BECOMING A RESIDENT

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ABSTRACT

In this thesis the meaning of relocation is examined for six elderly people in Northern Tasmania who voluntarily left their own homes and moved into two hostels for the frail aged. The research method of ethnography was used to guide the study. Periods of participant observation in the hostels and in-depth interviews with each of the six key participants, at approximately three monthly intervals over a nine month period following admission, were the main methods of data collection. Data was also obtained by interviewing other hostel residents, nursing staff associated with the relocation process, and significant others of the key participants. Data analysis occurred concurrently with data collection. Qualitative content analysis was used to inductively derive themes and sub-themes from the data. The themes and sub-themes were in turn validated with the key participants. Three major themes, **"PREPARING FOR RELOCATION", "FITTING IN",** and **"LEADING THE LIFE I LIVED"** emerged from the data. Preparing for relocation was a difficult time for the key participants. Decisions about where to relocate and what possessions to dispose of and what to keep had to be made. During this period, they were actively supported by professionals and significant others. Fitting into the hostel was a smooth process for five out of the six key participants. Some had been previously admitted on a short term basis and were familiar with staff and routine. Hostel staff were identified by the new residents as the most important group who helped in the adaptation phase. They facilitated residents self- care and encouraged them to pursue previous activities either within the hostel or in the community. Many features of the resident's new lifestyles were able to be integrated to provide continuity with their previous lifestyles as the key participants relocated in the same geographical area in which they had previously lived. Outside social contacts and recreations were maintained. One key participant exhibited features of poor adaptation to the hostel. She spent the day

within the confines of her hostel room pursuing aspects of her previous lifestyle.

The study demonstrated that for five out of six key participants the most stressful part of the relocation process occurred in the the preparation phase. Adaptation to the new environment and integrating aspects of old and new lifestyles were relatively smooth processes.

Reasons for this smooth transition were concerned with the key participants making their own decisions regarding the choice of hostel and the timing of entry to the hostel. During these decision making processes, they were helped and supported by the professionals and significant others. Other reasons for the smooth transition period related to the key participants' knowledge of the hostel's physical surrounding, routine and staff.

All key participants in one hostel had previously been admitted to the respite area adjoining the hostel. The key participants of this hostel also relocated from homes in the immediate neighbourhood thus they were able to easily maintain continuity with aspectsof their previous lifestyles. The key participants in the other hostel did not have a choice of hostel accommodation. They belonged to a smaller rural community but were known by staff members and other residents prior to their admission.

Staff members in the hostels also contributed to the smooth transition. They demonstrated positive attitudes towards the new residents adapting to the hostels and saw their roles as helping the elderly maintain their independence, thus providing an environment which helped the integration of old and new lifestyles.

CHAPTER 1
INTRODUCTION AND OVERVIEW

1.1 Introduction and Background

The aim of the research reported in this thesis was to uncover how becoming a resident in a hostel for the elderly is experienced by those who undergo this transition.

IN AUSTRALIA, as in other countries of the western world, the fastest growing segment of the population is the elderly. At present 8.6% are over 65 but it is predicted that the figure will have risen to 12.9% by 2021. In a projected population of 20.9 million, 2.7 million will be over 65 and almost 1 million of these will be 75+ years (Pollard and Pollard, 1981, 28-29).

Some of the features of the elderly aged 75+ include a majority of females (65%). Some will have no children whereas others will be socially or geographically isolated from their families (Russell, 1981). Many will suffer from multiple chronic health problems such as osteo-arthritis and osteoporosis, cardiovascular disease, vision and hearing difficulties, cognitive impairment, depression and mental illness, falls and urinary incontinence (Bould, Sanborn and Reif, 1989).

Despite disabilities, the majority of elderly people are able to remain in their own homes. Federal and State initiatives are directed toward establishing

> "... a range of home and community care services for frail or at risk aged persons ... in order to facilitate the maintenance of those persons in their own homes" (Home and Community Act, 1986).

Unfortunately, approximately 10% of the elderly do develop health problems that are sufficiently severe to require relocation to residential care (Kendig, 1981).

The type of residential care available is dependent on the degree of disability suffered by the elderly person. If some physical assistance or minimal supervision is required then hostel accommodation would be considered suitable. Hostels, however, have no provision for care at night, except in an emergency. When an elderly person has disabilities, which are severe enough to require care over a 24 hour period, then a nursing home would be the appropriate institution.

RELOCATION is a potentially stressful event in anyone's life but for the elderly who have to move into residential care, there are the added stressors of declining health, finality of move and possibly loss of social support. These stressors, along with the changes in lifestyle resulting from relocation, can produce further health problems in someone whose homeostasis is already precarious.

MY INTEREST in relocation has been sharpened both by personal and professional experience. During the past twelve years I have lived in four different countries. I view relocation as a time of significant disruption, when extra demands are made on the physical, emotional and social resources of the individual. The older I became, the more difficult was the process of relocation, possibly because of depleted energy reserves.

As well as personal experiences, two other incidents concerned with relocation have made vivid impressions on my memory. Both involve the elderly.

I recall with clarity, over 20 years ago, my elderly uncle by marriage describing to me, with a great deal of emotion in his voice, how he had just taken his 98 year old mother to a nursing home. The experience was for him a totally negative one and he ended by saying he would have preferred to have taken her to the cemetery!

The second, more recent occurence, happened whilst I was working as a clinical teacher in a nursing home. It involved an 85 year old lady who had recently been admitted. She had previously been a highly respected and active member of the community and had been involved in several organisations and charitable causes. After living in the nursing home for 4 weeks, she decided to become a permanent resident and spent an afternoon at her old home sorting out her possessions. On the following day she described angrily to the student nurse and myself how she was being "put away" by her son and his family and that she was unable to prevent the process. My attention was once more drawn towards the phenomenon of relocation.

My search for a thesis topic rekindled thoughts on relocation and the elderly. A brief literature review indicated that although relocation had been studied for over 30 years, nursing research on the topic did not commence until the late 70's. Until that time the subject had been mainly the perogative of gerontologists and urban planners. Research studies in the 80's have been aimed at identifying the adverse effects of relocation and determining ways of minimising them (Burnette, 1986). However, nurse researchers agreed that the area was poorly researched both qualitatively and quantitatively (Burnette, 1986, Rosswurm, 1983, Young, 1990). There had been no research studies on relocation and the elderly in Tasmania, the island state of Australia, where I proposed to carry out my study.

REGISTERED NURSES working in the community and in residential care institutions are often involved in the provision of help and support to the relocatee and his/her family. As the percentage of elderly in the population increases, nurses will play an increasing role

> "... in community care, to provide support to carers of the elderly in their own homes and to appropriately assess changing needs for care and services. Increased ratios of registered nurses will be required in hostels, in nursing homes and other institutionalised settings ..." (Curtis, 1987, 13).

The dearth of research studies and the increasing involvement of nurses with elderly people who relocate, convinced me that the topic was an appropriate one to study.

1.2 Research Aim and Methodology

INITIALLY, THE AIM OF THE RESEARCH was to investigate the meaning of relocation for the elderly person as he/she moves from his/her own home into a nursing home. The research question considered relocation from a qualitative perspective and required the relocatees to "tell it as it is".

Preliminary observations, and discussions with community and residential care nurses indicated that people were not usually admitted to a nursing home until their condition had deteriorated to a degree not compatible with their participation in a research study. The relocation phenomenon which occurred with a person moving from his/her own home to become a permanent resident in a hostel was judged to be a more appropriate focus for the study. The research question was amended accordingly to read "What is the meaning of relocation for the aged person as he/she moves from his/her own home, to become a permanent resident in a hostel?"

ETHNOGRAPHY was the research methodology chosen to guide the study. It is an established research method originally used by anthropologists to discover unknown facts and lifestyles of many different cultures (Leininger, 1985). More recently the ethnographic method has been used by other disciplines including sociology, psychology, political science and nursing (Germain in Munhall and Oiler, 1986). The purpose of an ethnographic study is to understand the cultural and contextual meanings people use to interpret their

experiences (Spradley, 1979). Methods used to obtain this information rely heavily on participant observation and intensive interviewing of key participants, over an extended time period. The researcher is able to learn the meaning people attach to activities, events, behaviours, knowledge, artefacts, rituals and other aspects of their lifestyle (Germain, 1986).

The rationale for choosing ethnography as a research method was that it is directed towards disclosing the perspective of relocation as it is being experienced by the participants. The methodology aims to discover the structural characteristics, shared meanings and expectations which shape and hold together the experience of relocation for the relocatees.

Data were obtained by interviewing six newly admitted key participants from two venues, on three separate occasions, over a period of approximately nine months. Relatives of key participants, other hostel residents, staff involved in the process of relocation and elderly people on the hostel waiting list were also interviewed. Periods of participant observation were carried out in both venues. The data so obtained was analysed to develop a portrait of the people who had relocated in this way and the context in which they experienced the process of relocation. The developing lifestyles of these people as new residents also emerge.

1.3 Summary

In this chapter, the phenomenon of relocation is identified as a research topic. Its relevance to the increasing ageing population and to nurses working both in the community and residenital care has been described. The researcher's perspective on relocation is outlined. A literature review on the elderly and relocation indicated the topic had been poorly researched both quantitatively and qualitatively. No studies had been previously undertaken in Tasmania on relocation and the elderly. The research question and the chosen methodology of enthnography to guide the study were briefly described. Strategies for data collection were outlined.

Following on from this overview, in Chapter 2 the relevant literature will be reviewed. Research methodology and data collection will be outlined in Chapters 3 and 4. In Chapter 5 data analysis will be described. There is a discussion of research findings in Chapter 6. In Chapter 7, the final chapter, the implications of the findings for nursing theory, nursing practice and nursing research as well as the study's limitations will be discussed.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction to the Concept of Relocation

In the first chapter, the general area of interest for the thesis has been described. In this chapter, literature relevant to the topic of relocation, as it refers to elderly people moving from their own homes to extended care institutions will be reviewed.

The word RELOCATION is used to describe several different environmental changes. These may be residential, moving from one home to another; (i) inter-institutional, transferring from one institution to another; (ii) intra-institutional, transferring from one area to another in the same institution; (iii) residential/institutional, moving from home to an institution (Rosswurm, 1983)

In the literature reviewed, elderly people with varying degrees of disability have relocated to institutions which provide a variety of levels of care. There is no doubt that these factors have contributed to the conflicting results associated with relocation (Thomas, 1989). Relocation may be either voluntary or enforced and much of the early literature focused on involuntary relocation which occurred in the U.S.A. during the 60's and 70's as a result of urban renewal or safety regulations which dictated the closure of some nursing homes (Coffman, 1981). As this thesis is concerned with the human experiences of six elderly people voluntarily moving from home to hostels for aged care, the literature review will focus largely on voluntary residential/institutional relocation.

2.2 Enforced Relocation in the 1960's and 1970's

Government Acts in the U.S.A. which were concerned with urban renewal, road building, housing projects and safety in nursing homes commenced in the late 1930's. These regulations resulted in enforced residential and inter-institutional relocation for groups of

elderly people. Coffman (1981) notes that by the 1950's the potential effects of enforced relocation for the elderly were recognised by gerontologists and their concern to further explore the phenomenon resulted in many research studies during the 1960's and 1970's. These studies gave rise to controversial findings. Some research results demonstrated negative consequences for relocation which were increased morbidity and mortality rates, whilst other research studies showed no change or even some improvement in the health status of relocatees.

Many of the studies, which were associated with increased morbidity and mortality rates, were carried out on individuals who were not given any choice. These people were relocated from one institution to another or within the same institution. Studies which demonstrated negative outcomes include Aldrich and Mendkoff (1963), Jasnau (1967), Killan (1967), and Bourestom and Palastan (1975) as cited by Borup, Gallego and Heffernan (1980).

Studies which demonstrated no significant effects on mortality or morbidity rates following enforced inter or intra instituitional relocation included Gutman and Hebbert (1975), Lawton and Yaffe (1970), Miller and Lieberman (1965) and Wittels and Botwinick (1974) as cited by Borup, Gallego and Heffernan (1980). These researchers concluded that in 75% of the studies in the U.S.A. to date, there was no significant increase in the mortality rate following relocation.

Two researchers in the 60's studied residential/institutional relocation. Lieberman (1961) cited in Coffman (1981) researched the mortality rates of nursing home residents during their waiting-list time and to one year after relocation. He reported a higher death rate amongst the relocatees than those on the waiting list. Ferrari's (1963) study cited in Schulz and Brenner (1977) compared two groups of people entering institutions, those who relocated voluntarily and those who had no choice. Within the first ten weeks of entry, 16 out of 17 residents (94%) who were involuntarily

relocated died compared with 1 out of 28 residents (2.6%) in the voluntary group.

Explanations for the inconsistent results began to appear in the literature during the late 70's and 80's. Schulz and Brenner (1977) in their review and theoretical analysis of relocation and the aged, suggested that variations in the research data could be explained by the individual's responses to the stressful nature of relocation. They postulated that the stress could be mediated providing that the individual was able to choose his/her own venue and the new environment was predictable and controllable. Coffman (1981) identified the diversity of procedures for investigating "the relocation effect" - a phrase used to explain the negative consequences of relocation, as the reason for the controversial findings. He analysed the research findings of 26 studies on relocation, with procedures to give comparable mortality rate scores. His results indicated that increased mortality rates were present no more often than increased survival rates. However, neither an increase or decrease in survival or mortality rates was found as often as the lack of significant change in either mortality or survival rates, following relocation. Using this evidence, Coffman (1981), attempted to dispel the notion of the negative effects of relocation which had been described "... by such graphic terms as transplantation shock, admission stress, relocation stress, relocation shock and transfer trauma" (p 484). He concluded that there probably existed "a pure relocation effect" and described this concept as "no more nor less than a pure stress effect" (p 494).

Bourestom and Palastan (1981) suggested that the controversy regarding the positive or negative consequences of relocation for the elderly should not continue but researchers should turn their attention to types of populations and post relocation environments, in order to determine which groups and under what conditions, the positive and negative effects of relocation are likely to be found. There is evidence that study of some of these areas commenced in the 70's when researchers began to consider relocation as a process instead of a discrete event.

Beaver (1979) researched the relationship between the decision making process prior to relocation and relocation adjustment. She studied retrospectively 108 elderly residents who had voluntarily relocated to a retirement apartment home in Los Angeles, over a three year period. Two groups, the highly successful adjusters (N=56) and the unsuccessful adjusters (N=52) were identified using a questionnaire completed by apartment staff. Data was collected from the two groups by personal interview. Direct observation and staff records were also used to augment data. Results showed self reliance in both groups, 30% of the successful adjusters and 29% of the unsuccessful adjusters didn't discuss their decision to relocate with anyone. However, 40% of the successful adjusters and 45% of the unsuccessful adjusters sought help with decision making from relatives, whilst 30% of the successful group and 26% of the unsuccessful group asked friends for help with decision making. Beaver identified only two differences between the groups that were statistically significant. 52% of the successful adjusters considered the available activities in the apartment block prior to relocation compared with 29% of the unsuccessful adjusters. The other statistically significant finding concerned adjustment and number of venues considered. One venue only was considered by 46% of the successful adjusters and 59% of the unsuccessful adjusters indicated they considered one venue only. Two venues were considered by 34% of the successful adjusters and 10% of the unsuccessful group considered two venues, whilst 23% of the unsuccessful adjusters compared with only 9% of the successful adjusters considered three or more venues. The most significant predictors of successful adjustment were found to be good physical health and outgoingness.

Successful and unsuccessful adjusters were also studied by Rodstein, Satvisky and Starkman (1976) who researched the personality characteristics and the physical health status of 100 elderly individiuals on admission and at the end of the first month following relocation to a long term care institution in New York. They related their findings to initial successful or unsuccessful adaptation and health maintenance. The physical health status of

these elderly people was determined on admission and monitored during the first month by physicians. The study group was also evaluated by psychiatrists for the quality of adjustment, nature and degree of mental disorder and reactions to stress. The medical and behavioural changes were analysed independently and then correlated. Results identified four distinct sub-groups: smooth adjustment, no significant changes (33 subjects); smooth adjustment with significant medical changes (17 subjects); severe adjustment problems but no significant medical changes (31 subjects); severe adjustment problems with significant medical changes (19 subjects). However 58% of those with severe adjustment problems initially, adapted satisfactorily within the first six months. When individuals did not have health problems which could have impeded their initial adjustment, the quality of the adjustment appeared to the researchers to depend heavily on personality, temperament and the social context in which the relocation took place. Those elderly with outgoing personalities and who were able to develop new relationships integrated more easily into the long term care facility. The poor adjusters were described as being emotionally detached, aggressive and sometimes suffering from paranoia. Rodstein, Satvisky and Starkman (1976) concluded that although relocation was initially a stressful experience for 67 out of 100 elderly demonstrated by either deteriorating physical health or severe adjustment problems, the majority of this group adjusted well after six months in the institution.

