved one through death or divorce is unquestionably a life shattering experience, the losses related to relocation may be equally devastating. These losses may include, for example, the loss of friendship ties, familiar neighbourhoods and community identity associated with where they lived and in which they were familiar. Not surprisingly, Davis (1994) has observed that loss for the elderly may be much more difficult than for other groups. Even though changes and loss are stressful at any age, changes experienced by older adults tend to follow each other in rapid succession, often leaving the elderly little time to adapt to one before facing another.

In addition, whereas many elderly people have learned to adapt to change throughout their lives, they are often without the resources, vigour and supports, which were available to them in earlier years (Davis, 1994).

Other identifiable effects of relocation that have been reported are the loss of home, the loss of familiar care givers and environment (Garrett (1987) and Davis (1994) found that the intensity of this loss experience varies with the individual and the individual's place in the life cycle, specifically whether one is in the early, middle or later stages of ageing. For instance, the younger adult is more likely to respond by adapting quite well. Of those who experience difficulties, according to Davis (1994), some become depressed but respond quite well to treatment. Researchers have for a long time been looking at potential additional problems like mortality, psychological decline and depression,

specifically related to relocation and have identified effects such as transfer trauma, relocation stress and relocation shock to describe the effects of relocation on some older adults (Cohen-Manfield, 2000; MacKinney & Melby, 2002; Rosswurm, 1983).

A study by Coffman (1981) found that the stress of moving to a care facility was not so much due to the move itself, but rather to emotions associated with the change, particularly emotions associated with concerns about the quality of care that they would receive and the extent to which social support would be available after the move.

Nay (1995) reported the ways in which older people deal with their residential care experience vary and may depend on a number of choices and approaches used by care givers. Nay concluded that older people's perceptions of loss were related to the absence of objects and symbols associated with their past. A similar conclusion was reported by Denermark & Ekstorm (1990): older people's loss of attachments to their past, such as their homes, often leads to their feelings of insecurity, lack of control and personal identity. These feelings, the authors assert, have a tendency to cause the elderly person's suffering and anxiety. Thomasma, Yeaworth & McCabe (1990) found that losing their independence and ability to maintain privacy, causes anxiety and stress for nursing home residents.

Factors such as: the older person's unique life history, transfer circumstances, a belief that the new place is their only choice, the match between themselves and the facility environment has been correlated with how well residents deal with relocation. Thomasma, Yeaworth & McCabe (1990) suggested that experience before placement, such as a limited role in making the placement decision and feelings of abandonment by the family members, further reinforce negative feelings of older people about relocation.

As a result, Young (1990) contends that new residents may go through changes by assuming their awareness of the changes in their abilities. Thus, they are capable of living healthy and financially independent lives and are able to contribute to their families and the society.

How well older people resolve these demands and become members of the residential home community, is referred to as adjustment (Brook, 2004; Cram & Patton, 1993). Nay (1995) has classified residents' perception of different losses following placement as abstract, material and social. Abstract loss, according to Nay (1995) and Wilson (1997), includes loss of role, lifestyle, freedom, autonomy and privacy.

Furthermore, as identified by Fiveash (1998), loss of privacy and autonomy associated with regimentation of daily living to meet the demands of group living are major factors in adjusting to residential care. Nay (1995) found material loss on the other hand, to be loss of home and personal belongings. In another context, Peterson (1999) identified social loss as related to loss of friends, family and pets. Based on these findings, it is therefore important to understand how elders deal with such relocation experiences.

Social support and adaptation to unfamiliar settings are particularly pertinent when the elderly population includes a sizable proportion of overseas or foreign-born people whose culture and language skills are often different from those of the majority of Australians. Even though the deleterious outcomes of admission to nursing homes have received some attention in the literature, the same cannot be said about studies that look at the experiences of such admission. The demographic changes reported above present our society with a number of challenges, especially in the provision of quality health and residential care for CALD adults. While there have been attempts to address the needs of Australia's CALD people by Federal authorities, little is known about the experience of the CALD elderly, as they use health and supportive services. For the most part, minimal research has explored the experiences of CALD residents in nursing homes. Nay (1995) and Fiveash (1998), suggest that the CALD elderly differ from other older Australians in residential aged care, but little is known about how they differ.

As Garrett (1987) argues, the problems that older relocated elderly face may be compounded for immigrants as they may have fewer ties to their new communities, and less language capacity. Thus, it is important to focus attention on the growing foreign-born older Australian residents and how they cope with the experience of relocation.

2.4 Cultural Impact of Ageing: The Role of Family Caring for CALD Elderly Persons.

The terms 'old', 'older people' and 'elderly people' are often used as general descriptions of those who have passed a certain age. Even though who is considered an old person varies from culture to culture, researchers tend to chronologically distinguish between those people over 60 or 65 and classify them as aged (Brubaker & Power, 1976; Johnson, 1990 and Freund, 1997, Gorman, 2000). In the same way, one can look at different levels of ageing: the young age, the middle aged, and those over 80. While the definition of social differs from society to society, from early childhood, we all grow up in a culture that has various images of different age categories, and we learn the characteristics that are associated with these different gradations (Gorman, 2000).

According to Saraswathi & Pai (1997), from early childhood, we grow up in a culture that has various images of different age categories and we learn the characteristics that are associated with these different categories. The imagery of different age groups, Saraswathi & Pai (1986) state, is a cultural product.

Different cultures give different values to old age and these values can affect and are also reflected in the care, treatment and views of the elderly (Diop, 1989; Deka, 1993; Saraswathi & Pai 1997; Hurwicz, 1995).

In a majority of African societies, Diop (1989) found that old age is viewed as a sign of divine blessing and that in a number of African languages the elder is the 'big person'. Some African women who reach middle age experience the removal of restrictions in an often gender-typed society (Akukwe, 2008). According to the author, as African women reach middle and old age their status and power is approximately the same as the men.

Akukwe, (2008) and Togunu-Bickersteth, (1987), states that in traditional Nigerian society care of the ageing is provided within the extended family system, which has been ingrained in the culture of the people. For many elderly people, the later years are

usually the most fruitful years of their lives (Akukwe, 2008). The author adds that it is culturally imperative for children to support and respect the aged.

Cultural values play a role in the care of the elderly in most Asian societies. Holmes & Holmes (1995) describe a Confucian emphasis on filial piety, which requires that all family members respect and obey elderly family members. In Japanese society for example, according to O'Leary (1993), the concept of '**on**' permeates. O'Leary states, '**on**' is the norm of reciprocity and plays a role in describing Japanese relationships where a favour or benevolence is granted by person A to person B. The resultant debt is that person B owes person A. Thus, children care for their ageing parents reciprocally, as payment for previous care and essentially what they have become (O'Leary, 1993).

In Indian society, elders are respected for their wisdom. They are viewed as authoritative, protective and nurturing and are depended upon to provide emotional and social support (Deka, 1993). Looking after parents is considered '**punya**', or earning merit in the after life. There is also a belief in the need for interaction with the elderly in order to transmit traditional values such as sharing, caring and patience to the younger generation (Deka, 1993; Saraswathi & Pai, 1997). Old age is regarded as a period of 'rightful dependency' with the support of the extended family and in particular, adult sons. The elderly remain active, albeit perhaps taking on different activities. In India the elderly control family wealth and power, arrange marriages and counsel younger people. Old age often involves a movement toward greater spirituality and religious involvement and fewer household obligations (Holmes & Holmes, 1995).

The Chinese value a long life. Traditionally, Chinese elderly were referred to as sage, venerable counsellor and seer (Yu & Wang, 1993). Confucianism has played a role in the care of ageing parents. Caring for the ageing is significantly impacted by Confucian principles about family and relationships. Parental control, obedience, strict discipline, filial piety, respect for elders, reverence for tradition and maintaining harmony are all attributed to the influence of Confucianism.

Care for ageing parents is a source of pride, and children who neglect their parents are looked upon with shame (Angel & Angel, 2006). Confucians believe that bonding to the parents is morally imperative (Chui, 2000; Wei-Ming, 1994).

In Islamic society, age has been found to command authority. Honour and respect for the elderly is emphasised in the Qur'an. It is assumed that families will look after the elderly. Traditionally, elderly parents live with the eldest son (Luna, 1989). The thought of 'putting one's parents in a nursing home' is not acceptable to Muslims according to Spector (1991). Muslim families do not abandon their elderly or sick no matter how impractical the demands and responsibilities for their care (Spector, 1991). Elkholy (1981) noted that in the Middle East the elderly gain status and do not experience the loss of self-esteem or self-worth that often occurs in Western culture.

2.5 Conclusion

Previous research indicates that cultural differences exist in how ethnic groups view their relocation. While there has been some attempt to research the needs of Australia's CALD people, for the most part, very little has been done to explore the experience of CALD residents in residential facilities.

CHAPTER THREE: METHOD AND METHODOLOGY

3.1 Introduction

The objective of this study was to explore the nursing home relocation experience of culturally and linguistically diverse (CALD) elderly in the northern metropolitan region of Melbourne, Australia. As explained in this chapter, The Grounded Theory Methodology was selected for data collection and analysis. The chapter is divided into two sections. Section one discusses the research approach, methodology and the methods used for data collection, data analysis and data management for this study including:

- Research framework
- Justification of using an interpretive research paradigm.
- Overview of the Grounded Theory methodology (GTM)
- Rationale for selecting GTM from the range of interpretive research methodologies,
- Symbolic Interaction (SI), the theoretical perspective that underpins the Grounded Theory methodology
- Research questions and SI perspective
- Methodology
- Data collection
- Data analysis

Section two provides an in-depth description of the study process using the selected methods and methodology described in section one. The section also addresses ethical consideration, details of the research sample; as well as the process for accessing participants and entering the field. In addition, the data gathering and analysing techniques utilised and the procedures undertaken to ensure rigour are described.

3.2 Section One: Selecting the Research Methods and Methodology

The design of a research study begins with the selection of a topic and a paradigm (Creswell, 2003.) The researcher requires an understanding of the underlying assumptions behind 'valid research' in order to justify the methodologies and methods to be employed in the research design (Myers 1997, Creswell, 2003). Crotty (1998) identified that, justification of the methodological choice should relate to the theoretical perspective that underpins the research paradigm.

Following Crotty, (1998) Creswell, (2003) and Myers (1997), the methodology and methods used for this study were selected in response to three questions:

- Which paradigm is most consistent with the chosen research question?
- Which methodologies are consistent with the paradigm and the research question?
- Which of the methodologies consistent with the paradigm are most appropriate for the research question?

In order to establish a clear framework for explaining the stages in this study, a summary depicting the four element of research design set out by Crotty (1998) was adopted to answer these questions.

3.2.1 Is Research Paradigm Consistent with the Research Question?

Research as described by Mertens (2005), is a systematic investigation or inquiry through which data are collected, analysed and interpreted in some way in to "understand, describe, predict or control an educational or psychological phenomenon or to empower individuals in such contexts". However, Mertens identifies that the exact nature of research is influenced by the researcher's philosophical stance, in turn informing the methodology and thus providing grounding for its logic and criteria.

Research paradigm is defined as a set of basic beliefs and principles that represent a "world view that defines, for its holder, the nature of the world", the individuals placed in

it, and the range of possible relationships to that world and its parts". (Guba & Lincoln, 1994, p.107).

The paradigm contains the researcher's ontological and epistemological premises, which affect the questions the researcher asks and the interpretations she or he brings to those questions (Denzin and Lincoln, 2003).

Crotty (1998, p10) defines Theoretical Perspective as the philosophical stance informing the methodology and thus providing a context for the research process. Social researchers identify three main paradigms, i.e. positivism, interpretism and critical theory/postmodernism (Beck, 2004; Creswell, 2003; and Crotty 1998).

Research which applies the positivist paradigm, tends to predominantly use quantitative approaches (methods) to data collection and analysis, though not necessarily exclusively, while the interpretivist/constructivist paradigm generally operates using predominantly qualitative methods (Silverman, 2000; Mertens, 1998; Becker 1993 and Burns, 1997) The critical theory/postmodernism paradigm provides an opportunity for "multiple methods, different worldviews, and different assumptions, as well as different forms of data collection and analysis in the mixed methods study" (Creswell, 2003). For this study, an interpretive paradigm was considered most appropriate.

3.2.2 Rationale for Selecting the Interpretive Paradigm

Selection of the research paradigm was based on the purpose of the research and the interpretive paradigm's suitability for exploring the research questions. This study began with a general interest to explore the relocation experiences of CALD elderly in nursing homes. Of particular interest was the significance of cultural diversity. The research questions were:

- How do selected older CALD Australian residents experience relocation to a nursing home in selected locations in Melbourne?
- How, if at all, did these residents and the researcher perceive their cultural heritage as influencing their experience?

- How do older CALD adults describe their experience of relocation to an interviewer?
- To what extent can exploratory research using the Grounded Theory Methodology contribute to the development of relevant and useful conceptual frameworks and hypotheses that can inform the development of policies and practices associated with the relocation to a nursing home (or other aged-care services) of overseas-born (and other) CALD elderly.

Answering these questions required a research design and methods of data collection and analysis that accessed the meaning of experience from an insider's viewpoint.

Ontologically, the research question assumes a relativist view, a fluid definition of suggesting an interpretivist/constructivist paradigm and methodology as most appropriate. Epistemologically, the study requires a methodology that can access the subject experiences of people living the process, to understand participants' and how they are shaped.

3.2.3 Selecting a Methodology

As Gibbs (2002) states, interpretive methodologies are based on the assumption that people are constantly interpreting the events in their lives, making sense of the world around them, and acting in response to those understandings. As I was interested in understanding how CALD elderly interpreted a particular event in their lives and how they made sense of the moved to long term care, this seemed to be a good fit. Interpretive methodologies are appropriate when the goal is to better understand any phenomenon about which little is yet known, and to gain new perspectives on things about which much is already known, or to gain more in-depth information that may be difficult to convey quantitatively (Strauss and Corbin, 1990; Crotty, 1998). We know very little about the experience of relocating to a nursing home, for any elder, but particularly for CALD elderly. Theory testing research would presume a greater knowledge about the experience of CALD elderly, in order to determine the appropriate theories to use. Therefore, this study did not aim to test existing theories, but to discover new insights

into the relocation experiences among culturally and linguistically diverse (CALD) residents in long term residential aged care facilities.

3.2.4 Rationale for Selecting Grounded Theory from the Interpretive Research Methodologies.

Carson et al (2001) suggests that three characteristics are required of a research problem in order for Grounded Theory to be applicable. The first of these is that the research should be interpretive.

The second is that, the research should be about complex social processes. As Bowers (1988) argues, Grounded Theory methodology can be used to examine how people act on the basis of their interpretations of events that occur in their every day lives.

Research questions were designed to explore the complex social process of relocating to residential aged care. Choosing the GT methodology would allow me to explore aspects of life as it was experienced by CALD elderly living in nursing homes by adopting a systematic method to study their experience of relocation. GT would also allow me to capture the participants' experience and derive a general theoretical framework that could help to describe the complex interactions and meanings associated with the experience of relocation to long term care facilities. Another reason why I chose GT is that, being a novice researcher, the methodology of GT, which are designed to develop a well-integrated set of concepts that provide a systematic and thorough theoretical explanation of the social phenomenon under study, will give me clear directions as opposed to ethnography, phenomenology and action research that do not generally provide much guidance and are less systematic.

The following is a brief overview of (GT) as a research methodology, a discussion of (SI) the theoretical framework underpinning the GT methodology and a description of its relevance for my research questions.

3.2 5 Overview of Grounded Theory (GTM)

Developed by Glaser and Strauss (1967), the Grounded Theory has been refined by Glaser (1978), Strauss and Corbin (1990), Schatzzman, 1991, and recently, Charmaz (2000), Clarke (2004) and Bowers (2009). The GT evolved into three main approaches: the 'emergent approach' of Glaser, the 'systematic approach' of Strauss and Corbin and the 'constructivist approach' of Charmaz, Clarke, Schatzman, and Bowers (2009).

While it is well beyond the scope of this discussion to review or contrast the different approaches of GT, it is important to note that fundamental to each is a commitment to empirically grounded discovery of theory, (such that theory 'emerges' from the data 'readily (not forcibly)' (Glaser & Strauss, 1967, p. 3),

This step-by-step approach of data collection and analysis of GT was a good guide for to stay focussed. According to Miller & Fredericks (1999) Strauss and Corbin's (1990) method of GT is seen as being essentially the clearest theoretical exposition of this important research tradition.

This study followed the Strauss and Corbin's systematic approach of Grounded Theory. The GT approach, according to Strauss and Corbin (1998), consists of a set of steps whose careful execution is thought to 'guarantee' a good theory as the outcome. It is imperative to consider the theoretical perspective and the theoretical basis of Grounded Theory, Symbolic Interaction (SI) in order to understand GT.

3.2.6 Symbolic Interactionism: The Theoretical Perspective

The theoretical underpinnings of the Grounded Theory method can be traced to the ideas of George Herbert Mead (1863-1931) Herbert Blumer, and others. At the core of Mead's arguments is the notion that human beings have a sense of self that develops through interaction with others. Mead believed that, in order to understand human behaviour, it is necessary to understand the meanings that external stimuli hold for people. Thus Mead saw individuals as acting in a social context in which meaning is ascribed to objects and actions, basing their actions on those constructed meanings.

Indeed, Mead believed that the constructed meaning systems provided the key to understanding the link between individuals and society.

The notion of constructed meaning and its influence on social behaviour is the central and critical idea in the symbolic interactionist position. Humans' interactions with the world are mediated through meaning making and interpretation (Blumer, 1969). This understanding of the role of meaning and interpretation in social behaviour was further articulated by Herbert Blumer, one of Mead's students at the University of Chicago. According to Blumer (1969), three premises underpin symbolic interaction as a theory. The first is that human beings act out meanings of daily events. Secondly, that human beings arrive at these meanings through interaction with others. Thirdly and finally, that those meanings change and adapt as different events or aspects of an event emerge (Blumer, 1932).

Like Mead, Blumer focussed on the concept of self and our social psychological experience. It is this ability to hold a concept of who we are and to take action in light of our view of ourselves that forms the basis for the formulation of meaning and experience. Thus, social and physical objects are defined by a person's interaction with them and in light of their view of who they are. Once these objects are defined, they then become imbued with meaning and value. Consequently, according to Blumer (1969), people's actions towards the objects in their world are sensible in light of the meanings and values these objects hold for them. These meanings and values lead to self-directed behaviour. Further, because the self is always subject to re-interpretation, one's definition of the self can change. For example, new experience has the potential to change the sense of self, change the meaning of objects and thereby lead to changes in behaviour.

3.2.7 Symbolic Interaction (SI) and My Research Questions

As previously stated, the broad research question that provided the overall focus for data collection and analysis was: What is the experience of relocating to a nursing home for overseas born older people from culturally and linguistically diverse background.

This broad research question was divided into four more narrowly focussed questions, which are:

- How do the selected older CALD Australian residents experience relocation to a nursing home in selected locations in Melbourne?
- How, if at all, did these residents and the researcher perceive their cultural heritage as influencing to their experience?
- How do older CALD adults respond to their experiences of relocation?
- To what extent can exploratory research using the Grounded Theory Methodology contribute to the development of relevant and useful conceptual frameworks and hypotheses that can inform the development of policies and practices associated with the relocation to a nursing home (or other aged-care services) of overseas-born (and other) CALD elderly.

Blumer (1969) holds that the basic premises of SI are: “social reality is a social production, and humans are able to guide and shape their own and others' behaviour as they manipulate symbols, words, meanings, and languages” (Charon, 2003, p.60). For example, cultural groups understand themselves based on patterns of intertwined beliefs and lines of action that express common meanings of various social objects. Cultures are constantly evolving in response to changes in the environment. In short, culture is learned and integrated into our understandings of our ‘self’ (Charon, 2003).

Individuals and groups can and do change their ethnic or cultural identities and interests through such processes as relocation, migration, conversion and assimilation or through exposure to modifying influences. Alternatively, they may maintain their cultural identities in new ways that are partly dependent on context and the meanings they find in their environment (Becker 1993). This description of SI applied to interactions among CALD residents, families, staff and the wider community which shape their own and others' behaviour. In such a context, elderly residents may create shared patterns of aligned actions. It is important then that meanings attributed to the changes that the elderly experience are understood to “play their part in action through a process of self-interaction” (Blumer, 1969, p.5).

Therefore, using the SI perspective of GT provides a way to interpret psychological and social processes that elderly and others develop to help CALD persons make sense of their world when relocated to long term care facilities.

The second of Blumer's premises is that the meanings attributed to an object are not intrinsic to that object, but derive from formative social processes associated with "others", thus, the meaning associated with an object may change over time. Bowers (1988) states, "Meaning of the social object is derived from the way in which others act towards it". For example in this research, the social object that is explored is 'relocation to aged care'. Nursing home relocation has no meaning in itself; rather, its meaning is derived from the way the CALD elderly react towards relocation and the consequent objectification of their experiences. Thus, the meaning of the social 'object', nursing home relocation is socially derived, contestable and negotiated through interaction. One objective of this research was, then, to explore the experience of elderly CALD residents in aged care by developing a theory "from the ground up" (i.e., a Grounded Theory) using what was observed empirically (and what the researcher experienced subjectively to understand how this experience was influenced by certain elderly residents' social interactions before, during and after their relocation.

Thirdly, self-interaction and social interaction construct common meaning and social (joint) acts and overall, supports naturalistic inquiry of this type aimed at uncovering meaning from the point of view of the elderly CALD residents' experience in the residential aged care facility. This study aims to identify how elderly CALD aged care residents 'talk to themselves' about their decision to relocate, what the relocation means for them culturally, and how social interactions in the new environment are understood, and how the residents relate to their sense of self as ethnic. From the SI perspective, society both shapes and is shaped by the individuals within it. Society in this study is multifaceted. It is society of origin, society the residents have moved to and the society of the nursing home. This twin shaping process is continuous as people interact, individually or in groups, make meaning out of their own experience and others' feedback and decide to continue or adjust their current actions.

In summary Blumer assumes (1969) that a human being can be an object of his own actions; he is an object to himself and he acts towards himself and guides himself in his actions towards others on the basis of the kind of object he is to himself. We form images of ourselves through a process of role taking. In this way, we see ourselves the way we believe others to see or define us. Symbolic interaction describes what happens between and within people and what influences their unique behaviours or reactions to a particular set of circumstances.

3.2.8 The Grounded Theory Methodology (GTM)

Research methodology encompasses techniques and procedures used to gather and analyse data (Carson et al 2001). Similarly, Crotty (1998, p 7) states, methodology determines, “The strategy, plan of action, process or design lying behind the choice of particular methods and linking the choice and use of methods to the desired outcomes”. The strategies or set of steps associated with the GT methodology are as follows: Plan of action-design of the study so that analysis is grounded in the experience of participants; researcher’s prior understandings about the phenomenon do not determine codes and analytical categories. Interview questions and recruiting are influenced throughout the study by analysis of prior interviews. As the desired outcome is to understand the place/importance of culture for CALD elderly who have relocated to aged care, the sample will also include some variation in cultural focus of aged care settings, comparing homes that were not explicitly culturally focussed (religion, other residents, name, and neighbourhood).

3.2.8.1 Theoretical Sampling

Theoretical sampling is the process that informs data collection based on the developing theory whereby the analyst jointly collects, codes and analyses the data and decides what data to collect next and where to find them, in order to develop the theory as it emerges (Strauss & Corbin, 1998). The sampling process is guided by emerging theory, which is in contrast to most other methods whereby the sampling decisions are made prior to the beginning of the study and are rigorously adhered to (Strauss and Corbin 1990).

Through the use of theoretical sampling, the emerging theory can be extended and broadened by identifying circumstances that might challenge the limitations of the theory, thereby, requiring a modification of the emerging theory. The object of theoretical sampling is to uncover diversity by facilitating the identification of a full range of possibilities that are theoretically relevant to the research question (Strauss & Corbin, 1990).

By identifying emerging gaps in the theory the researcher will be guided to sources of data (Charmaz 2001). Strauss & Corbin describe this in two ways (1) sources of data (who to ask, what to look at) and (2) focus of data collection (categories to be explored further). In theoretical sampling, data collection continues until sufficient data have been gathered to create a theoretical explanation of what is happening.

Theoretical sampling can be divided into two types, (Strauss & Corbin 1990) open sampling and variation sampling. Open sampling involves samples that will provide the greatest opportunity to gather the widest range of relevant data relating to the phenomena under investigation. Variation sampling, on the other hand, involves deliberately moving from situation to situation, gathering comparative data on diverse categories.

Initially, all Grounded Theory studies begin recruiting participants being guided very generally by the purpose of the study and other constraints such as time, participant availability and researcher interest (Bowers, 1989, p.54). Similarly, Chenitz & Swanson (1986) maintain that the researcher using GT should initiate the sampling process by interviewing any individuals with experience allowing them to inform the researcher about the phenomenon of interest.

3.2.8.2 Memo Writing

Memos are a specialised type of written record (i.e., code notes, theoretical notes, operational notes) that are intended to be analytical and conceptual in nature rather than descriptive (Strauss and Corbin 1998). Memo writing is an ongoing process, which begins with initiation of the research and continues throughout analysis of the data and write-up of the findings.

Writing memos helps the researcher to think more critically about the process and look at the data in new ways. Similarly, Charmaz (2003) maintains that memo writing helps to elaborate processes, assumptions, and actions that are illuminated through the coding process. Strauss & Corbin (1998:218) state, "Memos are important documents because they record the progress, thoughts, feelings, and directions of the research and researcher - in fact, the entire gestalt of the research process". Through memo writing, the researcher records leads for collecting data both for initial coding and later theoretical sampling.

The goal in Grounded Theory according to Strauss & Corbin (1998) is to link interpretation and empirical reality. Thus, memos rely heavily on raw data to help maintain the connections between interpretation and observation by examining them directly. Memos are used to "provide the gist for making precise comparisons, fleshing out ideas, analysing properties of categories, and seeing patterns" (Charmaz 2003:262).

3.2.8.3. The Simultaneous Collection and Analysis of Data

In Grounded Theory there is a constant interplay between the data collection and the data analysis. The researcher moves between initial data, analysis, and subsequent data collection, and then extends this movement to include literature as data to compare the emerging theory with data from the same participants at different times and data from different participants (Strauss & Corbin 1990).

Data are examined line-by-line and coded according to dimensions related to study phenomenon. The researcher examines her data to reveal how the participants make and act out of the meanings of events. The analysis process involves considering dimensions related to the coded data. In addition to asking 'what all is involved here', the researcher reflects on and asks questions of the data to reveal how participants' actions might change according to different perspectives and in different contexts. This process known as constant comparative analysis requires that the researcher continually look for contexts where participants may act differently (Strauss, 1987)

3.2.8.4 Constant Comparison

More specifically, the constant comparative method in GT means, comparing the views, situations, actions, and experiences of different people; different contexts, strategies meanings, comparing data from the same people at different times; comparing incidents; comparing the data with categories; and comparing categories with other categories (Charmaz, 1995; 2003). By using this constant comparative process, hypotheses are allowed to emerge, eventually resulting in a theory that is truly grounded in the data (Strauss and Corbin 1990). At the heart of the GT methodology, Strauss and Corbin (1990) refer to three coding procedures: open coding, axial coding, and selective coding.

3.2.8.5 Open Coding

The first stage of the analysis as described by Strauss and Corbin (1990) is the process that involves "breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss & Corbin, 1990, p. 61)

Thus, data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena as reflected in the data. Strauss & Corbin (1990) suggest that it is through this initial step in the data analysis that one's own assumptions are challenged, leading to new discoveries. In the open coding phase minute sections of the text made up of individual words, phrases and sentences to identify and develop concepts in terms of categories that are supported by the text, are examined (Strauss & Corbin (1990)).

3.2.8.6 Axial Coding

Axial coding refers to the analytic activity for "making connections between a category and its sub-categories" developed during open coding (Strauss & Corbin, 1990, p. 97). That is, reassembling fractured data by utilizing "a coding paradigm involving conditions, context, action/interactional strategies and consequences" (p. 96). Strauss and Corbin (1990) warn researchers "that unless you make use of this model, your Grounded Theory will lack density and precision" (p. 99).

During the process of axial coding, the relational and variation sampling technique is used, where data is sought depending on its ability to suggest relationships among a category and its sub-categories, or its ability to support or falsify a plausible relationship of a category with its subcategories.

3.2.8.7 Selective Coding

The final stage of data analysis in GT is selective coding (Strauss & Corbin 1998), which builds upon the foundation of the previous open and axial coding efforts. Selective coding is "the process of systematically coding to fill in categories that need further refinement and development. Also in selective coding relationships among categories are developed and validated as well as links between the core category and other categories are built (Strauss & Corbin, 1990, p. 116). According to Strauss and Corbin (1998) the core category should have the analytic power to "pull the other categories together to form an explanatory whole" and "should be able to account for considerable variation with categories" (p. 146).

Selective coding involves the integration of the categories that have been developed to form open and axial coding steps. During this phase, the interview questions are focussed and directive in order to fill in the developing theoretical framework, identifying a story line and writing a story that integrates the categories in the axial coding. These codes are generated and validated using the constant comparative method and coding, at each stage, terminates when theoretical saturation is achieved with no further codes or relationships among those emerging from the data.

3.2.8.8 Theoretical Sensitivity

Theoretical sensitivity according to Strauss & Corbin (1998) is the ability to recognise what is important in the data and to give it meaning while collecting and analysing data. Thus, the researcher requires insight to enable him/her to conceptualise the data and to separate the essential from non-essential data.

Strauss and Corbin believe that theoretical sensitivity comes from a number of sources, including professional literature, professional experiences, and personal experience. As Patton, (1990) adds, the credibility of a qualitative research report relies heavily on the confidence readers have in the researcher's ability to be sensitive to the data and to make appropriate decisions in the field.

3.2.9 What Specific Methods are Most Consistent with the Research Question, and the Selected Methodology?

According to Beck (2004), the three most common data collection methods in interpretive research are, observation (participant and direct), individual interviews, group interviews (focus groups). This study used repeated, in-person, individual interviews as the data collection method. Given the concern with understanding meanings, interpretive researchers have often preferred collection techniques such as interviews; focus group and participant observation. In this study the specific method consistent with the Grounded Theory methodology is interviewing. Interviewing is used to gain first hand information from its source and to gain the views and subjective experience of research participants.

3.2.9.1 Interviews and Interviewing in Grounded Theory

Although different from other types of interviewing, GT depends on flexibility and responsiveness, as researchers collect data and analyse simultaneously from the initial phase of the research based on the analysis. Interviewing as described by Creswell (2006), comes in many forms and types. Interviews vary in the degree of structure; that is structured, semi-structured, and unstructured. They can be formal or informal. They vary in depth and in the extent to which the topics covered will be predetermined. Grounded Theory combines unstructured; semi structured and structured interviewing,

depending on the phase of the study and the purpose of the interview. (Chenitz & Swanson, 1986; Bowers, 1988). In Grounded Theory, early interviews employ mostly unstructured interviewing. At this point, listening to participants recounting their stories is very important (Strauss and Corbin, (1990). That is, the interview is directed by the story of the participants.

As Charmaz (2000) cautions, researchers cannot know exactly what the most significant social and social psychological processes are in particular settings, and must start with areas of interest to them and form a preliminary interviewing questions to open those areas basing on the analysis of the initial responses. Interviewing at this point is designed to allow the participants to guide the interview and to determine the topics discussed.

The role of the interviewer is to push the participant for elaboration of depth and detail. During the discovery phase or initial interviews, the interview questions are open-ended and expansive. As suggested by Rubin and Rubin (1995, p 46), with open-ended questions “you want to cast your net initially as broadly as you can, both to get a range of responses and to make sure that what you later ask has meaning to the conversational partners.” As analysis proceeds and the researcher enters the axial coding phase, semi-structured interviews are used.

