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## The lived experience of the aged care nurse

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THE LIVED EXPERIENCE  
OF THE  
AGED CARE NURSE

BY

Christine Martin, R.N., B.A (UWA).

A Thesis Submitted in Partial Fulfilment of the Requirements  
for the Award of Master of Nursing  
at the School of Nursing, Edith Cowan University

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## **Abstract**

### **THE LIVED EXPERIENCE OF THE AGED CARE NURSE**

The purpose of this phenomenological study was to describe and interpret the common, shared meanings of the experience of aged care nursing from the perspective of the registered nurse working in a nursing home. There are insufficient registered nurses being attracted into aged care, with resulting difficulties in maintaining regular staffing levels in nursing homes. Previous studies conducted in Australia have predominantly used quantitative research methods to investigate various influences on the recruitment and retention of aged care nurses. These studies do not take into account the practitioners' perceptions of their experience of aged care nursing.

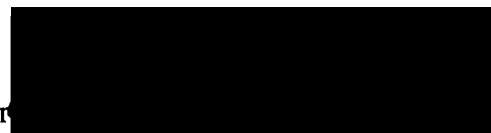
A purposive sample of 15 registered nurses was interviewed and the resulting data were analysed using phenomenology to identify thematic structures of the experience of aged care nursing. The NUD•IST qualitative data analysis software package was used as an analysis tool. Significant statements were coded, patterns and relations between categories were identified and the categories were clustered into conceptual, hierarchical themes. Four major themes emerged as being central to the experience of aged care nursing - Gratification, Rapport, Non-productivity and Conflict. While constraints and obstacles to productivity and personal and political conflict may be seen as the negative aspects of aged care, these experiences were relieved by uplifting events described within the framework of resident care and rapport, and collegial support. The nature of aged care nursing is both complex and ambiguous but nurses have readily identified the interwoven threads of the experience.

Findings from this study will increase the depth of understanding of aged care nursing and hence contribute to the development of a nursing home environment which enriches the experience of both nurse and resident.

### Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signature



Date:

20 Feb '97

## **Acknowledgments**

To the registered nurses who gave me their precious time and shared their experiences with me, my sincere thanks.

To my principal supervisor, Andrew Yung, I express my deep appreciation for his constant encouragement, expertise and quest for excellence. My thanks also to Christine Ng for her innovative guidance and to Patricia Percival for her enthusiasm early on.

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## **CHAPTER ONE**

### **Introduction**

#### **Background**

The structure of the aged population is an important indicator of changing levels of need for aged care services, including nursing home care (Australian Institute of Health & Welfare, 1993). In Australia, the proportion of people aged 80 and over is increasing at a substantially more rapid rate than the rest of the aged population (Mathur, 1996). Some of the issues associated with population aging, such as demand for health services and residential care for the frail, are cause for concern. The number of people aged 85 and over is expected to increase 61% between 1991 and 2001 (Hugo, 1992), and it is this group who have the highest nursing home residency rate. Perhaps more significant for aged care nurses, the number of people with dementia is expected to rise 93% between 1989 and 2011 (Jorm & Henderson, 1993).

The principal role of nursing homes is to care for those members of the aged population who have chronic, long-term problems, and nursing is by far the largest occupational group within the health care workforce (Commonwealth Department of Human Services and Health, 1994). Continuing problems with institutional care for aged people relate to difficulties in both recruiting and retaining qualified nurses (Palmer & Short, 1989).

In the US, it is estimated that an extra 85 000 to 100 000 nurses will be needed to meet growth in aged care nursing (McMinn, 1996) and while Australian

projections of the number of aged care nurses needed by the year 2000 are not available, there is a general shortage of nurses predicted to hit in the year 2001. This position is expected to worsen as there is currently a shortfall in the number of available university places being filled by nursing students (Attrill, 1996). It was anticipated that the decision to transfer pre-registration nursing from hospitals to higher education institutions would provide nurses with a better foundation for adjusting to the changing health care delivery system and enhance the status of nursing (National Health Strategy, 1991). This does not appear to be the case however for aged care nursing. Stevens and Crouch (1995) investigated five NSW schools of nursing and found that over the first two years of the undergraduate nursing course there was a significant decline in students' desire to work in aged care.