Engle (1985) chose to study a four day post relocation time frame. She acknowledged that nurses frequently noted changes in health status following admission to a nursing home but used Coffman's (1981) analysis of the research into relocation to postulate that no changes in health status would be detected. Fifty five individuals over sixty years of age, who were relocated to a nursing home from hospital for long term care or rehabilitation, were interviewed on day one and day four following admission to determine their mental and functional health status. Mental status examination assessed level of consciousness, attention/concentration, orientation, memory and higher cognitive functioning. Functional health status

was measured using six activities of daily living which were evaluated by the scaled outcome criteria. No significant differences were found between days one and four. Engle attributed her findings to the fact that mental status had been stabilised in the previous institution, both nursing home and hospitals were similar institutions and therefore degree of change was minimal. The majority of the relocatees (90%) indicated they had been given adequate information about the change. Relocation was discussed with familites by 81.8% of the participants. The family was acknowledged as an important support system during the relocation. Engle described the need to continue studying relocation over different time periods and to assess the individual prior to relocation as well as considering environmental characteristics.

Dooghe, van der Leyden and van Loon (1980) also researched the post relocation period using a retrospective approach. They investigated the lifestyle of 360 institutionalised elderly individuals, one quarter of all the residents in both public and private homes for the aged in the Belgian province of Limburg. Using a structured questionnaire, they examined the reasons why and the way in which individuals had relocated, their reactions to the new environment and the extent to which they had developed new relationships, in order to determine how these variables affected life in the institution. The multivariate impact of these variables on the degree of adjustment was determined using multiregressional analysis. Loneliness was the main predictor of poor adjustment to institutional life. Degree of disability, age of individual and length of residence had little effect on the adjustment process.

Sherwood, Glassman, Sherwood and Morris (1974) studied individuals prior to relocation. Their concern was that previous researchers to date had considered only the adjustment of individuals <u>in</u> and not <u>to</u> institutions. Their research focused upon whether individuals selected by a previously developed prediction instrument, as being more suitable to enter a long term care facility in Boston, would adjust more easily, than those who were judged to be less suitable for admission. The dependent variable adjustment was measured by

using three components of life dissatisfaction: reaction to life events; generalised emotional state; deprivation in former years.

The research findings demonstrated in the pre-relocation period, the group judged 'more suitable' was more dissatisfied with life than the group identified as less suitable. After relocation, the life dissatisfaction of the more suitable group decreased, whereas life dissatisfaction in the less suitable group either increased or remained the same. The researcher described the need to further investigate the effects of change on individuals prior to, during and after relocation.

Research into relocation during the 1970's investigated the pre and post relocation periods and the ways in which individual characteristics affect the relocatees ability to adjust to their new environment. It remained difficult to draw conclusions from the studies - differing populations, time frames for adjustment, types of environment and research methodologies gave rise to inconsistent results.

2.3 Relocation in the 1980's

The 1980's saw a further change in direction in the study of relocation. Many research studies in this era focused attention on the post relocation environment and the paths by which the negative effects of adjustment to this new environment could be minimised. From the late 70's gerontological nurses began to investigate ways in which nursing interventions can be used to guide the elderly during relocation.

Mullen (1977) discussed the importance of PLANNING FOR RELOCATION by the elderly and the involvement of nurses in helping them to understand the facilities available. She suggested nursing support based upon crisis intervention theory, should be readily available to the new relocatees and their families. Rosswurm (1983) also discussed the use of the crisis intervention theory following relocation. Using research findings, she applied

Aquilera and Messick's (1978) problem solving paradigm for crisis intervention to produce a framework from which to develop nursing interventions. Relocation is a stressful event which leads to a state of disequilibrium in the elderly. According to Aquilera and Messick (1978), the elderly person will experience the need to restore equilibrium and thus reduce stress. This process will occur providing three factors are present: (i) realistic perception of the event; (ii) adequate situational support; (iii) adequate coping mechanisms. If one or more factors are absent disequilibrium will persist and a crisis develop. In order to help the elderly gain a realistic perception of relocation Rosswurm (1983) identified the need for nurses in the pre-relocation period to be involved in assessing the health of the elderly client and providing information about the most appropriate environment for his/her needs. The elderly client is thus able to remain in control of his/her own decision making. Following relocation, the nurse endeavours to facilitate support for the client from his/her family and the staff of the institution, as well as providing an environment where the client is helped to maintain independence. These factors further help to reduce stress. Rosswurm (1983) commented that little was known about the elderly's coping mechanisms, but nurses could help by supporting coping mechanisms that had been successfully used by the elderly during stressful situations in the past and by providing opportunities for their clients to make the new environment as similar to the old one as possible by furnishing with personal possessions and memorabilia.

When the elderly relocate from home to institution their personal space is much reduced. Hence, possession loss has to take place. Although a few possessions and memorabilia are brought by the elderly to his/her new environment, the decision regarding the number of possessions that should be retained and relocated is often dependent on the size of the personal space available. McCracken (1987) studied the emotional impact of possession loss on 75 elderly women who relocated to independent living accommodation for the elderly in a mid-western town in the U.S.A. She found a decrease in possessions correlated with the appraisal of relocation as a

threatening event. Almost a third, 32.4% of the sample valued furniture as the most important item they had lost and the items were prized equally for their association with people and their utilitarian value. McCracken identified an increased role of the nurse in the pre-relocation period as an educator exploring possession loss with groups of elderly people.

A qualitative study was carried out by Chenitz (1983) in order to guide nursing interventions during the early post relocation period. Chenitz used grounded theory methodology to collect and analyse data from 22 women and 8 men, on admission to two nursing homes in San Francisco and at intervals for the next 6-9 months. Informal interviews with nursing staff, physicians and clients' families were also carried out. Clients' medical records were reviewed and periods of direct observation were carried out in the nursing homes.

Chenitz (1983) identified four conditions which affected the elderly's responses to relocation: (i) centrality - the importance of the admission in their struggle to maintain control over their own life; (ii) desirability - acceptance of the nursing home as a desirable place to relocate; (iii) legitimation - finding a reason or reasons for admission; (iv) reversibility - perception of the duration of stay in the home. Those who were able to believe that the admission was desirable, legitimate, temporary and voluntary were able to accept the nursing home to varying degrees.

The elderly clients described relocation as a time of on-going adjustment and Chenitz used the term "status passage" from anthropoligical theory to "... explain movement, from one of life's resting places, the status, to another" (Glaser and Strauss, 1971, cited in Chenitz, 1983, 223). Passages may be so stressful for the individual that they precipitate a crisis. The crisis will present as resistance to the nursing home environment. Chenitz (1983), like Rosswurm (1983), uses crisis intervention theory as a guide for nursing interventions. She advocated the development of a therapeutic relationship with the client, helping them to understand

the situation and reinforcing their coping skills. Crisis resolution, according to Chenitz, takes about eight weeks. Sometimes the crisis is not resolved and the client fails to adjust.

As already indicated, FAMILY MEMBERS OF RELOCATEES are often involved in the process of relocation (Beaver, 1979; Mullen, 1977; Rosswurm, 1983). Johnson and Werner (1977) investigated family events that preceeded the decision to relocate and the relationships between these events and the family's guilt feelings. A questionnaire which asked for details of pre-admission experiences and decision making processes surrounding relocation was completed by 55 people, each one identified as the relocatee's closest relative. Guilt feelings were measured by assessing the relatives' response to four items, for example, "I feel guilty when I think of my relative in the home", using a five point scale, strongly agree to strongly disagree, with no opinion as the neutral point. They found that the majority of relatives had below average guilt scores. When the relocatee was immobile or failed to recognise people there were low guilt scores. Shared decision making with other family members regarding admission of their relative to the nursing home was also associated with low guilt scores.

Minichiello's (1987) Australian research also investigated the decision making process among family members prior to their relatives admission to a nursing home. He asked 92 residents in nursing homes what part they played in the decision making process. More than half said they took little or no part in the process, a further 13% had "some say" and 34% had "much say". The family, usually sons and daughters, were identified by 35% as the persons most involved in the decision making process. Minichiello described a typical pattern of behaviours, the family independently decided their aged relative could no longer cope in his/her own home, so they sought the help and advise of the general practitioner (G.P.). The G.P. listened to the family who became his informants, whilst their aged relative was described as the silent patient. Admission to a nursing home is dependent on medical diagnosis, although in some instances the need for care is social - the family is unable to

continue providing help and support and there are inadequate community services. Minichiello recognised the family as assisting with a medical diagnosis to facilitate admission and lessen the guilt associated with placing the aged relative in a nursing home. However, as family members adjusted from their roles as care givers, ties with the parent in some instances strengthened and closer relationships developed. These findings are consistent with those of Smith and Bengston (1979).

An issues paper entitled "I'M STILL AN INDIVIDUAL" which was described as a blueprint for the rights of residents in hostels and nursing homes was published by the Australian Federal Government (1989). Some of the major issues raised by residents during the investigative process were: (i) lack of control over decision making prior to entering the institution; (ii) loss of independence, individuality and privacy; (iii) anxiety regarding abuse and harassment from other residents; (iv) poor access to medical practitioners and therapists; (v) poor quality food, little or no choice; (vi) loss of continuity of previous religious and social activities; (vii) poor provision of a home-like environment.

As a result of this report, the Australian Federal Government published "A Guide to Residents Rights in Nursing Homes and Hostels" (1989). A proposed charter of resident's rights and responsibilities was included in the document. The intent of this charter was to ensure that such areas as individuality, independence, privacy, religion and culture are respected. Initially, the proposed charter gave cause for concern by some religious bodies who owned nursing homes and hostels because of the inclusion of the right of residents "... to have sexual ... needs and preferences treated with respect" (p 41). However, difficulties were resolved and the charter was accepted by all Commonwealth funded nursing homes and hostels.

Although there have been numerous studies carried out on relocation and the elderly, Thomas (1989), in a paper presented to the 24th Conference of the Australian Gerontology, remained critical of the

methodologies used. She considered results, in many instances, to be inconclusive because of sampling errors. In some studies, the reliability and validity of measures used as predictor or outcome variables were not established by the researchers. Thomas noted that only a few studies based their choice of variables on sound theoretical bases. The characteristics of the institution involved in the research were often not described well and these characteristics need to be defined clearly because of the wide variation in quality and situational constraints. Because of the methodological issues surrounding research studies on relocation, Thomas concluded that much uncertainty about the topic still exists.

2.4 Summary

Review of some of the literature associated with relocation of the elderly that has occurred over the past 30 years, indicates that this phenomenon has been studied from many perspectives. During the 60's, relocation was described as a discrete event and its association with morbidity and mortality rates was identified. The findings were conflicting. Some studies demonstrated increased morbidity and mortality; other studies demonstrated a decrease in morbidity and mortality rates, or no change, following relocation. During the 70's there was emphasis on the study of relocation as a process and research focused on events in the pre-relocation period and post relocation adjustment by the elderly. The reviewed research studies of the 80's were largely concerned with determining ways to help the elderly and their families cope with relocation. Although understanding of relocation has increased throughout the past three decades and the phenomenon is now viewed as a complex multidimensional concept influenced by many factors, significant gaps in knowledge still exist (Burnette, 1986; Young, 1990).

In the following chapter, the formation of a research question associated with relocation and the elderly and the choice of an appropriate methodology will be discussed.

CHAPTER 3
METHODOLOGY

3.1 Introduction to Qualitative Research

The formulation of the research question and the choice of ethnography as an appropriate research methodology to guide the study are discussed in this chapter. Ethical conditions, including that of informed consent in ethnography, data collection and data analysis in ethnography, are also described.

The literature review carried out at the time of the research proposal demonstrated relocation for the aged was a complex process, influenced by many variables. Also, little was known about the processes preceeding residential change and those concerned with adaptation to a new environment (Burnette, 1986, Young, 1990). The significant knowledge gaps indicated the need to further explore the phenomenon. In the situation where little knowledge exists about a specific concept or experience then it is appropriate to use qualitative research in order to arrive at a rich description of the phenomenon (Field and Morse, 1985). Parse, Coyne and Smith (1985, 3) describe the purpose of qualitative research as identifying

> "... the characteristics and the significance of human experiences as described by subjects and interpreted by the researcher at various levels of abstraction."

Qualitative research is thus concerned with identifying, interpreting and documenting as fully as possible, the essential characteristics of the phenomenon under investigation from the participant's viewpoint (Leininger, 1985). The research usually takes place in the natural setting so that the setting becomes part of the phenomen being studied. The question guiding this research study was formulated to investigate relocation from the perspective of the participants and asked:

"What is the meaning of relocation for the aged person, as he/she moves from his/her own home to become a permanent resident in a hostel?"

3.2 Ethnography and the Ethnographic Method

The qualitative research method chosen to guide this study was ETHNOGRAPHY. This research method was developed by anthropologists in the late nineteenth and early twentieth centuries in order to describe the ways of life of specific cultures in a scientific manner. Leininger described ethnography as the

> "... systematic process of observing, detailing, describing, documenting and analysing the lifeways or particular patterns of a culture or subculture in order to grasp the lifeways or patterns of people in their familiar environment (in Cahoon, 1987, 11)."

In order to carry out this process, the researcher must gain entrance to the participants' environment and explore with them the meanings of activities, events, behaviours, knowledge, artifacts, rituals and other aspects of life which form the basis of their culture (Germain in Munhall and Oiler, 1986, Omery in Salter, 1988). The purpose of ethnography therefore is to describe the participants' world from his/her point of view (Spradley, 1980). However, as well as exploring the meaning of the participants' world from his/her viewpoint, the emic perspective, the enthnographer also seeks to gain information on the specific culture from the outside or stranger's viewpoint. The stranger's viewpoint is known as the etic perspective. In the past, there has been a tendency for different ethnographers to favour one of the two perspectives. Today, it is more common to integrate both perspectives into the research methodology giving rise to a comprehensive description in the culture under study (Pelto and Pelto in Parse, Coyne and Smith, 1985).

Over the past two decades, the research method of ethnography has been increasingly used by nurses (Leininger, 1985).

Omery states

> "when nurse researchers wish to understand some actual or potential human response to illness, that is, some health belief or practice from a specific cultural or social perspective, they should employ ethnography (in Sarter, 1988, 17)."

Ethnographic research may produce broad and long term studies of complex cultures (maxi or macroethnographies) or small units of a single social instituion (mini or microethnographies) (Germain, 1986, Leininger, 1985). Examples of macroethnographies by nurses include Melia's (1982) study on student nurses "Tell It As It Is" and Field's (1983) research into four public health nurses' perspectives on nursing. Microethnographies by nurses include Aamodt's (1984) study on "Discovering a Childs View of Alopoecia" (in Munhall and Oiler, 1986) and "The Experience of Ageing" (in Parse, Coyne and Smith, 1985). The emic perspective was sought from six elderly key participants who had recently relocated. The viewpoints of significant others of the relocatees, professionals involved with the relocatees in addition to the field notes of the researcher provided the etic perspective.

In this study, the ethnographic method was used to discover the perspective of relocation as it was experienced by the six elderly participants. Data gathering used the two major activities of ethnographic research, participant observation and the ethnographic interview.

PARTICIPANT OBSERVATION enables the researcher to take part in the day to day experiences of those he/she observes in ways which result in as little change as possible (Germain, 1985).

Junker (1960) in Germain (1985) and Omery (1989) described four types of participant observation which may be used during data collection. These are: complete observation, observer as participant, participant as observer and complete participant.

If the researcher uses COMPLETE OBSERVATION, he/she may be invisible or visible to the study population but does not interact with them.

In the OBSERVER AS PARTICIPANT role, the researcher is visible and his/her reasons for being present are known to the population under study. The focus is on observation but the researcher may participate in on-going activities.

In the PARTICIPANT AS OBSERVER role, the group under study are aware of the researcher's activities. The researcher's focus is participation and observation plays a subordinate role.

The researcher may assume the role of COMPLETE PARTICIPANT, the observer role is not revealed and the researcher becomes a member of the group being studied.

Today, the complete participant and complete observer roles are less often used. These roles are considered unethical as they deny informed consent to those being studied.

Field notes are made throughout the periods of participant observation. Their aim is to provide a rich and accurate description of all the researcher sees, experiences, hears and thinks during the time he/she is present in the setting. As soon as possible after the period of participant observation, the notes are reconstructed. Also, at the time of reconstruction, the researcher's reflections on the period of participant observation are included in the field notes.

In the more formal ethnographic interview observation is integrated with the periods of participant observation. The ethnographic interview aims to uncover cultural meanings from an emic perspective by using direct questions as well as informal conversation. Spradley (1979) describes three types of questions which can be used to guide the ethnographic interview. These are DESCRIPTIVE, STRUCTURAL AND CONTRAST QUESTIONS.

DESCRIPTIVE QUESTIONS provide a word-picture of the participants' lifestyles, for example, "Can you describe what it was like for you to move from your own home to live in the hostel?"

STRUCTURAL QUESTIONS aim to add to the descriptive data by discovering organisational details of the culture, for example, "What activities take place in the hostel?"

CONTRAST QUESTIONS aim to highlight differences, for example, "What is different about living in the hostel compared to living in your own home?"