In semi-structured interviewing, the interviewer requires more focussed information and asks specific questions to gain it. As the study is nearing the end of data collection and analysis, interviews often become quite structured. Charmaz (2006) suggests that interviewers may wish to have a list of topics they want participants to talk about but that they are free to phrase the questions as they wish, ask them in any order that seems sensible and join in by discussing what they think of the topic. It is also suggested that interviewers may wish to have a list of topics they want participants to talk about but that they are free to phrase the questions as they wish, ask them in any order that seems sensible and join in by discussing what they think of the topic.

Given the advantages associated with semi-structured interviews, both from the perspective of the participants and the GT methodology itself, data collection in this study centred on semi-structured, repeated, in-person, individual interviews with participants.

3.2.9.2 Summary

This section has provided an overview of the various theoretical perspectives that influenced the choice of the methodology and methods for this study. Social research paradigms have been presented and discussed, which have influenced the interpretive approach chosen for this study and have located Grounded Theory within the interpretive research methodologies.

An attempt has been made to clarify the steps and procedures within the study process that were not always obvious. The next section provides a continuation of that research journey.

3.3 SECTION 2: Research Design - Application of the Grounded Theory method to this Study

3.3.1 Introduction

As indicated in section one of this chapter, Strauss and Corbin's GTM approach was used to generate substantive theory about CALD elderly residential aged care experience.

This section provides a detailed description of the research design and account of the research process. The section also addresses ethical consideration and details of the research sample, as well as the process for accessing participants and entering the field. In addition, a description of the data gathering and analysis techniques utilised and the procedures undertaken to ensure rigour, is presented.

3.3.2 The Setting

In order to develop a model of the experience of CALD elderly residents relocating to nursing homes, an appropriate and sufficient pool of participants was needed to draw from. The first goal was to identify facilities that had residents from different cultural backgrounds who were born overseas.

While too early in the process to know what theoretical sampling needs would arise, including residents from various places, representing multiple cultures would likely facilitate later theoretical sampling needs. At the same time, theoretical sampling of conditions might be facilitated by variation in the way culture was integrated into daily life or the degree to which a particular culture was reflected in the operation of the home.

For that reason, an ideal facility sample would include: facilities that included residents from other cultures but did little to promote a particular culture, facilities that deliberately acknowledged cultural origin as important as well as those that did not and, ideally, a facility that was designed for a particular culture.

For example, ideally the sample might have included ethno-specific homes that look after specific nationalities (i.e., Italian or Greek residents only) and the others that had elderly residents from a mixture of different ethnic groups. Due to site selection difficulties (described later in this section,) it was impossible to follow the initial site-sampling plan. The final sample included all homes with a mixture of elderly from different ethnic backgrounds, some born in Australia and some overseas. The final site sample included four aged care facilities located in the northern metropolitan region of Melbourne, Victoria.

The northern region of Melbourne was selected because of its richness in terms of ethnic diversity. The immigrant population in this region is relatively high with approximately 20% Eastern Europeans, 20% Asians, and the remaining 30% is made up of newly emerging communities from a variety of regions, including African and the Arabic. For ethical as well as methodological considerations, homes were chosen in which this researcher did not know the staff, residents or their families.

3.3.3 Entering the Field

Entering the field began with ethics approval from the Australian Catholic University Human research Committee. As a requirement of the approval, permission from the four nursing homes in the northern suburbs of Melbourne, Victoria, Australia to conduct the research had to be granted by the centre managers. Obtaining the ethics approval from the university involved completion of an application form that required submission of the names of and approval from the facilities I intended to conduct the study.

Although the approval from the university was quick, some difficulties were encountered in identifying facilities that would agree to participate in the study. Fifteen nursing homes in the northern metropolitan region of Melbourne were invited, via post, to learn more about the study and to consider participation. This allowed a personal introduction, a brief description of the intended study, the study sample criteria and a request for the facility managers to respond if they were interested. Also included were contact details (phone numbers and an email address). See (Appendix) for a copy of letters requesting permission and participation of the nursing homes.

Of the fifteen invitations posted, only two responded positively and agreed to a meeting to further discuss the study. Another ten invitations were hand delivered to facility managers resulting in two acceptances. So out of the twenty-five invitations sent, only four facilities agreed to participate in the study. The rest responded that they were either too busy or did not believe that any of their residents met the eligibility criteria. Others responded that the few CALD residents in their facilities either were unable to communicate in English or were unable to communicate meaningfully because of dementia.

Another requirement to complete the ethics approval from the university was to ensure availability of counsellors to respond to the needs of any residents who might need their support. Approval was obtained from the Northern Migrant Resource Centre to use their ethno-specific counsellors, if required, during the study (Appendix 2).

Following ethics approval, a meeting took place with each of the four facilities managers who had agreed to participate.

In two of the facilities, a meeting with members of their Boards of Management occurred and in another this researcher met with the resident advocacy group.

The resident advocacy group of this facility comprised of two division 1 registered nurses, one division 2 registered nurse, a personal care attendant, volunteers, family members and a priest.

In the fourth facility, a staff meeting was attended to describe the study. Centre managers of the four facilities were present in each of the meetings where the proposed study was detailed and the data gathering process explained.

Staff members of the four facilities and advocacy groups supplied the names of participants, whom they thought fitted the selection criteria, were willing to participate and had agreed to be approached by this researcher.

3.3.4 Gaining Access to Vulnerable Populations

Gaining access to vulnerable populations, especially those who are institutionalised, requires several layers of permission. According to Patton (1990), ethics is typically associated with morality, and both deal with matters of right and wrong. In general, the literature concerning ethical care given to older cognitively intact and cognitively impaired patients emphasises an understanding and a confirmation of each resident as a unique human being with individual preferences, resources and the ability to master their life (Chenitz & Swanson, 1996). Since the study involved the use of human subjects, primarily elderly people from CALD backgrounds, there were a number of special concerns and issues that I needed to be aware of. More importantly, this meant that I needed to pay special attention to the autonomy of the residents and prevention of harm. The following sections describe how autonomy and harm prevention was ensured throughout the study.

3.3.5 Autonomy

Protecting participants' autonomy began with my initial meetings with the managers of the selected facilities to develop an effective process for recruiting participants.

Managers were provided with copies of an information letter (Appendix 3) explaining the research project. They were also provided with the information letters prepared for the potential participants (Appendix 4) in which residents were assured that their participation in the study was voluntary and that they would be able to withdraw or refuse participation without penalty. During the second round meetings with the centre managers, the opportunity arose to meet with potential participants, along with the centre managers, to answer any questions and to individually confirm their interest in participating in the research. Informed consent forms were given to the willing participants to sign (Appendix 5).

To be sure that the study was explained and the rights of participants outlined the consent forms were read to the participants before they were signed.

Many residents in residential aged care facilities live with age related hearing and visual impairment (Rikkert, van den Bercken, ten Have & Hoefnagels, 1997). Therefore, consent forms were in large black font on white paper to facilitate readability. Verbal consents were also sought and obtained from participants before interviews in addition to the signed consent. This approach was taken to allow participants to withdraw from the study if they were having second thoughts.

3.3.6 Preventing Harm

There were two possible sources of potential harm to participants from this research: (1) harm resulting from participation in the research (e.g., acute emotional reactions to certain questions); and (2) harm resulting from breach of confidentiality. (Rikkert, van den Bercken, ten Have & Hoefnagels, 1997). These were addressed in the following ways:

3.3.6 (A) Harm Resulting from Participation in the Research

According to Holloway & Wheeler (1995), older adults from diverse cultural backgrounds have historically confronted societal barriers of varying degrees. The multiple barriers have helped define who the older individual has become.

The many life situations have helped shape the social, political, and economic outlook and status of older individuals from diverse cultural backgrounds (Holloway & Wheeler 1995).

An ethical issue that was anticipated when the proposal was written was the possibility that the interviews would bring out emotions that the participants or this researcher would not be able to address. Therefore support and approval was sought from the Northern Migrant Resource Centre's ethno-specific social workers and counsellor to take care of the residents who might need this. The potential participants were informed of these arrangements. Participants were also assured that if the interviews caused any distress, the interview would either be terminated until they felt ready to continue or stopped altogether.

3.3.6 (B) Harm Resulting from Breach of Confidentiality

Current literature reveals that, participants frequently feel or fear that their views have been misrepresented or taken out of context and may worry about how the sharing of stories and the writing and publishing of their comments might affect their lives or their care (Holloway & Wheeler, 1995). Therefore, it was important to maintain confidentiality of the interviews and privacy of the participants (Sugarman, McCrory & Hubal, 1998).

As a researcher, one is privy to sensitive information that should not be exposed. This issue was addressed in the following ways:

Participants were assured that any information given to me would not be taken out of context, nor used to identify or harm them in any way. Participants were also assured that code names would be assigned to them and their facilities and that nothing would be written with their name on it or any identifying details associated with quotes such as name of the residential aged care facility.

In addition, at the end of analysis participants were given the opportunity to evaluate and verify whether their comments had been accurately represented. No information from the interviews was shared with staff, family or other residents.

3.3.7 Sample Criteria.

The criteria for inclusion in the study were: born in another country, residents of the selected facility be comfortable participating in an interview, able to speak English and willing to sign a consent form. A decision was made not to include non-English speaking persons in this study because of the need to complete the study in a time frame within the guidelines of university Doctor of Philosophy enrolment periods. The cost of interpretation of transcripts was also a factor in this decision. As minimal literature was obtained regarding the study focus, it was considered that English speaking overseas born Australian residents would be able to articulate their experiences of relocation and the aims of the study achievable.

It was also important that they were able to understand the purpose of the study. Exclusion criteria, which were: having a diagnosis of dementia or being assessed by the staff as too ill to participate. The staff of the four facilities provided me with names of residents who fit these criteria and had agreed to participate. A time was then arranged to meet with each potential participant, where the study and the consent process were explained, consent obtained and a time arranged for the initial interview.

3.3.8 Rationale for Inclusion and Exclusion Criteria

According to Strauss and Corbin (1998) it is important not to restrict the subject pool by predetermining what conditions or dimensions of the experience might be relevant.

For example, limiting the pool to only people who had been at the home for longer than a specific period of time, or were seen as cooperative or problematic, or who were part of a tight cultural community or had let go of many cultural practices would impose relevance that could not possibly be known at this time. As none of this was known prior to the study, there were no imposed restrictions on participants. Consequently, all residents who were willing, able and had been born abroad and had consented to participate in the study were taken.

3.3.9 Sample Characteristics

Since careful and detailed coding of data is essential in GTM, (Charmaz, 2006) it requires in depth, high quality data to work from. Without such data, quality coding is not possible. Although not assumed to be theoretically relevant, personal characteristics such as marital status, life experiences such as education, work history, and family were also sought to provide a database, which might later be used to facilitate theoretical sampling.

There were a total of twenty participants from four residential aged care facilities who participated in the study. Participants ranged in age from 61-92 years. Five of the participants were Italians; three were Greeks, two Macedonian, three Croatians, one

Latvian, two Maltese, one Russian, and three Indians. All but one of the participants lived in the northern region of Melbourne for a period of time, varying from 10 years to 50 years.

The remaining participant chose the facility in that area because his brother, who has his Power of Attorney, lived close to the facility. There were twelve females and eight males in the study population.

Sample

Composition

Italians	5
Greeks	3
Macedonians	2
Croatians	3
Latvian	1
Maltese	2
Russian	1
Indians	3
Total	20

Characteristics

- Age Range 61-92
- Gender
 - Male 8
 - Female 12
- Exit point
 - Hospital 6
 - Homes 14

Table 1: The Composition and Characteristics of the Study Sample.

Under two years	Three to six years	Seven to ten years	Over ten years	Average years in RACF
2	15	2	1	5

Table 2: Length of Time Living in the RACF

3.3.10 Sampling Strategy

In keeping with theoretical sampling directions, the study began with two participants. The strategy used to select the first two participants for the initial interview was very

general in the sense that the participants had experience with nursing home relocation; they were overseas born from different ethnic groups. However, once the two interviews had been conducted, theoretical sampling was used.

3.3.10.1 Theoretical Sampling

When the first two interviews were analysed and dimensions and properties were identified, I selected participants and altered interview questions to facilitate comparative analysis among the emerging dimensions and properties.

Consequently, the selection of the participants was neither a random selection nor a totally *a priori* determination but rather on concepts generated through ongoing analysis and testing of initial hunches (Strauss and Corbin 1990). For example, finding a difference in the experience of those who moved from home and those who relocated from hospital or a rehabilitation centre, I then ask whether and to what extent entry point influenced the experience of relocating.

At no time during the study was it possible to determine in advance when sufficient data would be gathered. Consequently, as suggested by Strauss and Corbin (1990) in research carried out for discovering theory, the researcher cannot cite the number or types of participants or conditions from which data will be collected prior to the completion of the research. Theoretical sampling in this study continued until sufficient data had been gathered and a theoretical explanation and its key features were created.

3.3.11 Data Gathering

As indicated in section one of this chapter, repeated, in-person, individual interviews were chosen to collect data for this study.

3.3.11.1 The Interview Process

To provide a relaxed beginning to each interview, a mutually convenient time and place were arranged with the research participants for the interviews. Participants were given

the option of having the interview conducted in their own rooms or in another quiet and private area in the nursing home.

Most participants preferred to and were interviewed in their rooms, although some chose quiet places: One participant chose to be interviewed in the nursing home library, while another chose to be interviewed on the back veranda of the nursing home, which led to a beautiful garden. One participant selected a garden and another patio.

While an experienced research interviewer may be able to conduct an interview with minimum difficulty in most settings, as a novice interviewer, I was more comfortable in some settings than others.

In particular, I felt more comfortable with participants when interviews were conducted in gardens, patios and a library as I was hopeful that such a setting separate from their rooms, might encourage the development of trust, and the ability of participants to regard the process as independent of the nursing home.

Feeling comfortable with the interview process and being in a setting that was personally reassuring meant less distraction during interviews and a greater focus on the participant's stories when conducted outside their rooms, even though there was an increased risk of being interrupted. With this in mind, it was not possible to determine the extent to which respondents were concerned by or modified their comments. No adverse effects were observed nor was the effect that any of these public settings may have had on the participants explored. It was believed that some of the respondents might have felt intimidated by the presence of others or less willing to share aspects of their stories without privacy.

Each interview was started with a brief, personal introduction so that participants would hopefully begin a process of developing trust in an outsider who was independent of the nursing home.

3.3.11.2 Unstructured Initial Interviews

In accordance with GTM, unstructured interviews were employed during the initial interview with each participant. During this first interview, I asked a very general, open-ended question that invited the participant to tell me about their experience of relocating to a nursing home.

By asking mostly broad, open-ended questions during the initial interviews, participants had the opportunity to respond more elaborately and in greater detail than had I focussed their attention on regarding specific aspects of their move to a nursing home.

These contrasts with the nature of interview questions that were asked during follow up interviews, at which time the interview question would be more focussed, with the focus determined by issues and themes that had emerged during earlier interviews.

Some examples of an initial opening question are:

“Can you tell me what it is like for you to be here in this nursing home?”

“Could you please tell me how you came to live here”?

“Tell me, what was it like coming here?”

“How is it like being here”?

After hearing a participant’s answer to my initial question, I would ask follow up questions that encouraged participants to discuss how they constructed whichever aspects of their reality they had mentioned and how their actions and decisions were related to these constructions. That is, I would respond immediately to what participants said. When possible, I would ask follow up questions that would encourage a participant to make comparisons. In GTM, using follow up questions to encourage a participant to make a comparison is described as one form of ‘theoretical sampling’. A particular participant is asked a question because they represent someone in the sample of CALD elderly who made this particular kind of comparison. Even in early interviews these follow up questions were semi

structured and informed by conceptual depth I was attempting to gain. For example, one participant described her experience of the care given to her in the nursing home. The participant touched on a few issues about which I wanted to gain more information. She said that some of her possessions were getting lost; there were changes in staff, new and young staff coming in every day. The following was the conversation between the participant and interviewer. (P = participant, I = Interviewer).

C: How is it like being here?

P: It has been a very hard experience for me. There is many change. Everyday new staff come, all young staff. They don't know me and they always rush.

C: Can you go into more detail about the difference in how you are cared for by staff who know you well and those who don't? Can you give me some examples?

P: They don't know me and they always rush. They get lost; my things are getting lost everyday. They put my things together with everybody's clothes and give it to someone else. They don't ask me how I take shower, dress or eat, and because I cannot talk well they rush and don't listen. They do things without asking. They just do it. The few regular girls, most of them are older and experienced, they don't rush; they know me, they know where things are and they know what I like, but they only work few days here. I think they can't work many days because they are getting old themselves.

I obtained depth and added complexity in participant (P's) story by asking her to provide more details without guiding her. I left it up to her to direct the topic and take the lead, thereby ensuring that my analysis would be grounded in (i.e., based on) her experience and perceptions, rather than my own.

This meant that the participant shaped the content and structure of the interviews, at least during the initial interviews. For this reason, residents who took part in the study are referred to as 'participants', in preference to describing them by terms such as interviewee or subjects, which might imply that they were expected to adopt a more passive role during the interviews and/or respond only to narrowly -framed interview questions.

Questions of this type, according to Charmaz (2006), are sufficiently general to cover a wide range of possible responses while being narrow enough to elicit and elaborate a participant's specific experience.

The opening questions were intended to put participants at ease with the interview process. Specifically, participants appeared to understand, that in this style of interviewing, there were no 'right' or 'wrong' answers to questions and that they had a high degree of control over what was discussed.

My intention was to learn about participants' experience of relocation. However, I soon realised that all of the participants' began their answers to my questions by describing not only their relocation to a nursing home but also how their process of relocation had begun.

My initial intention, taking account of the frailty of many of the participants, was for most interviews to be completed within 20 to 40 minutes. This did not happen. The shortest interview required an hour and a half; the longest interview continued for about two hours. I became aware, after a few interviews that because of minor interruptions, such as receiving or making phone calls, toilet trips, and because of most participants' slow speech, very little data could be collected in less than 40 minutes. Nonetheless, I had to terminate most interviews after 40 minutes, as either interruption occurred that precluded the interview continuing or participants became fatigued.

Participants were so eager to tell their stories to a willing listener who asked questions about what they were discussing that, in all cases, they asked me to return to continue talking with them. Hence, the interviews were conducted in one to two sessions, each lasting between one hour and one hour and 20 minutes. The more interviews I conducted, the more focussed they became in response to the ongoing analysis of what they had already told me. I focussed each subsequent question to encourage participants to raise issues that they had shown were important to them and to allow the interview topics to adapt to the insights and interests of each participant. I realised that,

as I conducted additional interviews, I become more skilled in directing a participant's discussion in a particular direction and away from unrelated issues.

3.3.11.3 Later Interviews

As analysis proceeded into the axial coding phase, I developed semi-structured interview schedules. During this phase, I asked more focussed questions in order to encourage participants to provide their interpretation of particular aspects of their experience, which they had already mentioned. I wanted specific information on the emerging theory.

For example, when I wanted to know more about 'deciding to move', a category that was identified in my previous data analysis, I would ask questions such as:

Can you tell me about when the decision was made for you to come here?

How long had you been thinking about it?

Had you talked to anyone about it before you made the decision?

Who else was involved in the decision for you to come here?

When the research process was nearing the end of data collection and analysis, interviews often become quite structured as GTM required me to identify, as much as possible, variations in the experience of different participants. For example, I would focus a question as follows:

Many people have talked about the adjustment they experienced coming to a nursing home. Can you tell me what that was like? What were some of the things that you remember about that? How did you handle your first few days or weeks here? How has that changed?

3.3.12 Data Recording

Consistent with GTM, I collected transcribed and analysed data concurrently throughout the study. I was convinced at the beginning of the study that recording the interviews was appropriate and necessary. Preparing theoretical and methodological memos during analysis helped me to clarify the linkages between the core concept, relocation to a nursing home and major categories of analysis that were raised by participants.

3.3.12.1 Taping Interviews

A small audio tape recorder was used, with the participants' verbal permission, to record each interview.

Tape recording proved to be a very successful method of data collection, as it allowed the full content of interviews to be available for analysis later, without requiring the interviewer to give any attention to writing more than a small number of personal notes during the interview.

In this way, the participants gained the sense that the interviewer was giving them full attention and the interview process flowed smoothly without the need for the interviewer to break the process in order to write extensive notes.

Voice recording of interviews gave much better qualitative data because taping preserves the wording, the tone of voice, the silence, laughter, sighs, crying, etc., while the brief notes ensured that nothing was missed and could be listened to repeatedly.

3.3.12.2 Recording Post Interview Notes

A face sheet and post-interview comment sheet (see table 4) were used to identify data, book keeping and recording incidents during the interviews.

A condensed report with a code for the facility, the cultural background of participant, age, level of care, how long they have been a resident in the facility and the duration of

the interview was used. Table 2 below is an example of the face sheet with post interview comments.

INTERVIEW 2 (LSP O2PA) Post Interview Comments: 12/01/06				
Interview date: 12/01/06	Code No: LSP OIPA	Facility: 3	Copy Transcription	Copy report
Participant details	Age: 68	Gender M FM	Role: resident in low care	Length of interview: 1hr
<p>Participant's details: PA is a 68-year-old resident who has been living in the facility for 8 years. A Maltese by birth PA's parents lived in Egypt till she was 11 years old when they moved to Ireland. It was from there that she came to Australia 50 years ago. She got married to a Maltese and had two sons. She was the caregiver of her cognitively impaired husband when she fractured her hip and couldn't walk anymore. With poor mobility she was no longer able to look after her husband or herself. In consultation with her family, decision was made for both PA and her husband to move to the facility together. Two years ago, PA lost her husband.</p> <p>Interview Comments/Reflection</p> <p>It is 2pm and I have just finished interviewing PA in facility 3. When I asked that we went somewhere private, PA took me to the facility Library. She said nobody will disturb us in the library. It has been quite an experience and a challenging one too. I know myself to be a strong person but I think I surprised myself today. This lady got emotional when she was telling me about her husband who also up until 2004 lived in the facility. I asked that we discontinued the interview and perhaps do it later but PA insisted that she wants to continue as she remarked, "this is so good for me you know Cecilia, this is something I haven't been able to do and it is so painful. The girls here are very good but they are always very busy they don't "stop to chat" Now I think here I failed in my role as a researcher and quickly put my nurse cap on. What did I do? I shed some few tears. Although it wasn't obvious to her I really had to restrain myself. To hide my tears, I asked that I made her another cup of tea and then I was able to just walk down the corridor to wipe the tears. I realised as nurses we become so task oriented that we sort of miss the most important things. Just stopping and having a chat would have been easy but we have failed this lady. I don't know if it is right to do this but I just couldn't help myself and told PA my own experience of loosing someone close (my father) I guess the good thing I saw was, PA became more comfortable sharing her story. I had trouble cutting in to ask questions because she kept going and wouldn't stop. She looked relaxed when talking to me. She asked if I would come in and say hello to her next time I visit the facility.</p> <p>I wanted to stop the interview after 40 minutes but I wasn't able to because PA hadn't finished telling me about her and it would have been rude to ask to continue the next day. It was time for her lunch but she told me not to worry about lunch as the interview is a better food and besides, she had already arranged for her food to be kept warm.</p>				

Table 2: A Face Sheet and Post-Interview Comment Sheet.

3.3.12.3 Writing Theoretical Memos

During the course of each interview, I took notes about comments and questions about which I wanted to ask the participants when I returned. In effect, I wrote memos to myself about some queries I had about a category or property, particularly about relationships between and amongst categories. I compared and thought critically about the process of interviews and looked at the data in new ways. Since it was impossible to readily keep track of all the categories, properties, and generative questions that evolved from the analytical process, writing memos constituted not simply my 'ideas' but also involved the formulation and revision of theory during the research process.

Sometimes a code was revised, if I noticed in my memo that I had lapsed into using labels that were not grounded in specific responses of individual participants. For example, a code that had originally been labelled 'three years ago' was later revised to 'length of time'; 'lost the strength in my right arm and leg' was later revised to 'loss of physical strength'; 'needed a lot of help to look after myself' was later revised to 'needing assistance'.

Coding made visible some of the components and analysis done while memo writing guided the linking of relationships of categories to each other.

3.3.12. 4 Transcribing of Recorded Data

Strauss and Corbin (1998) highlight that novice grounded theorists can be over-enthusiastic about data collection and conduct a series of interviews without concurrent analysis, possibly resulting in a missed opportunity to sample on the basis of emerging concepts. In order to allow concurrent analysis of the content of interviews, I transcribed each interview, verbatim, shortly after the interview had concluded.

The process of transcribing the interviews was tedious but required that I listen to each, piece by piece. Undertaking the transcribing myself was necessary, as I was able to control the analytical process.

That is, had the transcription been performed by another, I would have read through them differently and would have listened differently to replaying of each interview. As a result of this different process, I might have come up with different, but not less appropriate, categories, labels, revised labels, interpretations and conclusion. The process led to one particular set of results.

The transcribed interviews contained data that I had sometimes considered to be irrelevant at the time of the interview but which often later emerged as important during the analysis process. In this way, early and rich interviews became a continuing source of theoretical sampling as the focus of the study evolved.

3.3.13 Data Analysis

I have gathered and analysed the data of this study following the Grounded Theory methodology. Data analysis procedures were, in fact, not discrete and separate activities but overlapped in actual application. The following sections are a more detailed description of the analysis.

3.3.13.1 Analytic Procedures of this Study

In this study, data analysis was a continuous process undertaken with emphasis on different aspects of coding throughout the entire study. In keeping with Strauss and Corbin (1990), I began the analysis with the transcription of my first interview, following the three step coding procedures in the following order as per Strauss and Corbin's direction of analytic sequence; open coding, axial coding and selective coding.

3.3.13.2 Open Coding

I started the open coding process with general labelling of the concepts used by participants to describe their experience, including the dimensions and properties of each concept as they arose. For example, an early concept specified by the first participants was progressive loss of physical strength.

A dimension of that concept designated by these participants was getting weak. I employed line-by-line analysis of the transcript to break the data down into discrete parts.

Minute sections of the text made up of individual words, phrases and sentences were examined closely and compared for similarities and differences to identify and develop concepts. I coded directly onto the transcript to relate the coding directly to the text. Below is an example of how I conceptualised the first two interview transcripts of the response to the initial question (Table 3.0).

<p>Initial question: What was it like to come here?</p> <p>Responses:</p> <p>DM: <u>“Three years ago, (length of time) I realised (experiencing) that I was getting weak and weaker.(progressive loss of physical strength) I needed a lot (amount of need) of help (nature of need) to look after myself. (Purpose of need-ability to look after self)</u></p> <p>FG: <u>I wasn’t so strong anymore (change in strength) and all three (number of children) of my children had moved interstate (where moved to) with their partners (who moved with). I wasn’t going to bring them back to Melbourne (what would not be done) to look after me. I looked after my mother and father(past experience of caregiving) in my home (where caregiving took place)and the children had told me(past promise/from whom) they would do the same(reciprocity) for me when I get to this age (history- serial reciprocity).</u></p>
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**Table 3: Initial Coding of Data Collected from Two Participants
(Red Indicates the Emerging Categories)**

This initial coding although changed over time provided a good beginning framework by allowing me to focus on some of the main concepts in the data and was vital in preparing for the next interviews. After analysing the first six interview transcripts, I realised that instead of telling me about their relocation experiences, all the participants were in fact talking about how their relocation started (the pathway in).

Common to all interviews as a description of how the related process began the strategies they used to respond to early losses and the options they saw as available. Next in the open coding, I began to place concepts into categories and subcategories.

Table 4 below is an example of how one category and its sub categories were developed.

Initial question : ***What was it like to come here?***

Raw Data	In Vivo Code	Theoretical code
<i>I realised that I was getting weak and weaker</i>	Getting weak and weaker	Physical losses
<i>“When my wife died, ... I said no. My Maria is gone, it is hard to stay in the house</i>	My Maria is gone	Relational losses
<i>My daughter had a stroke and she went to the hospital for a long time so there was nobody”</i>	She went to the hospital for a long time so there was nobody”	Supportive losses

Table 4: Categories and Sub Categories Developed after Analysis of the First Six Interviews

Types of losses participants experienced were coded as: physical, relational and supportive loss.

Following the recommendations of Strauss and Corbin (1990), data were constantly compared within and across interviews and questions like ‘why, how, in which way, how much, when in the relation, and whom?’ were asked of the data.

Constant comparison, according to Strauss and Corbin (1998), the making of comparisons is an essential feature of the GT method. More specifically, the constant comparative method compares the views, situations, actions, and experiences of different people; comparing data from the same people at different times; comparing incidents; comparing the data with categories; and comparing categories with other categories (Charmaz, 1995, 2003). Constant comparison helped me threefold. Firstly, constant comparison across interviews kept me grounded in the interviews and constantly being challenged with new data, thereby decreasing the tendency to impose a preconceived understanding.

Secondly, my precision was increased in grouping similar into increasingly abstract categories. Thirdly, it assisted me to further subdivide concepts, which are variations on the first, to ensure consistency in grouping like with like. For the coding process to be rigorous, I then went back through the available data and re-coded in relation to the new categories. The Table (5) below is an example of how I compared participants' responses to identify dimensions and sub dimensions.

RAW DATA	Dimension	Sub- dimensions/properties
<u>Three years ago, I realised that I was getting weak and weaker.)</u>	time in the past Type of loss	Beginning point (How do others think about the beginning of the trajectory Physical loss (what other types of losses?)
<u>I needed a lot of help to look after myself. I wasn't so strong anymore</u>	Purpose of help Amount of help Reason for help	What specifically was needed? How much help was needed What were specific reasons triggers?
<i>My husband was looking after me at home After I had the stroke; I lost the strength in my right arm and leg so my husband did almost everything for me.</i>	What was done Who looked after When was it done How much was done Losses experienced	Looked after (what all is included in this?) Husband (who else looks after) After stroke (what other things trigger this?) Everything (what are all the things that others do?) Lost use of arm (what other specific losses lead to looking after?
<i>Then he got killed in the car accident</i>	Reason for caregiver loss Suddenness of loss	Death (What are the other reasons?) Immediate (how else are caregivers

Table 5: Comparison of Data from the Same Participants at Different Times

As more data were collected, I continued open coding, but also begun to identify 'categories' rather than labels. The categories were formed from groups of words from the initial coding which pertained to the same phenomenon. For the coding process to be rigorous, as suggested by Strauss & Corbin (1998), I went back through the available data and re-coded in relation to the new categories.

As each new concept emerged, I compared it against existing concepts and categories for both similarities and differences. I compared the stories of people with slow versus more sudden decline as well as the type of decline and the ability to access resources to protect them. I also began to ask theoretical questions such as:

What is the length of time someone spends experiencing loss before thinking about needing help? And how does this vary? How much loss and what type of loss leads to deciding they need help? What other losses do people experience? What do people do as loss progresses? Does it matter what type of loss? What did they do themselves and when did they start thinking that they might need some help? What sort of help did they think they needed?

What sort of things, by themselves, made someone start thinking about needing help? What were the clusters that added up to someone thinking they might need help? Are multiple moves considered more difficult than one move? In what way is it more difficult?

What emerged out of these theoretical questions was that there was often not a single trigger for someone to start thinking about the options of care or seeking assistance with their care. Some participants moved as a result of accumulated problems over time, leading eventually to loss of ability to care for themselves or to be cared for by others. Some moved as a result of sudden loss of ability following illnesses, or injury. With others, there was a combination of things leading to loss of ability to care for themselves at home and or other reasons such as: wanting to continue to play important roles, and wanting to maintain relationships. I continued with data collection and coding using the constant comparison approach. Through the constant comparative process, concepts were labelled as: 'Experiencing losses', 'History of care giving', 'Considering the consequences of care giving', 'Considering offers of care', 'Reasons for considering relocation', 'History of trying other care giving situations'.