Many nurses have a distorted and overly negative view of aged people and aged care nursing (Heliker, Brophy & Naughton-Walsh, 1993; Lookinland & Anson, 1995; McCann, 1988; Timko & Moos, 1991). Short (1985) found that a combination of dissatisfaction with working conditions and failure by managers to provide work satisfaction elements such as recognition and achievement has resulted in high turnover rates and apparent shortages of nurses. More specifically, difficulties in attracting nurses to work in nursing homes has been found to be related to work satisfaction (Jones, Bonito, Gower & Williams, 1987), the heavy nature of the work (Smith, 1992) and low status (Purseley & Luker, 1995). The belief that aged care nursing is undesirable as a career choice is ill-considered in the face of increasing demand for services.

### Significance of the Study

Although there has been considerable research into nurses' attitudes to aged care, their reasons for working or not working in long-term care facilities, the incidence of burn-out, and various aspects of "caring" in the nursing home environment, there are few studies which address the more basic question of what it is like to be an aged care nurse. With the impending shortage of nurses in Australia, and the reluctance of newly graduated nurses to take up aged care, it is apparent that the increase in demand for aged care services will not be met. Nurses in this area of nursing are in a unique position to describe their experience of aged care nursing, but have had limited opportunities to do so. Qualitative research, in particular phenomenology, is especially relevant to aged care nurses because it offers a "new way to interpret an individual's involvement in the world" (Beck, 1994a).

The aim of this study is to interpret and describe the meaning of the lived experience of registered nurses working with the aged in nursing homes. Recognising and understanding the essential nature of aged care nursing will enable better resident care and increased productivity. Greater insight into the experience of aged care nursing may also contribute to the development of new strategies for attracting nurses into this area of work. Given the implications for nursing of our aging population, there is a need for research that elaborates, describes and explains nurses' experience of caring for the elderly in the nursing home environment.

### Purpose of the Study

The purpose of this study is to explore the meaning of the lived experience of aged care nursing, from the perspective of registered nurses practicing in nursing homes. The description and interpretation of the shared meanings of gerontological nursing will enhance understanding of practicing nurses' experiences in caring for aged nursing home residents, and stimulate further research in this area.

### Objectives of the Study

1. To identify and interpret the shared meaning of aged care nursing as practised in a nursing home.
2. To describe the lived experience of aged care nurses, working in a nursing home.
3. To broaden the growing body of knowledge related to aged care nurses and nursing.
4. To use this information for further research and recommendations.

### Definition of Terms

**Nurse/aged care nurse:** any registered nurse licensed with the Nurses Board of Western Australia, practicing clinical nursing in a nursing home.

**Resident Classification Instrument (RCI):** the document used to determine the level of care required by a nursing home resident, and hence the government funding for which the nursing home is eligible. Residents are assessed annually using a series of items concerning self-care, mobility, behaviour and communication. Possible resident scores range from RCI 1 (high) to RCI 5 (low).

**Resident Outcome Standards:** a prescriptive set of 31 nursing home standards which stipulate the obligation of nursing homes towards their residents under common or civil law (Macdonald & Bates, 1989).



**Standards Monitoring Team (SMT):** a team which visits nursing homes at least annually and reviews the quality of care received by residents in terms of the Resident Outcome Standards. It has the potential to apply substantial sanctions (including withdrawal of Commonwealth benefits) where homes persistently fail to meet the required standards (Australian Institute of Health & Welfare, 1993).

### Assumptions Underlying the Study

The phenomenological method as purported by Husserl (1962) is approaching the phenomenon, through the process of bracketing, with no preconceived expectations or assumptions which may impose the researcher's personal and theoretic bias on the generation and analysis of data. Crotty (1996, p. 20) describes bracketing as "a sincere endeavour not to allow one's beliefs and assumptions to shape the data collection process and a persistent effort not to impose one's own understandings and constructions on the data". Beliefs, biases, assumptions, presuppositions, and theories about aged care nursing were explicated and set aside by the researcher (see Appendix A). The assumptions underlying this study therefore, are as follows:

- Aged care nursing is physically hard work and emotionally draining.
- Aged care is frequently a last resort for nurses who have not kept up with further education, are older and under-confident in their abilities.
- Humour and relationships with colleagues are what keeps aged care nurses going.
- Aged care nursing attracts people who are giving, patient and self-sacrificing by nature.