Spradley (1979) states that the three types of questions and the others which evolve from them will both increase and substantiate the data collected during participant observation. Interviews are usually tape-recorded with the participant's permission and transcribed in order to facilitate data analysis.

3.3 Ethical Aspects

In order to protect the rights of human subjects in a research study INFORMED CONSENT must be obtained. Informed consent includes explanation of the study to prospective participants, assurances regarding confidentiality and anonymity, obtaining permission to record interviews, as well as indicating that the participant is free to withdraw from the study at any time (Field and Morse, 1990). A consent form was designed which included the abovementioned areas (see Appendix B). This form was used to obtain formal consent from professionals and relatives of the elderly participants who were interviewed. The elderly key participants were offered the consent form or the alternative method of recording their consent on a separate tape prior to each interview. Recorded verbal consent appears a preferable method for elderly people who may have difficulty in reading a consent form due to poor vision and who may find difficulty in writing because of arthritic finger joints. Verbal consent recorded on tape provides a permanent record of the consent procedure. The consent is recorded on a separate tape

kept solely for that purpose. The participant's name is therefore separated from the data thus preserving anonymity (Field and Morse, 1990). All the elderly key participants recorded their consents verbally.

Prior to the data collection, permission to conduct the study was obtained from the University Human Ethics Committee (see Appendix A) and the administrators of the two hostels which were to be used. The administrator of one venue provided written permission whilst the administrator of the other venue stated verbally that the participant's consent was all that was required.

Two copies of the transcribed interviews and field notes were made. One copy was stored in a locked filing cabinet in the researcher's own home and a second copy remained in a locked filing cabinet in the researcher's work office.

3.4 Data Analysis

In ethnography the two processes of data collection and data analysis occur concurrently. Qualitative content analysis is employed in order to inductively develop patterns or themes from the data. The data are sorted and coded to identify these emerging patterns or themes (Germain in Munhall and Oiler, 1987). Early data analysis enables the researcher to return to the participants for verification and expansion of these emerging themes. Leininger notes

> "Discovering recurrent statements, action modes, patterns and themes requires considerable thought as one examines the data to be sure it fits with that informants shared with the researcher. Checking and rechecking to be sure themes are accurate are extremely important" (in Cahoon, 1987, 30).

The subjective meanings of relocation for the key participants will emerge from the data, as a result of analysing, comparing, and contrasting the themes. These subjective meanings are verified by

additional interviews and further periods of participant observation. A portrait of the people, the context in which they experience the process of relocation and their new lifestyles will develop from the themes.

3.5 Summary

In this chapter the formation of the research question and the rationale for the choice of ethnography as a research method to guide the study were discussed. Data collection and data analysis in ethnography and the need for informed consent to protect the rights of participants were outlined.

In Chapter 4, the venues, participants and specific features of the data collection will be described.

CHAPTER 4
DATA COLLECTION

4.1 Introduction

In this chapter, the data gathering process for the study is described. Six key participants, who had recently become residents in two hostels for the elderly in Northern Tasmania were interviewed at three monthly intervals over a period of nine months. Data gathering also included interviews with close relatives of key participants, other hostel residents and professionals involved in the relocation process. Details of participant observation, the other main data source and a description of the two hostels, in which the data gathering process mainly occurred, are also included.

4.2 The Key Participants

The first step in the data collection concerned ascertaining the process whereby elderly people came to enter the hostel. Originally, it was envisaged that all key participants would be residents in the same hostel for the elderly in Northern Tasmania. However, within the time frame for the study it became apparent that only three new residents, who were suitable and willing to become participants, were admitted. Criteria employed to assess the suitability of residents were, that there was no apparent mental impairment and English was spoken as a first language. Information on these criteria was sought from the pre-admission report of the Geriatric Assessment Team (G.A.T.) and the hostel records. Several residents with short term memory loss were admitted, these were unsuitable and others did not wish to participate in the study. Three further key participants were sought from a second hostel in a small coastal town in North East Tasmania.

In Tasmania there are a total of 22 hostels.

> "Hostels provide care for elderly people who need assistance at particular times with certain activities of daily living such as dressing or bathing, or with provision of meals or laundry. However people who live in hostels do not require continuous professional nursing care (Commonwealth Department of Community Services, Hobart, 1987)."

There are four free standing hostels whilst the remaining eighteen are attached to nursing homes for the elderly. The hostels are of varying sizes from 10 - 65 rooms, the median size being 29. Most hostels provide a private bedroom which the resident may personally furnish. There are communal dining rooms and lounge rooms for the residents. The population of a hostel remains stable until a resident dies or his/her health deteriorates to a stage where he/she requires more extensive nursing care. Transfer to a nursing home then occurs.

ADMISSION to hostels and nursing homes is arranged by the GERIATRIC ASSESSMENT TEAM (G.A.T.). This service was established in 1984 as a result of the Commonwealth Government's 1983/84 budget initiative to fund a number of pilot geriatric assessment programmes. Three regional teams were appointed in Tasmania to provide a state wide service. Each team is multi-disciplinary consisting of a nurse, a social worker and an occupational therapist. No medical practitioner is included in the team because it was envisaged that the client's own doctor would be involved in the assessment process. The general objective of the Geriatric Assessment Team is to

> "assess frail or disabled elderly persons with a view to achieving a better match between their needs and the allocation of services (Atkinson and Curran, 1987, 1)."

Potential clients are referred to the G.A.T. members by a variety of professionals and non-professionals. Health status assessment is

usually carried out in the client's own home. Initially, solutions to client's problems are sought from within the family and community services. Residential care is recommended only if health deteriorates to a level where the person's needs cannot be met by the community services. If hostel or nursing home care is required, the G.A.T. add the client's name to an "urgent" waiting list which is circulated twice monthly to residential care facilities. Potential residents are asked to nominate three facilities in order of preference. Every effort is made to provide the client with his/her first choice. If admission is essential, second or third choices may be the only options at the time. Acceptance of second or third choices does not prevent the client from transferring to the first choice of venue when there is a vacancy. The recommendation of the G.A.T. for all admissions is required by the Commonwealth Medical Officer if a financial subsidy is to be claimed. Residential fees are varied according to ability to pay. Residents are also asked to make a monetary donation when they move into the hostel if they are able to do so.

4.3 Hostel A

HOSTEL A, the hostel in which three new residents became key participants in the study, is situated in the outer suburbs of a city in Northern Tasmania. It is one part of a large building complex which also houses respite (short term) accommodation, a day care centre for the elderly and a specialised unit for the care of ambulant residents suffering from Alzheimer's and related diseases. The specialised unit is self-contained and secure. Other facilities in the complex include units for the independent elderly and a social centre used by the unit occupants. The buildings are set in well maintained grounds where there is an abundance of trees and bushes. The nursing home, which is administered by the same charitable organisation, is not physically attached to the hostel. It is an older building situated two kilometres away in an adjoining suburb. The complex, of which the hostel is a part, is relatively new having been opened in 1985.

The accommodation at Hostel A consists of 30 rooms (four of which can be used for two married couples). These rooms are situated on either side of a corridor which forms one wing of the building (see Appendix C).

> "Each hostel room has a bed, inner spring mattress and built-in wardrobe with drawers. All rooms have a toilet and handbasin and 25 have showers" (Residents Information Sheet, undated)

As well as the residents' rooms, there are two small communal lounge rooms at strategic intervals in the corridor. Their positions give residents, whose rooms are furthest from the dining area, an opportunity to rest, when they are journeying to and from their meals. One of these rooms is known as the sewing room, as a member of staff uses the venue to repair clothes and linen. The other lounge room has a television and is referred to as the quiet room. Both rooms have extensive views over the grounds, fields and hills beyond the building. At one end, the corridor opens into a third lounge room which is larger than the other two. This lounge room is called "Mrs I's lounge room" by some residents. Mrs I has been a resident since the hostel opened. Her own room is adjacent to this lounge room. She often sits in the lounge room, either on her own or with one or two other residents, for short periods during the day. The dining room is situated at the beginning of a corridor which joins the hostel wing to other parts of the building. It is open plan, that is, not separated from the corridor by a wall or screen and so meals are eaten in full view of "traffic" proceeding up and down the corridor. Several of the tables seat eight people, others are for four. At meal times, the tables are covered by tablecloths and each table has a small vase of fresh flowers. At one end of the dining room there is a kitchenette which is used for serving the meals and washing up the crockery and cutlery afterwards (Field Notes, 27 March 1990).

THE THREE KEY PARTICIPANTS IN HOSTEL A were introduced to me by the Assistant Director of Nursing who liaises with the G.A.T. regarding the admission of new residents. These were Mr C, aged 86 years; Miss D, aged 86 years and Mrs N, aged 90 years.

At this first meeting I explained the purpose of my study, answered any questions that the residents wished to ask and gained their verbal agreement to participate. A mutually convenient time was arranged, usually within two to three days of the first meeting, in order to commence the interview schedule. Subsequent interviews with the key participants were arranged in a similar manner to the initial interview. The residents were visited and a mutually convenient date and time for these interviews to take place was agreed upon.

The Sister-in-Charge of the hostel and other hostel workers at Hostel A were interviewed and asked to describe their perceptions of the relocation process. During the interview they were also asked to identify hostel residents who may be involved in helping the key participants in the process of relocation. Several of these "staff-selected" residents, who had been in the hostel for longer periods than the key participants, were interviewed to obtain their perceptions on relocation and their involvement with the new relocatees.

The residents of Hostel A were mostly retired professional people. Initial encounters with these people led to impressions of a "conservative" community. In order to help my acceptance by the residents my appearance when interviewing was formal. A dress, panti-hose and shoes with small heels were always worn. A name badge was worn for identification.

4.4 Hostel B

HOSTEL B, is situated in a small coastal town (population 10,000) in North East Tasmania. It is a relatively new building, having been opened in August 1988, with accommodation for 10 residents. The

hostel was built as an extension to an already established 20 bed nursing home. The two buildings are connected by a short corridor. Hostel accommodation for the elderly residents consists of 10 rooms with ensuite bathrooms arranged in two wings which radiate from the communal open plan kitchenette, dining and lounge area (see Appendix C). The resident's rooms are larger than the ones at Hostel A but contain no bed or built-in cupboards. Residents have to provide all their own furniture. In each room there is a tray with utensils for making tea or coffee when the resident wishes. The hostel/nursing home building is situated in a quiet road two minutes walk from the town and the sea. There is a small garden at the rear of the building and beyond the garden are several units for the independent elderly.

Contact with Hostel B was made by telephone and an appointment with the Director of Nursing, to explain the purpose of my research, was made. After initial discussion, I was taken on a tour of the building and introduced to three new residents who met the criteria and who agreed to participate in the study. These were Mrs O, aged 84 years; Mr D, aged 91 years and Mr P aged 82 years. Hostel B was a 2 hour car journey from my home so planning well in advance was important. Appointments were made with the three key participants for the following week, and a reminder was mailed to each participant so that it arrived the day prior to the interview. This approach was successful and used for the second and third interviews.

There seemed to be less formality in Hostel B than in Hostel A. All residents appeared to know one another and there was more interaction in the communal dining/lounge area than I observed in Hostel A. This area included a single large dining table and chairs, in addition to an oven and facilities for washing and storing cutlery and crockery. The lounge area contained several easy chairs, a television and a wood-burning stove. The latter is a feature of many Tasmanian homes.

At this hostel, it was only possible to undertake serial interviews with the key participants. Other residents did not meet the criteria for the study or were unwilling to participate. As previously, staff members in this venue were also interviewed. My appearance, when visiting this less formal community, was more casual than when I went to Hostel A. A sweater and trousers were worn and a name badge was again used for identification purposes.

Interviews with the six key participants and other hostel residents were conducted in the privacy of their rooms. In order to minimise distractions, a "Do not disturb" notice was temporarily fastened to the outside of the door. All the key participants had some degree of deafness. They were asked to identify the most effective but comfortable distance for the interviewer so that both persons could be heard (Burnside, 1988). Face to face encounters were used with all clients so lip reading could take place if necessary. As consent was recorded verbally prior to each interview on a separate tape, this provided a guide to the volume of speech necessary for the interview. A short list of open-ended questions which were descriptive, cultural or contrast in type, as described in Chapter 3, (Spradley, 1979) were used to guide the interviews.

The first interview focussed on events leading to relocation, the relocation process and first perceptions of the hostel. In the second and third interviews life as a hostel resident was discussed.

No difficulties were encountered in finding suitable interview venues for the hostel staff. They were always willing to nominate an empty room where the interviews could take place. Verbal consent from key participants was sought before relatives were approached. Two key participants only were willing for their relatives to be involved in the study. These people were contacted by telephone and subsequently interviewed in their own homes. The format used for these interviews was similar to that used for the key participants.

No reasons were given by the other key participants for excluding their relatives from the study. A statement which indicated key participants did not wish their relatives to be contacted was accepted.

4.5 Participant Observation

PERIODS OF PARTICIPANT OBSERVATION were undertaken in the hostels at intervals between the serial interviews with the key participants. These periods were initially approached with a feeling of insecurity. Early visits to both hostels left the impression that the Registered Nurses regarded me with a good deal of suspicion (Field Notes Hostel A, 19 March 1989; Hostel B 22 March 1990). The other large concern was that my presence as an observer would affect residents' behaviour. Would they frequent the lounge rooms if I were visible? I was obviously not a staff member nor a potential resident. The decision to wear a registered nurses uniform with a name badge that identified me as a member of the School of Nursing Studies, Tasmanian State Institute of Technology, helped my acceptance by staff and residents in Hostel A. They were familiar with the Institute's students who came weekly for nursing practice with their clinical teacher and I was identified as belonging to that group. The residents in Hostel A were willing to converse with me if I joined their various groups in the lounge room (Field Notes Hostel A, 20 April 1990).

During the periods of participant observation I adopted the role of observer as participant. The focus of this role is that of observation, although participation in activities can occur. The researcher was able to participate in some of the resident's activities in Hostel A, such as helping with bingo sessions and pushing a resident in a wheel chair around a garden centre, when the residents went to buy plants and tools for their own newly established garden. Germain in Munhall and Oiler (1986) notes that the researcher should be willing to reciprocate in some way to help maintain good field work relationships. Reciprocity, according to Germain "... enhances data collection and need not interfere with

objectivity if change induced by the researcher is minimal" (Munhall and Oiler, 1986, 8, 14).

In Hostel B, the participant observer role was less difficult to fulfil. Short periods in the lounge/dining area provided a view of the two wings of residents' rooms so I was able to observe on-going activities. The residents who came to the lounge room were eager to talk and it was not difficult to record experiences, except for two residents with speech impairment. I was invited by the residents to sit at the table with them for morning tea. Afternoon tea was offered to me by one of the residents when I was writing field notes at the nurses station which was situated at the entrance to one of the bedroom wings (Field Notes Hostel B, 3 May 1990; 4 May 1990).

Brief field notes were made during the periods of participant observation. As soon as possible after the participant observation period these notes were enlarged to provide a more complete description of the event.

SUPPLEMENTARY DATA SOURCES used, were the resident's health records and nurses' reports. The health records verified that the criteria used to determine suitability for participation in the study had been met. These records also contained G.A.T. assessments of the participant's health status, assessment of their environment and recommendations regarding suitability for admission to a hostel. They provided useful background information and verified facts described by the participants during relocation.

Nurses records were scanty. Reports were only written if something untoward happened to the resident or if he/she was temporarily ill in bed. However, those records did provide some details of the key participant's behaviour between visits to the hostel. This information was used as an aide-memoire, in some instances, when interviewing the key participants.

4.6 Summary

In this chapter, the data collection process for the study has been described. The ways in which data was obtained by interviewing and participant observation were detailed. Also included in this chapter is a brief description of the two hostels where the majority of the data was gathered.

In Chapter 5, the processes of data sorting and data analysis will be outlined. The themes and sub-themes identified from the data will be described.

CHAPTER 5
DATA ANALYSIS

5.1 Introduction and Overview

In this chapter, the process of data sorting and data analysis are described. The major themes emerging from the data are detailed. These concerned **"PREPARING FOR RELOCATION", "FITTING IN TO THE HOSTEL ENVIRONMENT" and "RESIDENT'S LIFESTYLES".**

5.2 Data Recording

IN ETHNOGRAPHIC STUDIES data collection and data analysis occur concurrently. After each interview, the tape was reviewed in order to familiarise myself with the content (Field and Morse, 1990). Any omissions or points which required clarification were noted in the field notes, which also included reflections on the visit to the research area. Secretarial help was used to transcribe the audio tapes. During transcription wide margins were left on each side of the page for coding and additional notes. The written transcription was duplicated. One copy was stored in a locked container in the work office whilst the "working copy" remained at home. The transcript was checked for accuracy and margin notes were inserted to highlight emotionally significant areas as indicated by tone or volume of voice. Each page of the interview transcript was coded with the participant's synonym, venue and serial number of the interview.

Field notes were recorded on paper, which again had wide margins on either side of each page, to facilitate coding and further comment when necessary. These notes were duplicated and one copy stored along with the interview transcripts. The "working" copy remained at home and was filed according to date and venue.