As the purpose of GTM is to identify core processes from the point of view of the participants, the categories that emerged were all based on how they understood their

situations, what was most important to them and how they made decisions about the path to take. The focus here was on developing categories in terms of their properties and their dimensions. It was very useful to pose questions and then further analyse the data in an attempt to answer them (Strauss & Corbin, 1998). The final step of the open coding process was identifying the properties of the emergent categories and delineating the dimensions of the set properties until nothing new was yielded or, in other words, saturation is attained. As Strauss & Corbin (1998) assert, once categories are formed in open coding, they are fleshed out in terms of their given properties and dimensions. The properties are "characteristics of a category, the delineation of which defines and gives it meaning" (Strauss & Corbin, 1998, p. 101).

In the subsequent interviews, the questions became more focussed. The dimensions of 'Experiencing losses' were explored with prompts such as:

Think back to just before you came to live here. Can you tell me what led up to your coming here? What was happening with you? How was your health? Were there any things that you were having trouble with? Was anyone helping you? At what point did you realize you couldn't do things anymore? What difference did this change make in your life? When did you start thinking of getting some help?

I had discovered from the first six interviews that, as participants experience health problems or debilitating conditions, they become aware of difficulties in their daily lives and start to find out how to deal with the life changes they experience. Dimensions illustrate how each property can vary along a continuum (Strauss & Corbin, 1998)

As a result of dimensionalising, the relationships between categories began to emerge, with some categories being sub-summed as dimensions or properties. Below is an illustration of the category 'Experiencing losses' which culminated in the concept 'Needing some assistance' and became central to the GTM.

CATEGORY	DIMENSION	PROPERTIES
Experiencing losses	Needing some assistance (i.e. Intermittent versus ongoing need, A new understanding of need and ability ,precipitating events, Outside views of need, Loss of abilities (i.e. ability to care for self and others, ability to play a role	Degree of assistance. Intermittent versus ongoing need Types of loss: Physical strength, physical ability, Care giving Mechanisms of loss: death, illness

Table 6: Dimensions and Properties of the Category: ‘Experiencing Loss’

In order to conduct analysis, the GTM requires rich data about the constructions of the participants. In this case, it was participant’s constructions of ‘experiencing loss’, problems leading to relocation, history of care giving - considering the consequences of care giving for caregivers, considering offers of care, reasons for considering relocation, history of trying other care giving situations, that were the objects of exploration.

The Table (6) below illustrates the entire open coding process.

Conceptualising	Categorising	Developed Properties & dimensions
<p>EXPERIENCING LOSS.</p> <p>Length of time, Nature of loss</p> <p>Trajectory of loss, Becoming aware (of loss)</p> <p>History of dealing with physical ability loss</p> <p>Type of loss: caregiver</p> <p>Mechanism of loss: death</p> <p>Increasing severity of condition</p> <p>Losing ability to help</p> <p>Poor health, Loss of ability to help sister</p> <p>Alcohol, Reasons for injury: Diminished mobility</p>	Types of losses	<p>Loss of physical strength)</p> <p>Loss of ability to care for self</p> <p>Age related changes</p>
	Causes of losses/ Mechanism of loss	<p>Loss of husband as a care give - through death</p> <p>Difficult relationship</p> <p>Poor health</p>
	Consequences of losses	Loss of role
<p>CONSIDERING OPTIONS OF CARE</p> <p>History of care giving: formal</p> <p>Loss of care giver: evicted</p> <p>Judged as not qualified by others</p> <p>Distance to provide care</p> <p>Imagined burden on caregiver</p> <p>Lack of reciprocity</p> <p>Increasing severity of condition, consequence of severity of condition, Offers of care</p>	Options considered	
	How options were considered	
	What influenced the options	

**Table 7: Open Coding Sequence of this Study
Inspired by Strauss and Corbin (1998)**

3.3.13.3 Axial Coding

While still continuing with open coding the emphasis shifted to a greater focus in axial coding, the process of relating major categories to other major categories through their subcategories (Strauss & Corbin, 1998). To begin with, the properties and dimensions that had been discovered in the open coding phase were re-examined in terms of conditions and consequences (Strauss & Corbin, 1990 pp. 124-5).

Four main concepts were identified both according to the frequency with which they were cited in the data (directly or indirectly) and also by their power to explain 'what is going on'. For example, if a participant described beginning to think about a move as he or she experienced losses, the dimensions of 'experiencing losses' were developed by going back to the line by line analysis of the data and asking myself questions such as: (1) When did they experience loss? (2) What loss did they experience? (3) How was loss experienced? (4) What did they do when they experienced loss? What conditions influence each of the above and how?

In subsequent interviews, the questions became more focussed (based explicitly on a need to fill out the subcategories, dimensions and properties of experiencing losses and responding to loss. Participants were prompted with questions such as:

- Can you remember back to when you began having some difficulty?
- What sort of losses were you experiencing?
- What did you do at the time to try to accommodate these losses?
- What did you do and when did you start thinking that you might need help?
- What sort of help did you think you needed?

Each question generated new dimensions, giving depth and complexity to the categories and embedding them in the context.

For the purpose of illustration, I will continue the analysis with 'experiencing loss'.

1. How the loss was experienced

- Participants talked about experiencing new loss or becoming aware of existing losses such as:
 - A fall
 - Illness
 - Loss of buffer
 - Loss of care giver through death or inability to continue with care.(death , inability to continue)
 - New awareness (Someone else pointing it out - in hospital, from family)
 - Anticipating their future needs

The process of identifying, labelling and arranging categories that began during initial open coding continues during axial coding (Strauss and Corbin, 1998 p. 124).

Responding to losses, participants considered options (strategies) to gain assistance such as:

- Revising the physical loss
 - Going for rehabilitation,
- Support to replace lost ability
 - From council
 - From family
 - Moving in with family
 - Having family move in
 - Other?
- Eliminate the need for lost ability
 - Modifying their homes
 - Supportive caregiver
- Anticipating future

I took all the above and created a category. This is the way I carried out the analysis and explored other categories the same way.

None talked about relinquishing the role. While lost ability could sometimes be addressed, lost role, it seemed, could not be. The options participant considered were coded as in the following example:

Responding to loss	Strategies
Rehabilitating self	<i>I thought if I worked on getting in and out of bed and into the chair, I could do the rest for myself but the physio said my stroke was very bad, I couldn't do that again.</i>
Modifying environment	<i>I got the bathroom fixed so I could go in with my wheelchair and also some rails that I used to pull myself up on when I was getting in and out of the bath or dressing.</i>
Bringing in support	<i>"First the Italian nurse from the immigration office (migrant resource centre) was coming every day, two times. But she couldn't check the sugar and also give the insulin.</i>

Table 8: The Options (Strategies) Participant Considered

Comparative analysis allowed me to identify common experiences and those that were associated with specific conditions such as, physical changes, making demands on others, loss of ability to look after self, and others were the conditions that promoted participants' awareness.

Below is an example of the comparisons made of participants' responses on what losses they experienced, when and how they experienced the losses.

When they experienced the losses	How they experienced the losses	What losses they experienced
<i>"When I had the stroke", After a sudden illness</i>		Ability to care for self
<i>When my wife died, When a companion was lost</i>	loss through death	Companionship
<i>I came here for respite and my husband said he cannot take me back because he cannot look after me at home. After hospital stay</i>	Refused care and professional decision to relocate	
<i>"Five years ago, the greedy sister in law and her children sent me to the hospital when I took a turn and I haven't been home since". After a hospital admission</i>	Refused care	Loss of ability to stay home
<i>.....the doctor said "You cannot look after yourself anymore" In the hospital</i>	Professional decides can no longer care for self	Loss of home
<i>"I wanted to look after her. I know her better than anybody. Sometimes she will not eat her food and I have to talk to her like a child you know. ...So I was worried if she refuse to eat." Continuing important role When wife continued to decline</i>	Wife needing more care	Role loss potential

Table 9: Comparisons Made of Participants' Responses on When and How They Became Aware of Problems

In order to optimise the conceptualisation of links between categories and, the subsequent integration of categories, diagrams were used.

Strauss and Corbin (1990) state that diagrams enhance the conceptualisation process by encouraging the researcher to see theoretical codes related to properties, conditions, strategies and consequences. Constructing diagrams, Strauss and Corbin (1990) assert, helps to show how the categories relate to each other to develop the theoretical codes. Inspired by Strauss and Corbin, through the diligent use of diagrams, I was able to discover relationships that may not have been readily apparent. Examination of a diagram also indicated gaps in the analysis where the categories or emerging theory needs further development (Strauss & Corbin 1990).

In this case, gaps that I identified were explored in the subsequent interviews. Examination of a diagram indicated gaps in the analysis where the categories or emerging theory needs further development (Strauss & Corbin 1990). The diagrams illustrate where I was at this stage.

3.3.13.4 Selective Coding

The selective coding stage of the analysis involved the selection of the core category by: filling in categories that needed further refinement and development, developing a conditional/consequential matrix to show the relationships among categories and comparing each category with other categories to see how they cluster or connect. The following section illustrates how the selective coding was performed.

3.3.13.5 Selecting the Core Category

The core category as defined by Strauss and Corbin is the central phenomena representing the main theme of the study and must relate to the other categories in meaningful ways (Strauss & Corbin, 1998). After the initial attempt to re-organise categories as attributes of concepts addressed during the axial coding phase of the analysis, I realised that the categories were not at a sufficiently abstract level to even come close to the level needed to become core categories. I continued to write and ask myself conceptually orientated questions.

For example, what took participants to the facilities in the first place? How did they decide to move? How did they make sense of 'being moved' into a nursing home?

I realised there were many more levels that needed to be explored before I could make a decision about which category had the greatest ability to organise the processes people went through as they experienced loss. I re-examined memos and the data available to me to see if there were any new connections that could be made and further abstract levels to be explored. This process led to the construction of a higher order of categories. While labelling the concepts, I recorded the methods of analysis and my interpretations for future discussion and also questions for next interviews in my memos.

I needed to look for variations in these things. At this stage in fact, none of the participants interviewed earlier in the study talked explicitly about their culture before they were asked but once prompted, all of them had something to share about it.

My growing understanding of the data, concepts, and their properties also guided further data collection in relation to which participants to select and areas to sample more about (theoretical sampling).

Analysis of interviews from the first six participants did not yield significant references to culture. This created a dilemma for me, as my intended topic was Relocation to a nursing home: the significance of cultural diversity. I therefore conducted follow up interviews with the same participants to ask explicit questions about culture, being careful not to impose my assumption that culture made a difference in how older adults experienced living in a nursing home. To accomplish this, I developed questions to explore participants' experiences related to culture while remaining open and nondirective enough not to impose my assumptions about the relevance of culture.

The questions chosen to explore participants' experience in relation to cultural influences were formulated and more focussed but open enough to give room for their total experience.

What generally happens in your culture when people get old and cannot do things for themselves? Is that the same since you are here in Australia or does living in Australia change that? (If yes) How does it change here?

Tell me about your culture. How important is your culture to you?, Are there any ways that you have brought your culture with you?, How important is that to you?

Are there things from your culture that are important to you that you have lost by coming here?

Are there any practices that you still have regarding your culture, what are they?

Are there people here to share your culture with? What difference does it make to be looked after by people not from your culture?

Once prompted, all of the participants had something to share about their culture. However, culture became important for most of the participants at the point of 'considering options'. This was evident when identifying and considering the options available to them, once they had become aware of their own difficulties. This discovery shifted the focus of my study from moving to a nursing home to the decision-making that occurred prior to such a move. The table below shows the comparison of the initial interviews and the follow up interviews I carried out.

Initial interviews	Follow-up interviews
CONSIDERING OFFERS OF CARE	CONSIDERING OFFERS OF CARE
Who offered Family Participant What offers -moving in with family Consequences Refusing offer/Rejecting offer Moving to a nursing home Reason to reject -Proximity to family -Fairness to caregiver -Expertise of potential caregiver -Caregiver capacity -Ability to reciprocate meet expectations	Who offered Family Participant What offers -moving in with family Consequences Refusing offer/Rejecting offer Moving to a nursing home Reason to reject Reciprocity (what they expect) -Reciprocity (what family expects) -Proximity to family -Fairness to caregiver -Expertise of potential caregiver -Caregiver capacity -Ability to reciprocate meets expectations.

Table 10: Comparison of Initial Interviews to Follow-up Interviews on 'Considering Offers of Care' (Differences in Red)

While this review of the developing theory provided me with a framework that represented the interaction between conditions and consequences and the dynamic way in which events occurred, it also helped the selection of the core category for the study: Relocating and settling in to a nursing home.

Consequences are the result of the actions/interactions with the core category (e.g., what they experienced, or did not experience when they moved into the nursing homes, and the strategies they used to settle in the nursing home.

Many of the concepts discovered in the open coding were not readily interpretable in terms of actions, reactions, conditions or consequences and it turned out that the key to making sense of them was to reach an understanding of which concepts were interactions. Once these were identified the other components fell into place around them. This analysis led me to a much more in-depth exploration of the pathways into aged care than I had initially intended. Thus, what took participants to the facilities in the first place, how they went about deciding to move, and how they made sense of 'being moved' into residential aged care were seen by participants as integrally related to their culture and their cultural identification. The in-depth exploration and identification of the relocation process not only helped identify the options participants looked at and decision making process leading to their relocation but also indicated their experience and the strategies they used and also led to the discovery of what was significant or relevant in terms of participants' cultural beliefs.

As I continued to code the twenty interviews, theoretical saturation was reached on the four main categories and their subcategories. Strauss and Corbin (1998) define theoretical saturation as reaching a point where no new (conceptual development) seems to occur during coding. Thus, saturation occurs when the data yields no significant new concepts. The most important categories that Strauss and Corbin suggested the researcher should aim towards saturation are the core theoretical categories.

As the purpose of GTM is to identify core processes *from the point of view of the participants*, the categories that emerged were all based on how they understood their situations, what was most important to them and how they made decisions about the path to take. It was very useful to pose questions and then further analyse the data in an attempt to answer them (Strauss & Corbin, 1998). The final coding process was identifying the properties of the emergent categories and delineating the dimensions of the set properties until no new concepts or categories was yielded, or in other words, saturation is attained.

I had originally intended to recruit and interview approximately 20 participants, but lost hope after my 12th interview when three of my prospective participants died and two fell ill and were admitted to hospitals. Two other prospective participants became confused after a short illness and pulled out of the study. I then aimed at 17 participants and interviews. After interviewing the 16th participant, I realised a few more were needed to be sure that categories had been sufficiently 'saturated'. I then thought of applying to the ethics committee of Australian Catholic University (ACU) for permission to recruit add on new facilities to enable me to reach my target.

While in the process of applying, I became lucky. In fact very lucky and had calls from two of the four participating facilities. The good news was that, in one facility, there was a new resident who couldn't wait to be recruited for my study. Additionally, one participant who was hospitalised for hip surgery had been discharged back to the nursing home. In the other facility, another prospective participant had been discharged from the hospital. I quickly jumped at the opportunity and recruited my 20th participant. Overall, I interviewed 20 participants and undertook thirty six interviews in total with four participants being interviewed once and sixteen being interviewed two times.

The nineteenth and the twentieth interviews generated no further development of the categories and subcategories of the core category. At this point, I determined that more interviews would simply serve to confirm what was already found rather than discover new categories. All categories were systematically compared, cross-referenced, and related to each other in terms of their types, properties, dimensions and consequences.

Thoughts and insights revealed in the course of constant comparing of categories were also highlighted by memo writing to conceptualise and hypothesise theoretical links between categories.

3.3.14 Evaluating Quality of the Study

In research, regardless of the research design and method, it has been suggested that the researcher must explicitly state the evaluation criteria for the study's methodological quality (Silverman 1999). Similarly, Strauss & Corbin, (1998) stated that, all research studies require evaluation in terms of the procedures and process of the methods used to generate the research findings. Grounded Theory analysis has been described as telling a 'story about people, social processes, and situations' (Charmaz, 2000 p. 522). In Grounded Theory research according to Strauss & Corbin, (1998), two aspects in evaluating methodological quality and rigor are the following: (1) how the researcher works with literature and experience in the field (methodological rigor), and (2) how the researcher is positioned before and during the study (researcher's position).

3.3.14.1 Methodological Rigour

Grounded Theory aims to be a rigorous method by providing detailed and systematic procedures for data collection, analysis and theorising, but it is also concerned with the quality of emergent theory. The criteria for rigor as developed by Glaser (1978, 1992) and Strauss & Corbin (1990, 1998) suggest that data are treated as reproductions of reality. This implies that the research question must be related to the research aims, be appropriate for the research phenomenon and data collection must follow the logical direction of analysis. The criteria illustrate concerns with verification, craftsmanship and the effectiveness of knowledge for prediction control. The criteria proposed by Glaser & Strauss and Strauss & Corbin for a rigorous Grounded Theory study includes the determination of fit, plausibility, generalisability, and control.

Determination of fit is referred to as the relationship of core category to the salient social problem and its ability to account for most of the variation in behaviour used to address the problem. Thus, the study result should fit the phenomenon, provided it has been carefully derived from diverse data and is faithful to the everyday reality of the area.

The researcher needs to demonstrate that analytic decisions follow directly from the analysis that are grounded in empirical data (Strauss, 1987). In this study, I took the results back to the participants at the end of analysis in selective coding and asked them to evaluate if their data is being accurately identified and described.

This, as Strauss and Corbin suggested, assisted me in guarding against biases and also to achieve precision. Checking for rival explanations, a method was adhered to, which also forms part of the analytical procedure of Grounded Theory method in theoretical sampling. For the results to fit, all processes contained within the Grounded Theory method were evident in the study documentation and demonstrated this process of internal consistency (Strauss & Corbin 1990). These processes include, amongst others, the use of constant comparison method of data analysis, the use of theoretical sampling and theoretical memos as described in this chapter. Transcripts from the data have been used to demonstrate how the principles of open coding, axial coding and selective coding have been applied.

Plausibility, the degree to which the research process and theoretical formulations fit reality, provides understanding and is useful. In other words, the findings should provide understanding and be comprehensible to both the persons studied and others involved in the area (Strauss & Corbin 1990).

As the theoretical construct and conceptual categories emerged from the data, I returned to several of the participants and discussed with them. Occasionally the presentation of the emergent theoretical construct and categories were greeted with expressions such as:

yes exactly, you are such a great listener.

However, on other occasions, the presentation of a new or modified category would attract statements such as, *what I meant was...* or *I think I wanted to say....*

The purpose of this process of continuous feedback was designed to ensure the categories were accurately portrayed from the perspective of the participants and

reflected on their experience and that it is “faithful to the everyday realities” (Glaser & Strauss 1967, p.239).

Strauss & Corbin (1998) advocate returning to the participants to gain feedback to see what does not apply and what, of significance, has been omitted. Another reason was to achieve both a believable and plausible explanations when participants were satisfied that my interpretations with of the closely resembled their reality of the relocation process and their main concern. Often the lack of association with a particular category could be attributed to the conceptual title given to the category. Returning to the data in this case enabled me to use a title, which is more relevant and could be easily associated with by both the participants and aged care practitioners.

Relevance and work: A core category Glaser postulates that fits is relevant and works not only is subject to qualification and modification but also integrate a theory so that it is dense and saturate with relationships (Glaser 1978).

Workability refers to the capacity of a Grounded Theory to “explain what happened” and it is achieved by “getting the fact” by systematic social research (Glaser 1978, p.4). As describe previously, I have followed the systematic process of Grounded Theory method in this study. Glaser (1992) argues, if a Grounded Theory has both fit and workability, it also has relevance.

Relevance means, of what interest or importance is the theory to the study participant’s practitioners in the area of research and other researchers. The sharing of knowledge gained in one context can be usefully applied to another and in this case should be made available for other practitioners in the field of aged care. I will demonstrate data ‘fit’ and describe the study detailed enough so that others can evaluate the importance for their own practice, research and theory development in the conclusion to this thesis.

Reproducibility, according to Strauss & Corbin (1990) refers to the ability to implicate findings under similar conditions and rules for analysis about the phenomenon. Strauss & Corbin (1990) propose that reproducibility can be achieved by thoroughly describing

the research context and assumptions central to the research. I have therefore stated Grounded Theory perspective in detail in the previous section of this chapter.

Generalisability, according to Strauss & Corbin (1990) relates to the study findings. “It should provide generality, given that the data are comprehensive, the interpretation conceptual and broad, and the theory includes extensive variation and is abstract enough to be applicable to a wide variety of contexts in the area”.

To enhance generalisability in this study, I kept records of my analytical decision making to demonstrate that it follows directly from the analysis that are grounded in the empirical data. The tracking process was used by identifying why particular theoretical decisions were made and how the analysis directed me to ask particular questions of particular participants. I also composed an interviewee summary, which contained tentative interpretations of the in-depth interviews and served as material for member check.

Control, as Strauss & Corbin propose implies that the substantive theory must enable the person who uses it to have enough control in everyday situations to make its application worth trying (Strauss & Corbin, 1994, p. 273). It should provide control, in the sense of stating the conditions under which the theory applies and providing a basis for action in the area. A Grounded Theory researcher, Strauss & Corbin (1990) propose, is aiming to understand and to explain the processes that participants use in their every day life. When the researcher has been effective, the response of the participants was positive and exciting as they become aware that another has understood their world. A rigorous and well-executed Grounded Theory research will demonstrate to the participants their actions, how they change in different contexts, what works for them, what gets in the way and how they experience the outcome of all these factors (McMillan and Schumacher (1997)).

Page (1997) suggested when the researcher makes public the reflective process by which he or she got involved in during knowledge production, validity is increased. As a means of managing these hazards, any scholarly texts (including those written by me), as analyses applied to data gathered were documented. Descriptions of the effects of

interactions on interview data and attention to relationships between me and my participants were necessary for attending to the rigour of Grounded Theory findings. Both these processes required me to take the role of another and to be able to reflect on my own position in relation to the field of study.

3.3.14.2 My Position as a Researcher

The researcher using the Grounded Theory method becomes immersed in two worlds. The researcher's position, furthermore, Patton (1990) also adds that the scientific observer is part and parcel of the setting, context, and culture he/she is trying to understand and represents.

To this study, I brought several years of first-hand experience as an aged care nurse and teacher of registered aged care nurses. Moreover, as a migrant myself, I have had some experience with issues of acculturation as I relocated to Australia from a completely different culture.

This experience made me aware of and be sensitive to the issues faced by people with CALD background. However, they raise some risks that I might impose my 'expertise' as either an aged care nurse or a immigrant. For example, being human, and with my ethnic background and experience, there could be failure to hear what a participant says, experience a (close) relationship with the participants, or feel obliged to protect them from 'outsiders' as, for example, other researchers.

In dealing with these issues, Grounded Theory researchers usually prepare themselves for entering the field by initial memos reflecting what they already know, the experience they have had, which relates to the phenomenon and their attitudes towards the phenomenon they are about to study. In this way, the researcher develops a theoretical sensitivity for the area of study and a heightened awareness of their assumptions. In this process, the researcher is checking out and becoming aware of where they are positioned in relation to the study phenomenon.

I enhanced my theoretical sensitivity by constantly comparing concepts and categories to look for differences and similarities, through questioning, formulating tentative answers and checking out provisional answers by referring to data during data analysis. My personal values, beliefs and experience as an insider have been made explicit so that the reader can judge how this may have influenced the investigation and interpretation of data (Strauss & Corbin, 1999).

The thought and emotions that impacted upon me throughout the study led to critical awareness as an insider in the research process. My experience and personal insight related to being an insider and researching immigrants whom I am a part of have also been described. This awareness led me to checking and rechecking my interpretations of categories and was further achieved through peer debriefing.

This strategy involved regular meetings with peers of a Grounded Theory group, which consisted of beginners and expert researchers, mid-way through the data collection.

The group was invaluable when I was clarifying the basis of my understanding of the main concern participants as the categories emerged. These peers asked questions and supported the research process. This technique can help establish the credibility of the researcher and value of the research, through peer review and feedback (Patton, 1990).

Peer debriefing also occurred between me and my supervisors, who checked results through all stages of the analysis. The peer debriefing process raised a number of issues, such as the use of a common language, clarification of concepts, categorisation and sub-categories. These issues were addressed by revisiting the data, and through the use of recursive questioning in later interviews designed to clarify concepts and stay grounded. The group meetings forced reflection of potential biases that could occur as an insider and also helped me to clarify the biases of interpretations for the emerging social and psychological process and identification of the core category as it emerged.

3.3.15 Summary

This chapter has justified the decision to adopt GT to achieve understanding of the significance of cultural diversity in CALD elderly nursing home relocation. The theoretical and procedural perspectives of Grounded Theory have been discussed and the application of this methodology in the present study in term of sampling, data collection and analysis and verification of results has been detailed. The stories of the participants have been identified.

The findings on relocating to a nursing home included seven categories, experiencing losses; responding to losses; considering offers of care; deciding to move to a nursing home; searching for and selecting a nursing home; moving to the nursing home and settling in. Each process is described in detail and supported with statements from the participants in the following chapters.

The themes, fit, plausibility, generalisability and control have been discussed as a means of enhancing the quality and hence the rigour for this study. Also discussed in this chapter is how I positioned myself before and during the research and the strategies used to enable evaluation and rigour of the study.

THE STUDY FINDINGS

Pathway to nursing home relocation

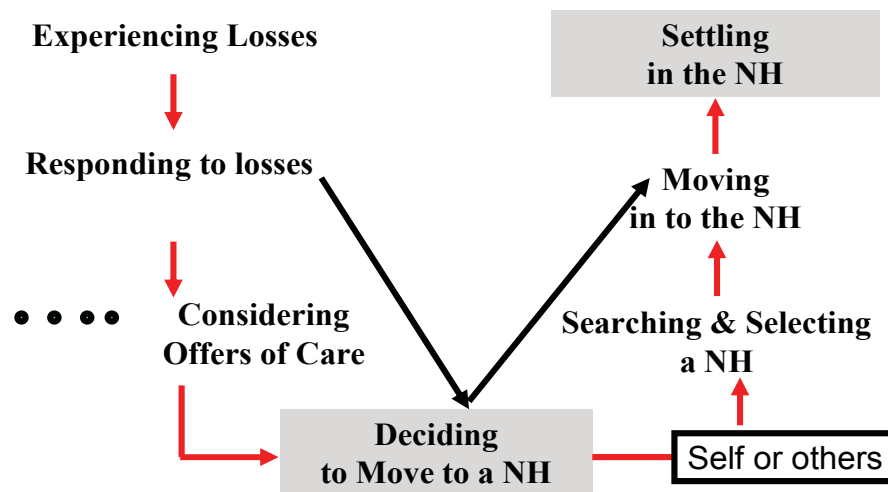
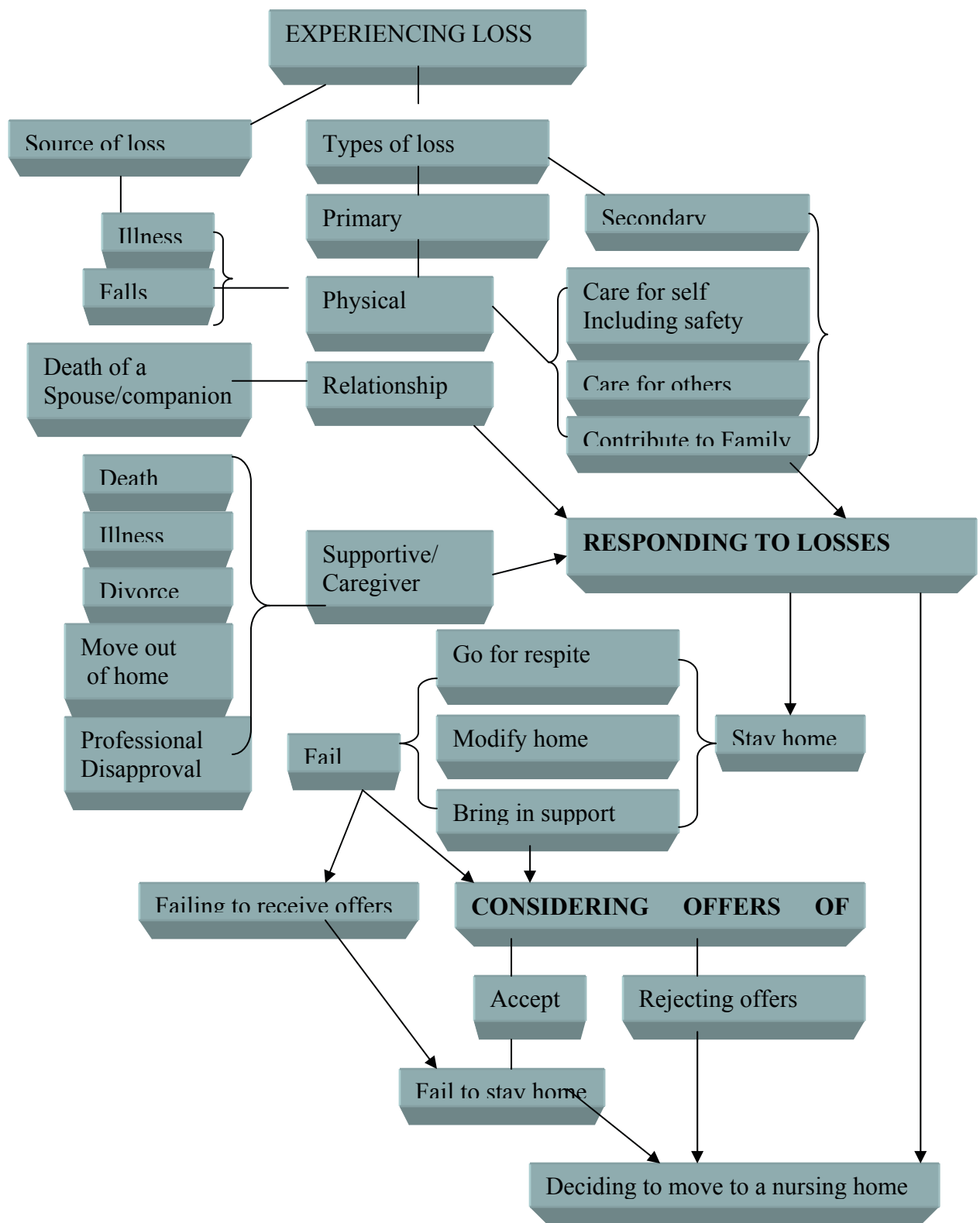


Diagram 1: Overview of Study Findings

(The dotted line on the left refers to considering offers of care as shown in Diagram 1, represents the ones who accepted the offers and therefore were not included in the interviews).

As shown in the diagram above, the analysis generated seven categories: experiencing losses; responding to losses; considering offers of care; deciding to move to a nursing home; searching for and selecting a nursing home; moving to the nursing home and settling in. The significance of cultural diversity in relocation to a RACF was the major aim of the study. However the findings of the study focus on the relocation experience of the participants as cultural relevance to relocation was not a major finding. In the following four chapters each of these categories will be described in detail and supported with statements from the participants (supporting statements used in describing the study findings are direct quotations from the participants).

- Chapter four reports on loss experienced by CALD elderly, how they responded to the losses and how that led them to considering options and offers of care.
- Chapter Five explores how CALD elderly decided to move to the nursing homes, searched for and selected a nursing home.
- Chapter six presents participants' experience after moving into the nursing homes
- Chapter seven focuses on the strategies CALD elderly nursing home residents use to adjust and settle in.



**Diagram 2: Starting the Pathway to Nursing Home Relocation:
Experiencing Loss**

4.0 THE STUDY FINDINGS

4.1 Experiencing Loss

4.1.1 Introduction

The study finding suggests that three types of loss, occurring singly or in combination, can initiate the pathway to residential aged care. These are: physical, relational and supportive. This chapter provides some insights into the loss that older adults experience, how they interpret, reinterpret and respond to the loss they have experienced and the consequences of that loss in a way that sets them on a pathway, directly or indirectly, to the nursing home.