- Aged care nursing does not enjoy an equal status to nursing in the acute sector.
- Working in aged care requires a narrower knowledge base and less technical know-how than acute care.

### **Structure of the Thesis**

Chapter one introduces research topic and provides the contextual background for the study. The lack of research into the practice of aged care nursing in the nursing home setting, and how that impacts on recruitment will be discussed. The objectives of the study are stated and the significance and purpose of the study explained.

Chapter two provides a critical review of the published literature relating to the practice of aged care nursing in the nursing home setting. The strengths and weaknesses of prior research are reviewed and conclusions drawn concerning what still needs to be investigated, and the most appropriate research methods.

The third chapter describes the research method. It includes design, sample and setting, the profile of the informants, bracketing and in-depth interviews, strategies for validating meanings, ethical issues and the methods of data collection and analysis.

Chapter four describes the phenomenological approach utilised for data analysis and presents the findings which emerged together with an exhaustive description of the core themes.

The last chapter includes a discussion of the findings and a conceptual framework related to the experience of the aged care nurse. The implications of the study are then considered and recommendations and suggestions for further research proposed.

## **CHAPTER TWO**

### **Literature Review**

#### **Introduction**

According to Streubert & Carpenter (1995) the review of literature should follow data analysis in order that a pure description of the phenomenon is more likely to be achieved, and that researcher bias is less likely. Burns & Grove (1987) take a similar approach by stating that the literature should not be reviewed until after data collection. In this way, the information in the literature will not influence the researcher's objectivity, and the description of the phenomenon will include only what is seen in the real situation and not what is read in the literature.

Patton (1990), however, argues that a review of relevant literature helps focus the study and assists in finding out how others have approached similar concerns. This view is supported by Field & Morse (1990) who point out the obvious disadvantage of researchers "reinventing the wheel" or rediscovering previous research.

In this study, a brief literature review was carried out prior to data collection in order to place the study within the context of gerontological nursing and to examine the current literature on the experience of the gerontological nurse. Subsequent to data collection and analysis, a further, more extensive literature review was considered. The review concentrated on particular aspects of the experience of gerontological nursing - nurses attitudes to the aged, resident care

factors, characteristics of the aged care nurse, and choosing aged care.

Understanding the lived experience of aged care nurses requires an overall view of their experience.

### **Attitudes.**

Nurses' attitudes towards elderly people have been the subject of extensive research over the past few years. A considerable number of those studies suggest that nurses hold negative attitudes towards gerontological nursing and other work with the elderly (DeWitt, 1988; Gomez, Blattstein & Gomez, 1985; Haight, Christ & Dias, 1994; Heliker et al., 1993; Lookinland & Anson, 1995; Melanson & Downe-Wambolt, 1985; Palmer & Short, 1989; Palmore, 1980; Philipose, Tate & Jacobs, 1991). Three of the most pervasive aspects of stereotype of aging are that older people are physically incapable, mentally incapable and intellectually frail (Palmore, 1990; Wright, 1988).

Several studies have identified factors that influence nurses' attitudes towards elderly people. Contradictory findings have been reported on the correlation of age of nurses and their attitudes. Older nurses were found by Wright (1988) to have more favourable attitudes towards the elderly and Oglesby (1992) found that there was a positive correlation between the age of the student nurse and their willingness to work with the elderly patient. Haight et al., (1994), in a longitudinal study of the effect on ageism in students of a three year curriculum, found that age had a linear effect since attitudes improved as age increased up to age 40. McCabe (1989), however, reported the reverse; that older nursing personnel held negative attitudes towards old people.

In studies by Adelman, Fields and Jutagir (1991) and Slevin (1991) it was found that among nurses in Northern Ireland, male nurses were more likely to express negative, stereotypical responses towards elderly people than female nurses. Contrary to Slevin's findings, gender had neither a positive nor a negative impact on attitudes in studies of student nurses in the USA (Lookinland & Anson, 1995). These contradictory results may reflect the different methodologies used in the studies rather than a cultural difference in attitudes.