5.3 Data Analysis

In order to inductively determine patterns or themes from the data, qualitative content analysis was employed. Recurrent words, phrases or segments of prose were identified and highlighted in the transcripts and the field notes. These were then categorised into themes, for example, many different activities contributed to the theme **"PREPARING FOR RELOCATION".** The appropriate theme was noted in the margin. The data was further sorted by cutting and pasting relevant areas onto sheets of paper and filing these papers into a folder for the theme (Field and Morse, 1987). Material from each theme was then examined in order to identify sub-themes, for example, **"PREPARING FOR RELOCATION"** was a time of decision making which included the sub-themes **'early and immediate plans'** in addition to the **'disposal of possessions'.** When a specific segment of data was catergorised into more than one sub-theme then the material was photocopied to ensure that both sub-themes contained the appropriate segment. The identified themes and sub-themes were expanded when necessary and validated with the key participants (Parse, Coyne and Smith, 1985).

Following data analysis, there emerged three major themes. Each of the themes was closely linked to the next and together they comprised the process of relocation as experienced by the key participants. The identified themes were **"I've got to go somewhere", "PREPARING FOR RELOCATION", "... fitting in" to the hostel, "ADAPTING TO THE NEW ENVIRONMENT"** and **"the life I lived", "A RESIDENT'S LIFESTYLE".**

Within the theme **"PREPARING FOR RELOCATION",** the sub-theme **"future plans"** was identified. This sub-theme included placing one's name on the waiting list of the hostel of choice and making early decisions regarding the disposal of possessions.

Long term preparations for relocation were made by two key participants in Hostel A. Mr C and Miss D had placed their names on a waiting list maintained by the nursing home owned by the

same charitable trust as Hostel A. When the hostel was opened in 1985 Mr C was asked if he wished to transfer his name to the hostel waiting list. At that time he was still managing to live independently in his own home and hostel accommodation with minimal care seemed a more likely option in the future, than extensive care in a nursing home.

> Mr C - "Well about 12 years ago my wife and I, we made application for admission to M.M. (nursing home) ... In the meantime M.M. ... they contacted me and they told me ... that they were opening this place here and asked me if I was still interested. I told them I was but I had lost my wife and I would be on my own so we decided that when I was ready to come in I'd let them know" (Interview 1).

Miss D who broke her elbow at the beginning of 1986 was an early resident in the respite care area following the opening of the complex. She described making the decision to have her named placed on the waiting list for Hostel A at that time.

> R - "... when did you decide that you wanted to come to Hostel A?"
>
> Miss D - "When I was at respite ... the first two months that respite had opened."
>
> R - "Did you put your name down at that time?"
>
> Miss D - "Yes, straight away. I had always had it down for M.M."

No other evidence of long term planning for relocation to a hostel was described by the remaining key participants. The residents of Hostel B, who became key participants, could only have made plans to relocate to a hostel situated outside their own georgraphical area, as there was no hostel accommodation available in the town before 1988.

Two of the key participants in Hostel A, Mrs N and Miss D, made plans for disposal of possessions whilst they were still living independently.

> Mrs N - "Well ... I'd say about two years ago, I took them (two daughters) through the place and I said that while I'm here, I think we will go through and you each say what you'd like. And they did that and they wrote a list of what they wanted" (Interview 1).

Miss D had also made some preparations regarding the disposal of her possessions although on her own admission "...not a lot". Her niece, Mrs R, confirmed that

> "She had made out a list of certain things she wanted distributed around the family."

The sub-theme **"immediate plans"** included the right time to relocate, and disposal or retention of possessions. These decisions were shared with signicant others and/or the professionals. The key participants described their decision making at that time as inevitable and final.

Decision making, immediately prior to relocation, was shared with significant others and the professional except in Mr E's case (Hostel B). He described sharing his decision only with the professionals. The G.A.T. endeavours, whenever possible, to maintain the aged person in his own home with community and voluntary services, in addition to family support. When the person's health deteriorates to a stage when a greater degree of care is required than that provided by the community services then hostel care would be recommended. There was not total agreement between the residents and the professionals about the **"right time"** to relocate. Mrs N decided it was time to move from her unit into Hostel A. The unit and the nearby hostel were both part of the same building complex and physical relocation was only approximately 110 metres. Mrs N

recalled the G.A.T. member's assessment of her health status at the time she made her decision.

> "He told me, they thought I was on the borderline. So I thought I was not going to get any better. I was very surprised to get in so soon."

There was nobody on the urgent waiting list for Hostel A when a room became vacant so it was offered to Mrs N. Vacant rooms have to be occupied within three days, otherwise the financial subsidy from the Commonwealth Government lapses.

The professionals, with some help from her grandson, had to convince Mrs O that the time was right for her to relocate to Hostel B. Mrs O had previously been a resident in the nursing home eighteen months prior to the hostel being built. When admitted to the nursing home, Mrs O's mobility was poor even when she used a walking frame. She was occasionally incontinent of urine, had little appetite and the G.A.T. noted that "she drinks sherry anytime". Her medical diagnoses were anaemia, congestive cardiac failure and alcoholism. Intake of alcohol ceased on admission. During the time she was a resident in the nursing home, her health status improved. Apart from requiring a little help with showering and dressing, she was able to meet all her own activities of daily living. Consequently, when Hostel B was to be opened the Director of Nursing in conjunction with the G.A.T. recommended that Mrs O transfer to the hostel.

> R - "Who suggested that you might move into the hostel from the nursing home?"
>
> Mrs O - "Oh, Matron (Director of Nursing) ... Because I could do so much for myself, I would be happier here ... The Matron took me up one night and showed me and I said oh well, here goes. They badly wanted my bed for another lady ninety eight ... so I thought to myself, well I can do things for myself ..." (Interview 1).

According to the nurses report on Mrs O at the time when relocation was suggested, she was vey apprehensive about her ability to cope in the hostel. The nursing home staff requested her grandson's aid to convince Mrs O that the time was right for relocation to the hostel.

Miss D also needed assistance from the professionals to help her make the decision to relocate. She did not move directly from home to Hostel A. A fall in her home resulted in a fractured neck of femur which was surgically pinned in the general hospital. She described several traumatic experiences whilst in hospital. These mainly occurred in the rehabilitation ward to which she was transferred after a week in the orthopaedic ward. This independent lady described how she was given little help or encouragement to rehabilitate during this time. After several weeks, whilst she struggled to walk using a walking frame, she was told she had three days to find other accommodation. There was no vacancy in Hostel A so she was admitted to a small private nursing home where she had to share a bedroom with two others. This nursing home was not purpose built but a two storey family house, which had undergone minimal alterations prior to its present use. The home is set in pleasant grounds but access to the garden is very difficult if a resident is disabled and his/her bedroom, like Miss D's is on the first floor. There is no lounge room, so Miss D passed the majority of her days sitting by her bed. She found that the narrow winding passages in the nursing home did not permit her to practise walking. Miss D remained in the nursing home for three months and she described her condition and her feelings when eventually a room became vacant in Hostel A

> Miss D - "I had gone down so far, I couldn't do anything. I was losing my wits anyway. There was nobody to talk to except the very nice staff. When they asked me if I wanted here (Hostel A) Sister X, (Assistant Director of Nursing), came to see me. I said 'I don't think I can stand another one'. She said 'Well don't you think you'd better?' and I said 'I don't think I can stand it.' And then I thought well, give me twenty four hours and the next morning I said 'Yes please, I will come at once.'"

Decision making about relocation to the hostel was discussed with relatives by all key participants except Mr E, one of the early residents in Hostel B. He was a widower who prior to relocation lived with his son. There was long standing conflict between the two men who led independent lives, barely speaking to one another. Mr E recalled that the community health nurse helped him make his decision.

R - "Did you make the decision yourself ...?"

> Mr E - "I think probably Sister Y may have been responsible for that ... I did think at one time I might be able to live in the hospital ... but they told me no. I thought a lot about it. I did think at one time I might go to the Salvation Army or something like that ..." (Interview 1).

The role played by significant others varied from that of consultation to a more active part in the preliminary procedures such as communicating with G.A.T. and the hostel administrative staff.

Mrs N described discussing her decision with her daughters

> Mrs N - "I have two daughters that are very good to me and look after me in every way and we talked together about coming into the hostel." (Interview 1)

Mrs L (Mrs N's daughter) confirmed this happening

> "She made the decision herself but she did talk it over with us."

Mr C (Hostel A) described his godson's contribution to the decision making

> "I have a godson and his mother, she was in here. He said to me, now when we get mum settled, we'll get onto you, which he did. So we came up here to see about it ... and then he handed me over to here ... and they (G.A.T. and the liaison A.D.O.N.) came to see me and talked to me so nice about it." (Interview 1)

There is little warning that a hostel room is to become vacant. A vacancy arises when a hostel resident dies, or requires more extensive care and has to be transferred to a hospital or a nursing home. The empty room is offered to the person whose name is at the head of the urgent waiting list for that hostel. Within three days the room has to be furnished (usually by the relatives) with the intended resident's own furniture and he/she relocates to the hostel. At the same time, usually, the house from which relocation took place has to be emptied of all surplus possessions and prepared for sale. Disposal of possessions was carried out by significant others in the presence of the key participants. The subject was described at length by two key participants who relocated directly from their own homes to the hostels.

Mr C, a childless widower, described emotionally the help given by friends prior to relocation to Hostel A.

> Mr C - "... they came up ... and sorted everything out, stacked and put it in places, I handed it over to them and they did everything ... I didn't do much ... they took it over and they did it all for me." (Interview 1)

Mrs N's two daughters dealt with the disposal of her possessions after they had helped Mrs N to relocate from her unit into Hostel A.

> Mrs N - "... the girls moved me over here, then they did the cleaning up over there ... It was a terrible job and they were so tired of it all. It is the disposing of everything, ... we divided between the two girls what they wanted out of the unit and then each one helped their daughters and gave them what they wanted and there was very little that had to go to a mart." (Interview 1)

Disposal of possessions was only briefly mentioned by Mr P who relocated to Hostel B. He received help from his sister-in-law and step-daughter to empty his home and prepare his hostel room. Mr E of Hostel B referred transiently to the fact that "everything that

is in here I brought from home." Mrs O, who relocated from the nursing home to Hostel B, had furniture brought from her former home which she still owned and where her grandson was currently living.

The reasons given by the key participants for their relocation were often vague. In most instances, deteriorating physical health and an inability to meet the activities of daily living were discussed. However, Mr E highlighted the conflict with his son as the main reason for his relocation to Hostel B. Whatever the reasons for requiring to relocate, the key participants described their decision as inevitable and final. No mention was made of the possibility of returning home.

Mr P in Hostel B recalled

> "I've got to go somewhere. I can't stay ... I couldn't do anything. I couldn't cut lawns, the house was deteriorating ... and I had to get out ... The time had come, I had to go. I had no choice." (Interview 1)

Mrs N in Hostel A stated

> "You have a big decision to make and you have got to accept it which I have done." (Interview 1)

Mr C in Hostel A made his decision after viewing the hostel's facilities

> "... I had a look around ... and I decided that this is where I would make my home." (Interview 1)

Miss D from Hostel A said

> "... well I realised I must. There was no question actually, I couldn't go back."

Miss D's decision was made during rehabilitation following her fractured femur.

Adaptation to the new environment or **"FITTING IN TO THE HOSTEL"**, the second major theme, was not a difficult process for the key participants. They described their thoughts and feelings immediately after being admitted and the sub-theme **"first impressions"** emerged from the data.

The key participants identified the hostel staff and significant others as providers of help and support during this time. Little mention was made of the contributions of other residents to the **"FITTING IN"** process, although staff in Hostel A named several residents who subscribed informally to helping new residents adjust to the hostel environment.

Mr P of Hostel B describes his early impressions of his new environment, the contribution of the hostel staff and significant others

> "The change over was nothing ... everybody made me so welcome. And the staff, the atmosphere about the place ... the most friendly atmosphere which was good. And that night (his first night at the hostel) I was just thinking about going to bed . My close neighbours (from his former home) they came over to see me and see if I was alright and settled in. I thought that was lovely of them ... and before I went to bed ... one of the staff knocked on the door and said 'I'm V ... welcome to the place .' Well I felt that good. I went to bed a very happy man." (Interview 2)

Mr E recalled being admitted to the hostel and the help he was given by the professionals at the time

> "... It was just like going out of one house into another. I was made ... like as if I was one of the owners or something, immediately I came in here ... and its been nothing but happiness ever since ... I settled down immediately ... the doctor and the hostel staff they're very friendly ... Matron and some of the sisters I knew previously."

Miss D described that time spent with two old friends who were also hostel residents would have contributed to her adaptation but their health deteriorated rapidly after her admission and both residents had to be transferred to other institutions.

> "Well there were two friends here when I first came but unfortunately both got sick. One had to be moved and the other moved ... those were the ones I particularly missed. I was looking forward to seeing a lot of them."

She commented about the first days in Hostel A.

> "Everybody helped, you know, all the staff. They were wonderful."

Mrs N recalled her admission to Hostel A.

> "I just knew I had to accept it ... and I came in thought the room looked very nice, the way the girls (her daughters) had put the things and I just came in and lived here, just went on from there." (Interview 2)

A second sub-theme, which emerged during the **"FITTING IN"** period, was the **"expectations of the hostel staff"** regarding the behaviour of new residents. The staff recognised relocation as a traumatic time, described interventions they used to help new residents but they were eager for the new residents to "fit in" to the hostel.

Sister F who was responsible for Hostel A as well as the respite care area noted

> "... I can usually pick up whether they are happy about coming in or whether they have some doubts about doing the right thing. Also bereavement ... is usually quite strong ... about losing their house ... sometimes they are parting with relatives, they've been looked after by their daughters, this is also very hard for them. Even furniture and clothing that they had to give up to get in ..."

Mrs K, a domestic worker in Hostel A, who cleaned the resident's

rooms stated

> "... it is very traumatic for them, especially when they come in and then have to sell their own home. You just have to be patient and very kind because they don't fit in in a week or a month. It takes a lot longer than that."

Sister F described interventions which she employed initially to help new relocatees settle down.

> "I arrange for a nurse to show them around the building so that they have a general orientation of the place ... and the medication ... I find out just exactly what they want or whether we can help them with that. I don't really feel I should push them into anything ... I like to introduce them to other residents. Especially a good place to do that is at the dining room table because usually where they are placed is where they stay, unless they want a change and ask for it. I introduce them to the staff as well, especially the nurse who looks after them. It helps them to get more comfortable. I do try to spend more time with them initially and call in on them throughout the day."

Mrs Q, an enrolled nurse, who cared for the residents in Hostel B, employed a similar approach to Sister F during the resident's first days in the hostel.

> "... not to force them into sort of complying with the norm, complying with everyone else. You give them time to settle in, introduce them to other people. Just try to get them involved with what everyone does and just give them the time they need to settle in. You can sense when they are ready to jump in, when they have settled in and are happy."

Mrs H, the nursing assistant in Hostel A, described the majority of new residents as "eager to fit in". In referring to her routine of care for each hostel resident she noted

> "The majority of them are happy to fit in with me as much as me fitting in with them."

During the time data was being collected at Hostel A, an activities aide was employed to organise recreational pursuits for the residents. She described her role in helping new residents to adapt to the environment.

> "I try to meet them as soon as they come in ... I try to say to them what we do and how we like them, that they are welcome to join in all the activities. I try if they are settling in well, I try to take them on the first outing as ... if you are all out in a group they tend to mix in a lot better and then after you have broken that initial ice, then they're a lot better after that."

A third sub-theme, which emerged during the **"FITTING IN"** period was the **"new resident's perceptions of his/her surroundings".** These included the structural environment, other residents and staff.

Positive comments were made by the key participants about the structural environment. Miss D who had spent much of her life in the country remarked that she appreciated "... the freedom and lovely views. I can walk and do what I like more or less." (Interview 2)

Mr P said of Hostel B

> " You just can't improve upon it in any way at all. It's perfect as far as I'm concerned ... You have to live here to appreciate just what it's like." (Interview 2)

Mr C's impression of Hostel A was "It's a very good place to be in, wonderful really." (Interview 2) Mrs N of Hostel A commented "I think it's a wonderful place really, the food is very good." (Interview 2)

However, Mrs N did complain about the small dimensions of her new room.