4.1.2 Physical Loss

When describing the 'beginning' of the pathway into residential aged care, the older adults interviewed for this study frequently identified physical loss and development of chronic pain as the problems for which they sought assistance. Although at this point of experiencing physical loss, older adults were not anticipating a move to aged care, for many, the 'beginning' of the pathway into residential aged care began with some type of physical loss.

Types of physical loss participants talked about included: endurance, comfort, balance, mobility, and resilience. According to participants, physical loss and its consequences rendered them unable to engage in routine daily tasks such as getting in and out of bed, moving around the home, getting out to shops, fixing meals or recovering from a daily task.

Physical loss had serious consequences for the ability of the participants to engage in important roles such as, caring for themselves and keeping themselves safe, caring for others, and making important contributions to the family. These roles were fundamental to their sense of themselves as wives, grandparents or spouses.

4.1.3. Loss of Ability to Care for Self

Physical loss rendered some participants unable to look after themselves thereby making the older people prone to falls and injuries. For some, this was an indication that they could no longer look after themselves.

Describing their loss of ability to look after themselves, participants talked about walking, doing their shopping, cooking meals, and attending to their hygiene. For example, one participant whose worsening medical condition made him weak said he found it difficult walking even short distances around his house. He stated:

My ticker was the biggest problem. The doctor said my hypertension was getting worse. I only had to walk from here to there and I will be puffing. It made me weak and tired so much that I could not walk to the shops anymore.

As one participant acknowledged, looking after himself became a challenge,

I realised that I was getting weak and weaker. I needed a lot of help to look after myself. showering, changing my clothes and even feeding myself sometimes. I wasn't so strong anymore.

Several of the participants described increasing difficulty recovering from minor illnesses. For example one participant stated:

I was always in bed because I was feeling very weak. So when I had the cough it went very bad. It took a long time to stop

Physical comfort /pain

Chronic pain had significant consequences to the ability of the participants to engage in necessary activities that were vital to self-care and the ability to remain at home. For example, participants described how pain caused them difficulty in preparing meals, gardening, shopping and getting in and out of bed.

As one participant stated,

I was able to cook and do the shopping and everything but it was sometimes a little bit hard because of the pain in my hands.

Another participant who found it difficult getting in and out of bed due to pain described,

The pain was so bad .I found it difficult moving around or even getting in and out of bed.

Another participant described the impact of pain on his activities of daily living as:

At that time my only problem was the pains in my joint that made it difficult to cook shower, or even feed myself sometimes for example, I just put up with the pain when the pain medications did not work. Some days, just getting out of bed was difficult at least not always so I was alright.

4.1.4 Loss of Ability to Remain Safe

A consequence of accumulating physical losses also influenced the perceptions of the older adults of their personal safety. Perceptions of diminishing safety were primarily associated with poor mobility; pain management and the resulting increased likelihood of falls. In addition to perceiving an increased risk of falling, participants were concerned about a decreased ability to respond effectively to a fall, injury or other danger. One participant described how he could easily fall on the floor *and be unable* to get up. He also talked about how difficult it would be to get out of the house if he were in danger as there was no one around to help.

You imagine if my daughter is at work and say there was fire, who can get me out of there? Or let's just say I fall on the hard concrete, the bathroom floor, I would have to wait for my daughter to come home to get me up. It was just an accident waiting to happen.

Describing concerns about safety in relation to pain, some participants talked about how the pain often promoted a reciprocal effect of loss of balance leading them to fear of falling. For example one participant stated.

The pain was sometimes very bad, I found it very difficult to stand up or even walk. I was worried that if I stand up, I will fall and break my legs

Balance and slow reflexes, arthritis of the hips or knees and muscle weakness also led to some participants feeling unsafe and at risk of falling.

As one participant stated:

I found it difficult moving around or even getting in and out of bed. I discussed with my son who advised that I try living at home first but it didn't end well. I was ok for a month or so then I had a fall trying to transfer to the toilet. I broke my hip and had to go back to the hospital.

Safety concerns were also related to pain medications. For example a participant who was prescribed pain medications for her arthritis feared falling asleep from the effect of the pain medication she was prescribed and the consequences that could occur stating:

The pain was too much and the more tablets I take the more I become weak. It make me feel sleepy. I didn't want to put something on the stove and fall asleep. I could burn the whole house down

Other participants had similar effects from pain medications they were taking. One participant described her experience as:

I was good then the pain got bad and the doctor put me on strong painkillers. That one makes me sleep a lot and my daughter said I could fall if I go out in the back yard or the laundry.

4.1.5 Loss of Ability to Care for Others

Physical loss and its consequences also created challenges for some participants in their efforts to provide care for others: spouses, children and grandchildren. In particular, pain was described as frequently interfering with care-giving activities. Grand parenting was an extremely important role for many of the participants interviewed. The physical losses they were experiencing often interfered with their ability to engage in things they associated with this role. For example, one participant described the impact of pain on her inability to collect her grandchildren from school.

The pain in my joints was awful. The children's school was around the corner. So I will bring them home and my daughter will take them when she finishes work. She works too

hard my daughter and I was helping her that far I couldn't walk anymore. So my daughter asked her friend, pick the grandchildren for her.

Another participant described how her increasing pain from arthritis interfered with her ability to assist her granddaughter to look after her newborn baby, a very important role for her. She stated:

Before my arthritis was very bad, I show my granddaughter to feed the baby, I hold the baby when she cries and I talk to her to stop. The pain came very bad. Now I can't do that I will drop the poor baby on the floor.

Many of the participants also continued to help their adult children, often by providing childcare. This role was also of vital importance to most of the participants. Physical changes they were experiencing also began to interfere with their ability to do things that would help their adult children. These older adults experienced considerable distress when pain or physical decline interfered with their ability to continue helping. As one participant stated:

The children have to look after their families and I cannot help them because I am useless now I cannot walk. I cannot mind the grandchildren any more. The pain made too much for me.

After she was diagnosed with chronic airway disease, one participant stated she became weak and lost his ability to help her single parent son by taking his two children to school. She described her experience as:

Walking them to school and back took a lot of energy, which I did not have anymore. One day I was crossing the road to the house holding hands with the children when a driver had to brake very hard to stop hitting us. I walked too slowly. I didn't want to kill myself and my grandchildren.

There were too many impatient drivers on that road I couldn't take a chance. So I gave up helping my poor son who had to be both mother and father to these children.

Being a caregiver for a spouse was a role many had experience with. Changes in physical health commonly led to difficulty maintaining this important role.

Another participant who was providing care for a frail spouse began to notice a decrease in his own level of strength, and with it, a diminished ability to provide the care that his wife needed stating,

...I did everything for her. I looked after her for 3 years all by myself. ... I was getting tired all the time.

Some participants were living with or providing care for other family members, such as adult siblings. For most, this was also a very rewarding role, which they were reluctant to relinquish. One participant, who enjoyed looking after his sister, had to give it up when he became weak and needed help with his own care. He stated:

My health was not good and I wasn't able to look after my sister who depended on me so much. I love my sister. I didn't mind looking after her. I loved doing that. She is my own blood and I didn't care how difficult she had become except that I wasn't capable anymore.

Another participant who was looking after his disabled son and couldn't continue due to her decreased strength said she had to retain the council services she had in support of his son's care after her son went to live in the nursing home because she couldn't do things for herself. She stated:

I guess I got too old and weak to care for myself and my son, the one who had Parkinson's disease.

4.1.6 Contributing to the Family

As physical loss occurred and accumulated, older adults interviewed for this study, found it increasingly difficult to contribute to their families in meaningful ways. The ability to contribute was extremely important for many of the participants. One participant who could no longer tend the family garden was forced to relinquish his gardener/provider role and prevented from making an important contribution to the family's financial well-being and enjoyment. He stated:

I looked after my sister's garden, did some cooking while she was at work, picked up the grandchildren from school until my arthritis became this bad. My arthritis was getting bad and I couldn't help my sister that much any more.

Another participant who helped look after his brother described how his physical decline prevented him from helping with his brother's care as:

I used to give my niece a hand in looking after her father. I will take him to the toilet, feed him and put him to bed when my niece is at work. I became very weak and frightened of having another fall after I came back from the hospital. My niece had to leave her job to concentrate on my brother's care and mine as I was useless and needed help myself.

Being able to contribute was important to participants, but became much more important for older adults who had accepted offers of care from relatives and will be discussed again in that section.

4.2 Relational Loss

Relational loss, also identified by many participants as starting them on the pathway to aged care, can occur as a consequence of death, illness or abandonment (Goodman et al, 1991). The reason for relational loss reported by some of the participant in this study was death of a spouse. For many, this was the primary relationship and its loss had tremendous emotional impact. Of significance for this study, is that such relational losses were seen to influence decision-making about a move to aged care.

These influences operated in several ways. Living with a spouse influences how older people think about 'moving' to aged care, but not necessarily in the way generally assumed. While living with a spouse was often described as reason to stay home, making a move to aged care less likely, for some older people being committed to a spouse actually resulted in a quicker move to the nursing home. For example, some older adults, the loss of an important relationship resulted in a decreased importance of staying home, as the primary reason to remain home was no longer there. For example, one older man decided to move to the nursing home after his wife died, explaining:

When my wife died, my niece said she will come and stay with me in the house to make sure I am alright... I said no. My Maria is gone, it is hard to stay in the house so I want to come and live here...

In some instances, relational loss was the impetus to consider aged care as a way to renew or develop relationships to fill the void when a companion had been lost. For example, one participant who found himself very alone after the death of his wife stated.

I didn't need much help to look after myself because the council was going to continue bringing the nurse home and the meals on wheels as well as the cleaner. I just couldn't go on without her around. There was nobody to talk to.

I decided, if I go to the home I would have plenty of people like me, people who don't have anybody else to talk to.

4.2.1 Moving to a Nursing Home as a Way to Continue Care Giving

In some cases, older adults were experiencing decline that prevented them from continuing to care for a dependent or chronically ill spouse. Moving to a nursing home was a way to supplement the care they were able to provide, preventing or delaying a separation. For example, one participant, who was looking after his wife at home, was diagnosed with cancer and began to experience physical decline; making it difficult to continue providing care. When his wife was placed in the nursing home he could not provide her care and so asked to join her so that he could continue 'doing his job as a husband.' He stated:

I was worried all the time. I failed to do my job. I wanted to look after her. I know her better than anybody. Sometimes she will not eat her food and I have to talk to her like a child you know. Sorry about that but it is true. So I was worried if she refuse to eat.

Increasing dependency of the spouse being cared for might also lead to a move to a nursing home. For example, some older adults described how they considered nursing home as a way to obtain competent care giving assistance. Under these circumstances, moving to aged care was described as a way to continue caring for a spouse, as a way to continue an important role and to protect an important relationship.

One woman, whose husband was declining rapidly, believed that a move to low care would gain her the assistance she needed to keep him out of high care where they would be separated. Although they had planned to continue living at home, she realised

her husband's gradual mental decline would put him at risk for admission to high care, where they would be separated.

I wasn't the best myself you know, but we were coping all right until he became more confused and difficult to handle. I thought if I could have any little help with him, we will still be all right together.... He doesn't have to go to that side (high care) because I am here (low care). At least here I can keep an eye on him and get all the help I need with him.

Loosing a relationship prompted some participants to move to the nursing home as a way to stay together. For example after his wife was moved to the nursing home with dementia because he was deemed incapable of caring for his wife, one participant described his reason for moving as:

We went and she did not see me again. I cried. She will not sit down to talk to me. When we went home I talked to my daughter to ask for a room for me there and I can join my wife.

4.2. 3 Moving to a Nursing Home to Maintain Relationships

For some, the move to nursing home was an effort to renew or maintain relationships with children or grandchildren while maintaining some independence and preventing a negative impact on others. Moving to a nursing home near family was a way to 'be close' without creating a burden on family by expecting them to actually provide care. It also allowed older adults to look to formal caregivers in nursing home to provide care, allowing the older adult to see family frequently while preventing them from feeling dependent on their children. So for several of the older adults in the study, moving to a nursing home near family was seen as a very positive move, preserving both family relationships and a sense of personal integrity.

You see I did not want to bother my son in law all the time to take me out. ... My house is in Croydon and my daughter lives (here) in Rosanna. My granddaughter lives in Rosanna too.

4.3 Supportive Loss

Some participants identified the loss of support as the initiation of their pathway to RAC. While they had certainly experienced physical losses prior to the loss of support, they

were often relatively unaware of those losses until an important support was also lost. This intersecting of physical and support loss no doubt accounts for the well documented spouse loss as a trigger for moving to aged care (Grundy and Jitlal, 2001). Loss of a support person or caregiver occurred as a result of death, physical decline, illness, divorce or a move out of the home.

4.3.1 Loss of Caregiver Through Death

Sometimes the older person was well aware of what the caregiver had been doing for them and other times awareness only came with the loss. For example a participant was looked after by her husband with some support from the council after she suffered a stroke. The participant said she was unable to continue living at home after her husband's death because she had nobody else to continue with what her husband was doing for her.

My husband was looking after me at home. After I had the stroke, I lost the strength in my right arm and leg so my husband did almost everything for me. Then he got killed in the car accident.

Another participant who lived with his wife, and saw the assistance from his wife as merely her job as a good wife, said he did not see the depth of his disability until his wife died and he had to do things for himself. He stated:

When she was alive it never occurred to me that my disability was so bad because she did everything for me like any good wife would. I didn't have to do anything for myself.

4.3.2 Loss of Caregiver Through Illness

When a caregiver is also an older adult, such as a spouse or partner, they may become unable to continue providing care at home by becoming ill. For example, one participant who was in the care of her older husband could not go home to live after respite care as she explained her husband said he couldn't continue with her care due to his own physical decline. While inability to continue caring was often attributed to illness in a spouse, it was not unusual for these caregivers to be other family members. For example, one participant who was receiving help from her daughter when the daughter had a stroke and was admitted to hospital stated:

My daughter had a stroke and she went to the hospital for a long time so there was nobody.

Another participant who lost the support of her husband through illness stated,

He is not strong. That is why he cannot look after me and I came here.

4.3.3 Loss of a Caregiver Through Divorce

It has been well documented that ex spouses often come to the aid of people needing a caregiver (Mintz 2002). In this study, one of the older men who experienced a sudden physical decline related to a stroke was surprised to discover that his ex wife was unwilling to provide his care. This man had continued to live in the same house with his ex-wife and expected her to provide his care. He explained,

When we got divorced, we decided to stay in the same house but in our separate ways. The house was a government house under both our names. When I had the stroke, she said she couldn't look after me and I am not her responsibility as we are divorced.

4.3.4 Loss of a Caregiver Through a Move Out of Home

In other instances, caregivers were lost as a result of a move. For example, some caregivers moved because of a job transfer or following a marriage. This was seen primarily in situations where the caregiver was a grandchild. For example; one participant's granddaughter had been living with her, providing support, before she got married. Following the marriage, the granddaughter moved out. She stated:

My grand daughter was checking the sugar morning and night and was checking everything I ate. Then she got married and moved out.

Loss of a support person and needing a service that could not be obtained has been identified in the literature as common triggers for moves to residential care. What has not been identified is the interaction of various triggers, how they work together to increase or decrease the possibility that such a move will be considered. Also, while the

literature has quite a bit to say about the impact of caregiver fatigue on triggering a move, it is relatively silent on how the older adult considers the impact of their care on family dynamics, on their relationships with family members and on the relationships of family members to each other.

4.3.5 Loss of Caregiver Through Professional Disapproval

The loss of decision-making about moving to a nursing home was most likely to occur when the older person was in hospital and came under the direct scrutiny of professionals. For some, the professionals decided that their caregiver was not sufficiently able to provide the needed care.

For others, the participant was believed to be 'too much' for any caregiver. In both situations, professionals were insisting that the care giving situation was not safe for either the participant or the caregiver. Significantly, this was often over the objections of the caregiver and was perceived in each of these situations as a decision that neither the caregiver nor the participant could alter. There was a clear sense of impotence in terms of overriding the decisions of a professional.

One participant who went for rehabilitation described how the professionals deemed his son 'incapable of care,' told the son he could not continue caring for the father and consequently pushed the father into a nursing home. In some cases this is a relief to the older adult but to others, it is a serious disappointment.

They say can't look after me anymore

There were several participants who described losing caregivers while they were receiving care in hospital or in respite. While the data do not include the perception of caregivers, it is clear from interviews that participants saw caregiver loss in these situations as resulting from the generally unwelcomed intervention of professionals.

A few caregivers saw hospitalisation as an opportunity for caregivers to abandon them, often with the assistance of professionals who supported their decision. That is, caregivers who may have wanted to stop care giving found allies in the hospital or respite setting, to support their 'need' to stop care giving.

I came here for respite and my husband said he cannot take me back because he cannot look after me at home

In some cases, the caregiver was not around, seemed to disappear while the participant was in hospital, leaving the hospital staff with the impression that there was no caregiver. For example one participant stated:

My niece didn't come to visit for some time. I knew there was something wrong but I couldn't tell. I had no home and nobody to help me so when the social worker from the hospital spoke to me about coming to live in a nursing home to be looked after, I was happy.

Common to each of these descriptions is the acceptance of authority from the professionals who announce that the older person 'cannot go home.'

The social worker told my sons that I couldn't go back home because I wasn't in a position to look after myself.

In some instances, professionals intervened in a care-giving situation, convincing the caregiver or the person being cared for, that the care-giving situation was not working out.

.... They say can't look after me anymore.

One participant who had previously arranged to be cared for at home stated:

The bastard greedy people put me in here. I did nothing wrong but tried to look after my younger brother's family after his death and look at what they did to me. Five years ago, the greedy sister in law and her children sent me to the hospital when I took a turn and I haven't been home since.

4.4 Other Factors that Triggered Participants' Awareness:

Moving in anticipation: Some participants attributed their decisions to one or more of the factors identified above for beginning to think about moving to RAC. In addition to

experiencing loss, some older adults began thinking about a move to RAC in anticipation of future loss.

4.4 1 Preventing Relational Loss

Older people often consider how being cared for would affect their relationships with the caregiver, how it would affect the caregiver's relationships with their families and the caregiver's life in general and how it would affect relationships among the possible caregivers (usually offspring). Often citing the extent of work the caregiver is already engaged in, with family or paid work, the older person opted to move to a nursing home. For example; when a participant was offered home care by her son and daughter-in-law, she rejected the offer by saying:

I said to them, you have your lives and we couldn't possibly be a burden on you.

Another example of preventing relational loss is when one participant was offered home care by all of her five children. Competing to be caregivers for their mother, the participant said her children who were lovely to each other started arguing over her care. The participant explained her reason to move was to maintain good relationships among her children by saying:

Then the other sons said you have had Mum for that long we want to live with her too. My children are lovely to each other and because of me they argue? No I said I love you I will go to the home to live there so you can all come and see me

4.4.2 Preventing Role Loss

On closer reflection of their current situations, some of the participants thought about moving to RAC. This option was considered, in large part, when older adults believed that they were no longer able to contribute to the family. One participant was living with his sister and her family and helped with overall functioning of the house realised his declining physical health made him much less useful. Believing in the importance of being able to contribute and, being uncomfortable with his declining ability to do so, led to his decision to move to a nursing home.

In addition to his feelings about not being able to contribute, his declining abilities also caused a strain on his relationship with his bother-in-law. He felt ashamed about his failure to contribute significantly and worried that if the situation worsened his bother-in-law would certainly begin to see him as needing a lot and not being able to contribute much to the family. As he thought about the consequences of continuing decline, how both he and his bother-in-law might react, he decided to move to RAC. His decision was clearly influenced by anticipating his future needs and his desire to protect his pride and his relationship with his bother-in-law. Anticipating that a possible (although unknown) increase in physical decline could result in an inability to carry out his role in the home, diminishing him in the eyes of his bother-in-law and rendering him no longer useful to his sister, one man stated:

My arthritis was getting bad and I couldn't help my sister that much any more. I just couldn't cope with my brother –in-law.

4.5 Responses to Loss

A common feature of older people's understanding of their situations, preceding their move to a nursing home, is discovering a relatively limited set of choices to meet their needs. This often took the form of surprise that there were no service providers, or that there was no reimbursement for service providers who could bring the needed services into their homes. For example, one participant who wanted to stay home with the support of her son had to move to a nursing home because her son did not qualify for the caregiver allowance. She said:

You know what? Bureaucracy. The aged care services didn't think he qualifies for any money. He had his children too and the mortgage to pay. Therefore he worked too hard and due to this his yearly income went too high for any financial assistance to look after me. We had no choice but to sell my house and put me in here.

Another barrier to staying home was an inability to obtain specialised care such as wound care, blood glucose monitoring, and managing complex pain treatment. For example, one participant sought help from her local council when her nurse grand daughter who was monitoring her blood sugar levels had also had to look after her own sick mother. Even though the granddaughter continued to help her, the participant in this

study thought it was too much for her granddaughter so she asked her local council for help, which was not available. As she stated:

My grand daughter... she is a nurse... My granddaughter was still coming but she lived in Moorabbin and had her mother to look after too... It was too much for one person... First the Italian nurse from the immigration office (migrant resource centre) was coming every day, two times. But she couldn't check the sugar and also give the insulin.

The example above also illustrates how caring for family members (trying to supplement her granddaughter's care with a district nurse) and 'physical decline come together. As the older woman needed more assistance, she did not want the extra work to fall only on her granddaughter.

She said Nona, come and live with us... So I can monitor your sugar and help you cook diabetic food. I said ok because I didn't want to die in my sleep you know... I didn't want her to do too much especially when there was nothing I could do to help her or her mother

4.6 Summary

As older people experience health problems or debilitating conditions, they engage in many strategies to acquire the support they need in order to face their daily lives. Often there is not a single trigger for someone to start thinking about finding the care they need. Considering options of care or seeking assistance with their care, including a move to RAC, are influenced by many factors. These include; declined physical health, loss of supportive care giving and relational loss that lead to loss of ability to maintain safety, to continue playing important roles, and care for, or being cared for, by others. There were additional factors such as anticipating future needs and maintaining relationships, which also caused the older person to think about how to deal with changes in their lives.

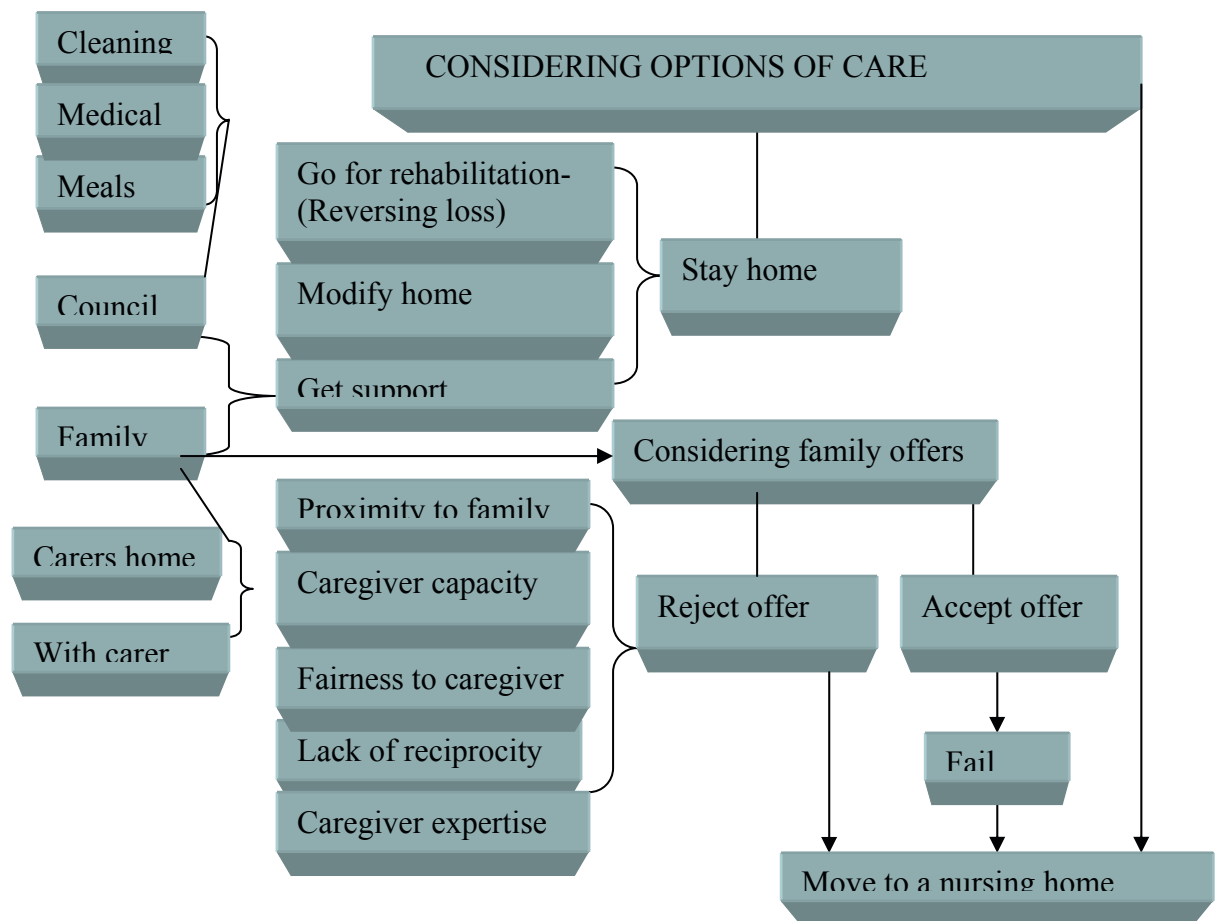


Diagram 3: Considering Care Options

4.7 Considering Care Options

4.7.1 Introduction

Most of the older adults in this study were not moved precipitously, but had time to consider their situations and make the decisions wholly or mostly on their own. For these people, there was often time to consider a number of care options either on the way to nursing home or instead of a nursing home. The question of other care options often leads to a discussion or re-assessment of their situation with their current care providers, in most cases family members, about the adequacy, effectiveness and impact of care-giving.

Some participants described thinking about their options without involving their children, while others described discussing the options with one or more of their children or grandchildren.

4.7.2 Considering Options: Initial Responses

Thinking about how to respond to the losses they experienced, participants described several options. Older adults interviewed for this study generally began by considering strategies that would allow them to remain in their own homes. Although the literature mostly addresses the question of caregiver availability as a predictor of moving to a care home, this study suggests that the situation is much more complex. Indeed, findings from this study suggest while some participants decided to move to the nursing home immediately after becoming aware of their disabilities like those described above, others began thinking about what to do about the difficulties they faced to enable them to continue to live at home.

Some participants tried to reverse the physical loss that led to their need for assistance, by going for rehabilitation to improve their ability to care for themselves. Some thought about or attempted to modify their physical environment, making daily activities less demanding, obviating the need for a caregiver. Others considered formal or informal support from their local council or from their families to enable them remain at home. This analysis is limited to individuals who eventually moved to aged care. It does not address those situations and individuals who were able to remain home. The following section describes the initial options considered by participants in this study

4.7.2.1 Reversing Loss - Going into Rehabilitation

Some participants attempted to reverse the physical losses by going for rehabilitation. They hoped that rehabilitation would allow them to become stronger, more able to care for themselves, or at least to remain safe, improving their quality of life and delaying a move to the nursing home.

While several used this strategy, there was very little success reported. In fact, it led to the opposite outcome for some, that is, it may have actually accelerated the move to RAC. The exposure to professionals often led to a formal assessment that the older

adult was no longer safe at home, resulting in a move to RAC. Some of the participants in his study described how their efforts at self-rehabilitation in a formal care setting simply brought them to the attention of professional who convinced them or their families that a move to RAC was necessary. For example one participant who had hoped to get better to go back home when she went for rehabilitation after a fall stated:

I thought if I worked on getting in and out of bed and into the chair, I could do the rest for myself but the physio said my stroke was very bad, I couldn't do that again

In this case, the physio was instrumental in convincing the family that the participant was not safe and should move to the nursing home.

Some were able to return home following rehabilitation, finding that it was difficult to sustain the results, necessitating a return to rehab after only a few. For some, the results could not be sustained. However, for most, a new problem developed shortly after returning home. For example, one participant who tried and failed explained:

That I try living at home first after the rehabilitation but it didn't end well I needed more care than we thought I would. I broke my hip and had to go back to the hospital.

Another participant who had a similar experience added,

I had another fall and went to the hospital for operation. Then I went to the other hospital for the exercise to help me walk again. After that I went back home with my son for about six months. Things were the same as before. Then I had the wetting problem. I just couldn't handle it.

4.7.2.2 Making Modifications Some participants considered modifying their houses such as installing rails, shower chairs and mixer taps in their bathroom to help them continue to look after themselves at home. For example one participant who said she only required assistance getting in and out of the shower stated she was able to look after herself after she had a bath mat, a shower stool and rails put in her bathroom by the occupational health nurse from the rehabilitation centre where she was treated. She continued on to say:*I also purchased the arthritic cutlery and cookware to make cooking and feeding a bit easy.*

Another participant stated:

I got the bathroom fixed so I could go in with my wheelchair and also some rails that I used to pull myself up on when I was getting in and out of the bath or dressing.

Modifying Activities

Some participants modified their activities in an effort to alter the demands they had to meet, making daily life more manageable. They described modifications such as cutting down the number of showers per week, getting assistance with bulk shopping and finding someone to cook several meals at a time instead of daily. As one participant said:

I didn't really need to have a shower everyday so I was having one every second day. My grand daughter sometimes brought me some food. I told her to cook and make few small portions so I can put in the fridge and warm up when I need it. I can warm and eat.

While some participants were able to stay at home with modifications to their physical environment and activities, others supplemented that with either a support from their local council or a support from their local council. For example one participant described how he coped at home when he had a stroke by saying,

4.7.2.3 Staying Home with Support: Support from Local Council

Several participants sought support from their local council to help them stay at home. In particular, participants attempted to access meals on wheels, a house cleaner, someone to help with their shopping and assistance with medical/technical tasks such as blood glucose monitoring, wound dressing and management of medications. Some participants continued to stay home with this support for up to a year. Most however described being able to manage with council support, for only a limited time, as the extent of the support was insufficient, particularly as they became more disabled. For example, one participant, who was having her wounds dressed, had to move, as they were not healing well and were becoming infected.

While many participants decided they would prefer to stay home, and attempted to acquire the supports needed to do so, many were surprised that there were limited

services or no service providers, or that there was no reimbursement for service providers who could bring the needed services into their homes. For example, one participant who sought technical support from the council but did not get what she needed remarked:

The council was not able to find me someone to come to the home and look after my diabetes. I gave up.

In some cases, there were formal carers available but the participant needed a particular service that the carer could not provide. So, while they were entitled to a carer, there seemed to be a mismatch between the particular needs of the participants and the service package. This is reflected in the following statement:

First the Italian nurse from the immigration office (migrant resource centre) was coming every day, two times. But she couldn't check the sugar and also give the insulin.

4.7.2.4 Staying Home with Support: Support from Family

Of all the care options the participants considered, care by their own relatives was preferred. Home care was offered to participants by family members either by asking participants to move in with the family or the family wanting to move into the participant's home to assist in care.

However, in each such instance, the participants thought carefully about how the offer would affect their relationship with that family member and how it would affect each of the other family members.