Nurses' attitudes towards work with the elderly no doubt reflect widespread negative stereotype of old age in society generally (Gibb, 1990). However, research on the effects of professional education on nurses' attitudes (Langland et al, 1986; Salmon 1993; Snape, 1986; Wright, 1988), found that educational interventions had beneficial effects on attitudes. Haight, Christ and Dias (1994, p. 389) concluded that "nursing education promotes more positive feelings towards older people." Other researchers reported no differences (Giardina-Roche & Black, 1990; Greenhill & Baker, 1986). Australian research carried out by Stevens & Crouch (1995) which surveyed a cohort of students in five schools of nursing over a three year period found that student nurses' attitudes in relation to working with the elderly do not improve during the course of their nursing education. Forty-nine percent of third year students held negative views of the elderly. Typical responses were that they found aged care nursing "slow", "not technical enough", "a slave's job" and "too taxing on one's patience." Another survey of registered nurses in rural Western Australia found "sufficient evidence from both the registered nurses' and consumers' interviews to confirm that negative

attitudes and stereotyping of the elderly have detrimental effects on the quality of care of the elderly” (Orb & Davey, 1994, p. 63).

### **Resident Care Factors**

Literature suggests that misconceptions and negative attitudes towards older patients has prejudiced the quality of the relationship between the elderly and the profession (Brown, 1988; Orb & Davey, 1994; Small, 1991; Wright, 1988). Koch, Webb and Williams (1995), in a phenomenological study of older patients’ views about their nursing care, identified strongly negative experiences couched in terms of loss; namely loss of self identity, autonomy, power, privacy, control and space. Discussion of the data with the staff working with the informants revealed that they were fully aware of the limitations of the care they were giving, but felt that they worked extremely hard and that, within the resource constraints existing, did the best job they could. Bradshaw (1995, p. 89) states that “patients want nurses to treat them with kindness, sympathy, comfort and communication alongside competent, scientific medical knowledge, technical excellence and skilled efficiency.”

Wurzbach (1996), in her descriptive, qualitative study of the concept of comfort and nurses’ moral choices, describes the primary roles assumed by long-term-care nurses as being those of communicator and mediator. The participants in her study faced “moral discomfort” when they believed they had not done as the good nurse would, when futile treatment was ordered, when they felt they had to try to influence a resident to change a decision, or when they were in situations where there was nothing they could do for the resident. Negative feelings in

clinical practice have been found by White (1996) in his repertory grid analysis of nurses' feelings towards clinical practice, to be generated from the situations in which nurses were not able to deliver the kind of care they felt was the most appropriate and best for the client. However, the findings of this study, which involved nurses working in acute care, may not translate to nurses in the aged care sector. White states:

This idea of the graduate nurse experiencing undue negative feelings may be in part an explanation of why many leave the acute hospital sector and seek out employment in areas where they have more autonomy, such as . . . care of the older adult. (p.148)

Many of the participants in a phenomenological study conducted by Milne and McWilliam (1996) related "struggle with time" experiences. As a nursing resource, time was perceived by some as being a quantifiable commodity and others as qualitatively experienced moments between nurse and patient. Milne and McWilliam warned that the omission of "caring time" from the allocation of nursing resource constitutes a serious threat to the profession of nursing and the patient's experience of care.

Lack of spiritual nursing care is often attributed to time constraints (Sodestrom & Martinson, 1987). In her phenomenological study of Christian patients' views of spiritual care, Conco (1995) found that, based on the described experiences of participants, taking time, active listening, being available, doing, sharing self, and showing acceptance and understanding were all valued, and were perceived as spiritual care in a variety of nurse/patient encounters.

Another aspect of the experience of aged care nursing is "emotional labouring." This has been defined as any labour involved in dealing with people's

feelings (James, 1989). In his consideration of emotional labour, Phillips (1996) suggests that the cost to the provider of emotional labour has been overlooked and that burnout, a psychological disorder disproportionately experienced by nurses, is one consequence of this oversight. Duquette, Kerouac, Sandhu and Beaudet (1994) performed a literature review of the existing empirical knowledge regarding factors related to burnout in nurses and found the best correlates to be role ambiguity, workload, age, hardiness, active coping, and social support.