> "You can't put much in the rooms (Hostel A) ... and I would have liked another chest of drawers but I thought well I've got most of my winter things and most of my summer things are down at my daughter's so that I can change around like that and manage in that way." (Interview 2)

Miss D who was very deaf and had poor eyesight described an early problem with another resident

> "... after tea I always go to the T.V. lounge and sit there from half past five until seven for the news ... somebody's been taking my chair and being a little bit difficult about it because it's closer ... so I had it out with her and she's been very good. I'm back in my chair." (Interview 2)

Mrs N also encountered some problems initially, with other residents at the dining table

> "I don't know very many here and I still don't. We sit at the dining table and nobody talks very much and you know nothing about them or what to talk to them about ... everybody's Mrs. Over there (the units for the independent elderly) we were all on christian name terms. ... It is a bit strange but they seem to like it that way so you fit in with it." (Interview 2)

The resident's perceptions of the staff were positive. Mrs N, Hostel A, stated "I'm happy. They're such a wonderful lot of people to be looking after us." (Interview 2)

Miss D described how the staff in Hostel A helped her to settle. "They ask you what you like and try to help you to do it." (Interview 2)

Mr E in Hostel B commented

> "they are at your service right from the morning and even during the night. I probably don't sleep so terribly good, they come in to have a look. I nearly always know when they come, they've got that big light. But I never let on I see them." (Interview 2)

Mr P, Hostel B, noted "the staff are fantastic ... from the Matron down ." (Interview 2)

The third major theme which emerged from the data was **"A RESIDENT'S LIFESTYLE"** or portraits of the key participants as residents. Two main sub-themes were identified, the first was concerned with continuing aspects of their lifestyles prior to relocation and was entitled **"continuing the old".**

Mrs N could not identify any changes in her lifestyle at Hostel A.

> "I go out practically every day. I'm leading the life I lived when I was in my unit. I play cards on a Monday, have visitors probably Tuesday or go out. Wednesday I play cards again over there (the social centre which belongs to the units for the independent elderly) and Thursday I have visitors again. Fridays, I leave that, you know, to do anything that crops up. Saturday my daughter comes in the afternoon and takes me for a run and on Sunday my other daughter ... takes me and I go to her place for dinner." (Interview 3)

Mr E at Hostel B described how he spent time fishing and bowling, although because his mobility was limited he was no longer able to bowl outdoors.

> "When I first came here I could move about quite freely and I used to spend a lot of my time fishing and bowling. Bowling was one of my sports in life. As a matter of fact, I still do a little bit of indoor bowling ... We have a place here, the senior citizens, I go there and I go up to Y (a small town 35 km from Hostel B) ... I still do a little bit of fishing ... just around the coast or sometimes down on the jetty." (Interview 2)

Mr E, aged 91, still owned a car and had a current driver's licence so was able to move around the district independently. Between interviews 2 and 3 he lost his balance whilst our fishing and cut his hand which healed well but he has not been fishing again since the accident.

Another regular recreational activity was visiting relatives.

> "... I go to Z (small community 20 km from Hostel B) every fortnight to have dinner with a brother of mine up there ... He's living on his own and I get some steak and some onions and an egg and he does the cooking and we really enjoy it. And after that I go see the sister ... she lives only about a quarter of mile away ... she would be about seventy five, I suppose." (Interview 3)

Mr P of Hostel B also demonstrated continuity from his former lifestyle to his new lifestyle as a resident. He had been a widower and lived on his own for seven years prior to relocation.

> "... this is my home and I carry on from where I left my other home. Like today, I washed these 'working' clothes because they've got an automatic washing machine. I washed them and pressed them. I go down and help wash up of a morning and ask the girls (nurses) if there is anything I can do for them. Perhaps I go down and post a letter for somebody or a message for somebody, help wherever I can. That's home." (Interview 3)

Mr C, in Hostel A, previously a very enthusiastic gardener recalled how he spent time helping to prune the roses in the residents' garden and carried out other small gardening tasks. He had previously owned a car but failing eyesight had forced him to give up driving when he came to the hostel. However, his former neighbour visited two or three times weekly and took Mr C for a short drive. If the weather was poor they went to the neighbour's home, otherwise they'd go wherever Mr C wanted. He often went to visit his sister in a nearby nursing home. Before he came to live in the hostel, Mr C had been accustomed to driving himself to the south of the state to stay with friends several times each year. His holidays still continued but now his friends came to collect him and brought him back to the hostel.

> Mr C - "Well I went for a week and my friends come and get me and bring me back again. Anyway they wanted me to stay a fortnight so I stayed an extra week and I've enjoyed it very much. I've even been down to Wrest Point and had a meal in the revolving restaurant." (Interview 3)

Miss D, Hostel A, however, who had limited mobility, complained she could not do what she wanted to though she did not attach blame to the hostel.

> "... my sight and hearing have deteriorated and I don't get enough to do. Also there are not as many junior ones (residents) here now I'm afraid because of sickness ... they've moved, some of them." (Interview 2)

However she was able to list activities in which she participated such as morning exercises, scrabble, cards, watching televsion and walking outside when the weather permitted. Her general health and mobility improved during the period of data collection and she became an eager participant of the outings organised by the activities aide. This provided her with the opportunity to get out into the countryside which she had always loved.

A sub-theme which evolved from interviews with Mrs O, key participant Hostel B, participant observation in both hostels and discussion with the hostel staff, was that of the **"invisible residents".** Mrs O was an **"invisible resident".** She remained in her room in Hostel B at all times, only leaving it to change her library books for others which were to be found on a bookshelf in a nearby corridor, or to go back to her former home for the day with her grandson who continued to live in the house. Her reason for remaining in her room was "... because I've never been one for going making friends with my neighbours or anything like that." (Interview 2)

Mrs O had spent the previous 2 years in the nursing home adjacent to the hostel and became a hostel resident when the building opened. She never went back to the nursing home to visit. One of her former friends from the nursing home had visited Mrs O. "One of them used to come but she's been rather sick lately, so she hasn't come." (Interview 2)

Within the confines of her room, Mrs O passed her days reading, knitting, watching televison and occasionally walking around her room with the aid of her walking frame. She did however have several regular visitors including her grandson.

> "... there is about seven or eight on a Tuesday night and they have a sing song ... in here ... they all sing with me and before they go they say a prayer." (Interview 2)

> "... there is a gentleman comes in every Thursday ... He always comes in and sits down and has a talk with me." (Interview 2)

> "There is a young chap works here ... he does my shopping for me if I want any sweets or anything." (Interview 2)

> "There was another Matron here when I first came .. she left when she was pregnant and had a little boy. She brings him in to see me." (Interview 3)

> "One lady (hostel resident) she sometimes brings in the morning tea and there is a gentleman (Mr P key participant) brings in the paper. He comes back and gets it when he thinks I've finished with it." (Interview 3)

During periods of participant observation I did not observe Mrs O venture from her bedroom. Mrs Q (enrolled nurse Hostel B) confirmed this behaviour.

> "She doesn't leave her room. She doesn't come out with the others, she's a lady who likes to keep very much to herself."

During participant observation at Hostel A, I became aware that there were approximately 50% of the residents who did not frequent the communal lounge rooms so I had no opportunity to talk with them. I observed these people in the dining room at mealtimes, as no meals were served in resident's rooms unless the resident was sick. After meals, these people disappeared. Mrs J, the activities aide confirmed that about 50% of the residents participated in the organised outings or activities. Some residents were able to pursue their former lifestyles whilst others preferred to remain in their

rooms. I was introduced to Mrs T whose former talent "embroidery" was well displayed in several beautiful pictures on the walls. She was currently producing cards of pressed flowers for the hostel funds. Mrs T told me

> "I stay in my room all the time, I don't make friends easily." (Field Notes, 27 March 1990)

It was not possible to interview other "invisible" residents as they were not willing to talk to me. However, my observations were confirmed by the enrolled nurse in Hostel B and the activities aide in Hostel A.

5.4 Summary

In this chapter, the processes of data sorting and data analysis have been described. The three major themes, with their sub-themes, which emerged from the data have been highlighted. The theme, **"PREPARING FOR RELOCATION"** included the sub-themes **"early decisions"** and **"immediate plans"**. The theme **"ADAPTING TO A NEW ENVIRONMENT"** comprised the sub-themes **"first impressions"**, **"staff expectations"** and **"new residents perceptions of their surroundings"**. The last major theme, **"A RESIDENT'S LIFESTYLE"**, contained two sub-themes **"continuing the old"** and **"invisible residents"**.

In the following chapter there will be a discussion on the research findings.

CHAPTER 6
DISCUSSION OF RESEARCH FINDINGS

6.1 Introduction

In this chapter the research findings will be discussed. Three major themes, each with sub-themes emerged on data analysis. These were **"PREPARING FOR RELOCATION", "FITTING IN TO THE HOSTEL"** or **"ADAPTING TO A NEW ENVIRONMENT"**and **"LEADING THE LIFE I LIVED"** or **"A RESIDENT'S LIFESTYLE".** Each theme and its sub-themes will be discussed separately.

6.2 Preparing for Relocation

An early sub-theme **"future plans"** surfaced from the theme **"PREPARING FOR RELOCATION".** This sub-theme was concerned with early decision making regarding a choice of hostel and disposal of possessions.

"Future Plans" made by two key participants included decisions made regarding choice of hostel. Mr C and Miss D from Hostel A both chose to place their names on the waiting list of the nursing home MM, whilst they were fit and active members of the community. At that time, there was no hostel associated with MM. Both key participants lived within easy walking distance of MM and were well acquainted with it. Mr and Mrs C, who was alive at the time the decision was made, regularly visited a friend who was a resident of MM. Miss D also had friends in MM and was " ... in and out all the time" (Interview 1). Miss D and Mr C were therefore well acquainted with the nursing home's facilities and personnel. Later, when Hostel A was built by the organisation which owned MM, Mr C and Miss D were asked if they would like to transfer their names to the hostel waiting list and they both agreed to the change.

Until G.A.T. became the "gatekeeper" of the waiting list for admission of the elderly to hostels and nursing homes, individual institutions maintained their own lists and made decisions regarding

urgent or non-urgent admissions. The distinction between hostel care and nursing home care was blurred. Howe and Preston (1985) analysed nursing home populations in all states of Australia. They noted that Tasmania had nearly three times as many ambulant, continent and non-confused nursing home residents as Victoria. At the time Miss D and Mr C made decisions about admission to MM the differing levels of care provided by hostels and nursing homes appeared to be ill-understood by the public and some institutions made little effort to categorise residents according to nursing needs. G.A.T. members identified that the elderly still experienced difficulty in appreciating the difference between the levels of care offered by hostels and nursing homes. The nurse member of the G.A.T. commented

> "... elderly people who often believe that a nursing home is the end of the road for them ... have a bit of trouble understanding the concept of a hostel. You have got to get them thinking 'this is what I need'. Whether it is their own thoughts or family telling them 'you can't cope, you need to go into a nursing home' I don't know but it is often difficult to get the client to understand that hostel care only is required." (Interview with nurse member of G.A.T.)

Although initially Miss D and Mr C had chosen to place their names on the waiting list for a nursing home, during their first interview they both demonstrated an understanding of the differences between the two insitutions. Prior to admission they had spent periods in the respite care area which shares facilities with Hostel A. Whilst in respite care, there is the opportunity to interact with hostel residents and develop knowledge of the hostel and the staff. Many hostel residents spent time in respite care prior to their admission to the hostel. Sister F in charge of Hostel A confirmed this.

> "... usually I'm told right from the beginning who is to be admitted. A good deal of the time I have some idea who this person already is. I have either nursed them before in the respite section or the hostel respite ...".

Mr C and Miss D were two key participants without direct descendants. The only other key participant without direct descendants was Mr P of Hostel B. He had a stepson and stepdaughter with whom he was in close contact.

Anecdotal evidence in support of early decision making by people without direct descendants has been heard recently from two single ladies in their early 60's who have sought to place their names on waiting lists maintained by their chosen hostels. Further research is necessary to discover whether early decision making is a more common feature of those people without direct descendants than those who have immediate family.

Early decision making, planning for the time when care in an institution is required, seems an appropriate activity to undertake when an individual is still active and mentally alert. During this time it is possible to visit nursing homes and hostels and decide upon a venue if/when care is required.

By 2016, 9.2% of the Australian population will be over 70 and these people will require an expansion of the current health services in order to provide adequate levels of care both at home or in institutions (Burnside Conference Paper, July 1990).

Although the elderly are a diverse group who age in different ways, to make a long term decision regarding care in a specific institution if/when it is required will provide some with the assurance that they will be able to relocate when it is necessary to do so. Early decision making could also lead to a reduction in stress around the time of relocation.

A second sub-theme **"immediate plans"** included decisions made about the right time to relocate and disposal or retention of possessions. These decisions were shared with significant others and/or the professionals. The key participants described their decision to relocate as inevitable and final.

Miss D and Mrs N drew up lists of items which were to be distributed amongst their family members. Mrs O, Mr E and Mr P left their homes occupied by either their children or grandchildren and disposal of possessions was not discussed by them in any detail.

The size of the hostel rooms limited the number of possessions which could be brought by the relocatees. In Hostel A the rooms contained a built-in wardrobe and a single bed, the remaining furniture usually a chest of drawers, television, easy chair(s) and small occasional table were supplied by the relocatees. Hostel B's rooms were larger but all furniture including the wardrobe, had to be supplied by the residents. These rooms comfortably contained a double bed, wardrobe, dressing table, two easy chairs, television and occasional table. Butler and Lewis (1977) in McCracken (1987) noted that possession change on relocation can be a contributory factor to loss of continuity with life history and loss of a sense of self or identity. Research by McCracken (1987) demonstrated that possession loss for elderly women was difficult and threatening.

Members of the G.A.T. encouraged potential relocatees, high on the urgency waiting list, to begin the process of disposal of possessions (Field notes visits to potential relocatees with G.A.T. member). They recognise disposal of possessions to be an added stressor at the time of relocation and advocate early planning for disposal/retention of possessions to help alleviate some of this stress. McCracken (1987) notes the need to explore with the elderly the meaning of possessions and suggests those possessions bringing back specific memories, as well as those supplying continuity of roles should be retained. One of the aims of the G.A.T. is to 'educate the public and other health professionals in aged care issues' (Philosophy and Goals of G.A.T., 1984). It would appear that they are in a unique position to offer education to groups of well elderly on such topics as the meaning of possessions and decision making associated with the need to decrease possessions (McCracken, 1987).

The decision to relocate was made by the key participants in consultation with significant others and the professionals. The role of significant others and the family varied from that of consultation to playing a more active part in the decision making process. However, all key participants identified that ultimately they made their own decision to relocate. These findings differ from those of Minchinello (1987) who noted on surveying 92 new residents of a nursing home, more than half said they had little or no say in the decision making process. Immediate family members were identified by 35% of the residents as being most involved in the decision making process. The doctor was identified as the decision maker by 24% of the residents, whilst 8% identified the involvement of the nurses and social workers. Although these residents would require more constant care than those entering the hostels, they were described as the 'less disabled' by the nursing home staff.

Timing of relocation is dependent upon the readiness of the potential resident to move to the hostel of choice and the G.A.T.'s decision to recommend the client for urgent hostel care. As well as carrying out an assessment of the relocatee's ability to perform the activities of daily living, G.A.T. take into account the needs and wishes of significant others and the medical opinion of the general practitioner. If there is an empty room in the hostel of choice then relocation can proceed. If there is no room available then the alternatives are for periods of respite care (up to three weeks) or to relocate to another hostel until a room becomes available in the hostel of choice.

The G.A.T. aims to maintain individuals in their own homes with the help of community services for as long as possible. For the most part there was agreement on the need for hostel care between the key participants and the residents. However Miss D and Mrs O required guidance from the professionals and time to consider relocation. Very little time is available as the hostel rooms are required to be occupied within three days of becoming empty otherwise the financial subsidy lapses. However, there is provision

for a trial period of four weeks, if a potential resident has any lingering doubts.

Mr P (Hostel B) identified his need for urgent hostel accommodation although G.A.T. considered him a non-urgent case. He refused help from community services and decided relocation to the hostel was the only solution to his health problems. Two attacks of arthritis had left him in constant pain although he looked and behaved as a 'fit and active gentleman' (Field Notes, Hostel B, 29 March 1990). After a six month waiting period, G.A.T. conceded to "public pressure" (Interview with nurse member of G.A.T. 28 May 1990). Mr P was a well known member of the local community and his demands were met as there was no-one else with more urgent need for a room in Hostel B. Mr P considered the hostel as a safe haven where he would get care and attention if he had further attacks of arthritis rather than being "... dumped anywhere" (Mr P, Interview 1). Mr P's arthritis prevented him from carrying out essential maintenance on his house and he was unwilling to permit others to help him. He was certain that it was the right time to relocate. His behaviour was similar to that of some potential residents of hostels prior to the advent of G.A.T. and supportive community services. These relocatees, whose names were already on the waiting list, would inform the Director of Nursing when they were ready to relocate and a room would be offered as soon as one became vacant. (Anecdotal evidence from hostel residents and staff). For Mr P the right time to relocate was when the house became too difficult to manage. Reliance on community services was not considered to be an alternative. It is likely there will be other elderly people, like Mr P, whose views on the timing of relocation differ markedly from those of the professionals. However, the system was sufficiently flexible to arrange Mr P's relocation at a time that he considered to be right.

When describing their decision to relocate most of the key participants indicated finality in the decision making process. They acknowledged there was no choice but to relocate to the hostel. The relocation involved disposing of most of their possessions,

possibly losing some social contacts and accepting the regulations of the institution. However, recognition of the finality of the decision making process could be a coping mechanism which helped to hasten adaptation to the new environment.