Participants often considered how being cared for would affect their relationships with the caregiver, how it would affect the caregiver's relationships with their families and the caregiver's life in general, as well as how it would affect relationships among the possible caregivers (usually offspring). Often citing the extent of work the caregiver is already engaged in with family or paid employment, the older person opted to move to a nursing home. For example, when a participant was offered home care by her son and daughter-in-law, she rejected the offer by saying:

I said to them, you have your lives and I couldn't possibly be a burden on you

Often being reluctant to ask for assistance from family members or being mindful of how much their family members might be doing for them, older people were often very selective about the services they would accept and what they were willing to go without. For example, while they generally did not feel they could go without technical care such as wound and diabetic care, they often thought about what daily care they could forego. One participant said:

I wasn't going to move out of my house; neither did I find it appropriate to ask my son and daughter-in-law to change their lives for my sake. They asked the council for someone to see to my ulcer and check the sugar, I was happy with that and stayed home for more than a year doing that. I only used few cloths so I didn't have to ask someone to wash them and only wash them when I could.

4.7.3 Considering Live-in Offers of Care

Older people interviewed for this study described how they and others responded to the losses and inability to engage in usual roles, as described above.

These responses were significantly influenced by cultural beliefs and practices and, in turn, this was identified as a significant influence on the pathway to residential aged care.

Until participants began discussing offers of care from their family, there was little suggestion that culture was an important consideration in their decision making about responding to loss or moving to the nursing home. However, when discussing the possibility of living with family members as a response to age related loss, their discussions were replete with references to 'my culture' 'people from my homeland', 'the way we do things' and 'the way my family does things'. Culture suddenly became the index by which many decisions were measured. It is not clear how these older adults thought about offers of care or moves to residential aged care actually differed from the way older adults from any other cultural group made decisions. Some of the participants

had received offers of care from family members. Others had not, although most believed that family members would certainly agree to do so.

The participants who received care offers from their families provided descriptions of how they thought about those offers and how they explained either acceptance or rejection of those offers.

Striking in its consistency across cultures, was a recognition of the importance of reciprocity when considering live-in offers of care from family members, how much assistance to expect or accept from family members, and how a move to the nursing home might work to maintain important cultural links and family relationships. Reciprocity came in many forms including historical, concurrent, individual and social reciprocity

4.7.3.1 Historical Reciprocity

Historical Reciprocity involves a strong belief that each generation owes something to the previous generation. Some participants expressed this as history repeating itself in a way that makes intergenerational obligations clear and non-negotiable. These participants saw expectations of historical reciprocity as firmly embedded in and reflecting their culture.

This reflects the culturally attributed belief that ‘we are people who care for the older generation. It is an important component and an expectation of our culture to do this. Historical reciprocity often comes with examples of how past generations have achieved this, *as a part of our cultural expectations*. Significantly, it is often explained as something unique to their culture, suggesting that other cultures may not have the same expectations. For example one participant who expected to be cared for by her children at home remarked:

My mother looked after my grandfather when we were growing up and we used to feed him his tea. Even as children, we helped. In my country, people look after each other so the family looks after old people.

The evidence for this might be in what participants saw their parents doing or in what they had done for their own parents. Participants who had cared for ill or dependent parents earlier in their lives now expected that 'someone', although not necessarily a particular person, would do the same for them. This is an important component of historical reciprocity, as it did not assume an equal exchange, that is, it was not necessary that they had actually done this for their own parents. They referred to intergenerational care giving patterns characteristic of their culture, to explain their expectations. One participant described how children 'in his culture' looked after their parents when they were old and no longer able to look after themselves as:

This is what we do in India. Children look after their parents when they get older and cannot look after themselves any more. You see normally the male child moves to parents' home with his family or bring parents to live with him and his family.

As care giving for family was central to a particular culture's expectations, these participants often saw it as a privilege rather than as an obligation. Care giving in these instances could be provided by anyone, for any other member. It did not involve an expectation that any particular family member would provide the care but that any or all could participate in this opportunity. Caring for your parents was, therefore, a privilege; something they believed caregivers felt rewarded for and looked forward to.

Care giving was discussed in terms of an opportunity for the younger generation to maintain cultural links. This reflected in statements by several participants where they struggled with 'not allowing' their children to care for them as taking something away from their children and not maintaining cultural continuity. One participant explained:

I thought I was being selfish denying the children their roles in my care and welfare, I knew what I had to go through looking after my own parents even though I am glad I did that.

Denying them the opportunity to care undermined cultural continuity. These participants actually worried about how to decide which of their children they would allow to care for them. One participant, who was unable to make the decision about which child would have this privilege, believed the only way to be fair was to spend time with all of them,

moving from one home to another. In this way, she would not upset any of them. She was worried that picking one of them could have a negative impact on her family relationship and therefore decided the nursing home was the best place to be, where all of them could visit and show their love for her. Each of these participants had had a very positive experience of care giving. One participant who looked after his own parents stated:

I looked after my mother and father in my home and I enjoyed doing it” and the children had told me they would do the same for me when I get to this age.

Historical reciprocity also extended to other family members, sometimes in the same generation.

I took care of my sister. I didn’t mind looking after her. I loved doing that. It was pretty hard but rewarding.

While most of the examples cited above are those in which the participant either cared for someone else or was part of a family in which the older generation was cared for in the family home, historical reciprocity does not require either. Simply acknowledging that this is ‘what we do’ as a cultural group and that they (the older participant), of course, would have been willing to care for a parent if the parent had needed care, was sufficient. For example, one participant said she had wanted to look after her parents but they died when she was young, so she did not have the opportunity to actually provide their care. She expressed the hope that her children would have wanted to do the same for her, noting that she would never have sent her parents for care, no matter how busy she was.

I wanted to look after my parents like children do in my country but they died when we were young. I wouldn’t let my mother go to a home for care no matter how busy I am.

4.7.3.2 Concurrent Reciprocity

In contrast to the forms of reciprocity described above, some participants described concurrent reciprocity as something that must be maintained on an ongoing basis. In

'concurrent reciprocity', past assistance cannot be banked for future use but must be earned continually. Descriptions of concurrent reciprocity were also embedded in cultural expectations. For example, assistance could only be accepted if and as long as, something of value could be offered in return. These descriptions included many references such as 'We help each other' or 'we all contribute'.

Once someone is unable to contribute to the overall work of the home, they no longer expect to be taken care of or even allowed to stay. The activities included in concurrent reciprocity were often role or gender-related. To be a man, one must be able to assist the female family members.

A grandparent will always help with the grandchildren. When these expectations could not be met, the older adult with this view of reciprocity was very likely to move to RAC. One participant explained her reason for refusing her daughters offer for home care by saying:

I am not strong anymore so I cannot help her with the children. So I said she should look after the children, I stay if I can help but I can't and it is not fair for her.

Role loss such as: caring for others (children and grandchildren in particular) and making contributions to the family were particularly important for maintaining this type of reciprocity. For those who focussed on concurrent reciprocity, the loss of ability to contribute in either of these two ways generally led the participants to decide that a move to the nursing home was a better option than accepting a live in offer of care.

Some forms of reciprocity did not seem to be linked to beliefs about their culture. Both individual and social reciprocity were not explained by references to their culture of origin or what 'people from my country do'.

4.7.3.3 Individual Reciprocity

A few participants talked about reciprocity in terms of 'pay back' for care they had provided from an individual family member. As one of the participants described:

I think it would only be fair as they say, you wash my back and I wash yours.

Drawing on a notion of individual reciprocity, one participant who explained her failure to receive an offer of care from her daughter explained:

Of course I will like to be home. Instead of me asking someone to shower me, I would prefer my own family to do that but this does not mean they have to do it. When my daughter had her children, I was busy working to pay off some bills so I did not stop to think I have to help her.

For those who focussed on individual reciprocity, losing the ability to provide care or to contribute to the family was not so important. What was important was what the participant had done in the past for their family members.

The belief that they had contributed substantially to others, left them with the expectation that they would or should receive offers from these same family members.

4.7.3.4 Social Reciprocity

Some participants had a macro/social view of reciprocity. Expectations for social reciprocity were related to a calculation of their past personal contributions to society *in general*, noting that they had worked hard, paid taxes, fulfilled their social obligations, and now that they were old and in need of care, there was a general social obligation to provide that care. These discussions were generally related to expectations for financial support *from society*. Their past willingness to help others who needed it should have earned them the right to be taken care of in return. These explanations did not seem to be embedded in an understanding of cultural practices and beliefs but simply in a sense of fairness that was not perceived as related to culture.

Social reciprocity intersected with cultural reciprocity as participants described how the absence of even 'a little bit of help' from the government would allow a family member to take up a care giving role and maintain cultural continuity. For example, one participant talked about how a small amount of financial assistance from the government would allow her son to care for her at home, but that financial support was not available, as

she did not qualify for financial assistance. Taking into account her past contributions to society, her generally good behaviour and the assistance she willingly gave to others when determining her eligibility for assistance seemed unfair. Considering only current financial circumstances seemed unreasonable. She stated:

Where I come from everyone is treated the same. You work hard; you decide what you want to do with your money. You don't just give the money to people and don't get it back when we need it. We don't work hard to look after others. We work hard so that when we get older, our family can look after us not strangers.

Some participants described more than one of these types of reciprocity in their explanation of failed or rejected care offers.

Significantly, participants who explained past care giving in their family or who had engaged in past care giving *because* they could not afford to pay for care, generally accepted an absence of care giving offers from their children. However, when participants saw past family care giving as done because it was a cultural expectation, they were much less accepting of their own children's failure to do so.

4.7.4 Explaining Failures to Receive Offers of Care

A few participants believed that living in Australia had broken a cultural link with 'the old country,' forcing them to accept 'the Australian way'. In some cases, the influence of culture determined the decision that was made. In other cases, it did not alter the decision about where or when to move but instead affected the reasons for and consequently the understanding of the decision.

4.7.5 Deciding to Move to a Nursing Home: Breaching Cultural Expectations of Reciprocity

In making their final decision to move to the nursing home, there were three explanations given by participants for breaching expectations about cultural reciprocity. These were: protecting relationships with or among family members; acknowledging and accepting the impact of a new context and culture; and 'poisoning' by the Australian culture.

4.7.5.1 Protecting Relationships

When considering life in offers of care, especially moving in with family, participants considered how being cared for would affect the caregivers' relationships with their immediate family members, how it would affect the caregiver's life in general and how it would affect relationships among the possible caregivers (usually offspring).

In several instances, it was the older person who rejected the possibility of being cared for by a willing family member or members, out of fear that it would jeopardize an important relationship in either their own or the caregiver's life. For example one participant, whose daughter offered to look after him at home, rejected the offer and decided to move to a nursing home stating:

My daughter brought me to Melbourne six years ago to look after me I think I ruined her marriage. Her husband walked out on her few months after I came and I hate to think I have done that to my poor daughter.I didn't want to annoy anyone like I did to her husband. I weighed the good and bad about me being at home with my daughter and found that the bads were more than the good.

While acknowledging the importance of both historical and individual reciprocity, she determined that the cultural context in 'the old country' was at odds with the Australia cultural context within which her daughter was living. So in order to protect her daughter from a life of loneliness, she acknowledged 'the Australian culture' as the basis for her decision to move into residential aged care, breaching cultural expectations of reciprocity.

As with other participants in this study, she expressed concern over the impact on her daughter of having to contend, simultaneously, with the Australian cultural context and the consequences of cultural reciprocity. She worried that her daughter's sense of historical reciprocity would not allow her to give up her care giving role. It was therefore up to the older mother to make the decision, even if it was contrary to her daughter's preference and denied her a sense of cultural continuity.

Many other participants acknowledged the difference in roles, of women in particular, compared with their country of origin. Protecting their children often involved

acknowledging and factoring into their decisions, the differences between these two cultures. This difference in the role of women made historical reciprocity difficult.

4.7.5.2 Acceptance of a New Culture

Participants talked about how adjustments in lifestyle had been necessary when they came to Australia. Many of their beliefs and the beliefs of their children had changed over time. They acknowledged that they and their families living in Australia were living in changed circumstances, different from those of the home country.

Most participants indicated that in their culture (countries of origin), family members looked after older people at home and that it was the family's responsibility to provide care for family members in old age. While some did not see this as reason to abandon cultural expectations, others believed that families were no longer able to honour expectations of reciprocity. Some even acknowledged that things may well have changed in the home country since they left, that the cultural changes they were experiencing were not necessarily about being in Australia.

The rate the world is changing so fast these days, ones culture does not matter. I would say in the Maltese culture, older people don't go to the homes to be looked after. The only time they get looked after is when they fall ill. The older people would be looked after by their own families. I don't know about the culture today because I have lived outside my culture almost all my life. I remember both my grand parents died at home at a very old age. Maybe, because my parents worked on the farm. These days everybody works in the office so there will be nobody left at home to look after old people.

Other things participants found different in Australia is that people have different jobs and the government can build nursing homes and train qualified staff to look after old people. They also acknowledge that, unlike their country of origin where people are very poor and cannot afford to pay hospital bills, they have to look after the older ones at home; here in Australia people have good paid jobs and can afford to pay for the care given to their parents.

Identifying the differences in care between Australia and her home country, one participant remarked:

In my culture yes, but even back in my country it is not like that anymore. I think every culture would like to look after their own at home but these days things have changed. In Australia, as I said people do not work on the farm, they also can afford to pay for the care their parents will get from other people. So it is completely different to my country where there is not enough money to pay for even hospital bills when people are sick. I know my children love me and they know I love them. This will never change.

Others speculated that their expectations might be inconsistent with their current circumstances and that what they remembered as 'culture' might actually have been more related to their particular circumstances in 'the old country'.

The older people would be looked after by their own families. I remember both my grand parents died at home at a very old age. Maybe, because my parents worked on the farm and there was no money to pay someone for the care.

Similarly, another participant described these differences as,

Australian culture is different of course to Indian culture I think, in terms of where old people go when they get weak and require someone to help them with staff. Here maybe because everyone is working and the government has money also to build the homes. In India there is not enough money to do that.

Most participants described having much closer living arrangements with extended family prior to immigrating to Australia. They remembered multiple generation households living together, commenting on how different it was in Australia with children paying separate mortgages and living interstate. As one participant said:

In Germany, family is bigger than that.We lived with all the cousins, aunties and grandparents on a big farm. That is why the children adore grandparents and will do anything to help them.

Acknowledging how lucky she was for her son to have married someone from her culture, another participant saw intermarriages as something that makes the difference between care in Australia and in her home country stating:

Another thing too I think is because of intermarriages. I say I am lucky because Maria too is Indian. If she was an Australian or Greek or Moslem or someone from any other culture I think things will be different. ... regards me as a mother and not a mother in

law..... He is lucky to have married an Indian girl who understand our tradition and take me as her own mother.

4.7.5.3 Poisoned by the Australian Culture

A few participants did not accept the cultural differences in Australia, expected that they and their families would continue to do things 'the old way.' For these older adults, seeing their children live differently, in particular, not offering to take them into their home reflected the influence of Australian culture. They saw Australian culture as 'poisoning' their children and going against the values they had been raised to respect. As one participant said, she spent all her life preparing her daughter to be a good daughter and to carry on the cultural traditions, but her daughter got married to an Australian who had "poisoned the daughter". She stated:

All these were in preparation towards our old age. This is what we do in India. Children look after their parents when they get older and cannot look after themselves any more.She is our only child and we wanted the best for her, gave her a good education and what did she do? She went and followed this Australian man. He has poisoned her. Australians don't care where they die but we do.

4.7.6 Summary

Considering care options when older people become aware of their disabilities, involves the interplay of a complex set of decision -making. As is often true with major life events and changes, the participants weighed their options, taking into consideration the realities of their current situation such as the loss of their abilities, or care giver, their future needs (for example, needing a missing resource service) and their ability to protect enduring relationships such as ties with children, before deciding to relocate to a RACF. Indeed, these findings indicate that the most frequently mentioned consideration is family relationships.

Considering their increasing needs for care within family relationships, the people interviewed for this study used the notion of reciprocity in several different ways such as historical, individual, concurrent and social reciprocity. However, when the final decision had to be made on their move to the nursing homes, participants considered and acknowledge several explanations for breaching expectations about cultural reciprocity.

These were: protecting relationships, acknowledging and accepting the impact of a new context and culture, and 'poisoning' by the Australian culture.

5.0 CHAPTER FIVE: SEARCHING FOR A NURSING HOME

5.1 Introduction

Searching for a place to go follows a determination that either the response to loss was not sufficient to remain at home and either there were no offers from family caregivers or the offers were not considered acceptable to the older adult. This chapter focuses on searching and selecting a nursing home after the decision to move had been made. Participants will be divided in to two groups in the following discussion. The first includes those who relocated from home. The second is comprised of the group who relocated directly from a hospital, respite or rehabilitation centre.

5.2 Establishing/Identifying Care Level

There are two levels of nursing home care: low and high. Whether the older person moves to low or high care depends on their eligibility for accessing the nursing home and the level of assistance they require. To establish their eligibility and level of care, they are assessed and must be approved for a care level by the Aged Care Assessment Team (ACAT). While the assessment determines the level of dependence of the older person and establishes the amount of assistance needed, it also influences the level of accommodation the older person is qualified for (Aged care Australia 2005).

Once the decision had been made to move to a nursing home, each of the participants, in both groups, was assessed by ACAT, approved as eligible for nursing home care, and designated as either low or high care.

When the older person moved from home, assessments were done in their own homes by ACAT that was linked to their community centre.

Those who moved from the hospital were assessed by ACAT based in the hospitals. Participants who were in hospital, respite or rehabilitation were each assessed by ACAT specifically designated for hospitalised older adults.

There was considerable variation in how much time people spent searching for 'the right home'. Most participants who relocated from home spent more than two months searching and making the decision about which home to select. In addition to having time to search for the right home, participants used this time to organise and prepare for the move.

Participants who relocated from the hospital and the rehabilitation centres spent little or no time on their search, preventing them from planning for the move or gathering the information needed to make 'the right' choice. Additionally, participants relocating from hospital, respite and rehab, professionals were often the primary decision-makers regarding whether they would go and to which home.

5.3 Getting Ready

After the ACAT assessment participants moving from home spent some time getting themselves ready to go to the nursing home. For some participants, getting ready included sorting out their possessions, distributing them among family members and disposing of their property. They also found this time useful as a way for the impending change to 'sink in'.

5.3.1 Sorting Out Their Property

Participants who relocated from home were able to spend more time planning for the move to the nursing home. For older adults who owned their own home, one of the most important considerations was disposition of the family home. Those, whose home had been in the family for many years and where they had raised their children, were extremely reluctant to sell their homes to strangers. Most expressed a clear preference to see a family member take over the family home. In some cases, participants were able to pass the family home to a relative. For some, keeping the family home also kept the hope alive that they might someday return to it. Selling the home to someone outside the family was considered as a tremendous loss, a loss of family continuity and a loss of a home to which they might someday return.

For example, one participant started the search after she sold her house to a relative stated:

I asked my children who can buy my house because I wanted to keep it in the family. My son got a new job so he had a good pay. He asked his sisters and we sold it to him and I was happy. Then I said to my granddaughter, I am ready to go, find me the home.

Having sufficient time to get ready also had financial implications. Although most found it difficult to come to terms with selling their houses, those who had time realised that they were able to sell their houses for a better price. A participant who relocated from home described her experience as:

What happened was, we had a bit of time on our hands waiting for a room in the nursing to be ready. So we were not in any rush. We had the house on sale for the two months I waited, after we agreed to sell the house and that is why it sold so well. It was really hard to let go the house but the boys had enough money from it for each to buy their own house. That made me settled because I knew they were all right. That was when I knew I will be ready when they call me.

One participant who was able to distribute her assets to her family members described her preparation saying:

All the jewellery was given to grandchildren. My husband had a ring that was given to him by his father. That too went to my only grandson. The rest of the things were left for who ever wanted them after I took out what I brought here. We all agreed to leave the furniture in the house for ... to keep and everybody was happy.

The situation was different for those relocating from hospital. For these participants, the search started as soon as the ACAT assessment was completed.

Moving from hospital or rehabilitation left little time to prepare. Most felt the move was rapid, they were not informed about how the selection was made and had little or no input into the selection of a home. For example one participant who had tried to stay at home and had failed after the hospital staff told her that she needed to go to the nursing home stated:

The social worker then gave us some paperwork to look at and also for my son to pick few nursing homes so that we could look at before my discharge. We had no time to think about how to arrange things before I go to the nursing home.

Another participant who was a direct admission from the hospital to the nursing home after a short illness described his experience saying:

I would have done anything to keep my house. This house I build means the world to me. To me, it had no value because I built it myself and I know it was very close to my heart. I didn't want to sell it let alone that cheap. All because I had no chance. They wanted to get rid of me so they sent me here as fast as they could and did not give me anytime to take care of my stuff before dumping me in here.

Another participant who relocated from the respite and did not have time to prepare stated:

I felt severe pain in my heart. I am a builder and I built my house myself. It was a solid house, big and on a big block of land. I built it to die there. It wasn't like the ones I sold. They sold it for half the price of its value.

Another participant who felt pain due to the property she left behind added:

We had only just moved into our unit And we had our beautiful garden we had just begun to enjoy. It was excruciating, a pain that you cannot describe to anyone

The lack of preparation for relocation was a consistent experience for those who moved from hospital and rehab.

5.3.2 Time to Sink In

Some participants talked about just needing time to think about the move and become accustomed to the idea. For example, one participant who relocated from home admitted she required some time to get ready for the move described her experience as:

I knew I wasn't ready and I needed some time for it to sink in. So talking to people, visiting places, and discussing it with the boys prepared me for it. I couldn't have moved straight away. I packed my things and gave some away to my family. I was happy with this one and two or three weeks after, they called me and said I can come.

Sometimes, coming to terms with the move involved talking it over with others, particularly family members. Several of the participants talked about how difficult it was for their children and how important it was to have time to discuss it with them and reassure them. A participant who relocated from home stated that his daughter found it difficult to come to terms with the move, even after the establishment of his eligibility and level of care. She described the time spent talking about her decision through with her daughter as:

My daughter took it pretty bad. It took my daughter five agonising months to even start looking at the home after she had the papers. I found it so difficult to convince her that I will be all right at the nursing home and that is what I want.

For some who had accepted and even welcomed the move, it was the family that needed time for the move to 'sink in'. Another participant who had also relocated from home described a similar experience stating:

I understood I will be better off in the nursing home but it took my son some time to realise it was inevitable. I guess it was because he had always thought he will be able to take care of me.

Describing their lack of preparation time, most participants who relocated from the hospital, rehabilitation centre and respite said, there was not enough time to discuss or to come to terms with their situation as in most of their cases the decision of moving to the nursing home was made by someone and in a rush.

It did not matter whether it was something that I was ready or not ready for. I just couldn't believe a day like that would ever come in my life. I was told I would be better off to come to the home. .It was hard to take and I really needed some time to think this through but the hospital just wanted their bed.

Another participant who went to respite and remained said:

All along I was convinced that I was here for a short while. So when the doctor told me he was going to continue seeing me here realised I could not go back home. It happened so quick I didn't have time to put my things in order. Now as I speak I am not sure what happened to my bank account. They only told me they have used the money to pay my way here....I save that money for those bludgers who never lifted a finger and I had no say what so ever.

5.4 Initiating the Search

5.4.1 Initial Criteria for the Search

Participants in both groups identified a number of things they considered about the homes. These key criteria included proximity of the nursing homes and managing health problems. Other factors related to culture such as food and language were also identified by all participants.

5.4.1.1 Proximity to Family

Proximity was a major concern participants or their family members had. For some older adults this was proximity to a family member. For some, it was proximity to their current residence, the neighbourhood they were familiar with. Closeness to where the family lived meant the family members could visit easily. As one of the residents said:

I wanted somewhere I could see the family, somewhere close to my son and the girls so they can come to visit regularly.

Proximity to family, for some, was about being close to someone who was deceased.

I also wanted to go and see George my husband at least on his birthday so I asked for somewhere close to where he was buried.

Proximity to church or a home with the right religious affiliation was important so some.

I am a Roman Catholic and I like going to church so I wanted a place that I can go for church.

Family members were also concerned about proximity. As one participant explained:

Then my son talked with my daughter- in- law which ones are good because she is a nurse. ---First she put eight nursing homes on her paper. Then my daughter she said two are far away so she cut that too. The three homes the social worker selected for me to look at were the ones close to where I used to live. I told her I couldn't go any further than that. All my friends are around the same age as me and it wouldn't be too difficult for them to come to see me. This one was the closest because two of the girls live not far from here.

While most were concerned with the facility being located close to the resident's or family's home, some sought proximity to the church, burial place of loved ones and where friends reside.

One participant said she chose her current nursing home because:

I also wanted to go and see George, my husband where he is buried, at least on his birthday. So I asked for somewhere close to Lalor.

5.4.1. 2 Proximity to Familiar People

Some participants believed that going to a home where they knew someone who worked there would increase the chances of good care. As one participant stated:

A few of the girls from our church do this kind of jobs. So my son said if we find a home that one of them works, I will be in good hands

Others anticipated finding some comfort in going to a home where they had friends. In one participant's case, she wanted to access to both a friendship and the family member of the friend. She stated:

So I said if I go there, I would be with N and L, her daughter will also cook for me and the girls don't live far away from me so they can come to visit anytime. The lady called me and said I am lucky but need to put my name down.

5.4.1.3 Proximity as Maintaining Cultural Consistency

Although participants expressed their understanding of the differences in aged care between their home countries and Australia, some tried to look for something close to what is practised in their home country. For example one participant said:

In Italy there are nursing homes but they are different to all the homes here. Every area has its own nursing homes. So people go to nursing home in the same neighbourhood they live. So they are close to the family and friends. I knew I could not find that here because we all don't live in one neighbourhood but I wanted something similar to the ones in Italy. They all speak same dialect. They know each other; they talk about the same things like, their history and children.

For some it was proximity to their current residence, the neighbourhood they were familiar with kept them close to the things they did as the neighbourhood culture. As one of the residents who used to play bingo with her friends and wanted to continue with that explained:

I wanted somewhere close to where I live so the old girls can come and see me. Where we can go to play bingo every now and then like we always have.

5.4.2 Managing Health Problems

For some participants, staff skills were an important criterion. In particular, participants who had concerns about the ability of the staff to manage their health problems, was a primary concern. For example one participant who has diabetes spoke of his concerns when looking for the home as:

I wanted to be happy and my diabetes looked after. I wanted to be looked after by experienced and qualified nurses because of my diabetes.

Another participant who relocated from home said:

I looked exhaustively at the advertisement to see what it was offering, the level of care, and quality of care, comfort, the organisation, and the social impact of place and so on. Generally, I wanted good care good services. And these were my priority when I inspected the homes.

5.4.3 Cultural Factors

5.4.3.1 Food

Equally as important as language, cultural food influenced their response to nursing homes. For example, one participant who relocated from home described her food preferences saying:

I also wanted where the food gets cooked and not the cook chill stuff. I am fussy with what I eat because I am allergic to many things. People who don't know much about food can make you sick with what they cook.

5.4.3. 2 Native Language

Finding people who spoke their native language was highly preferred in participants' search for a good nursing home. All participants stated a clear preference for a nursing home where at least some people could speak their native language. Native language was significant to participants in preserving their identity. It makes them feel close to their own culture and provides a means to share thoughts and ideas freely and to be understood. For example, one participant described how being among people who spoke his native language would help to preserve her personal/cultural identity remarked:

My Italian identity is very important to me.. So to me if the home it not Italian home or the people don't speak Italian, I did not waste my time to see.

Another participant who also preferred to go to a nursing home where her language is spoken, had described concerns over having to communicate in English, remarking:

I learnt that, when people get older they go back to speak their first language and forget any other language they have learnt. So I didn't want to be put in a home where the nurses will later find it difficult to understand me.

Another participant who relocated from home said:

I really wanted to go to a Macedonian home but there is only a few in this area and my sons didn't want me to go far away. They found this one that had about four Macedonians but there were many Greeks too so I said I will come here. Greeks and Macedonians are same people anyway and I can speak Greek language.

Having information printed in the participant's native language was highly preferred in participants' search for a good nursing home. They viewed this as significant in preserving their identity and as something that makes them feel close to their own culture. They also believed that this would offer them the opportunity to share thoughts and ideas freely and to be understood. Some participants believed that their language identifies who they are.

They were also concerned about losing the ability to speak their language if they moved into a home where no one could speak to them in their mother tongue. As one participant said

Here you pay too much money because it is private but at least we get what we want. Most people here speak my language, the food is Italian. Well Australian Italian but not too bad. The best thing is many of the girls here speak Italian so they understand when I say something. All the people here are like one big Italian family

5.5 Gathering Information

5.5.1 Participant Relocating from Home

In addition to the initial search criteria, participants begin to gather information about the possibilities, which often resulted in new criteria or a change in priorities. Participants relocating from home also gathered information from various sources to use when they visited homes.

5.5.2 Participants in Both Groups

One source of added information was the Aged Care Assessment Team (ACAT). The ACAT in all the participants' cases not only assessed them and established their level of dependence but also provided culturally relevant application material and a list of residential aged care facilities including those in their local areas with appropriate religious affiliation and cultural focus. Participants in both groups were given information by ACAT members to assist in their search and selection. Most notably, they were given pamphlets, booklets or magazines from individual nursing homes that included information about number of residents, ethnic background of residents in the facility, fee charging system, staff ratio and daily routines.

5.6 Accessibility of Information and Time for Collection

5.6.1 Relocating from Home

For participants who relocated from home, information gathering included what was readily offered to participant by ACAT, local doctors, social workers and friends, searching the internet and also what participants and/or their families requested from the facilities they intended visiting.

Some participants who relocated from home indicated that they were able to make phone calls to the facilities they intended visiting. Participants who relocated from home had time to search and requested extra information such as the proportions of different ethnic groups in the mixed race facilities, after visiting a few places.

5.6.2 Relocating from Hospital

Information was limited for the participants who relocated from the hospital or the rehabilitation centres. Unlike the participants from home, these participants relied in most cases only on the information supplied by ACAT and the health personnel. Pamphlets, booklets or magazines from individual nursing homes that included information about number of residents, ethnic background of residents in the facility, fee charging system, staff ratio and daily routines were provided by ACAT and health professionals and the few nursing homes they were able to visit.

5.6 3 Clarity of Information

Some of the Participants from both groups claimed although they were given information, they either did not have time to read or did not really pay much attention to it. Participants from both groups who could not read English identified that much of the information provided was written in English and was therefore not useful to them, as many could not read English. For example one participant stated:

Most of the brochures the lady gave us were written in English so it was hard for me to understand many things

Many participants perceived the information to be overwhelming, including a lot of duplication, which sometimes made it difficult to understand and made them unsure about which home would be better.

One participant who moved from home stated she read information on the fees and charges but didn't understand:

The part that was very confusing and difficult for me to understand was the charges. They don't say it clearly what the money, the charge pays for. It made me wonder if they will come with some more bills to pay after I go there.

Another participant who moved from home stated that he made a bad decision, not going to the home he preferred, because he misunderstood the information provided in the brochures. He described this by saying:

The charges for the homes were more deceiving than anything. I remember two of the houses we looked at were really good but when the social worker explained to us about the payments of things, I thought I couldn't afford them so we took them off our list. Then I came here I saw there is no difference in how much I pay. The only thing is we pay differently

Describing the difficulties she found reading the information provided, one participant who relocated from home stated:

It said in the booklet the social worker gave me at the hospital that, I did not have to sell my house, as my niece was my carer and she lived with me in the house. She was qualified to keep the house. I had too much to read and missed the important ones. I shouldn't have had to sell it if it was easy to read or I had paid attention to it. Instead, the house that I worked to pay for all my working life was sold

Participants who relocated from the hospital also found some of the written information to be confusing and overwhelming. The lack of time, difficulty concentrating and ill health gave them insufficient time to read and absorb what they were given. One participant stated:

Most of them same things I got confused. It was very difficult to understand and ... to follow. There wasn't much time anyway to finish reading all that.

For many, especially those relocating from hospital, this was all the information they had prior to relocating.

5.7 Activating the Search

Participants who relocated from home described making a list of preferred homes after considering the information gathered from these various sources.

In most cases, participants said they made a list of their needs and preferences to enable them to ask the right questions when they met with the facility managers. This was also a time to clear up some of the confusion they had experienced.

In addition to the initial criteria they had identified, participants began to develop additional criteria. These included things such as: whether they would be able to keep their own doctors, whether they would be able to maintain relationship with family and friends, expenses they were likely to incur, the process for handling medical bills, and dietary preferences.

For example one participant recalled how he talked about his preferences with his son and questions were prepared for clarification before visiting the nursing homes saying:

I had written things down so I didn't forget anything. I asked if I can keep my doctor, if I can go home on weekends to visit the children, my son also wanted to know who will pay for the pads. My son wrote everything down. I cannot remember now but we talked about the things I needed and wanted before my son wrote it all down. We asked the same questions everywhere we inspected

Participants relocating from home often involved family members in generating this next set of questions. One participant who relocated from home, described how valuable his family had been in gathering information prior to their search for the facility helped as:

The boys left no stone unturned, they made sure they covered everything I need and liked. So after all the phone calls and going through the information the assessment team gave us, plus the brochures we picked from the doctor's surgery, they made a long list. The more they read about and compared the facilities, the shorter the list became. Although it took a while to put things together, doing that made things easy and I was happy with what they picked for me.

At this point, participants all made phone calls to the homes on their list, which resulted in a scaling down of the list of homes they would visit. Additional criteria developed at this point varied quite a bit across the group. Some were most concerned about the number of people in each home who had been diagnosed with dementia, whether staff spoke their home language and availability of private rooms and toilets. In a statement reflecting the sentiments of many participants, one woman stated:

On the list we made, where the people can speak Croatian language and where they have single bedroom were like standard. We asked if they have their own toilets and staff in the single bedrooms... Things like a table, wardrobe and the size of the room were our very important to make me feel comfortable. The ones that didn't have them were taken off the list. After the phone calls then we cut out three homes and visited all the five we had left.

Some participants were more concerned with the cost and 'additional' fees charged. These participants focussed more on how charges were determined than on the specific amenities or characteristics of other residents. One participant said he looked for government-funded homes that took multi ethnic residents to find out if there were differences in the fees and charges. He stated:

I guess the differences between the governments owned homes and the private ones. Those that operate for profit and the ones that are run on charity, like the church ones for example, I noticed on my internet search that, the government subsidised ones took a mixture of nationalities and the fees were a bit better

Focussing on a particular combination of most important considerations, this participant narrowed his search to Government subsidised homes with a mixture of nationalities.

Family members with specific expertise seen as relevant to the search were often called on to give their opinions about the quality of facilities on the list. Nurses, in particular, seemed to be a source of information on whether the care in a particular home might be adequate. As one participant who relocated from home stated:

When the lady came to assess me, she gave my son the names and address of the government homes and the private ones in Preston, Epping and Greensborough. Then my son talked with my daughter-in-law which ones are good because she is a nurse. ---

First she put eight nursing homes on her paper. Then my daughter she said two are far away so she cut that too.

One participant who had assistance from her son described how some homes were eliminated from the list they had made through phone calls stating:

On the list we made, where the people can speak Croatian language and where they have single bedroom were like standard. We asked if they have their own toilets and staff in the single bedrooms.....Things like a table, wardrobe and the size of the room were our very important to make me feel comfortable. The ones that didn't have them were taken off the list. After the phone calls then we cut out three homes and visited all the five we had left.

While starting points varied, the factors considered were quite similar. That is, some participants begin putting the list together by identifying the places they could afford or that were near relatives. Others began by identifying places that were likely to have staff who could speak the participant's first others selected a religious affiliation for the first cut. Those with family members who had health care expertise were often called on to provide a judgment of care quality, adding that to the criteria already used. While ability to keep their own physician was seen as important, none actually used this to include or eliminate a particular home. While charging procedures and extra fees were important, most participants found this information very confusing and experienced difficulty factoring this into their final decisions.

Absent or confusing information made it difficult for some participants to properly plan their search and selection of the homes, participants from both groups claimed they might have chosen a better home than what they are currently in if they had better information on the fees and charges. Fear that they couldn't afford care was a factor in nursing home choice.

For example one participant who relocated from home said:

The charging system was complicated. My daughter didn't want to make any mistake to choose some place that we couldn't afford to pay. We all were under the impression that the government homes charge less than the private ones. If only we knew then that they were not much different, I could have gone to the one we say near my older son's place.

For participant who remained in the respite care they were, information about the charges was something they had no idea on. For example one participant stated,

I guess they checked the fees her before sending me here otherwise It wasn't anything I thought of. If anything at all I would say I was kept in the dark. Not only on the fees, but the care here too. I had no choice.

Participants who relocated from the hospital and the rehabilitation centre did not have sufficient time or information to consider the criteria that were important to them when selecting the right home, let alone to compile a list and visit the facilities that met at least their basic criteria as they had a limited number of homes. They were limited to only the homes the hospital staff or family members were able to take them to and had very little time to think about which home would be best for them.

One of the participants who relocated from the hospital described how the limited information restricted her choice of facility saying:

The hospital was in such a hurry to get rid of me and my grand daughter had to work. So she didn't have time to look for the home herself. The two I inspected with the social worker were the only ones I saw. There could have been better ones but I just didn't have the time

In situations where their family members lack the requisite knowledge to help in any meaningful way, such as what information to look for in their search, they resorted to professional helpers such as doctors, nurses, social workers or local priests.

For example, one participant who relocated from home said he was receiving pain medication through a pump so her daughter sought advice from his doctor as to an appropriate home where the participant's pump could be managed. She remarked:

My daughter she did not know and the Doctor said, here the nurses can look after my machine.

Others sought advice from people they trusted or with whom they associated some important aspect of the home, such as religious affiliation. For example, another participant who relocated from home said she sought help from her local priest:

I was talking to our priest about it. ...So he helped me.: He talked to all my children and told them about Catholic nursing homes where people go to be looked after.

5.7.1 Visiting Homes

Most of the participants who relocated from home conducted an initial inspection of the homes on their list. Some visited the homes with their families or sent family members to gather information they could use to further narrow the list. A few simply informed family members of their decision to move and completed the search themselves; some involved family members, friends and healthcare professionals in the search process.

From the information gathered and the list of nursing homes supplied, participants who relocated from home and/or their families continued the search and visited the facilities they had short-listed. Visits were conducted to learn more about facilities on their lists and to confirm what they had been said about a nursing home. Participants described two general strategies for visiting which were, scheduled and unscheduled visits. That is, some called ahead and made appointment to be shown the nursing home while others preferred to make surprise visits.

One participant who prearranged his visit said:

There are certain things you couldn't see or come across just by word of mouth, so what my son did, which I think was a good idea was that, he would call the manager and make time for us to go and see things for ourselves and then be able to ask the manager questions if we had any.

Similarly another participant who said she visited the homes after gathering information by talking to people explained:

They might be telling you things you want to know. So my daughter wanted us to go and see for our eyes. She said Mom if you see them and you like things about them then you can choose and not anyone to choose for you. They say here and the other two Italian places, the rooms are clean and big and every room is self-contained. I like big rooms and self-contained but no carpet... In one home the room was big but there was carpet. Another one not self-contained but very close to toilet and bath and here, big self-contained vinyl floor and clean.

Other participants who relocated from home made unscheduled visits believing that if they went unannounced, they would get a much clearer picture of what was really going on, they would see the usual situation in the facilities. They believed that things were often hidden from them if they made an appointment. For example a participant explained his approach of search by saying:

You tell them you are coming and expect to see any thing bad? They will do anything to cover up. I tried going to look around the facilities without telling any one, I went at a mealtime looking like I had come to see one of the inmates. Like I suspected, I found few things I did not like. They were caught off guard.

Most of these participants who relocated from home stated they visited between 4 and 6 aged care facilities. A few made an effort to see different shifts, having heard that staffing was different at different times of the day. Some participants said they visited different times of the day to find out how nurses from various shifts interacted with the residents.

For example, some participants who admitted they were not able to meet with the night staff, realised every shift is different in regard to activities and number of staff available, which some perceived might have made the difference.

The table below is an illustration of how many home participants visited and how many times they went back to visits the same homes.

Who went	How many participants	How many homes	How many times did they go back
From home	14	6 - 8	2-3
From hospital/rehabilitation	4	2 - 3	none
Respite	2	none	none

Table 11: Visits to Residential Aged Care Facilities

Participants who relocated from home visited six to eight homes and went back to visits the same homes two to three times. Those who relocated from the hospital and rehabilitation centres visited two to three homes, very briefly and were not able to revisit. Participants who were already in respite care stayed in the same homes, never having the opportunity to search or select.

5.7.2 Evolving Criteria

Participants (and/or their families) often changed their criteria after their visits to the homes. In some cases, they changed their views about things they had previously considered important.

In some instances, the visits led to entirely new criteria being added to their lists. For example how they saw the residents of the homes and staff interaction with residents. In other instances their initial criteria were confirmed to be fine and they continued to think those criteria were important. Cultural factors such as native language, environmental reminders of their home countries and food were other things participants or and their families paid particular attention to in their search for a good home.

5.7.3 Developing New Criteria

Most who visited with family members or were involved family members in the search, described an expansion of the list of criteria as a result. For most, family members added items they would not have considered, but which in many cases, they believed were important.

A participant who relocated from home had assistance from her granddaughter.

My grand daughter took me to see the Greek home in Fawkner and the one in Epping. She came with me to see this place two times.

Having a family member go along often added several dimensions to things considered about the environment in particular. As one participant said:

My daughter was very particular about the bedrooms; how big they were, do they have their own toilet facilities, were there rails in the bathrooms like we had at home, and she

also checked if they have a window, a reading light, a comfortable chair, a phone that I can use to call her when I need something, a closet, and drawers for personal belongings that I can keep my clothes and stuff. My daughter she wrote everything down and asked them

One participant who relocated from home and searched the home with her granddaughter stated:

My granddaughter wanted a home where there were a lot of activities to join in and not where everyone is sitting in front of the TV in the lounge room or lying in their bed like one of the places we looked at, I didn't want to go anywhere that everyone is too sick or too old to talk to.

Another who searched with a family member stated:

We were looking for a place where the residents spend some time together and have conversations. At this age there is nothing much we can do but to tell each other what we have done with our lives, our families and also be there for each other.

Participants who relocated from the hospital of the rehabilitation centres had little or no time to visit. While some were able to visit one or two homes, they were generally selected by staff and recommended to the older person and their family. Sometimes a family member visited for them. Sometimes the older person was taken for a brief visit with a professional. For example, a participant who went from a rehabilitation centre stated:

The social worker took me to see two homes and put my name down. Two weeks later the social worker told my son that a bed was available because someone had passed away. So I came here from the hospital.

Some participants perceived that homes with mature looking staff members meant that they staff were experienced which to them indicated that they provided good quality care. For example one participant who was particularly worried about the management of her diabetes described her selection criteria as:

Most importantly most of the people we saw looked experienced. I couldn't tell their ages but they weren't young and looked like they have been doing this work for a long time so

they know how to handle old birds like me. My granddaughter, the nurse also said the same thing

5.7.4 General Feel of Home

The participants identified multiple aspects of a good physical environment, which included the building and the potential for relationships with other residents in the homes they looked at.

5.7.5 Physical Environment

Participants reacted negatively to homes that looked like a hospital, where people **looked** sick or were in bed most of the day. For example one participant remarked:

Others talked about the layout of the facility, looking at kitchens and lounges, gardens or verandas; places where they could go to sit with visitors, where residents were dressed in their own clothes and not in pyjamas. They also attended carefully to cleanliness and safety of the building.

5.7.6 Cleanliness

Cleanliness was one aspect of the environment that all participants were interested in. During visits to the nursing homes, older people tended to look at the cleanliness in public areas such as activity rooms. They looked for signs that the home was clean and cleaned frequently.

I just wanted a nice clean, place where I could get help to look after myself and not where I could go and get sick. When you are my age, little things can knock you down easily. Some places we visited were so smelly and the carpets looked like they haven't been cleaned for a long time.

Another remarked:

The home looked clean, no urine smell, or dirty carpets like the others we saw in other places. It also had a big backyard and beautiful flower gardens at the back. To me it was important if this is where I am spending the rest of my life, it would have to be a good quality home.

5.7.7 Safety

Most of the participants talked about features of the buildings they inspected in relation to safety. For example one participant who perceived that floors covered in carpet are safer than wooden boards or vinyl stating:

The homes with floorboards or vinyl covers to me seemed a bit dangerous. They are too easy to slip on and fall so I preferred those with carpeted floors.

Another participant's engineering background and knowledge of building impacted on the things he looked for in his search for a safe physical environment.

Being an engineer, the safety aspect of the building was important. I looked at critical emergency features such as smoke detectors and fire alarms, and routes to emergency exits.

Whilst some participants looked for safety of the general building, others were concerned with other residents' unwanted and possibly unsafe behaviour. For example, one participant who said she had to put her own disabled son in a nursing home said she made sure things did not happen to her like it did to her son stating:

I asked the head nurse, I said, do I get protection from the ones that become aggressive, the ones who don't even watch where they go. What if I get hit by the ones who have dementia and cannot control their anger, Are there locks to the rooms so I can lock my room to keep them out?

5.7.8 Potential for a Relationship

While some participants had previously considered what the other residents were like, visiting the nursing home often brought this consideration to the fore, making this a more important criterion than it had previously been. They assessed the residents they saw in terms of how they looked generally, whether they looked bored or depressed, whether they were engaged in activities, whether they looked ill or whether they looked as if they had dementia. Residents who appeared to have dementia were particularly distressing to the older adults visiting a nursing home. A new concern that arose was whether these residents might be dangerous.

My granddaughter wanted a home where there were a lot of activities to join in and not where everyone is sitting in front of the TV in the lounge room or lying in their bed like one of the places we looked at.

For many participants, the older and sicker the residents looked, the less likely they were viewed as people they could talk to or have a relationship with. For example one participant described her criteria for searching for a home for a potential relationship as:

We were looking for a place where the residents spend some time together and have conversations. At this age there is nothing much we can do but to tell each other what we have done with our lives, our families and also be there for each other.

Some participants who had not considered other residents in their initial criteria became quite interested in the characteristics and behaviour of other residents after visiting the facility. For some, visiting raised new concerns about safety or the undesirability of being around so many people with dementia. For others, the sight of many people with dementia raised concerns about the inability to find friends or even people to talk to. Some participants looked for homes where families could visit easily, hoping to maintain or renew relationships with their families. For example one participant described how important it was to have a large private area where the whole family could visit and not feel restricted saying:

My daughter didn't want me to go into another hospital but where the set up is a bit close to what home looks like. A place I can relax and not to worry about visiting times. She said she will come with the children sometimes so we can all have lunch or dinner together.

Similarly, another participant who was assisted by her daughter stated:

My daughter was looking for a place where not many people are suffering from dementia. She also said I needed a place where there are other residents my age that I can talk to.

Some participants spoke about being able to continue doing things they enjoyed and finding people who shared their interests. This obviously relied on people who were able to communicate but added the further dimension of similar interests. Some were able to

observe residents engaged in interesting activities that they believed would be enjoyable. Considering activities was often the direct result of visiting and observing.

Another participant expressed a similar desire when she remarked:

I didn't want to go to a place and turn into a vegetable. You see what I mean? ...I wanted somewhere I can continue to live the way I lived at home. I suspected I will not get everything my way by the looks of things I saw in some of the homes but at least be able to do the things I like doing when I want to do them and people to do them with.

Control over daily activities was a concern that often arose during or following a visit. As one participant said:

We asked about the routines here and were told they are flexible. They said I could choose to do things as I wanted which is good what they forgot to tell me is what will happen when I get a lot weaker and move to high care. I hear there everything is according to time. That is I wouldn't be able to pick my bed times or when I have my meals.

5.7.9 Staff Interactions with Other Residents

Another criterion that was not considered by any participants prior to their visits but became important for several participants after their initial visits to nursing homes was the way nurses interacted with residents. Participants interpreted these interactions as reflecting how caring, respectful and friendly the nurses were. They talked about how the residents must feel as a result. One participant who saw nurses interacting with residents and related it to a sign of good care stated:

I must say, of all the inspections I did, I liked the way the girls were together with the residents in the activities. You could see their actions were genuine. The respect and the patience they had for the residents been genuine and very good. They were enjoying what they were doing just the same as the residents. Even the residents that couldn't talk or follow what others were doing seemed happy because of this good care.

Participants who relocated from the hospital, rehabilitation or respite care claimed they relied on what the information supplied to them by the health personnel in regard to the appropriateness of the homes to manage their technical or medical conditions. For example one participant who relocated from the hospital stated:

I wasn't thinking about comfort at the time. All I wanted was a place to get help and the rest of it was not so much important to me. I knew about the beer but that was just a bonus.

5.8 Confirming the Importance of What they had Already Believed to be Important.

5.8.1 Language

During their visits to the homes other participants said they paid attention to staff/resident conversations and also asked questions about the languages staff members spoke.

The nurse who opened the door for us greeted me in Greek language and said "Ti Kaneis". So I knew they will understand me.

Being able to communicate clearly, and being understood, was also related to participants' concerns about English. For example a participant said:

When we joined in on the activities, the staff were talking in Italian language. One girl came and asked me what dialect I speak and she started speaking with me. My daughter was very happy. Straight away she said, mum you can tell them anything if you get any problems and not to worry about your English. You see my English is not very good.

5.8.2 Environmental Reminders

Other participants said they judged the nursing home by the photos in the corridor and the information at the entrance of the homes as well as the brochures given to them by the facility managers even without asking. For example, if the photos showed important landmarks of their native countries and the information at the entrance of the homes are written in their native language, participants perceived that people in the homes are from their culture and speak their language.

They even had newspapers written in Italian at the front desk

Some participants described how exciting it was to find a home with photos of their homeland. This was particularly the case if the photos showed important landmarks of

their native countries or if information they were given was written in their native language. One participant remarked:

They even had newspapers written in Italian at the front desk

5.8.3 Food

Participants looked for the general quality in the food and the way it was cooked and presented. Some said they purposely made appointments to see the facilities at meal times where they could sample a meal to find out if the food was tasty and served at the proper temperature. For example one participant stated:

The espresso they gave me when I came with Father Michael was very good Italian style coffee too.

Another participant who said she spent a whole day in one facility and had meals while she was there said,

There were varieties of foods to choose from. There was a fish and chips dish with salad, and then there was pizza and pasta. I think I had ravioli or something Italian. It didn't taste like my cooking but it was alright

While some participants who did not have the chance to sample the food said they just read found the types of cultural foods facilities served from the brochures given to them by the homes when they visited, others said they assumed that the cultural specific homes served food of the residents' culture.

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5.9 Selecting the Nursing Home

After their visits to the homes to gather more information, thus asking questions, inspecting, trying out activities and food, reading brochures, participant and/or their families compared the facilities they visited putting the pieces together to help select their preferred homes. Based on the information gathered, participants identified a number of key concerns that impacted on them or their family's decision in selecting the homes. Factors such as participants' preferences, good care and services, sustaining relationships, control on daily living and cultural factors. The following section is a report on how these conditions affected the participants and/or their family's decision on the homes they selected.

Lack of information made it difficult for some participants to properly plan their search and selection of the homes, participants from both groups claimed they might have chosen a better home than what they are currently in if they had better information on the fees and charges.

Fear that they couldn't afford care was a factor in nursing home choice. For example one participant who relocated from home said:

The charging system was complicated. My daughter didn't want to make any mistake to choose some place that we couldn't afford to pay. We all were under the impression that the government homes charge less than the private ones. If only we knew then that they were not much different, I could have gone to the one we stay near my older son's place.

For participant who remained in the respite care they were, information about the charges was something they had no idea on. For example one participant stated:

I guess they checked the fees here before sending me here otherwise it wasn't anything I thought of. If anything at all I would say I was kept in the dark. Not only on the fees, but the care here too. I had no choice.

5.10 Summary

After their decision to move to the nursing homes, the elderly persons in this study went through a process of assessment to determine their eligibility and level of dependence

or accommodation. In searching for appropriate homes, participants relied on information provided to them by ACAT and other health care professionals, supplemented by word of mouth and more easily observed characteristics of the facility that reflected a sense of a good home. While some participants went through the entire process by themselves, most had assistance either from health care professionals or family members. Conditions such as the amount of time participants had to search, the number of homes inspected and their knowledge on the relocation process, their cultural background and the availability of information influenced participants and/or their families in selecting their preferred nursing homes.

Participants identified culture and language as factors that influenced their nursing home selection. In particular, some pointed out that information material are seldom available in a range of languages.

Participants also expressed that there were not many culturally specific homes in the areas in which they lived. In selecting the appropriate homes, participants and/or their families thought about the older persons' future care, feeling of continuity in life, familiarity and a sense of security that the care would be good. Other factors such as remaining close to their families and friends where they could sustain relationships and gain companionships with other residents in the facilities were also considered. They expected that ethno-specific nursing homes would satisfy and provide good care among caring staff with fellow residents sharing their cultural backgrounds language and experience.

CHAPTER SIX: MOVING IN TO THE NURSING HOME

6.1 Introduction

Having made the decision to enter a specific aged care facility, sometimes under constraints such as limited time to search, limited or confusing information and few ethno specific homes to choose from, participants' descriptions of their experiences in the homes were based on observations they made mostly relating to the criteria used in selecting the homes. The following section describes participants' experiences in the nursing homes and discusses how their selection criteria, and the searching process influenced their moving-in experience.

6.2 Care and Services

Participant's perceptions of nursing homes during the search and selection process had a great influence on their subsequent judgments about the facilities they moved into. Significantly, most of those who were surprised at what they found in the homes after moving in had relocated from hospital or rehabilitation centres and had had very little involvement in the search and selection process.

Most participants who relocated from the hospital and rehabilitation centres admitted the little or no time they had to search limited their chances of identifying which homes were more appropriate for their care needs. Most claimed they relied primarily or exclusively on the information given to them by health professionals. Most of these people had assumed nursing home nurses were different in their skills than the nurses in hospitals and did not expect them to be as competent as they discovered them to be.

For example, one participant who relocated from a hospital admission and had only a few weeks to select a home after visiting two nursing homes expressed her surprise at how positive the experience was:

This wasn't my thoughts of a nursing home. I had thought the nurses were different to the hospital ones and will not give me the type of care I had in the hospital. I had my own room and toilet unlike the hospital where about four of us shared a toilet and

shower room. There were nurses and bells like in the hospital and the nurses will come when you ring for something. In fact I was surprised the care here was much better than the hospital.

Similarly, another participant who also relocated from hospital after a short stay and was surprised at how easy it was for families to visit stated:

I saw families coming in to visit their relatives. In fact I thought people in here did not have anyone but I was wrong. Grand children came to see their grand parents and so on.

While some discovered there were positive sides to the surprises, others discovered their expectations were not met. For example one participant stated she chose one of the two nursing homes she inspected with the social worker. She described her experience stating:

I had no idea about what to expect or not to expect. The social worker said it is like a proper home, it is a good place and they look after people well. I really would have chosen a much better place had I had the chance to see a few more homes. There are so many routines here. This is nothing compared to a proper home.

Another participant who was unhappy with the facility had inspected only three nursing homes with her daughter and the occupational therapist from the rehabilitation centre where she was at the time stated:

There were so many things we didn't take notice of or tried to find out when we visited because we were always in such a hurry to go back to the hospital I was at the time and my daughter could not take me to see more.

6.3 Surprises

Participants who relocated from home experienced many fewer surprises after relocating. Some participants who had put considerable effort into visiting homes were disappointed when they moved in, finding things to be quite different to what they had expected. Most of the surprises were related to staffing and institutional policies that had not been visible. For example, while they had been aware of how hard the staff worked, they were surprised to find long response times for staff and a higher level of

stress among the staff than they had been aware of during their visit. One participant stated:

Everybody tells you that the nursing homes are understaffed, people in government are aware of that and I saw that when we were looking for a place. When we visited the homes, we always found a few staff around so I that sort of confirmed what I heard but I really didn't think it would be this bad. Sometimes you ring your bell and it takes ages for someone to come. This is because they are only a few of them looking after that many of us. The poor girls work so hard. They do too much

Some exceeded their expectations or were more positive than they had anticipated. For example, most reported they found many residents with dementia during their visit to the homes and so expected to put up with their behaviour but were surprised to find they were not what they had feared. For example, one participant who relocated from home had believed that the dementia sufferers she saw in the homes during her search could be dangerous and was worried about getting hit by them however; when she relocated she was surprised to find that they were not harmful after all. She stated:

I was worried about the dementia ones, I was scared if I go to a home where dementia people are, they can be aggressive or hit me you know. But here they don't even talk; they sit down somewhere and don't bother you. Most of them cannot even talk. So they are not dangerous at al.

6.3.1 Relocating from Hospital/Rehabilitation

Participants who relocated from the hospital and rehabilitation centres all expected to be provided with the nursing care that had not been available to them at home. Describing their satisfaction with this aspect of the experience, one participant stated:

They said I needed more help that we thought I would. Here they shower you feed you and make sure you are alright

Another participant who had been informed by the social worker from the rehabilitation centre she relocated from stated:

The social worker and the doctors told me the ones sick in the head are in are in every nursing home. She also said some of the homes separate them from the other residents. Maybe other homes did that but I didn't see that in any of the two homes we inspected.

When we inspected here and the other place, I saw a few of them. They are everywhere as the lady said but I don't mind. They are not hurting anyone they just cannot sit still.

Participants relocating from home who expected skilled care generally considered the care provided by staff to be good and a significant contributor to their positive experience in the homes. Being free of pain and discomfort, having well controlled blood sugar were indicators participants gave as good care. Several noted that they were able to obtain the health management and skilled care that their own families were not able to provide them at home. A participant who relocated from home talked about how right her choice was:

My daughter was particularly worried and so she asked the doctor which home can look after the pump. He suggested few places but we chose this one because my daughter's friend we met here when we visited confirmed that. She had her mother in here so she told us all about this place and we thought it was good so I came here. We made a right choice.

Others were pleasantly surprised at how only a few staff members seemed to be affected by the pressure which they assumed would be a strain for all staff. Some participants who had visited the home before moving, expecting to find staff that were extremely stressed and overworked, in fact found this to be true. For example, one of the participants stated that:

Everybody tells you that the nursing homes are understaffed, people in government are aware of that and I saw that when we were looking for a place. There were some places we found only three nurses looking after over thirty residents. The poor girls work so hard. They do too much.

One participant who assumed that older the nurses were more experienced and therefore could manage her diabetes better than a younger staff member, was not surprised with the care she was receiving. She said:

My sugars are very good now because the nurses are not like the young ones who have just finished their training. They are very good and very experienced they know what they are doing. Even my grand daughter, the nurse says they are very good.

Another participant said he had visited facilities without making appointment during his search for a home. He explained his approach by saying he wanted to know what exactly the facilities usually look like. He continued on to say:

Everything I saw when I did the inspection is what I found. They couldn't have hidden anything because they did not know I was coming. The way I saw them told me how they usually operate and this is exactly how they do things around here. I like it and that is why I came here.

While there were surprises, satisfaction and dissatisfaction in the experience for participants in both groups in varied ways, similar views were also shared on issues related to care and services. Participants from both groups spoke about their experience on privacy, safety, protection and possessions.

6.3.2 Privacy

Participants from both groups found greater loss of privacy than they had anticipated. Even those who visited multiple times had not 'seen' the lack of privacy that they experienced after moving in. For example, not being able to lock their rooms came as a surprise to most participants. Room sharing was also a privacy issue for those who were not in a private room. While they were aware of the sharing, the actual experience was much more difficult than they had assumed it would be. Having enough space for personal possessions and being able to personalise their own space were also described by participants as problematic. As one participant summed up:

We have single rooms here but we are not allowed to lock them in case there is fire. I guess this could not be helped but that leaves me no privacy. Even in the shower someone had to be there so that I don't fall. It didn't matter how much I stressed on my ability to still think for myself and to identify what is dangerous for me. There are policies everywhere.

Participants understood privacy as limited by their further declining physical functions, the realities of institutional life and the importance of feeling safe and secure within their environment. However, it remained one of the most difficult aspects of life in a nursing home.

As one participant said:

There are certain things we cannot have our own way and this is one of them. They are for our own benefit. If I fall and the call bell is not within my reach, I will have to rely on someone passing to find me so I guess if the door is locked or even closed it will be dangerous

Most considered sharing rooms less than ideal, particularly because they have to think about how other residents would feel in every thing they do.

6.3.3 Protection of Self

Issues of safety were expressed by participants in terms of their inability to protect themselves and their personal possessions. Some participants experienced behaviour of residents suffering from dementia to be distressing at least and in some cases to threaten their safety. They were disappointed that neither the dementia sufferers themselves nor the staff members in the home were able to intervene effectively. One participant who found it difficult coping with other residents' behaviours stated:

The dementia people touch everything, they don't watch where they are going and they can make you fall you know. One man wants to go home all the time so he calls for his wife every night and the noise is too much.

6.3.4 Protection of Possessions

Some participants lost property such as clothing or personal items while in the home either due to poor laundry management or through other resident's behaviour (i.e. Other participant identified things such as policies and safety measures restricting them to leave doors unlocked even though they live in single rooms). For example, one participant who lost her clothes stated:

They put my things together with everybody's clothes and give it to someone else.

Another participant who lost some possessions through the offending behaviour of other residents stated:

The people with dementia go anywhere. There is a man in the other corridor that empties every fridge he finds. He came here one day and helped himself to some fruits and muffins I had. I am forever hiding things. Sometimes too I don't leave my room. If I am here and anyone comes in I will see them.

6.4 Relationships

Some participants moved to a nursing home near relatives or friends, anticipating that they would be able to see those relatives on a regular basis, or moved to homes in their neighbourhood, anticipating that they would continue to be involved in neighbourhood activities and relationships. Maintaining or even increasing contact with family and friends was particularly important to the participants. Some were able to achieve this while others were not.

Participants relocating from home who had time to search and chose a nursing home close to their family or neighbourhood described their experience as positive. For example a participant who moved to maintain a good relationship among her children because they were arguing over her care stated:

It is good I came here sister. Here all my children come to see me. They all do something to make me happy they come here with their families and on my birthday they all come and we sit together and had dinner.

Another participant who said he moved to save his relationships with family members stated:

I chose this home to be close to the children so they can come to visit me. My son and his girlfriend come here every week. My other son who works close by comes here everyday from work to see me. Sometimes they take me home for dinner and bring me back I am really happy.

The situation seemed to be somewhat different for those who relocated from hospital and rehabilitation centre. For example, a participant who relocated from the hospital and had not had time to search for a home close to her son and daughter stated:

Because we were in such a rush, we chose the first one that became available. The ones in Preston where my family lives were not available then. Now things are so hard particularly for my daughter who works in the city and travels far everyday. I only see her once a month. It is too far for her and I don't blame her except I miss the grand children

6.4.1 Finding New Relationships

While participants had varied expectations and capacities to interact with other residents some participants were able to establish new friendships. For example one participant in a multinational nursing home stated he selected the home because he saw people he perceived could be a good company. He described his experience after moving in from his home stating,

I have made some few friends. I mean there is not a great deal of people to choose from but I get on well with almost everyone. We are four blokes in my room and we enjoy each other's company. Not that we have much to talk about but at least we have much in common and we share our life stories, share a few beers and tell our naughty jokes.

Another participant described his luck in finding a companion, something he would not have achieved if he had remained at home. He stated:

I have made new friends and have got something I wouldn't have if I was still living at home with my family and had not come to live in the home. I wouldn't have found E would I, if I didn't come here.

Social interaction and participants' ability to have meaningful contact with others were considered by all participants during their search and selection of a nursing home. Most participants described seeing many residents suffering from dementia during their search for a home and were surprised at the ability to make new friends.