6.3 Fitting into the Hostel

The second major theme was **"FITTING INTO THE HOSTEL"** or **"ADAPTING TO THE NEW ENVIRONMENT".** Within the theme three sub-themes emerged. The first of these was the sub-theme **"first impressions".**

Adapting to the hostel environment was not considered to be difficult. For several key participants, it brought positive benefits. Mr E (Hostel B) left a hostile environment; Mr P (Hostel B) actively sought relocation in order to leave his unmanageable home; Mrs O (Hostel B) gained a room of her own rather than a shared one which she had previously occupied in the nursing home and Miss D (Hostel A) found plenty of space in which to practise walking.

Hostel A was not a new environment for the key participants. They had all previously spent some weeks in the adjoining respite care area. They were known to the staff and also had knowledge of the hostel routine and regulations. Mr C and Miss D (Hostel A) had friends who were already resident in Hostel A. On relocation to Hostel B, Mr P renewed acquaintance with an old work mate who was also a resident there. The three basic conditions described by Chenitz (1983) which make a positive contribution to relocation to a nursing home were centrality or perception of the degree of disruption; desirability or positive acceptance of the need to relocate and legitimation, finding a plausible reason for relocation. The key participants did exhibit centrality, the process of relocation was not identified as being disruptive. There was evidence of desirability, relocation was described in positive terms, negative consequences were rarely mentioned. Legitimation was demonstrated by the key participants. All had plausible reasons for admission.

The second sub-theme to emerge from the data during the **"FITTING IN"** period was that of **"staff expectations"**. The key participants were vague about the length of time taken to adjust to their new surroundings. Answers varied form "immediately" (Mr E, Hostel B) to "about six weeks" (Mr C, Hostel A). Staff in the hostels identified that there was a "fitting in" period for all new residents. Sister F in Hostel A and Mrs Q, the enrolled nurse in Hostel B, described their role as one of unobtrusive guidance providing the new relocatee with time to adapt to his/her new environment at his/her own pace. The activities aide in Hostel A adopted a similar approach. She waited until "... they are settling well" before she invited the new resident to go on his/her first outing. She identified the increased opportunities for social interaction during outings as being particularly beneficial for the new resident.

The staff did not refer to the possibility that a resident may never adapt to his/her new surroundings although two residents in Hostel A made brief reference to the fact (Field Notes, 20 June, 1989). Chenitz (1983) identified resistance to nursing home admissions occurring in two forms which are dependent upon the way an individual deals with stress. The new resident may demonstrate resigned resistance which is characterised by loss of will to live, or forceful resistance which manifests itself in angry outbursts and non-compliant behaviour.

Miller and Russel (1986) found that nurses estimated residents as being more satisfied with life in a minimal care institution than the residents identified themselves. Inability of hostel staff in this research study, to recognise residents who do not adapt to a new environment could be related to their lack of understanding of the processes of adaptation, or possibly the staff did not consider non-adaptation as important, as the focus of the interviews was towards the ways in which they helped new residents to adapt.

The third sub-theme to emerge from the data at this time was the **"new resident's perceptions of his/her surroundings".** These included the physical structure of the building, as well as hostel staff and other residents.

The key participants commented positively (with one exception) on the structural environment. Both hostels were relatively new, had been purpose built and each resident had his/her own room with ensuite facilities. There was access to communal lounges and dining rooms. The multi-purpose space in Hostel B which contained kitchen, dining and lounge areas was particularly home-like and well used by the residents (Field Notes, 22 March 1990). In Hostel A's little lounge rooms the chairs were arranged around the walls giving them an institutional like appearance. There was an open plan dining area resulting in a steady stream of staff passing through at meal times. No adverse comments were made by the key participants regarding the dining room and small lounge rooms. Only Mrs N (Hostel A) found the size of her bedroom inadequate. There was insufficient room for a second chest of drawers which she would have liked to bring and the built-in wardrobe was too small to contain all her clothes. Difficulties regarding the disposal or retention of possessions have already been described. The furniture which may be retained for the practical purpose of furnishing the hostel room may not be the well loved pieces that residents would bring if there were more available space for their belongings. One potential hostel resident had marked affection for an antique dining table and chairs which had belonged to his wife's family for several generations. No-one else in the family wanted these heirlooms, he knew he could not take them with him and so they were sold prior to his relocation (Interview Mr H, 6 June 1990). The amount and type of furniture that potential residents may bring is controlled by the size of their hostel rooms.

Hostel B has accommodation for ten residents from a population of approximately 10,000 people. The probability of the relocatee knowing one of the established residents is high. Mr P met with a former work mate when he was admitted. Friends and

acquaintances who are hostel residents may provide the relocatee with help and support during the process of adaptation. None of the key participants acknowledged this fact although staff from Hostel A identified residents, already known to the key participants whom they considered had been helpful in the adaptation process.

The small number of residents in Hostel B and its physical structure contributed to the development of an interactive community. The residents shared the mealtimes, sitting around a large table. They were able to tolerate the silent behaviour of the schizophrenic and the two ladies with short term memory loss, as well as help the 'two invisible residents' who didn't venture out of their rooms.

Hostel A had a more formal approach to mealtimes. Residents were advised over the P.A. system that meals were being served. On admission, each resident was allocated a place at a specific table by the Sister-in-Charge and he/she remained there unless a change was requested. Men and women sat at separate tables. Initally, Mrs N found that taking meals in the dining room was not easy. She had difficulty in hearing what was said by the other occupants and she disliked their use of formal titles referring to one another as 'Mrs'. This problem was mentioned during the second interview but it had resolved itself by interview three. Miller and Russell (1986) found that mealtimes were a pleasant experience for 85% of residents in a minimal care unit. Socialising during this time had important significance for the residents. The physical structure of Hostel A, with residents rooms situated on either side of a long corridor, did not lend itself to social interaction among the residents. Periods of participant observation indicated that many residents retreated inside their rooms after meals and closed the door. Mrs N led an active life outside the hostel and so mealtimes were the only opportunity she had to become acquainted with other residents. This activity took longer than she thought it should.

Miss D's problems with a resident were different. She had claimed a specific chair in the communal lounge from which she watched

the early evening news on television. This chair was near the television set, its position helped to compensate for Miss D's impaired hearing and sight. However another resident began to occupy this chair but when confronted by Miss D agreed to move. Territorial claims in communal areas do occur in institutions for a variety of reasons. Sometimes they are initiated by staff of nursing homes who will seat an immobile resident in a specific place day after day. Anecdotal evidence suggests that conflicts arising from territorial claims are usually resolved by the residents. A pecking order develops, the longer the length of time in the hostel, the higher is the individual's position in the pecking order and the greater is the likelihood of gaining and maintaining territorality in communal rooms.

All key participants highly praised the hostel staff. Participant observation revealed that staff offered assistance when it was requested but residents made their own decisions related to their activities of daily living. These findings were consistent with those of Miller and Russell (1986) who found that residents in a minimal care institution felt comfortable with staff who acted as facilitators of self care.

6.4 Leading the Life I Lived

The third major theme to emerge from the data was **"LEADING THE LIFE I LIVED"** or **"A RESIDENT'S LIFESTYLE".** This theme was concerned with the integration of aspects of the key participants old and new lifestyles.

The degree to which elements of the previous lifestyle were incorporated into the key participant's lives as residents varied considerably. All the key participants exhibited some features of pre-relocation living in their new lives. The major factors which prevented several of the key participants continuing some of their former activities were poor mobility and sensory deterioration. Mrs N who was mobile and had two daughters who were ready to

act as chauffeurs, recounted how her weekly activities had not changed at all. Mrs N had moved a relatively short distance, approximately 200 metres, from her unit to Hostel A. She had friends in the units whom she visited regularly, as well as playing cards with them in the recreational centre which was adjacent to the hostel.

When first admitted to Hostel A, Miss D found she had insufficient activities to occupy her day. She blamed her deteriorating vision and hearing for this inadequacy. Her mobility was also limited and initially she was reluctant to take part in outings because she was suffering from frequency of micturition (passing urine). However she did endeavour to keep herself active by utilising some of the facilities at the day care centre which was in the same building as the hostel. When her health improved she began to attend the social outings organised by the activities aide.

The activities aide (Hostel A) was keen to assist the hostel residents to continue their former hobbies and recreational pursuits whenever possible. Gardening had been a favourite pastime of several residents. Raised garden beds were organised. Tools were purchased using the advice of the residents and flowers, vegetables and herbs were planted by them. Materials grown were either to be used by the hostel or sold in the hostel shop. Anyone with expertise in handicrafts was encouraged to pursue these activities, selling surplus goods in the shop. Any profits were used to buy more materials to make goods for the yearly fete. The activities aide described her role as helping the residents of Hostel A to maintain their hobbies and recreational pursuits whilst at the same time assisting them to develop into a community. Prior to her appointment, many of the residents of Hostel A remained alone in their rooms between meals.

There was no activities aide in Hostel B. The enrolled nurse in charge of the hostel endeavoured to keep the residents as active as possible by encouraging them to take part in the day-to-day household chores. They prepared their own morning and afternoon

tea, set the tables for meals and washed the cutlery and crockery afterwards. Some residents also helped to clean their own rooms. Social outings did take place from time to time. They were organised in conjunction with the nursing home residents.

Opportunities were available for new residents to continue aspects of their former lives whenever possible. Residents were encouraged to continue their hobbies and recreational pursuits. Maintaining previous social networks was facilitated as key participants chose to relocate to a hostel within the same neighbourhood as their previous home. These factors helped to minimise the impact of relocation and to promote the process of adaptation.

The second sub-theme to emerge at this time was concerned with the behaviours of **"the invisible residents".**

One of the key participants, Mrs O, chose never to venture outside her own room in Hostel B unless she wanted a different book to read. Library books were to be found on a shelf in the corridor outside her bedroom. The other reason for venturing outside her bedroom was to visit her former home where her grandson now lived. She made no attempt to socialise with other residents and admitted she was unaware of their names although Mr P visited her everyday to lend her his newspaper and another resident brought her morning and afternoon tea. Mrs O was profoundly deaf which made communication with her difficult but she also acknowledged that she had never actively sought to make friends. During interviews she became tearful when subjects such as her old home and her family were mentioned, so the researcher decided not to pursue these aspects of life with her. In spite of her seclusion she identified regular visitors to the hostel who came to see her, although she was vague regarding their identities. Mrs O was popular with the staff. They called her "Gran", the name by which she like to be known (Field Notes, 3 May 1990). She continued to pursue former hobbies, she knitted, watched television and read a great deal. Her behaviours of "sadness and crying" were similar to those of the "resigned resistors" described by Chenitz (1983).

Dooghe, Vanderleyden and Van Loon (1980) identified loneliness as the main factor which prevented the elderly adjusting to life in an institution. They noted that the situation was further complicated by a feeling of not being part of the institution and a lack of support from fellow residents. Mrs O did not acknowledge that she had not adjusted to life in the hostel and the staff described her as "content". They also identified her as being "settled" in the nursing home where she had lived for 2 years prior to relocating to the hostel.

Emotional behaviour similar to that experienced by Mrs O was exhibited by Mrs Y, a resident in Hostel A, whilst being interviewed. She had been identified as being particularly friendly to new residents by the hostel staff although she was reluctant to describe herself in that manner. Mrs Y described her feelings about life in Hostel A

> "... people say are you enjoying it? and I don't know the answer to that. I am, I think, very fortunate to be here and I like everybody. I don't say I don't enjoy it but there is a difference between [pause] you see I was so happy at home ... I can't compare it to say I enjoy it." (Interview 28 June 1990)

Further questioning did not elicit reasons for her lack of enjoyment in Hostel A. Like Mrs O, Mrs Y did demonstrate lack of adaptation to the hostel environment, although staff again did not recognise this fact.

An invisible resident was also identified in Hostel A. Mrs T passed her days in her room, except for meals. Unlike Mrs O, she did not become tearful when discussing her former lifestyle but stated she didn't think she would ever adapt to life in the hostel (Field Notes, 27 March 1990).

It was not easy to obtain further information on invisible residents as they were reluctant to communicate with me. It seems probable they are a mixed group, some continuing many aspects of their former lifestyles outside the hostel, whilst others remain inside their room demonstrating features of lack of adaptation to the hostel environment.

6.5 Summary

In this chapter, the research findings have been discussed under the identified themes and sub-themes. The implications of the study for nursing theory, practice and research and the study's limitations will be described in Chapter 7.

CHAPTER 7
IMPLICATIONS OF THE STUDY FOR THEORY, PRACTICE AND RESEARCH AND LIMITATIONS OF THE STUDY

7.1 Introduction

In the preceeding chapter the research findings were discussed. In this chapter, the implications of these findings for nursing theory, practice and nursing research and the study's limitations will be discussed. In Australia as in other industrialised countries, the percentage of elderly in the population is rapidly increasing. In 1990 15% of the population were over 65 years of age and it is predicted that by 2031 those 65 years and above will form 19-20% of the total population of the country (Australia's Health, 1990). The elderly are the biggest users of health care services (Burnside, 1988). Those over 60 years of age account for 50% of all acute hopsital bed days and their average length of stay increases from 6 days at 60 years to 17 days at 85 years or above. The growing number of elderly people in the population will result in an increased demand for both acute and extended care beds in institutions and the need to employ more people to care for the frail ageing members of society, in both community and institutional settings (Mid Term Review, 1990). The changing composition of this elderly group will pose challenges for nurses and undoubtedly shape their contribution to society in the coming decades.

7.2 Transition Theories and the Helping Role of the Nurse

Young (1991) describes Bridges (1980) process model on transitions as being a helpful way to understand life's changes including relocation. Bridges (1980) divides the transition process into three phases: (i) endings; (ii) neutral zone; (iii) new beginnings. Chick and Meleis (1986) describe a similar general structure for transitions. They identify three phases: (1) entry; (2) passage; (3) exit. For the elderly people in the research study, the meaning of relocation emerged comprising three phases: (i) **"PREPARING FOR RELOCATION"**;

(ii) **"FITTING INTO THE HOSTEL"**; (iii) **"THE RESIDENT'S LIFESTYLE".** The first phase of preparation did involve "new beginnings" or gaining "entry" to the hostel. Decisions regarding where to relocate, which possessions could be retained and which possessions had to be disposed of, in addition to leaving supportive friends and neighbours were all activities which were identified by the residents during the pre-relocation period as being particularly stressful.

Fitting into the hostel environment posed a few minor problems for key participants. Familiarity with hostel routine and staff in addition to being able to maintain close links with their previous lifestyle were obviously key factors which helped to facilitate their adjustment. This period fits well with Bridges neutral zone - the time when the elderly come to terms with losses from their old lifestyle and begin to positively accept the new lifestyle. Chick and Meleis describe this phase of the transition process as a 'passage', again an apt description for the period in which the new resident begins to integrate the old and new lifestyles.

The third phase in Bridges model is described as "new beginnings" and called "exit" by Chick and Meleis. For the newly relocated elderly, their lifestyles as residents emerged. The residents became more active, made new acquaintances in the hostel, sometimes renewed old acquaintances and began to pursue activities offered by the hostel. They passed through the "exit" from their old to their new lifestyles.

There is no doubt that these models provide a simple but effective way to study life changes such as relocation. This theoretical conceptualisation enables the nurses' roles in each phase to emerge more clearly. The endings or new beginnings is a time when the resident needs help and support during his/her decision making and coping with his/her losses. The zone or passage when elements of the old and new lifestyles are integrated usually involves much reflection and introspection on previous life experiences. Again, the helping role of the nurse becomes important. Some of the aspects of the helping role of the nurse, as identified by Benner

(1984), would enable the nurse to provide support for the resident during the "endings" and the "neutral period". Useful aspects of Benner's helping role are:

> "... Presencing: being with a patient .... Providing comfort and communicating through touch .... Guiding a patient through Emotional and Developmental change : Providing new options, closing off old ones: Chanelling, Teaching, Mediating" (p 50).

When newly relocated residents moved into the third stage of the transition, new beginnings or exit, they had come to terms with their losses, old and new lifestyles were firmly integrated and they were clearly identified as hostel residents, taking part in the activities of the institution. Nursing practice in this phase is predominantly concerned with facilitating the self care of the residents and using strategies to promote their health.

7.3 Implications for Nursing Practice

At present, when caring for the elderly in institutional settings, nurses focus on the resident's physiological needs. Periods of participant observation and interviews with registered nurses indicated they performed dressings, inserted eye drops, recorded blood pressures and carried out other technical nursing procedures. There was little time for individual interaction with residents and although the phenomenon of relocation was recognised as a traumatic event, accompanied by grief, the nurses understanding was that, as time passes, residents will adapt to their new environment. One key participant, Mrs O in Hostel B, and also Mrs Y, a resident in Hostel A, demonstrated features of poor adaptation even though Mrs O was described by the staff as "content" and Mrs Y was identified as someone ready to help others settle into their new surroundings.

It is important to note that most registered nurses currently caring for elderly residents in hostels and nursing homes were educated in acute hospitals and so bring some of the regimented behaviours associated with acute nursing practice to extended care institutions, for example, schedules of bathing, toileting and feeding (Garrett, 1991). The primary focus on caring for physiological needs and the task orientated approach to nursing practice leaves little time for nurses to care for the residents psycho-social or spiritual needs. These nurses were only minimally introduced to psychology, sociology and human development during their basic training and so have little knowledge regarding the care of residents psycho-social needs. The same topics were highlighted by an anonymous writer in the Tasmanian newsletter of the Royal College of Nursing, Australia, September 1991. The author described the loneliness and subsequent death of a ninety year old resident of a nursing home.

> "There's no doubt in my mind that the nursing staff did their best with the resources that they had. Most, if not all of the RN's hadn't taken behavioural science courses during their training, and didn't realise that nurses have to manage nursing homes as social systems. How else can we provide for "contact with persons who can help (residents) to get in touch with other human beings, feel related to them, and work collaboratively and live productively with them. Even if they had taken such courses the staffing levels were so low that nurses rushed from resident to resident just making sure that basic physical requirements were met. Any talking or caring was not infrequently hurried and sometimes even just a little rough. There was not much time to listen and to talk, to laugh and to joke, to touch and to cuddle, to be there for each other for extended unhurried periods. Oh we did our best - but let's face it, it just wasn't good enough" (September 1991, p 2).

Nurses caring for the elderly in hostels require opportunities to reflect on their work practices and to further develop their knowledge and skills. If they are to play an effective role in the provision of health care for the elderly, then they must be given the opportunity to expand their knowledge on the psycho-social aspects of ageing and to develop skills which will help the elderly

cope with the ageing process. Interventions such as reminiscence therapy, life reviews, oral history interviews, have been demonstrated to be useful tools which aid the elderly to increase their social interactions, affirm their own uniqueness (Burnside, 1990). These interventions thus help the individuals come to terms with ageing and cope with life events such as relocation.

In order to implement newly developed skills, nurses would have to consider changes to present work practices. Some interventions which aimed to meet the resident's psycho-social needs could be practised whilst meeting physiological needs, e.g. the processes of bathing and dressing, if implemented according to individual need and not as a daily routine, could become more leisurely activities, with ample time for social interaction between nurse and residents. Time for other interventions could be made available by re-arranging working schedules. During periods of participant observation, the researcher became aware that medicine rounds, conducted in the dining room of Hostel A, occupied the registered nurse for twenty minutes during breakfast, lunch and tea times. The need for this time consuming procedure was queried with Sister F who explained that the relocatees were given a choice on admission, either they could retain their own medicines and self medicate, or the nursing staff would store and give out their drugs at the appropriate times. All residents chose to hand over their medication on admission. The same procedure applied in Hostel B. Nurses administered all the drugs. Some residents have periods away from the hostels, staying with relatives or friends, others go out for days. During these times, the residents assume responsibility for their medications and it would seem logical to encourage them to continue this process when they return to the hostel. Not only would residents have another opportunity to provide self care which would help to promote their self esteem but changing work practices for the nurses would give rise to more time in which they could effectively pursue their role as providers of holistic care by meeting the individual physiological and psycho-social needs of the residents.

If nurses emphasised their willingness to meet the resident's psycho-social as well as physiological needs then those residents who exhibited signs of poor adaptation to their environment, would be more readily identified and strategies which explored problems and tried to find solutions could be used to help these individuals.

Care of the elderly is a relatively new specialist area and nursing practice is challenged to find innovative ways of meeting the needs of this diverse group of people. Qualified nurses are an expensive commodity. If they do not re-define their responsibilities and update their knowledge and skills to provide holistic care then their role as carers for the elderly in hostels could be taken over by other professions.

There was evidence of resident participation in the day-to-day management of both hostels. In Hostel B the enrolled nurse and the residents worked together to maintain the standard of cleanliness of the environment, the preparation and serving of morning and afternoon tea, setting the table for meals, clearing away and washing up the dishes afterwards. There was less evidence of resident participation in Hostel A although a little did occur. All residents who were able made their own beds and one resident was responsible for setting the tables for mealtimes. Other residents, with the help of the activities aide, were involved in producing handicrafts to be sold for hostel funds at the annual fete. The participant role of the resident is one which requires further development to the level where some residents will be involved with management in decision-making. A Guide to Residents Rights in Nursing Homes and Hostels (1989, p 18) suggests:

> "A recognised and internally publicised form of participatory decision-making be developed in consultation between residents and all nursing homes and hostels and this to be designed to be as flexible as possible to recognise and meet the various levels of contributions from residents..."

As the participant role of residents develops further, the power invested in the registered nurse will surely diminish. They will be regarded as a co-workers and not as authoritarian figures. If residents were able to play a more significant part in all aspects of life within the hostel and participate in the day-to-day activities a greater feeling of belonging to the place and regarding it as their own would be generated.

7.4 Further Research During the Adjustment Period

At present research studies on the elderly who relocate from home to an extended care facility have produced conflicting results. In this small study all the key participants except one coped well with the process. They did not discuss problems associated with the loss of their home and most of their possessions, that is, little evidence of the grieving process was visible but identified the approximate time period taken to adjust to the hostel environment. This time span ranged from "immediately" (Mr E, Hostel B) to "8 weeks" (Mrs N, Hostel A) after relocation. Key participants described hostel staff as being the primary source of help during the adjustment period. The staff's perception of their role with new residents was to help them learn about the physical environment and the hostel routine, give them time to adjust to their new surroundings and then involve the residents in the day-to-day activities if they wished to be involved.

In this study the process of adaptation remains unclear. What coping mechanisms, if any, other than staff support, did the elderly employ? Were there alternative strategies other than those mentioned by staff that were used during this period? One method which could be employed to aid the understanding of the adaptation process would be the documentation of the new relocatees behaviour. Residents behaviour is discussed by staff in an informal manner but written reports on hostel residents are only made if there is a change in an individual's health status. In order to further understanding of adaptation following relocation, careful documentation of new residents feelings and behaviour including

possible explanation for them, should occur. This documentation should also include nursing interventions and whether the outcomes were successful or not. Better written documentation during the period following relocation would not only help to further understanding of adaptation but would also contribute to a more general comprehension of the meaning of growing old. If this more detailed documentation were extended to include all hostel residents, knowledge of the frail elderly would be enhanced and problems which required further research would be highlighted.

During periods of participant observation the researcher encountered several residents in Hostel A who were admitted for either three or six week periods of "respite care". They all appeared well adjusted to their new environment and identified their relocation as a voluntary, legitimate and temporary event (Chenitz, 1983). During other nursing experience, the researcher had encountered elderly people admitted for respite care who were angry, unhappy and unable to adjust to their new environment. Engle (1985) in her research on temporary relocation and the elderly found a high anxiety level in 8 out 57 residents immediately following relocation though this anxiety did not impair cognitive functioning. Engle described the likely reasons for the anxiety as the potential or actual stress of relocation or the impact of the unknown environment on the individual.

It is likely that the numbers of temporary relocatees will expand in the future as more choices regarding health care become available for the rising numbers of frail elderly and their families. Primary care givers for this group are often elderly spouses or middle aged daughters, who need rest and relaxation from the care giving at intervals and assurance that their relative is being cared for satisfactorily during these periods.

What is the meaning of relocation for these temporary residents? How do the primary care givers cope with the separation? What are the implications for nursing practice, when "respite" residents are admitted to the hostel?

The people in the study who were categorised as "invisible residents" remain a puzzling phenomenon. As has been suggested already, it is likely that the invisible residents are a diverse group comprising different sub-groups. Some are physically fit enough to continue pursuing outside interests and are only seen at mealtimes. Others who do not totally adapt to their new environment prefer to remain in their own rooms for as much of the day as possible. Chenitz (1983) described this reclusive behaviour as "strategic submitting" when the individual concentrated their energy on living life as it had been lived previously. Both Mrs O (Hostel B) and Mrs T (Hostel A) demonstrated reclusive behaviour. They moved from their hostel rooms as little as possible. Both ladies commented that they had never been able to make friends easily in the past and did not want to be involved in the hostel's activities.

Pearlman in De La Cruz (1986), described the changes produced by relocation as leading to conflict. The conflict occurred as a result of the wishes of the elderly to remain in their own surroundings and function independently, although there is a need to accept their new environment and the possible loss of independence. According to Pearlman, the unresolved conflict will lead to loneliness, "an unnoticed inability to do anything while alone" (Peplau, 1982). The loneliness leads to feelings of powerlessness, "perceived lack of control over situations" (Gordon, 1985) and separation from others, thus suffering from social isolation. Social isolation is described by Gordon (1985) as a situation for which the isolated individual blames others and which is unsatisfactory and intimidating. Social isolation leads to loss of self esteem as the individual's minimal contact with others allows little time for the concept to be promoted. The lowered self esteem gives rise to further feelings of loneliness and thus the cycle is compounded. Although the two ladies in the study chose to isolate themselves from their peers, they could not be described as suffering from loneliness. They were both active and productive within their own hostel rooms. Loneliness is non-productive. It is possible that a sub-group of invisible residents could demonstrate features of this loneliness cycle. Following

identification of this sub-group, therapeutic interventions could be employed to help these residents break from the loneliness cycle.

In the future, nurses working with the elderly both in the community and in extended care facilities, will encounter increasing numbers of individuals who relocate for varying time periods. Knowledge of the process, its likely outcomes and the ways in which the elderly can be helped to cope during this period of change and adjustment are all important aspects of nursing practice. Some parts of this multi-faceted concept require further exploration so that succeeding generations of elderly can be guided through the process with informed nursing interventions.

7.5 Limitations of the Study

The aim of the study was to describe the process of relocation from the perspective of individuals as they moved from their own homes to aged-care hostels.

Ethnography was the methodology chosen to guide the research process. Data collection consisted of serial interviews with six key participants who relocated to two hostels, interviews with staff associated with the relocation process, other hostel residents and the key participants' significant others. Collection of data also included periods of participant observation in both hostels. During the periods of participant observation, field notes were recorded and these notes were augmented, as soon after the participant observation period as possible. Field notes provided a description of the researcher's experiences during the time she was present in the settings. Analysis of data revealed three major themes, each with several sub-themes. The emerging themes and sub-themes were in turn validated with the key participants.

7.6 Evaluation of Qualitative Research

"QUALITATIVE RESEARCH" is often criticised because its methodologies do not define rules for achieving reliability and

validity, concepts employed by those undertaking quantitative research to authenticate their results (Le Compte and Goetz, 1982; Sandelowski, 1986). Some researchers agree that as differences exist in the purposes, aims and intent of qualitative and quantitive research methodologies, then different criteria for evaluating validity and reliability in the two types of research are required (Leininger, 1990; Omery, 1988). Other researchers reject the concepts of validity and reliability as being useful for evaluating qualitative research. They support the viewpoint that the concepts used for evaluation should "... reflect the basic assumptions of the research approach being used" (Parse, Coyne and Smith, 1985, p112). Therefore, they advocate the use of different concepts to evaluate quantitative research. A suggested framework, with dimensions and standards, for appraising qualitative research was developed by Parse, Coyne and Smith (1985) from Batey's (1977) analysis of the research process and Kaplan's (1964) norms of validation.

In the framework referred to above, the conceptual, ethical, methodological and interpretive dimensions of the research are each examined, using the standards, substance, clarity, and integration for each dimension. The standards, substance examines the credibility of the ideas; these must be supported by appropriate evidence. Clarity is concerned with organisation and presentation of the ideas in a logical manner, whilst integration considers the flow of ideas emerging in such a way that they form a unified whole. Parse, Coyne and Smith (1985) provide criteria for each standard as it relates separately to each of the four dimensions. These criteria have been used as a guide to discuss the study's limitations.

In the conceptual dimension, the theoretical basis of the phenomenon under study, its relationship to health and the discipline of nursing is assessed. Voluntary relocation for the elderly who moved from their own homes into hostels for the aged was thought to be a stressful event. The stress is an added burden to the physical and sometimes mental infirmities from which these elderly people often suffer. The key participants identified activities

surrounding relocation, that is, decision making, selling home, discarding or selling possessions and, in some instances, moving away from support persons as particularly stressful occurrences. It is therefore possible, that the stress of relocation could lead to a further deterioration of health status and this would impede the individual's ability to adjust to his/her new lifestyle. During the pre-relocation period, community health nurses are often involved in the care of these elderly in their own homes, helping to assess their readiness and suitability to relocate, assisting with decision making and supporting significant others. Following relocation, the registered nurse in charge of the hostel is responsible for helping the relocatee to adapt to his/her new environment, and at the same time helping to maintain his/her health status and well being. Relocation was clearly identified as a health related concept and within the study the possible consequences of relocation have been demonstrated to be a significant area of nursing practice for those nurses working with the elderly, both in the community and in institutions.

Theoretical support for the researcher's initial perspective is found in the literature review which traces the developing knowledge on relocation and the elderly over the past thirty years. Initially, it was recognised as a discrete but stressful event. The stress accompanying relocation, resulted in increased morbidity and mortality rates in the post relocation period, being demonstrated by some research studies. Other studies showed no change or a decrease in morbidity and mortality rates in the post relocation period. The conflicting results occurred because of the different methods of data collection and data processing used by the various researchers (Coffman, 1981). Events surrounding relocation became a source of interest to researchers during the late sixties and seventies. They focused attention on decision making in the pre-relocation period and on the adaptation of the elderly to their new environment in the post relocation period. Knowledge generated in these areas has enabled researchers in the eighties to develop research studies which investigate ways to minimise the negative effects of the post relocation period for the elderly residents.

In the conceptual dimension the standard of clarity is concerned with the phenomemon under study and the research question - are both these concepts clearly stated? Is the research question phrased as an interrogative statement? The concept of relocation and the elderly and the rationale for carrying out research with elderly participants who relocated to an aged-care hostel was discussed in Chapter 1. A literature review on the topic carried out for the research proposal indicated that there were still significant knowledge gaps surrounding relocation and the elderly and for that reason it was decided to explore relocation and the elderly using qualitative research methodology. The research question was formulated to investigate the meaning of relocation from the participant's viewpoint. It was expressed as an interrogative statement, and read, "What is the meaning of relocation for the aged person as he/she moves from his/her own home to become a permanent resident in a hostel?"

The standard of integration in the conceptual domain examines the relationships between the phenomenon, the frame of reference and the research question. The rationale for the research question is clearly stated in Chapter 3. There was little known about events in the immediate pre-relocation period or the ways in which the elderly adjusted to their new environment. The research question develops logically from the literature review and the personal and professional experience of relocation.

In the ethical dimension, the scientific merit of the study and the protection of the participants rights are evaluated.

From analysis of data collected during the study, there emerged three themes, each with sub-themes. These themes were related to the process of relocation as experienced by the key participants. The study also highlighted some aspects of the realities of nursing practice within the two hostels. The nurses spent a good deal of their day carrying out technical procedures and had little time for individual interaction with residents. There was a lack of knowledge of the residents' psychological needs and this prevented

some therapeutic interventions from being utilised in nursing practice.

Guidelines for the protection of participants rights are discussed fully in Chapters 3 and 4. Selection of prospective participants was made initially with the help of the nursing staff in the hostels. The researcher was introduced to potential key participants by the nurses. Participation in the study was requested after assurances regarding anonymity, confidentiality, the right to withdraw from the study at any time and the need to obtain permission to record interviews had been given. These are evident on the consent form which was used by the professionals and the key participants relatives (see Appendix B). The elderly key participants were offered the alternative of recording their consent on a separate tape prior to each interview and they all preferred this method.

The researcher also has an ethical responsibility to ensure accurate interpretation of the data. In ethnography, data collection and data analysis occur concurrently. Data are sorted and coded in order to identify the emerging patterns or themes. Verification and expansion of the themes with the key particpants occurred at subsequent interviews. When the research findings were documented the emerging themes were supported by using direct quotations from the key participants descriptions of the phenomenon so that readers can clearly identify the similarity between the themes and the descriptions.

In the methodological dimension, the area examined is whether or not the data obtained are adequate to answer the research question. If a descriptive analysis of a specific culture or subculture, that is, new relocatees, is required then ethnography is an appropriate method to use (Germain in Munhall and Oiler, 1986). Interviews with key participants in the study and periods of participant observation of the subculture are the two major methods of data collection used by ethnographers. Six elderly people, three residents from two different hostels were key participants in the study. The number of key participants was limited, partly because

of the small number of admissions to the hostels during the time frame for data collection and partly because some relocatees were unwilling to participate or not considered suitable due to their short term memory loss. It is likely that a larger sample of key participants would have provided material to strengthen and augment the emerging themes. The data gathering process of three serial interviews at approximately three month intervals with each of the six key participants provided detailed information on the relocation process and their subsequent adjustment to hostel life. The nine month time frame appeared adequate for all the key participants. They identified that they had adapted to hostel life during this period although one resident showed features of poor adaptation.

In ethnography the process of data collection and data analysis occur concurrently. Qualitative content analysis, the method used for data analysis, is the method used by ethnographers to analyse data. Content from all data sources was logically analysed in order to inductively derive the emerging patterns and themes (Germain, 1986). These major themes and their sub-themes were subsequently verifed with the key participants. From these themes, a portrait of the key participants, the context in which they experienced relocation and the development of a new lifestyle in the hostel emerged.