6.4.2 Link to Culture

Most participants who selected ethno-specific homes thought finding friends among a few lucid residents would be a bit easier with a common language and shared interests. Most participants in multinational nursing homes described how correct this assumption was. Those who were able to find other residents who shared their language experienced this as a very positive aspect of the home.

For example one participant in a multinational home stated:

We don't speak same language.... I am from Croatia, if they are Croatians too, we can share our history and tell stories and we will all know what we are talking about.

A participant who relocated from the hospital was disappointed to find that the 'Italian' home had residents who spoke a dialect quite different from his own. He had been expecting other residents who he could speak with in his home language. She stated:

I thought I will be all right and will have company because there are many Italians here. I don't have a friend here. In here many people speaks Italian language but different dialects so it is hard to understand them.

6.4.3 Losing Important Relationships

Participants who were unable to sustain prior relationships described many obstacles they faced. Some described the inability to have regular or frequent contact with family members because the friends and family members they wanted to see were also old and frail and were therefore not able travel to visit them in the home.

Others decided that they did not want to be seen in their current situation because they are not the person they used to be. For example, one participant who perceived that coming to the nursing home had made him look older than his friends of the same age did not want his friends to see him. He said:

I don't want anyone to see me like this. George came to see me last year but I told him to have a rest and not to come any more. He is old too and his daughter is looking after him at home. He still looks young and I look so old.

Relationships with familiar and trusted healthcare providers, especially doctors, were also important to many participants.

Most participants relocating from home had believed that they could continue to be seen by their own doctors but, when they moved in, found out that they had lost their doctors either because of a location change or because of facility policies. For example, one of the participants had been seeing her doctor for over thirty years, trusted and liked him because he spoke her language and understood her. The participant couldn't continue to be seen by this doctor after her relocation to the home because by nursing home policy required that only the facility's doctors see residents. Losing her doctor was a severe loss. She stated:

The doctor who sees me is always in a hurry to go somewhere. He speaks different dialect so sometimes he doesn't understand what I say. He doesn't know what is wrong with me really. He always wants my granddaughter, the nurse to tell him about my sickness. My own doctor knows everything about me.

6.5 Control of Daily Living

The ability to make meaningful choices was regarded as lacking in a variety of ways as described by participants. In both groups, participants described their surprise on the changes they experienced in the control of their daily living. The older people talked about their dissatisfaction on how things are carried out differently, privacy, activities, access to outside and safety. Some examples included choice of meals and contribution to decisions about hygiene care. For example, one participant expressed:

...they don't ask me how I take shower, dress or eat, and because I cannot talk well they rush and don't listen. They do things without asking. They just do it. But I can see them you know. I am like a baby now....You see, even if you look after children, they get happy if you do what they want. You take your time to talk to them. I am 65 years old."

Even participants with ample time to search did not anticipate some things. For example, one who had not anticipated that he would be so uncomfortable when female nurses attended to him added:

I am a very shy person that is all. I get a bit embarrassed and uncomfortable when the girls give me shower and dress me or put my bottle in.

Other participants described how they were formerly able to cook whatever they wanted in whichever way they preferred. Expressing how they liked their food well cooked and hot but now it is either overcooked or undercooked and cold. One participant seemed to have accepted her loss of control over daily living and the loss of her carer by saying:

I can't be looked after by my husband, I live here and my family lives elsewhere, I rely on staff for every little thing.

Participants talked about no longer having control, deciding on whenever and whatever they wished to eat, because what they had at home had changed into eating at specific times or when meals were served. Their ability to decide on when to watch TV or listen to the radio, when to go to bed and wake up at the time they chose was also lost for

some participants, with some commenting on how they thought they were treated like children. As one stated:

I was surprise when I was always told it was too late to watch TV and to get changed and go to bed. Just like you tell the children it is time to go to bed. I was always upset about that because I have never been to bed before 10 O'clock at night. Here they wanted me to go to bed even before 8 O'clock. We all have to be showered and dressed for breakfast at the same time like the army or something.

Some participants perceived that things were done due to changes in staff such as turn over, their ages, experience and their orientation to the facility.

For example, one participant stated:

Everyday new staff come, all young staff.....They don't know me and they always rush. ... They get lost; my things are getting lost everyday. They put my things together with everybody's clothes and give it to someone else.

Others expressed some understanding on staff turnover as and acknowledged the reason why things were done differently. For example, one participant acknowledged the difficulty by saying:

Nursing home work is difficult so they don't last long here. If they do, they only do a few days. So you don't see much of our regular staff.

Some participants attributed the different way of doing things to a lack of time. One participant stated:

I say all the time to staff I will have shower later but they say they have very short time to finish their work and if I don't have shower now they will not have time anymore.

6.5.1 Access to Outside

Only a few participants had thought about access to the outside. Participants who had previously been going out whenever they wished were no longer able to do so. This was extremely distressing for those who spent much of their time outside. Those who had visited had been led to believe that this area was 'accessible' to residents, not realising that access was restricted in some homes to times when they were accompanied by staff. For example, one participant expressed his frustration by saying:

This place is like prison. I cannot go anywhere outside the home. I have to ask for permission to do everything so some one can see what I am doing and make sure I will not kill myself.

6.6 Cultural Experience

Staff members from the same cultural background or who spoke the same language as the participants were preferred by most. They believed that people from their culture would be more compassionate and understanding. Being nursed by staff from the same cultural background made them feel more loved and respected when receiving care. For example, one participant expressed a belief that she was seen as 'less of a burden' by staff from the same cultural background. Another participant who prefers to be looked after by a nurse from her culture stated:

Someone from the same culture understands me better. It is most likely they will do things the way I do things. For example, a Hindu agency nurse will know not to give me cow meat in my food. The few Indians here cannot speak the Indian language so there is no difference between them and the Australian girls

Some participants perceived that nurses with an Australian background are less respectful, less patient and less hardworking. They also expressed the belief that Australian nurses sometimes bullied other nurses, regarding them as less capable or inferior.

One participant described the care and attitude of Australian nurses and compared with the nurses from other nationalities as:

Quite frankly you see that in the Australian girls. They do things anyhow. They are the ones that set the rules. They even do that to the non-Australian nurses. There are few of them who don't like the agency nurses of different nationalities. The Somalia girl who left us was actually bullied by those Australian girls. People from other countries get to do the dirty jobs while the Australian girls do little and smoke all day. Why do you think they do that? It is because these other people have come to their country and so they have to pay them somehow. These other people, I mean our kind. They cannot afford to lose their job because they will not be lucky to get the Centrelink allowance if they don't have work. So they put their body and soul into their work.

6.7 Consequences of Consistency Between Expectations and Experience

6.7.1 Inability to Sustain and Maintain Relationships

Experiencing difficulties in sustaining relationships with friends and families and interacting with other residents due to either a physical or communication problems contributed to loneliness and isolation for some participants. Participants reacted to these experiences with sadness and crying. For example, a participant who said he did not get a visit from his son described his reaction as:

..my son wouldn't come to visit me either. I mean the one in Sydney and works for Telstra. I was very sad and cried everyday.

Other major reactions participants described were withdrawal from participation in activities, and loss of appetite. As one participant said:

I stayed in my room and wouldn't come out or talk to anyone for more than a month.

6.7.2 Loss of Control of Daily Activities

Loss of privacy, autonomy, freedom and property led to feelings of sadness and anger.

Sadness: Participants reacted to feelings of sadness by withdrawing from participation in activities or even eating. Whilst also experiencing physical problems (i.e. poor communication), one participant who expressed feeling sad due to the loss described above, said it was just too difficult for her to complain. She stated:

Nothing, I accept and keep quiet. I cannot look after myself. I take what I get hoping that one day I can do things for myself.I feels sad..... I am like a baby now.

Anger: Participants who experienced anger blamed either their families or the Government.

6.7.3 Loss or Absence of Cultural Expectation

Experiencing difficulties with their cultural expectations led to loss of identity, individuality and dignity. Some Participants reacted to loss with frustration. For example, one participant who was unable to continue her personal and familial culture expressed her frustration by stating:

At home with my family we had our own unique way of doing things. We did things our own way but always thought about each other's feelings. The respect my children gave me as a mother, the companionship I shared with my husband, the things we all liked as individuals and tiny little things like even how the same food we are all having is served differently for each other. The way I clean my house and arrange my things and the time I took to do things. Not having any of these now is so frustrating but there is nothing I can do because I cannot look after myself at home.

Feelings of loneliness, isolation and emptiness were described by some participants as a consequence of their loss. Feelings of isolation and loneliness ranged from a vague sense that there was something missing in their lives to an intense sensation of emptiness and were significant to participants who had difficulties to continue practising their spiritual beliefs or religious traditions. For example, one participant whose religious tradition as a Hindu forbids her to have certain foods expressed how lonely and empty she felt for not being able to do that in the nursing home by stating:

I feel so lonely and empty; following my Hindu belief is very difficult because people don't understand. Someone from the same culture understands me better. It is most likely they will do things the way I do things. For example, a Hindu nurse or cook will know not to give me cow meat in my food.

6.8 Summary

This section has revealed that older people choose the homes they want to spend the rest of their lives in by carefully considering factors such as location, environment, language, food, nursing staff and residents' characteristics, as well as the availability of their special needs.

Having made the decision to enter a specific aged care facility, participants' perceptions of nursing homes and observations in the facilities when the relocation decision was made, affected their judgement of the facilities and influenced their experience.

There were differences in the experience and perceptions of the participants regarding where they had relocated. Participants who relocated from home and had ample time to search and select a facility and to prepare themselves for the move, had a much better experience than their counterparts, who rushed through the search and selection process with limited time and homes from which to choose.

Participants experienced loss and gain when they moved to the nursing home. Most considered the care given by staff as good and as a significant contribution to their positive experience in the homes.

Strategies, which participants used to deal with their experience and reactions to life in the homes, will be described in the next section.

CHAPTER SEVEN: SETTLING IN AND ADJUSTING

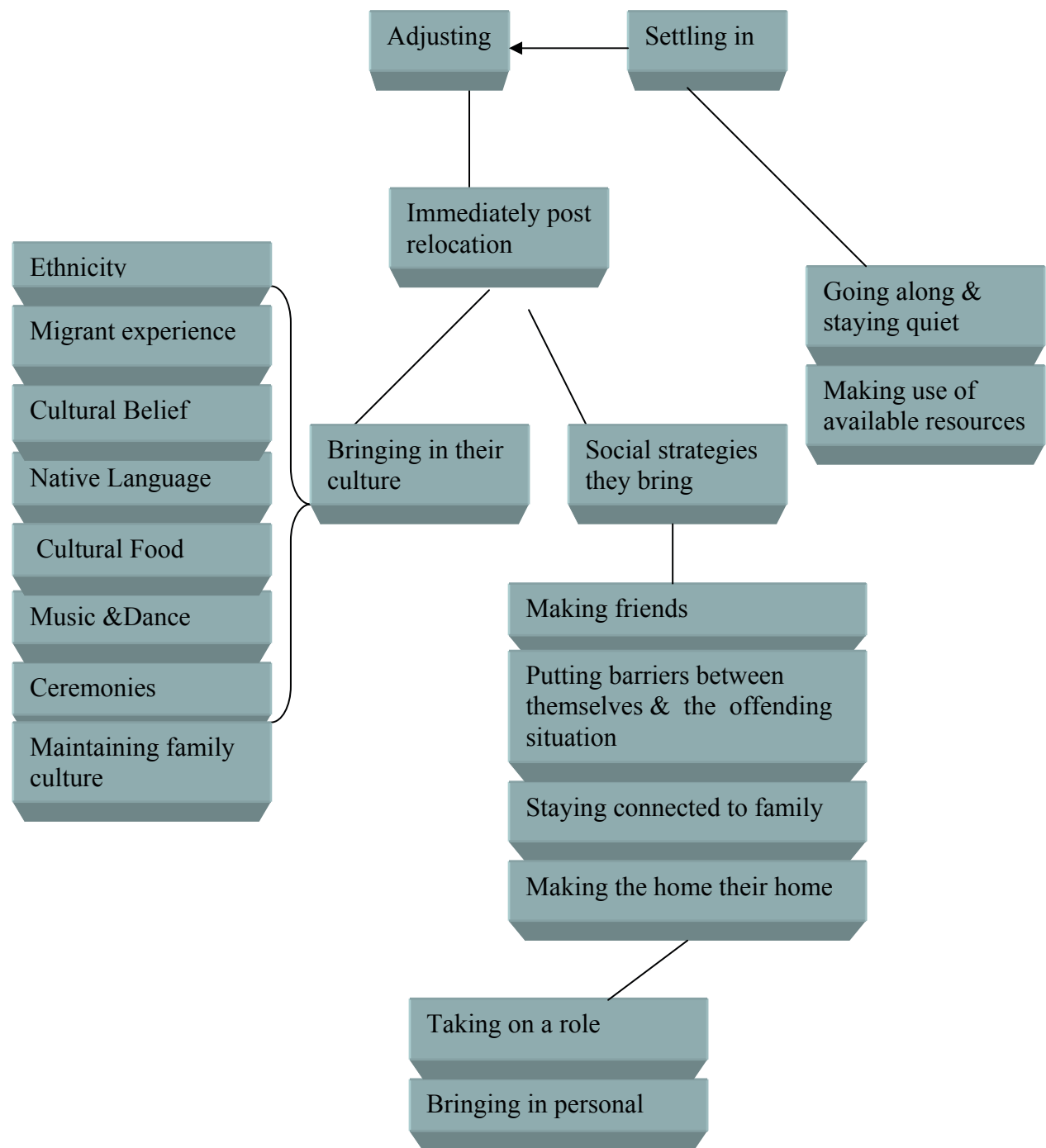


Diagram 4: Strategies Participants Use to Settle in and Adjust to the Nursing Home Experiences

7.1 Introduction

As a range of negative and positive experience was expressed, participants identified strategies that they have chosen to deal with them, in order to continue their lives in the home. There were strategies to settle in during their initial experience and strategies used to adjust to their ongoing experience in the nursing home. This chapter presents the description of settling in and adjusting strategies described by participants.

7.2 Settling In

Participants described settling in as conforming to the rules and routines in the facilities. These included going along and staying quiet, staying open to new experience and making use of available resources.

The following examples are descriptions of these strategies described by participants in both groups (those who relocated from home and those who relocated from hospital/rehabilitation/respite care).

7.2.1 Going Along and Staying Quiet

When bumping into rules and routines that were frustrating or distressing, many participants described 'just going along' and not saying anything. As one participant said:

I just kept quiet and allowed things to happen. It wasn't pleasant, but I got through and I am still here.

Another participant who took a similar approach said:

I kept to myself a lot and did what I was told in order not to cause troubles for anyone.

To other participants, going along is related to their acknowledgement of the realities of life in the home. They have accepted that certain things cannot be altered. As one participant remarked:

You take what you get and keep quiet. That is what got me through the first few months and I have continued to do that.

One participant who said she found it particularly difficult not being able to communicate with other residents and dealing with the 'rigid routines' of the nursing home during her first few months described how she managed to cope:

Beginning of everything is difficult which I have always told my grandchildren.

During the first few months, I thought if I just follow what everyone does and do as I am told, I will get used to things in no time and that is what helped. I started going to bed early even when it was hard, and getting up early and sitting in a room full of people you can even have conversation with.

Another participant, who relocated from home after failing to receive an offer of care from her daughter, expressed how fortunate she was to have any care and therefore learnt to accept things:

I needed help that my own child refused to give me. I was just glad to be here. I couldn't complain. I accepted things as they were and did what everybody did.

To other participants, going along and staying quiet meant trying not to read too much into things. One participant, who had perceived the nursing home to be similar to the rehabilitation centre she was admitted from, said:

The girls were doing everything to get me comfortable here. It was only fair to be appreciative of their efforts. In care institutions like here and the where I came from you don't expect things to go your way all the time. Sometimes things weren't what I wanted but as long as I got the care I needed, I tried not to read too much into things.

7.2.2 Making Use of Available Resources

Some participants claimed they occupied themselves with social and recreational activities available in the homes. Although physical limitation was a restriction, some participants claimed that by making use of whatever was available and appropriate, helped them to settle in and adjust to the often quiet, lonely and boring environment they found themselves in when they moved in to the nursing home.

Some of the resources for social and recreational activities for the participants included going out on day trips, having barbeques, eating out and playing bingo. Participating in these activities helped take their minds off any disappointment and gave them something to which they could look forward to. For example, a participant who had move from a rehabilitation centre to the home after losing his caregiver stated:

At the back here, are some olive trees and some few tomato plants. When I came here it was harvest time. So we had things to do everyday.

Individual activities such as the use of computers, watching television or listening to the radio also kept some participants occupied, kept their minds away from frustration and pain and also kept them in touch with their friends, families and the rest of the world. As one participant described:

My son bought me a camera for my computer last month. He said they want to see me when they are talking with me. Now even the little grand children talk to me and they show me their artwork they have done for me.

Other participants enjoyed having (social) recourse in the nursing home that was not available prior to the move. These participants were grateful to have something to look forward to each day.

I eat more than I did when I was living with my son. I get help; I sleep in a clean bed everyday. It is warmer here in winter and cooler in summer. We didn't have that on that filthy looking flat. We spent almost all the pension money on alcohol and little on food. I am able to walk around with this frame because I do some exercises with the physiotherapist. Because of all these things, I started getting better as soon as I got here. I knew there was something good in it for me so I took the opportunity.

Another participant described what helped her to settled saying:

I never complained. We went to mass everyday. There is a library you could go to for a read, we are allowed to have visitors and I personally couldn't ask for more.

7.3 Adjusting to The Nursing Home Experience

Although participants conformed to the rules and regulations, they did not necessary embrace them. They also developed strategies to prevent being neglected and to avoid upsetting their families. Participants described other strategies such as, social and cultural measures to adjust to the home. The following section describes these strategies.

7.3.1 Social Strategies

While participants experienced some limitations, most generally acknowledged that the nature of their circumstances, their further declining physical functions and the realities of institutional life limited the decisions and choices they could make. As participants' experience and reaction varied in different ways, so also did their adjustment to life in the home. Participants described social strategies such as making new friends, putting barriers between themselves and the offending situation and making the home theirs.

7.3.1.1 Making New Friends

Most participants in this study, particularly those who relocated to multinational nursing homes said they found it difficult to make new friends. These participants claimed that not being able to find many lucid residents and/or people who spoke their native language made it difficult to make friends. However, the few participants who were able to make friends described how friendships helped them adjust to life in a nursing home.

Participants identified how the convenience of having friends nearby presented a great opportunity to develop a sense of community. The potential for shared meals and other activities, as well as the opportunity to talk to others and share similar feelings, experience and personal history, were also identified as having contributed significantly and to have helped some participants adjust to, nursing home life. One participant in an ethno-specific home described his luck as:

I found myself a lady friend who also speaks the same dialect and she gets on well with my sister and her family. Her family accepts me. Anytime they come to visit, they come and see me too. They cook good Sicilian food and do better cooking too. I tell you the truth; I like this place better now and don't think I am missing out on anything.

Another participant in a multi-cultural nursing home stated:

I have made some few friends. I mean there is not a great deal of people to choose from but I get on well with almost everyone. We are four blokes in my room and we enjoy each other's company. Not that we have much to talk about but at least we have much in common and we share our life stories, share a few beers and tell our naughty jokes.

When describing friendships in the nursing home, several participants included staff. Friendships with the nursing home staff also helped some participants deal with occasional unpleasant experience. For example, a participant who reacted with anger and aggressive behaviour to staff that asked him intrusive personal questions about his past, became friends with another staff member who, out of respect, did not. Through this friend the participant managed to prevent other nurses from asking intrusive questions.

I was doing this to stop them from digging out my past life. D, my friend, the man who works here, looked after me. I liked him. So I told him to tell everybody not to ask me too much questions about my past. So they stopped and we all have been fine since. They leave me alone, and I don't bother them. I think it is a deal. I get on well with every one and I am so grateful for the help they give me.

7.3.1.2 Putting a Barrier Between Themselves and the Offending Situation

Learning to deal with nursing home life involved putting barriers between themselves and offending situations such as closing their bedroom doors if other residents are making too much noise or covering their ears with pillows to block noise at night.

One participant described what she does when dementia residents become noisy at night, thus making it hard for her to sleep:

There are few people here who are sick in the head and make noise sometimes at night. This is hard on anyone. The only thing is the people make the noise can't help it. They are sick in the head....There is nothing anyone can do.... I just cover my ears with my pillows and I can't hear them.

Other measures were also used such as sitting in the facility garden if they became annoyed with the unpleasant behaviour of other residents.

I just come to my room and close the door if I am not happy with something or I go and sit on the veranda and enjoy the garden.

This strategy was, of course limited by the policies in some homes, which prevented residents from freely accessing the outside. Another participant described the measures she takes:

I think the people here don't care but the place smell all the time. The dementia people touch everything, they don't watch where they are going and they can make you fall you know. So I stay in my room when I finish the games and also when I finish eating. My room smells good. The dementia people, they can't stop walking around and touching everything..... so I close my door and they can't come here... Sometimes I sit outside in the garden. They are not allowed to go outside so they can't annoy me

7.3.1.3 Staying Connected to Family

Many residents focussed on the importance of maintaining relationships with their families after moving into the nursing home. When they continued to feel involved and part of the family; when they did not feel abandoned; when they felt important.

Having additional support from a caring family who understood their situation made all the difference for most participants. In various ways, participants pointed out how their families helped and supported them during the first few months in the nursing home.

7.3.1.4 Family Support

Some participants stated that they felt settled just through seeing their families united and together. For example, one participant who relocated to the nursing home to maintain her family's good relationship stated that she was happy in the home after seeing them together and getting along well during a visit.

Darling, at my age, you want your family with you. It doesn't matter if they are rich or poor because family makes you happy. I am happy now because of my children they visit, they bring me food, they come for my birthday; they bring the children to see me.

Another participant who felt guilty about denying his children their right to look after him, dealt with his feelings through the support of his children. He stated:

My children started visiting and were taking me out to the house when they were in Melbourne. They used to take me out for a day or two in a row as a family leave to stay with them any time one of them came down to Melbourne. I think that helped me because in my mind we met each other half way. They got the satisfaction of playing the role as loving children and I got my wish to spare them the hardships. It did work very well.

7.3.1.5 Making the Home a Home

The definition of home for the participants influenced their adjustment to the nursing home. To most participants, home is where they felt happy and had good food, good care and felt secure, comfortable and are surrounded by family and friends.

These participants put considerable effort into making their surroundings look and feel comfortable and safe, participating in activities that bring them joy, and learning to live with each other regardless of their differences. Making the nursing home their home, included taking on a role and bringing in some memorable personal items from home and displaying them.

7.3.1.5.1 Taking on a New Role

Adjustment to the nursing home experience according to some of the participants has been much easier through their openness to new experience including playing roles that help in running the home. For example, one participant who enjoyed helping his friends in the house by running errands for them remarked:

We help each other as much as we can. J. over there cannot walk because he has no legs. He lost them in the war. So I get his morning paper for him when I get mine. There is another bloke who is getting a bit forgetful and we keep reminding him of things. We sit around one table close to the girls and they don't mind

Another participant who was able to help other residents, stated he was happy because not only was she able to care for someone, she continued doing what she enjoys. She stated:

In my family, we love people. We love helping others. I love helping people old or young. So what I do here is, I go around in the morning to talk to the people who cannot come out of their room. Most of them don't talk but the noise they make tell you that they enjoy the company. It doesn't bother me if they don't talk to me. I know that helps them.

One participant, who helps by feeding the facility's chickens, called the home his home because he is able to continue doing things that were important to him. He remarked:

I feed the chooks. I am only glad I can still be helpful you know and that gives me joy. I am happy here. This is my home.

To some participants, calling the home their home meant accepting others, staff and residents, as family.

We are all one big family now with things we like and don't like. You just try and do what you have to do to make everyone happy.

Another participant described his experience saying:

In here we are people from different backgrounds and have our individual needs but we are like a family. What affects one affects the other so to speak.

7.3.1.5.2 Bringing Special Items in to The Nursing Home

Special items were another thing participants described they have brought from home to make their room a comforting and familiar place. Items mentioned included quilts, pillows, vases, furniture and toys are brought in to create a home-like atmosphere and help them to accept their lives in the homes as a continuation of life. Participants also brought photos of significance from home to display on the walls of their rooms.

Although bringing in valuables is problematic, due to the fear of losing them, other cherished items were too large to bring in, as space was limited and they could not be accommodated. For example, one participant, who had displayed some of her memorable items in her room, including her late husband's photo spoke of them as:

I brought only the important ones like...here, the family at...funeral and me and...on the other side. The chair you are sitting on is from Italy. It was my wedding present from...father. He said I am a Queen of his house. He was a good man.

Participants described the use of photos they have displayed on the walls of their room as trying to make it look like their home. Especially pictures from long ago; their parents and siblings, photos of them in their youth and early adulthood, wedding pictures, and vacations. These photos participants said are helpful as are the memories from long ago. Participants described the significance of each of the pictures for example those that give hope, encouragements, and those that relax and comfort them. For example when one participant was asked what a home was to him, he remarked: *After all this is my home; he went on to say:*

Home is where I live. I am supposed to feel comfortable here but I guess I am working on it. I have put all those photos of my youthful days, my dear wife that I miss so much and seek comfort from when I feel a bit on the down side. These are my three children. I wake up in the morning and I tell my wife what I am doing for the day and that I will be all right. This is my grand father and me when I was young. Ever since I came to Australia, I have always asked him to share his wisdom.

Also, photographs are used in hope of inspiring dialogue between participants and the nursing staff. For example, as one participant stated:

I have had a good life and I enjoy talking about it you know. It gets boring here sometimes. So when the nurses come here they ask me and I tell them about me and my life and my beautiful family. ... I like it when they want to know about me

Another participant, who had lost the home that he built himself and in which he had lived in all his life, pointed at a picture on the wall and remarked:

I cherished that home because I built it and lived there all my life. I am never going to forget it, life must go on.

7.3.2 Bringing Culture In/Maintaining Cultural Connections

Participants described how settling in was influenced by their culture and their ability to 'bring their culture in'. They described bringing in their ethnicity, migrant experience, their cultural beliefs, language, rituals, food, music and dance. Most were surprised at the extent to which they were able to continue aspects of their culture while living in the nursing home. They talked about how being able to bring these has enabled them to fit in and therefore helped them to settle into the nursing homes.

7.3.2.1 Ethnicity

Finding a link to their home country in the homes has played an important role in settling in for at least some participants. Recognition and celebration of ethnicity provided participants with a satisfying personal and social identity and gave them a sense of belonging in the nursing home. Describing this, participants related to sharing not only their ethnicity with residents, families, staff and volunteers but common cultural practices that made them feel a kindred with others and also made it easier for them to interact with staff and other residents. They described having a sense of 'being with people who are like me'.

Participants expressed relief that they could retain an important part of their identity, one that many had gone to significant effort to retain over the years. For example, a participant described how being able to maintain his Italian identity has helped him settle in, stating:

My Italian identity is very important to me. Since I came to Australia, I have tried very hard to keep myself the same Sicilian man. I visited Italy often so that I will not forget where I came from ... I am glad I can still keep it.

Another participant stated,

In here everybody speaks Italian language. All my friends speak my dialect. Most of the staff members speak Italian too... We are the same so we understand each other well.

Most participants stated they preferred being looked after by staff from their home countries as they know and do things according to their culture. For example, one participant remarked:

She seems to make me feel much more comfortable. The first thing she does when she comes to work is to come to my room to check and see if I am ok. You see, I don't like my underpants going in the washing machine together with the other things. When I told her that, she asked me to leave them in a plastic bag in my bottom draw so she can wash them for me. She has been doing that since. Someone from the same culture understands me better. It is most likely they will do things the way I do things. For example, a Hindu nurse will know not to give me cow meat in my food.

7.3.2.2 Using Experience as an Immigrant to Settle In

Several participants equated the relocation into a nursing home to their initial migration to Australia. Drawing on their previous experiences of being new migrants to Australia helped them to adjust. As they did when they migrated to Australia, these participants found ways to maintain what they could from their old culture and, as many said, to accept the differences that they could not change and move on. Comments made by some participants were:

So just like I did when we first came to Australia, I have dropped some of the Croatian I kept plus the family culture I created with my family here in Australia. I am still dropping them.

Another participant added:

So I am doing exactly what I did when I came to Australia. Put up with it and get on with your life.

One participant related to her multiple ethnic backgrounds and her moving from one culture to the other had helped her adjust to the nursing home life. She stated:

I am a woman of so many cultures. I am a Maltese, Egyptian, Irish and Australian. I have moved around a bit so I am used to change.

Describing how being a migrant has helped him to adjust to the nursing home life, one participant explained:

My migrant background gives me an understanding when the non English speaking nurses struggle to explain things to me. Some of them are hard to understand.This reminds me of what my father and mother said they went through when they first came to Australia. If you are like me and you have a little idea what people like us feel with such a behaviour, you will understand?

7.3.2.3 Cultural Beliefs

Another way some participants used their ethnicity in adjusting to the nursing home life was seeing things from their perspective. Some participants described culture drawing from the realisation that their thoughts, perceptions, feelings and behaviours are consistent with those of other members of their ethnic group. For example, talking about how coming from a different culture helps deal with the nursing home experience, one participant described hers as different in the ways she looks at things and her understanding that everyone is different. She expressed her recognition that she belongs to a particular group that shares not only ethnicity but also common perceptions and ways of thinking. She admits her beliefs as an Indian helps her to see from the perspectives of other people. Also holding onto her belief of *karma* has helped her relieve her anger, which was caused by the refusal of her own child to look after her.

She remarked,

The only Indian culture I have with me now is the way I look at things, my language and my appearance of course. I know I am different and so is everyone here so I try to understand when someone does something I am not happy with. We Indians believe in karma. They say, what goes around comes around. If you are good to someone, someone will be good to you. My daughter will one day get this from her own children. So I don't worry about her anymore.

7.3.2.4 Native Language

Generally, participants described language in relation to their mother tongue. They talked about how being able to speak their mother tongue and have people around them who also speak it has helped them to settle in. Some also provided examples of how

their language allowed them to be helpful to other residents from their home country to settle in.

Through your own language you can comfort someone from your country and boost their spirit when they are down because you will know exactly what to say and when to say it. One Greek lady who has dementia always cries when she leaves after visiting. I go and talk to her in Greek language and explain to her how we need to stay here and so on. She listens and stops crying. It makes me realise I could be useful to someone. That alone has eased the pain and I can say now that I am ok.

Most participants expressed a fear of losing their English language skills as they aged, making many fearful that they would no longer understand or be understood by those around them who did not speak their native language. Having staff around who spoke their native tongue was quite comforting to these participants.

At least some staff here speak my language. When I get older and become demented so I forget English, they can understand me

In addition to their fear of someday not being understood, participants described language as more than just a means of communication.

Their language was also the carrier of their culture, allowing them to express themselves more fully than they were able to in English. When this was available, it gave them great comfort. As one participant remarked:

She does things because she wants to do that. She treats me like my own daughter she takes her time to do things for me and always makes sure she has done the right thing by me. Because she speaks my language, I am able to tell her how I feel and she understands too.

Participants spoke about how their mother tongue allowed them to more completely express their thoughts, perceptions, sentiments, and emotions. Continuing to speak in mother tongue made some participants feel 'whole'. Some participants likened language to a spirit.

I think in my language. I am not quite sure how to explain this but I know I understand things better when said in my own language. I remember all my family at home, the good times and the bad times we had, even my husband, in the language we spoke in. The words of encouragement, the poems we enjoyed, the jokes we shared as children and most of the things that brings back the memories were in my language. I still remember my grand mother's voice and her exact words when she first spoke to me about the effect of doing good things and not harming your fellow human.

When discussing the presence of caregivers who spoke their native tongue, they all felt a greater connection and believed they had been better understood than when they communicated in English, even though most could speak English fluently. In particular, they believed that speaking in their native tongue allowed them to more effectively express their gratitude, make requests and discuss. Some participants pointed out that, by speaking their own language to the staff and other residents, they were not inclined to worry about gestures and intonation patterns that might be incorrectly interpreted by others.

I could make a gesture for instance which might offend and Australia but not to the Macedonians because they speak my language and understand me.

Interestingly, some of the participants expressed a preference for carers who were themselves migrants, not only those from their home country. They believed that the common experience of migration made these carers much more accepting of language and communication difficulties that participants might have and made them more willing to explain things carefully, slowly and repeatedly as they understood the frustration of not being able to understand.

For some participants, the acceptance of being cared for by others was increased if the carers shared their culture. For example, one man said:

I don't feel like I am a burden on them because they are my own people, like my own children. I feel closer to them than Australian girls.

There was also comfort in simply hearing and being able to speak in their native language. One participant remarked:

Hearing the language is important, even if it's just a song

7.3.2.5 Traditional Food

Although participants often talked about food quality in relation to how it was cooked and presented, their elaboration of the cultural significance of food and eating focuses on

social values, meanings and beliefs rather than on dietary requirements and nutritional values.

7.3.2.5 1 Social Values

To most participants, food is an important part of celebrating important traditions such as Christmas, Easter and birthdays? Other talked about food as a medium to unite and strengthen their relationships with family and friends. Although most of the participants did not think the food in the facilities were good enough, the ability to either eat out or have family bring them in helped them to have quality time with families and friends as well as with other residents in the homes.

Policies varied from home to home, but social hours such as Happy Coffee/Cocktail Hour, where participants get served with their cultural food or drinks, provided a time of residents' interaction with people from their ethnic groups.

One participant perceived that his ability to settle in to Australian eating habits had made him an Australian:

.....we have our special day where we get our drinks. Some people have soft drinks, others have wine but I am now a true blue Aussie. I love my beer and so do my other mates. We Australian eat anything. We also put in orders for different meals like pizza, pasta, Asian or fish and chips. Every week we get to choose from two of these food groups.... When I have my beer with these blokes in here, I am at peace.

Another participant described the social value of food that had helped him settled in the nursing home stating:

We have family dinner, we tell stories to the grand children, drink Greek coffee, and with a little bit of grappa, dance with the grand children. With me it was not only the dinner that was special. It was because I had the family around and we did what made us all happy

Food to some participants is an important part of their religious observance and spiritual ritual. For example, participants of Roman Catholic faith are happy in the homes where they are supported in their fast during Easter time. One participant of the Hindu faith was

happy that the facility supported her diet of no beef; never feeling pressured to explain or compromise:

....she always checks that I have the correct food. My Hindu faith forbids me to have cow meat in my food and being a Hindu herself and knowing what is and is not Brahman; she makes sure nobody gives me. All the staffs know now so I am at peace with my God and I am happy.

Similarly, another participant who had selected the nursing home because of its religious affiliation described how food helped her to maintain an important connection to her religion saying:

Here I go to church and have communion every week. Easter time we eat Easter food. You are also a Catholic you know what I mean. The Nuns are good and they give us what we need. This is important to me. My catholic faith is not lost. It feels good at this age, to be able to hold on to something that brings closer to God.

7.3.2.6 Music and Dance

Relaxing with music particularly from their own culture was described by participants as one of the strategies that helped them to remember people, places and emotions from the past. Sometimes this tired up their memories from their younger years, helping them to find peace in the face of sadness and frustration through some difficult experiences in the homes.

For example, one participant described how listening and dancing to music from his home country, in his language reminded him of the old days stating:

Now I can't dance well but I sit in the chair and dance. I remember all the good time we had at the Greek club. When we dance like that we forget every sad thing. Here when I am having a bad day, I just listen to my old time music and I feel better.

To other participants; music and dance helped them to enjoy their social interaction with people from their culture.

On Italian nights, we get the Italian group here to play the Italian music. All the Italians here come and listen and we talk, dance and enjoy. Our families come too. The grandchildren like it very much.

Beyond the general association of music with culture, participants talked about the ability of music to lift them up even further in happy times, or provide comfort when they were feeling sad. Musical events such as, carols by candlelight, sing along, and concerts were enjoyed actively or passively depending on their physical abilities. Most of the participants enjoyed the sing-a-longs, in which they could request their favourite songs and participate with a leader.

If I ask them to play a popular Italian music that everyone can sing along, we sing and dance. Dancing to Italian music reminds me of when I was young and makes me feel young all over again.

Sometimes concerts are given by a church, school group **or nursing home friend** in the resident's native language. They can also dance to their cultural music.

7.3.2.7 Maintaining Family Culture

Most participants expressed that by being with the family, continuing with family tradition and celebrating in a way that brings in their culture, made participants happy and helped relieve some of the pain experienced in the home.

Some participants were happy not only to see their families together but also to be able to continue their cultural practices. For example, one participant whose family continues to play their role in support of her and also seeing her big family around her made her happy. She described her joy remarking:

....thing that has helped me is my big family and how everybody in the family knows they have to play their part to make me happy. In Italy this is same way they do it. Family looks after you. Not like here. Children don't care much about parents. They want to have their life. I eat Italiano food, play music, and have dinner with family when I want to. My children ask, mum you want this; you want that, they are good children not selfish. It is good to have big family. They help you when you are old. My family is what make me happy.

Another participant talked about his adjustment expressed his joy for being able to maintain his family tradition. He stated:

We had family dinner and barbeque at lunchtime for my birthday like before. I saw the beautiful grandchildren. I gave them presents; we did some painting together and took

many photos. I did that to their parents when they were growing up. This is life for us you know. Greeks celebrate the grandchildren differently too and because this was my first time of meeting them, I celebrated their birthdays too with mine. You know what. I cried but it was because I was happy.

Another participant who relocated to the nursing home together with her husband had the support from both her children and him and was able to continue her family culture. Culture, as what they did at home as husband and wife and continuing with family tradition, helped making the experience in the home better. She admitted:

Coming here turned our lives upside down but I think we were lucky in the sense that both of us were still together. I don't know what I would have done going through this without him.we spent our day's together playing cards, watching the movies and still I was able to keep an eye on him you know. He loved making me a cuppa in the morning, and then I will get his pills out for him so we can all take our pills together. We even went shopping together when the boys came to get us we would spend some time with them and when we get tired they would bring us back here.

One participant, who had severed his relationship with his family for sending him to the nursing home, described how family traditions helped him to reconnect to his family after settling in. Describing what had helped him achieve this, he said:

You see my niece, she said Uncle, I love you and I miss you so much. Your grand children want to see you. Can I take you out next week for your birthday? Before, I was upset with her and didn't want to go but she said grandchildren wanted to see me. Greeks like to play with grandchildren. That is what I wanted to do if I didn't come in here. So I went and had family dinner and barbeque at lunchtime for my birthday like before. We do that every year and I am now happy.

7.3.3 Summary

Participants identified strategies they adopted to help them settle in and adjust to their experience in the homes. Dealing with their initial experience, participants generally conformed to the rules and routines in the facilities by going along and keeping quiet and also staying open to new experience. Categorised under social strategies, participants used strategies such as making new friends, putting barriers between themselves and the offending situation and making the home their home.

The use of ethnicity, migrant experience, food, language, family, beliefs, music and dance were things participants brought from their culture. Although they experienced some limitations with their social strategies, most generally acknowledged that the nature of resident circumstances, policies, their further declining physical functions and the realities of institutional life, limited the decisions and choices they could make.

Additionally, many of the things participants talked about as specific to their culture are really universal. However, it still gives them a feeling of connection. The study found that it is not just the culturally specific things that allow people to feel connected to their old cultures but also the things that cultural believes are important.

Nurses from other cultures were viewed as good because they understood how to be patient with someone who is not a native English speaker. Australian nurses were seen to be impatient with non-English speaking staff, as they did not appear to understand what it is like to try to communicate in another language.

8.0 CHAPTER EIGHT: DISCUSSION AND CONCLUSION

8.1 Introduction

This study identified seven categories related to relocation of elderly CALD persons relocation to a RACF. The seven categories generated from analysis are experiencing losses; responding to losses; considering offers of care; deciding to move to a nursing home; searching for and selecting a nursing home; moving to a nursing home and settling in.

The study found that culture only plays a small part in the decision to relocate to a nursing home. The relocation process only reflected culture when family offers of care required consideration. This chapter will discuss in more detail the study findings, research, aged care practice, and educational implications; limitations and conclusion.

8.2 Discussion

The findings from this study provide some insight into how older adults understand and respond to loss. For example, the efforts by older adults who are experiencing loss to reverse accommodate and replace things lost add important new knowledge about the overall experience. Although these efforts were not the focus of the study, the finding raises important questions about how older adults respond to loss, the phases they go through in responding, how the environment (care providers and family members) support or interfere with these efforts and how the system might be altered to more effectively support older adults to respond in a way that allows them to be more successful.

While only two participants discussed the loss of a companion as decreasing the appeal of remaining home and increasing the likelihood of relocating to residential aged care, this is none-the-less an important finding. What is not clear from this study is whether the greater willingness to relocate after losing a companion is sustained over time or is temporary. It also raises questions about interventions that might increase the quality of life for the older person leading to a preference to stay home.

One of the most interesting findings from the study is how older people who migrated from other countries continue to weave their cultures into their lives, even after relocating to an environment that seems to lack the necessary support to do so. The points at which culture was a prominent factor was in considering the possibility of living with adult children, as a source of support, selecting a nursing home and settling in to residential aged care.

The findings from this study suggest that older adults are much more active participants in these decisions than is commonly recognised. While the views that participants from different cultures described as reflective of their culture were in fact common to several cultures, it is the feeling of consistency with one's own culture that provided the sense of cultural continuity. That is, believing that making decisions based on a particular type of reciprocity is important for and characteristic of being 'Greek, Italian, etc', even if that type of reciprocity is in fact characteristic of many cultural groups, and provides a sense of cultural continuity.

Understanding how an older adult thinks about reciprocity and its importance might be a key factor in assisting older adults to think about their options and in working with families to make decisions about care giving. For those who feel they can only accept care from families when they are able to continue reciprocating, It may be important to assist older adults to find ways of reciprocating that can be managed within the loss they have experienced. Understanding that this is important is certainly a first step.

Another very interesting finding is that several older adults in this study moved to residential aged care with an expectation that something in their lives would improve. For example, finding friends, continuing to care for a spouse, finding people to perform important tasks that need to be done, being closer to family and continuing or renewing important relationships were all identified by participants in this study as reasons to move into residential aged care.

While there has been research on the search and selection process, this study has contributed to our understanding of the strategies older adults engage in when trying to select a home. It is clear from the studies that seeing culture in physical and social forms

and hearing one's native language are important, providing comfort to people who had moved to a nursing home.

The finding that older adults are likely to lose control of the decision to move to a nursing home and, as a consequence, are more likely to be relocated when they come into close contact with professionals is a very important finding.

While more needs to be learnt about this process, it certainly has important implications for older adults and for the use of residential aged care as a care option.

8.3 Implications for Research

Unlike some Grounded Theory studies, which pursue great depth in a narrow substantive area, this study was designed to take a broader view of the relocation process, illuminating the overall trajectory. As a consequence of this approach, the study has identified a number of areas that could benefit from further research. Some of these are specific to concerns about culture and some are probably much more widely relevant. For example, the efforts to respond to ongoing loss, physical, supportive and companionship might yield vital information that has not been well explored. How older people think about care options, what they know, what they assume and what options are available that they do not know about, is not currently well understood. It may well be that early intervention, as they 'consider options' could further delay a move to residential aged care. It might also be important, and informative, to explore how public policies intersect with the options considered by older adults as they respond to ongoing loss. A glimpse of this was provided by the participant who was unable to hire her son as caregiver and the woman who could not find the right combination of resources to allow her to remain in her home.

One line of inquiry that was not pursued in this study was the pathway for people who moved in with family and were able to remain there despite continuing decline. While some of the participants in this study relocated to residential aged care because they were unable to engage in reciprocity, people who were able to remain with family, despite strong belief in the importance of reciprocity, should be investigated further.

Because the results from this study indicated that CALD nursing home residents draw on their cultural expectations and backgrounds in making decisions about relocation, cross-country comparisons or within country comparisons of a larger sample of CALD residents may provide more empirical evidence about the role of culture as opposed to non-cultural factors with respect to the literature on minority health, elder care and also relocation as a whole.

This study was limited to CALD elderly in nursing homes. As the finding did not only reveal participant's nursing home relocation experience but also the loss that was experienced and the decisions made on their relocation, a study that explores experiences of CALD resident living at home with support would be appropriate.

Also, with women outliving men in large numbers, future studies should also consider the gendered contexts of relocation among CALD people. Do the same experiences apply to men as they do to women? To sum up, despite the limitations of the study, the findings presented attest to the substantial role cultural forces often play in our understanding of several social and health-related behaviours.

8.4 Implication for Aged Care Practice

The findings from this study have implications for nurses in a variety of settings including: community health nurses, nurses who work in rehabilitation and respite, hospital nurses and those working in residential aged care.

8.4.1 Community Health

8.4.1.1 Identifying the Impact of Loss and Care Options

Older adults, especially those of immigrant and culturally distinctive backgrounds do go through a host of changes in their lives. Immigration and resettlement are associated with a wide range of physical and mental health problems, in particular, a complex array

of stresses and anxieties related to culture shock, culture conflict, loss of social status and narrowing social networks, to which older immigrants are particularly vulnerable.

While the focus of change in older adults is often related to physical change for all older adults, the impact on CALD elderly is much greater (Retsinas, 1991). For participants in this study, these changes were important primarily in their impact on important roles such as caring for themselves, others and ability to contribute to their families.

The tradition of caring for the elders in their families is identified and lauded as a desirable norm by the participant in the study, despite being recognised as a possible source of burden for their families. Community care is a major part of the system of age care in Australia, providing programs that allow people to remain in their own homes and retain their own lifestyles.

Respite Programs, which focus on frail aged people, who are cared for at home by family or other significant persons, is provided to allow the carer to have a break from their commitment to the aged person. Community care programs support older people to remain independent and living in their own homes and are a more cost effective way of providing health care for the older population. However, older people and/or their families however do not always have adequate knowledge of the existing services. The objective of the elderly living at home with their children may be commendable and can be assisted by policies such as increasing knowledge on community aged care services and the increased availability of respite care or home visits by community health professionals. Community health is not a large component of aged care currently. The findings of this study would support a greater involvement of community care for CALD person so that the tradition of caring could be continued.

8.4.1.2 Assisting with Reversing, Replacing Lost Supports

Moving to the nursing home was the first option for some participants in this study because additional care they needed was not available. The efforts by older adults who are experiencing loss to reverse, accommodate and replace things lost add important new knowledge about the overall experience. Provision of assistance by the community

aged care nurses for older people and their families to consider their preferences as well as safety issues and the ability of the family and caregivers to provide the needed full-time care could be helpful and cost-effective.

The community aged care nurses' understanding of how an older adult thinks about reciprocity and its importance might be a key factor in assisting older adults to think about their options and in working with families to make decisions about their care giving

8.4.2 Rehabilitation/Respite

8.4.2.1 What are They Trying to Accomplish

The study has identified that functional impairment was the reason for participants who relocated from the rehabilitation centres to move to the nursing home. Nurses in rehabilitation centres and social workers interventions including referrals to the community rehabilitation services could help, so that options for social and family support could be explored prior to deciding to place patients in a nursing home.

Helping to identify needs to remain home and exploring family support should be considered in all cases. Moving to a nursing home appeared to be the only option advocated by professionals to be suitable for care giving. Why this is so is not known by this study

The finding that older adults are likely to lose control of the decision to move to a nursing home and, as a consequence, more likely to be relocated when they come into close contact with professionals, is an indication that, nurses in rehabilitation centres are very narrow in identifying care options for CALD persons. The nurses could play an important role by helping the older person to identify what their needs are in order to remain living at home. Early referrals to the community aged care services in terms of which support services exist could be helpful. While more needs to be learnt about this process, it certainly has important implications for older adults and for the use of residential aged care as an option. As well as implications for respite nurse and social worker education on CALD persons care giving options.

8.4.3 Hospital

8.2.3.1 Identifying This as a Vulnerable Time

Among the causes of nursing home relocation, it has been found that it usually occurs at a time of distress and crisis, such as following an acute illness or hospitalisation. Patients admitted to nursing home facilities from the hospital are most vulnerable in the first few days after transfer (Chenitz, 1983; Willcocks et al, 1987; Johnson, 1990; Retsinas, 1991). This is consistent with the finding of this study.

Thus participants who relocated from hospitals found the first few months difficult, as they were not properly informed, therefore affecting their preparation for the relocation. A smooth transition with complete and timely sharing of information would help build confidence and dissipate anxiety for both the patient and the family.

8.4.3.2 Helping with The Search

Studies have found that the ways in which older people deal with their residential care experiences may depend on their perception of loss related to the absence of objects and symbols associated with their past (Nay (1995)). Also reported is their loss of attachment to their past, such as their homes, often leads to their feelings of insecurity, lack of control and personal identity.

These feelings are found to have a tendency to cause their suffering and anxiety (Denermark & Ekstorm (1990)). The finding of this study identified a lack of preparation for participants who were relocated from hospitals, compounded their negative experience in the nursing homes.

Participants' lack of timely preparation contributed to their inability to take care of their possessions, thus having ample time to sell their houses and distributing their assets influenced their experience. Perhaps a variety of community support services available in the community could be used, so that older people intending to move to the nursing home could be discharged back to the community to continue their care and thus leave more time to prepare before relocating to the nursing home.

Services such as Hospital in the Home and Meals on Wheels could be arranged by the hospital staff so that the older person could continue their care while making the decision on care options. Extended care services could also be used as an option to discharge older people while giving them the time and preparation needed to search and select their preferred home without being pushed out, as perceived by some participants in this study. Overall the time factor and consideration of being pushed into a NH were negative aspects of relocation.

8.4.4 How Residents See the Nursing Home

While nurses from cultures other than Australian were viewed as good because they understood how to be patient with someone who doesn't speak English as their native tongue, Australian nurses were seen to be impatient with non-English speaking residents and staff; as they did not appear to understand what it is like to try to communicate in another language.

To effectively address the needs of CALD people, nursing home staff needs to understand the social context and backgrounds of CALD people and how their cultural backgrounds influence their needs for services they provide to their residents.

Also identified is how the ability of the participants to express their cultural identity with others, sharing and connectedness evolved with their adjustment to the life in the nursing home.

In addition to Commonwealth Government 'Access and Equity Strategy' (A&E, 1997), and some nursing homes efforts to establish clusters of three or more aged residents from the same language and cultural background (AIHW, 2003), is to be appalled. Policy makers, service organisations and health care providers need to recognise that the more residents there are from the same language group, the easier it is to justify employing bilingual professional and domestic staff. Therefore building more ethno-specific nursing homes and continuing with homes with clusters of different cultural groups could provide these individuals with better experience in nursing homes.

Participants in this study identified the distress caused by finding out that the physician they have known for many years could not continue to see them in the nursing home. Participants were concerned that their new physicians might not know anything about them, contributed to negative experience. Nursing homes that provide their own physicians might need to look at sharing the older person's care with the residents' own physician, at least for the first year to help ease their transition to the home.

The study also identified that ability to make meaningful choices was regarded as lacking in a variety of ways, as participants described experience in the control of their daily living. The older people talked about how things were done differently at different times, privacy issues, access to outside, risk management and safety have negatively influenced their adjustment to the nursing home life.

Residential Aged Care standards have been set by government for quality assurance for the purpose of ensuring that care is of excellent quality, in good physical surroundings and the personal rights of clients are respected. These standards require that residents are encouraged to live as they wish and participate in a range of social experience; accommodation is homelike with privacy and dignity respected; health is maintained at the optimum level; and the environment is safe and free from risk of injury and accident (AIHW, 2003). Nursing home providers are to ensure that these outcomes are met. Proper planning and implementation of resident care and documentation would aid continuous improvement. For many participants in this study quality care was lacking from a cultural perspective.

8.5 Implications for Education

As Australia's ageing population continues to grow rapidly they are likely to experience multiple changes, declines, and losses, resulting in multifaceted needs. The needs of the elderly persons, particularly those of CALD elderly being varied and diverse, are likely to increase co-morbidity of physical and mental problems leading to increase in hospital admissions.

Many nurses in the acute care setting have had little, if any, specialist education in the care of older people and therefore do not understand the extent of their needs (Nay 1993). This will necessitate that the educational preparation of registered nurses focus on their role in managing care processes - and managing these differently to how they might have done for young and young adults traditionally.

Perhaps now the Postgraduate - Continuing Education scholarship, an Australian Government initiative aimed at increasing the skills of registered nurses working in the aged care sector should continue to be instrumental in differentiating the scope of practice for those in the health care workforce and in delineating expectations of health workers, including nurses, educated to a range of qualifications.

Long time experience in aged care nursing emerged as a key concept of good and quality care as perceived by some participants in the study. Developing activities, including formal learning opportunities, mentorship, and sharing experience by the older staff with long time experience in the nursing homes would help build effective nursing skills. Therefore, clinical education and professional development must be viewed as essential to the development of skills in nursing and promotion of good quality care services.

Education is a key strategy for improving quality of aged care and for maintaining and improving practice related to the growing evidence from research.

8.6 Study Limitations

There are several limitations of the study that needs to be considered and also addressed in future research. These limitations stem from two main sources methodological limitations related to this particular study and the particular method chosen as well as the study participants.

Sampling: Most of the methodological limitations were related to sampling challenges. Firstly, although the intent was to compare facilities that were exclusively for a particular

culture with those accommodating mixed cultural groups, it was not possible to do this. None of the culturally exclusive facilities was willing to participate.

Secondly, as very little was known about residents prior to interviewing them, theoretical sampling on several of the dimensions was not possible. The researcher was forced to rely on question evolution to facilitate comparative analysis, rather than sampling deliberately. This is a significant challenge for a Grounded Theory study and resulted in less depth in some important aspects of the study.

Thirdly, sample size was less than initially anticipated. This was also a consequence of difficulty finding facilities that were willing to participate. As indicated in the methodology section of this thesis, the difficulties I encountered in gaining permission in nursing homes in the northern metropolitan region of Melbourne restricted me to only four nursing homes.

Another limitation was the necessity of recruiting only participants who spoke English fluently. This necessarily excluded many people whose experience would have been valuable. However this remains a limitation of the study as the experience of relocation for this group of CALD elderly persons has not been presented in this study.

Not having an effective way to interview older adults with dementia was also an important limitation. There was no reason to assume that their experience was represented by those who participated, thereby limiting the ability to extrapolate to this population.

The sample for the study has limitations in that; CALD elderly who were born in Australia were not included in the study. Additionally, the study sample is predominantly European persons. This limits the use of findings with other groups of CALD elderly persons. For example, African and South American elderly persons.

Furthermore, participants in this study ranged between the ages of 61-90, making many of them frail and vulnerable to fatigue and minor ailments. Some of these participants volunteered to participate but were unable to follow through; others became ill or died during the study, adding to attrition.

Even though emergent patterns in the data are theoretically important, the small sample size reduces the generalisability of the results to a larger population. It is also important to note that the CALD population sample varied and included eight cultural groups. As such, there is the possibility that the experience of other elderly CALD people (e.g., Africans) may differ from other populations or cultural groups participating in the study.

8.7 Conclusion

The initial objective of exploring the participants' nursing home relocation experience shifted during the study to participants' experiences from the beginning of the pathway to nursing home relocation. Four major categories emerged from the data: (i) loss experienced by participants (ii) participants' responses to loss that they experienced, (iii) participants' experience on deciding to move and moving to a nursing home and (iv) how participants dealt with their settling in experience and adjusted to the nursing homes.

This study found that it is not just the culturally specific things that allow people to feel connected to their old cultures; but also the things, which all cultures believe are important.

The study findings also indicated that whilst some residents found the nursing home relocation experience to be acceptable, many reported that things are carried out differently in their culture and that their expectations about old age have, for the most part, been influenced by their own cultural upbringing, making it somewhat difficult at times for them to accept the realities of their situation - that they live in a different culture.

The four nursing homes in the northern metropolitan region of Melbourne and the twenty participants studied, constitute only a small proportion of all CALD elderly nursing home residents in Australia and therefore the findings could not be claimed as pertinent to all CALD elderly nursing home residents. Nonetheless, this study makes an important contribution to future discussions regarding cultural diversity in nursing home relocation

of CALD elderly in Australia. The study findings provide some insight into the conditions and contexts that impact on nursing home relocation.

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Appendix-01

94 Old Diamond Creek Rd
Diamond Creek
Victoria, 3089

Dear Centre Manager,

I am an aged care nurse who immigrated to Australia from Africa years ago. I also volunteer at the Northern Migrant Resource Centre in the northern region. My nursing and community experience has developed an interest in the significance of cultural diversity when a person relocates to a nursing home. I am now enrolled in a PhD programme in Australian Catholic University and my proposed study is designed to explore the experience of culturally and linguistically diverse people relocating to a nursing home.

I would like to recruit residential aged care facility participants into my study from the Northern region of Melbourne because of the high incidence of migrants living in this region. Participants would be asked to be included in an interview about their relocation experience taking approximately 20-40 minutes.

Could you consider giving me approval to recruit participants from your facility? Written approval is necessary from you to accompany my Human Research Ethics Committee application at Australian Catholic University.

I am happy to visit and give you more details of my research. Please contact me on phone or email.

Kind regards
Cecilia Yeboah.
Phone number: 94385681
Email: nanakual@optusnet.com.au

Cecilia Yeboah 14/09/06

Appendix-02



21 September 2006

Ms Cecilia Yeboah
94 Old Diamond Creek
Diamond Creek 3089

Dear Cecilia,

Title of Study: Relocation to nursing home: the significance of cultural diversity
School: Australian Catholic University
Program: PhD in Nursing

I am writing to confirm that the Northern Migrant Resource Centre is able to provide an ethno specific counsellor, psychologist or social worker to any of your study participants if they require one.

We wish you the best of luck with your research.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephanie Lagos", written over a horizontal line.

Stephanie Lagos
Chief Executive Officer

Darebin Office
251 High Street, Preston 3072
Tel: 9484 7944 Fax: 9484 7942

Moreland Office
13 Munro Street, Coburg 3058
Tel: 9383 6233 Fax: 9383 6299

Whittlesea Office
187-189 High Street, Thomastown 3074
Tel: 9466 4933 Fax: 9464 2871

Quality System

Appendix-03

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

INFORMATION LETTER TO PARTICIPANTS

Title of Project: RELOCATION TO A NURSING HOME: THE SIGNIFICANCE OF CULTURAL DIVERSITY

Name of Principal Supervisor: Professor Barbara Bowers &
Name of Co-Supervisor: Dr Colleen Rolls
Name of student researcher: Cecilia Yeboah.

Dear Participants,

I am an aged care nurse who immigrated to Australia from Africa. Currently, I am enrolled to a PhD programme at Australian Catholic University. My study is investigating elderly persons from culturally and linguistically diverse background experience of relocation to a residential aged care facility. The benefit of being involved in this study will include, giving participants the chance to tell their unique story of relocation experience and the cultural meaning of this event.

Participation involves an audio taped interview lasting 20-40 minutes at a location and time suitable to you. It is not anticipated that any risk to you will occur from your involvement in the interview. However, if you become unwell or distressed, I will stop the interview and obtain assistance from the staff. Additionally, counselling will be available from the Northern Migrant Resource Centre (NMRC) aged care division.

Involvement in the study will be voluntary. You are free to refuse consent altogether without having to justify that decision, or to withdraw consent and discontinue participation in the study at any time without giving a reason. Your care in the residential aged care facility will not be affected by refusal to participate in the study.

Confidentiality will be ensured during the conduct of the research and in any report or publication arising from it. The residential aged care facility will not be identified in any publications. Participants will be given a pseudonym and names not identified in any report or publication.

Any questions regarding this project should be directed to the Researchers Dr Colleen Rolls on telephone no 9953 3191 in the School of Nursing, Melbourne Campus, ACU National, Locked Bag 4115, Fitzroy, 3065.

CRICOS registered provider:
00004G, 00112C, 00873F,
00885B

Appendix-04

This study has been approved by the Human Research Ethics Committee at Australian Catholic University.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigators have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee care of:

Chair, HREC
C/O research Services
Australian Catholic University
Melbourne Campus
Locked Bag 4115
Fitzroy VIC 3065
Tel: 9953 3158
Fax: 9953 3315

Any complaint or concern will be treated in confidence and fully investigated. You will be fully informed of the outcome.

If you agree to participate in this project, you should sign both copies of the consent form, retain one copy for your records and return the other copy to the Researcher.



Barbara Bowers



Celicia Yeobah

Date Oct 1 / 06

Date 16/10/06

Appendix-05

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
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Telephone 613 9953 3000
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www.acu.edu.au

CONSENT FORM Participant's Copy

TITLE OF PROJECT: RELOCATION TO A NURSING HOME: THE SIGNIFICANCE
OF CULTURAL DIVERSITY

NAMES OF SUPERVISORS: PROF. BARBARA BOWERS, DR COLLEEN ROLLS

NAME OF STUDENT RESEARCHER: CECILIA YEBOAH

I.....(the participant) have read and understand the information
provided to me in the Letter to Participants. Any questions I have asked have been
answered to my satisfaction. I agree to participate in the audio-taped interviews,
realising that I can withdraw at any time. I agree the research data collected for the study
may be published or may be provided to other researchers in a form that does not
identify me in any way.

NAME OF PARTICIPANT.....
(Block letters)

SIGNATURE..... **DATE**.....

SIGNATURE OF PRINCIPAL SUPERVISOR.....
Barbara Bowers

DATE.....
Oct 1/06

SIGNATURE OF STUDENT RESEARCHER.....
Cecilia Yeboah

DATE.....

CRICOS registered provider:
00004G, 00112C, 00873F,
00885B

Appendix-06

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



CONSENT FORM Researcher's Copy

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

TITLE OF PROJECT: RELOCATION TO A NURSING HOME: THE
SIGNIFICANCE OF CULTURAL DIVERSITY

NAMES of SUPERVISORS: PROF. BARBARA BOWERS, DR COLLEEN
ROLLS

NAME OF STUDENT RESEARCHER: CECILIA YEBOAH

I.....(the participant) have read and understand the information
provided to me in the Letter to Participants. Any questions I have asked have been
answered to my satisfaction. I agree to participate in the audio-taped interviews,
realising that I can withdraw at any time. I agree the research data collected for the
study may be published or may be provided to other researchers in a form that does
not identify me in any way.

NAME OF PARTICIPANT.....
(Block letters)

SIGNATURE..... **DATE**.....

SIGNATURE PRINCIPAL SUPERVISOR..... *Barbara Bowers*

DATE..... *Oct 1 106*

SIGNATURE STUDENT RESEARCHER..... *Cecilia Yeboah*

DATE..... *16/10/06*

CRICOS registered provider:
00004G, 00112C, 00873F,
00885B

Appendix-07

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Prof Barbara Bowers Melbourne Campus

Co-Investigators: Dr Colleen Rolls Melbourne Campus

Student Researcher: Cecilia Yeboah Melbourne Campus

Ethics approval has been granted for the following project:

Relocation to a nursing home: The significance of cultural diversity

for the period: 15th November 2006 to 1st November 2007

Human Research Ethics Committee (HREC) Register Number: V200607 20

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed:

A handwritten signature in cursive script, appearing to read "J. Meashie".

Date: 16.11.06

(Research Services Officer, Melbourne Campus)

(Committee Approval.dot @ 31/10/06)

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