The method of content analysis is explained briefly in Chapter 3. This area could have been further strengthened with examples from the data collection. However, the subject is discussed in more detail in Chapter 5 and the emerging themes are illustrated by the descriptive data of the participants.

In the interpretive dimension, the implications of the study's findings for theory, practice and further research are evaluated. The meaning of relocation for the six key participants emerged as a process which related closely to the models on transition developed by Bridges (1980) and Chick and Meleis (1986). If the relocation process is conceptualised as a transition, using either of these

models then the nurses role can be defined more clearly in each of the three phases. Links between the research findings, theory and practice are apparent.

Other implications of the study's findings for nursing practice demonstrated the need for registered nurses to further develop their knowledge and skills on the psycho-social needs of the elderly and on specific interventions which can be used to help the residents cope with the ageing process. These implications relate in part to the new residents and in part to the management of all the frail elderly within the aged-care hostel.

Implication of the findings for further research include more investigation of the adjustment process, development of knowledge of the needs of the invisible residents and determining the meaning of relocation for individuals who are admitted for respite care and also the meaning of this concept for their primary carers.

The research findings were able to be incorporated into existing theoretical models. The scope of the study could be further extended by a more detailed investigation of the **"invisible residents"**. The implications of the study for nursing practice were highlighted and new strategies which could be employed by nurses were recommended.

7.7 Data Collection - The Researcher's Experiences

The use of the ethnographic method to discover the meaning of relocation for the six key participants, as they moved from their own homes to aged care hostels, proved to be an enlightening and enjoyable experience for the researcher. The key participants willingly provided detailed data about their experiences during relocation and adjustment to hostel life. During the interviews, the narrative would often stray from answering the question to

descriptions of people the key participants had previously known and events which had occurred earlier in their lives. These stories often proved so fascinating and so informative about Tasmania in previous years, that the researcher often had difficulty asking the participants to return to the topic of relocation.

All the key participants prepared themselves well for the interview. Appointments made one week in advance were never forgotten and these elderly men and women were always ready to tell their stories. In fact it was often difficult to persuade them to wait until the tape recorder had been switched on.

Several times after the interview had been terminated and the tape recorder detached from the power point, the participants provided potentially useful data during informal conversation. It was not easy to make a written record at the time or to recall their words with complete accuracy later. The researcher learned from experience to reassemble the tape recorder quickly and record the "after-thoughts".

The ability of this elderly group to recall recent events in detail often astonished the researcher. In many instances, the accuracy of this information was verified by the professionals or the key participants significant others. The researcher had endeavoured to prepare herself for interviews during which the elderly became distressed when asked about the events surrounding relocation. However, with the exception of one key participant, they were all able to discuss relocation in an objective manner which resulted in non stressful and enjoyable experiences.

Omery (1988), notes that "ethnography is often lonely". This was not the experience of the researcher. The elderly participants were very concerned for her welfare. She was offered morning and afternoon tea, as appropriate, by them and one very active eighty-two year old insisted on carrying her equipment to and from the car. As a result of the help and co-operation of this elderly group

of hostel residents, the data collection proceeded very smoothly and was an immensely rewarding occupation.

7.8 Summary

In this chapter the implications of the research study for nursing theory practice and research as well as the study's limitations have been discussed.

7.9 Review of Study

In Chapter 1, the topic of relocation and the elderly was introduced. The researcher's perspective that relocation is a potentially stressful experience was outlined. The aim of the research, to investigate relocation from a qualitative perspective using the ethnographic method, is described.

The literature associated with relocation and the elderly is reviewed in Chapter 2. Research studies concerned with relocation had occurred over the past thirty years and results were conflicting. Research in the 1960's focused on enforced relocation, when the elderly were moved from one institution to another, or from one area to another in the same institution. Some studies demonstrated an association between relocation and increased morbidity and mortality rates, others showed an association between relocation and decreased morbidity and mortality rates, whist some studies showed no change in the rates from the pre-relocation period. During the 1970's, emphasis was placed on relocation as a process and not a discrete occurrence. Events in the pre-relocation period and post relocation adjustment were studied. In the 1980's the literature was concerned with identifying ways to help the elderly and their families cope with relocation.

In Chapter 3 the formulation of the research question **"What is the meaning of relocation for the aged person as he/she moves from his/her own home to become a permanent resident in a hostel?"** is described. The rationale for the use of ethnography as a research method to guide the study is outlined. Data collection and data analysis in ethnography and ways to protect the participants rights are discussed.

The data collection process is outlined in Chapter 4. Interviews with the six key participants, their significant others, other hostel residents, and professionals involved in the relocation process, as well as periods of participant observation in the two hostels used in the study were the main sources of data. Brief descriptions of the two hostels used in the study are included in Chapter 4.

In Chapter 5 the processes of data recording and data analysis are described. Content analysis was employed to inductively identify recurrent words, phrases or segments of prose. These were then categorised into themes and sub-themes. Three major themes each with sub-themes emerged. The theme **"PREPARING FOR RELOCATION"** included the sub-themes **"early decisions"** and **"immediate plans".** The theme **"ADAPTING TO A NEW ENVIRONMENT"** included the sub-themes **"first impressions", "staff's expectations"** and **"new resident's perceptions of their surroundings".** The third theme **"A RESIDENT'S LIFESTYLE"** included the sub-themes **"continuing the old"** and **"invisible residents".**

In Chapter 6, there is a discussion of the research findings. The findings indicated that for the key participants the most stressful part of the relocation process were the events prior to the admission to the hostel when decisions had to be made regarding the choice of hostel, disposal of home and possessions and the right time to relocate. During this time, the key participants were supported by the professionals and significant others. Fitting into the hostel was a relatively easy process for five out of six key participants and integration of old and new lifestyles occurred smoothly and rapidly.

The implications of the study for theory practice and research and its limitations are discussed in Chapter 7. The three themes which emerged from the data during the relocation process related closely to the process model on transitions by Bridges (1980) and that of Chick and Meleis (1986). When the three themes of the relocation process are considered separately then the different features of the nurses' role during each period is apparent.

Implications of the study for nursing practice includes the development of skills by the qualified nurses to provide a more therapeutic environment for the elderly during the adjustment and post adjustment periods.

Further research during the adjustment period is recommended. During this study the elderly's coping mechanism during the adjustment period remained hidden to the researcher. Research regarding the needs of the respite care clients and their families is also suggested. Limitations of the study include the small number of key participants. A larger cohort would have augmented and enriched the data base.

7.10 Conclusion

The aim of the study was to uncover the meaning of relocation as experienced by six elderly key participants who relocated from their own homes to two hostels for the aged. Ethnography was the research method chosen to guide the study. Data collection consisted of three serial interviews at three monthly intervals with six elderly key participants who had recently relocated to one of the two hostels. Professionals connected with the relocation process, other hostel residents and the key participants significant others were also interviewed. Data collection also included periods of participant observation in both hostels.

Analysis of the data revealed three major themes. **"PREPARING FOR RELOCATION"** which included the sub-themes **"future and immediate plans".** The second major theme **"FITTING INTO THE HOSTEL ENVIRONMENT"** included three sub-themes **"first impressions", "staff expectations"** and **"the new resident's perceptions of his/her surroundings".** The third major theme included **"LEADING THE LIFE I LIVED"** or **"A RESIDENT'S LIFESTYLE"** included the sub-themes **"continuing the old"** and **"the invisible residents".**

Implications of the study for theory indicated the process of relocation related closely to the transition models of Bridges (1980) and Chick and Meleis (1986). These models were utilised to define features of the nurses role more clearly at each stage of the process. Implications of the study for nursing practice included further development of nursing skills which can be used during the post relocation periods. The needs of temporary residents who relocate for short periods of respite care and their families were recognised as areas of further research. Limitations of the study included the small number of elderly who were suitable and willing to be key participants in the study, a larger cohort would have provided a richer data base.

Relocation for five out of the six key participants was a relatively smooth process. They made their own decisions regarding choice of venue, disposal of possessions and timing of relocation. With one exception the key participants were well supported by significant others. All key participants were well supported during this early phase by the G.A.T. members. The preparatory period was stressful but adjusting to the hostel environment and integrating old and new lifestyles was proceeded with little trauma for five our of six of the key participants. One key participant preferred to continue many aspects of her former lifestyle and did not attempt to integrate the "old" and the "new". The key participants described the hostel staff as the key people who helped them to adjust to their new life as residents. Hostel staff demonstrated a positive attitude towards new residents adapting to their environment and

facilitated self-care thus helping new residents to maintain independence and self-esteem.

Relocation has the potential to be a stressful series of events and frail elderly people who relocated to a hostel were initially thought to be a vulnerable group whose health status was likely to deteriorate as a result of the process. However these frail elderly people were able to cope well with relocation though they had good support from professionals and significant others. Old and new lifestyles were integrated and a portrait of the hostel resident emerged.

RESEARCH OFFICE
MASSEY UNIVERSITY
PALMERSTON NORTH
NEW ZEALAND

20 February 1989

Ms J M White
Nursing Studies Department

Dear Ms White,

Research Proposal "The meaning of relocation for elderly people moving from home to a nursing home"

At a recent meeting of the Human Ethics Committee approval was given for the above proposal as outlined.

The committee also noted the issues of confidentiality have been addressed and that you will comply with professional standards as well as the ethical guidelines of Massey University.

Yours faithfully,

Ivan Snook

Professor Ivan Snook
Chairman
Human Ethics Committee

63) 69-079, 69-089, 69-099 Datex: NZ 30974, Mas Uni Facsimile: 505601

APPENDIX B

CONSENT FORM

Massey University - Department of Nursing Studies

1. TITLE:

The meaning of relocation for elderly people moving from home to a nursing home.

2. INVESTIGATOR:

Joan M. White
Masterate Student
Department of Nursing Studies
Massey University
New Zealand

3. VENUE:

4. AIM OF STUDY:

The primary aim is to describe the meaning of relocation for the elderly people who move into a nursing home.

5. YOUR INVOLVEMENT IN THE STUDY:

If you agree to take part in the study you will be asked to participate in an interview with the researcher, where the focus would be on describing the meaning of relocation for you or your relative or the new resident (delete as appropriate).

You will be asked to have the interview tape recorded or recorded in writing.

6. REQUIREMENTS OF THE STUDY:

The success of this study requires a willingness on your part to share with the investigator both your time and thoughts about relocation.

CONSENT FORM

7. STATEMENT BY PARTICIPANT:

I have read the above and have had all questions answered to my satisfaction.

I understand this study has been approved by Massey University Ethics Committee and the Nursing Home Board and that I may withdraw agreement at any time. I understand that complete confidentiality and anonymity is guaranteed. I understand that any information I provide or any observations of my behaviour will be used for research purposes only and will not be communicated to anyone in a way that would identify me personally. I further understand that opportunity to discuss the findings of the study will be provided by the investigator. I agree to take part in this study. I agree to have the interviews tape recorded/recorded in writing.

Signature of Staff Member .....

Signature of Relative .....

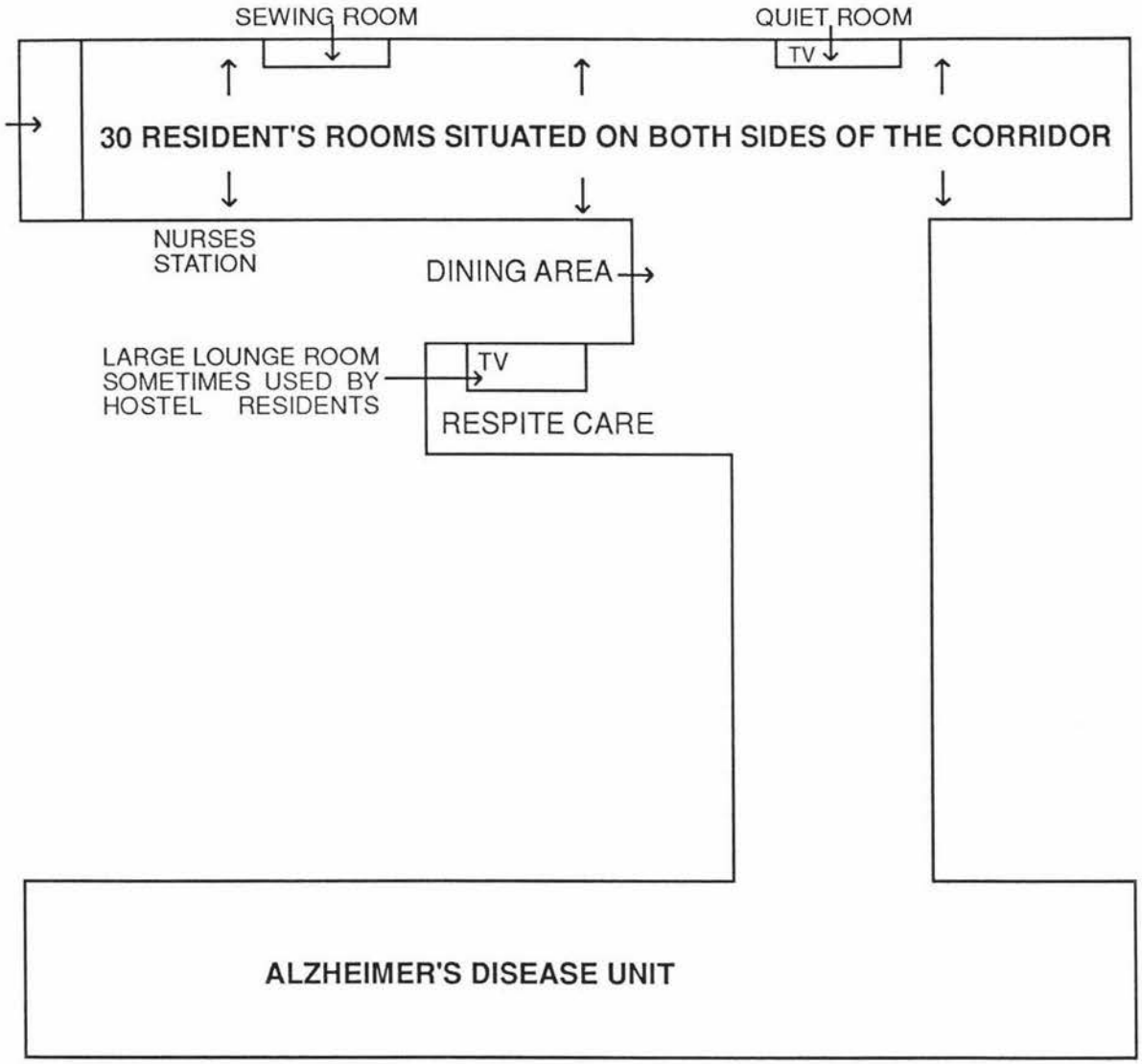
Date .....

Signature of Investigator .....

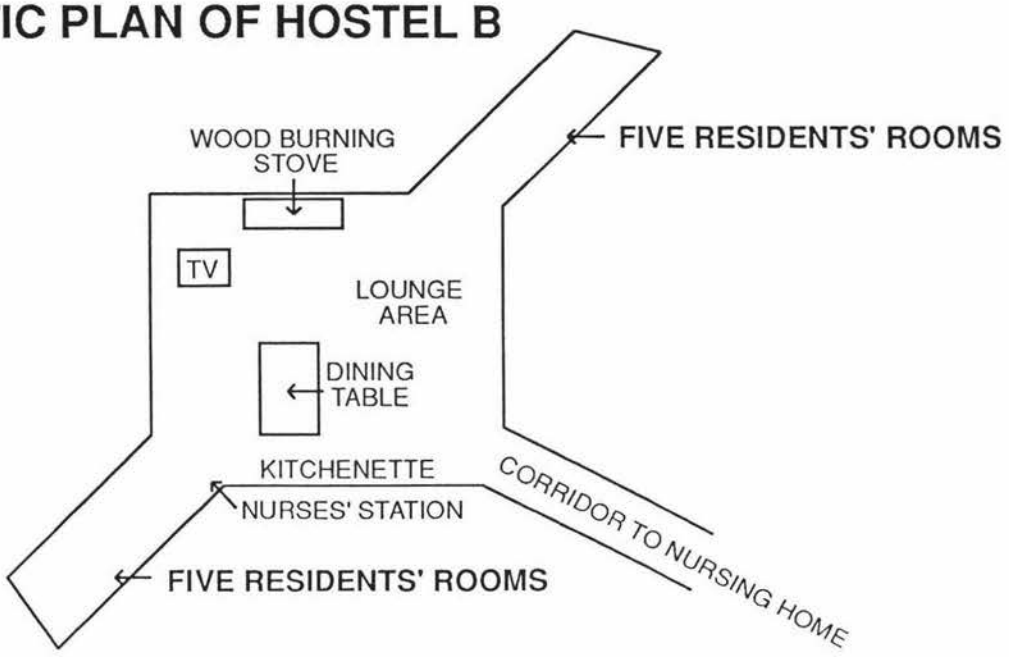
Date .....

APPENDIX C

AMMATIC PLAN OF HOSTEL A



AMMATIC PLAN OF HOSTEL B



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