### **Characteristics**

Chow (1994), in a triangulated study using both qualitative and quantitative approaches, found that an important factor which steers nurse practitioners towards any particular branch of nursing may be their personality characteristics and their attitudes. Her study found several perceived desired personality traits of gerontological nurses including acceptance, flexibility, respectfulness, consideration, tolerance, patience, tenacity, conscientiousness, sociability, sense of humour, warmth and empathy. Lookinland and Anson (1995), in a comparative-descriptive-correlational study, found that attitudes towards elderly people among registered nurses were affected by nurses' ethnicity. White nurses held more favourable attitudes than did black and Asian nurses. However, these studies were carried out in Singapore and the USA respectively, and findings may not be valid when applied to gerontological nurses in the Australian culture.

Personal considerations of communication, listening, advocacy, teamwork and knowing were indicated as being significant in a study of the critical aspects of nursing in aged and extended care undertaken by Pincombe, O'Brien, Cheek



and Ballantyne (1996). The study, using the critical incident technique, was conducted in a large Australian extended care facility with a population of 700 clients including those presenting with a range of degenerative and traumatically acquired neurological conditions. This environment is dissimilar from that experienced by nurses in smaller nursing homes, the majority of whose residents are frail aged, so it may be inappropriate to generalise this study to aged care nursing.

The need for nurses to have a sound professional identity and a high level of self-esteem and self-confidence in order to enact an advocacy role was found by Snowball (1996) to be important. Other personality characteristics of nurses that have been described in nursing literature as having a positive impact on clients' health-related behaviour are optimism (Stubblefield, 1995), vitality (Hover-Kramer, Mabbett & Shames, 1996) and, in dementia care, maternal thinking (Haggstrom & Norberg, 1996). Droppleman (1996) contends that nurses' anger can be channelled to empower and enrich them and the future of the nursing profession.

### **Nursing care**

The meaning of the concept of "caring" in nursing has been studied by Watson (1979) and Leininger (1981) who approached the phenomenon from a definitional angle utilising lists and taxonomies. Benner (1984) and Benner and Wrubel (1988) focused on the meaning and intuitive values of nursing care in order to enlarge our understanding of this concept. A phenomenological study of caring in nursing practice (Clarke & Wheeler, 1992) highlighted the importance

of caring from the perspective of the “giver” of care. They argued that, through gaining perspectives to enhance our understanding of the meaning of care, it will ultimately develop our understanding of nursing itself.

There is a distinction between “basic” nursing care, associated with the physical needs of the patient, and “technical” nursing care, determined by the disease process and medical interventions (Lawler, 1991). It is basic nursing care that can be seen as the essence of aged care nursing. Stevens and Crouch (1995, p. 241) argue that caring consists of “perceptual vigilance, theoretical knowledge of conditions with which one is likely to be confronted in a particular setting, the ability to make decisions regarding appropriate strategies to meet needs and alleviate symptoms, and the capacity to evaluate and modify action.” They describe these attributes as high-level professional capabilities that require intelligence, training and experience for their full development.

Standards of care for older people living in nursing homes in Britain were the subject of a recent study (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1994). It shows that the incidence of abuse and ineffective practice by nurses in nursing homes is greater than from any other area of practice. Britain lacks a universal protocol for standards in nursing home care and relies on individual inspectors to interpret national guidelines. The United States relies heavily on a federal protocol which, listing over 500 requirements, is unwieldy. In Australia, the quality of nursing home care is assessed in terms of 31 outcome oriented criteria (Resident Outcome Standards) in a program of nursing home regulations implemented in 1987 (Standards Monitoring Program). A qualitative study in which the Directors of Nursing of

410 nursing homes in the Brisbane, Sydney, Melbourne and Adelaide metropolitan areas were interviewed, found that the overwhelming majority reported the standards as clear and desirable (Braithwaite, Braithwaite, Gibson & Makkai, 1992). An evaluation of the Standards Monitoring Program in nursing homes, which included international comparisons, placed the Australian program at the forefront of aged care regulatory practices (Braithwaite, Makkai, Braithwaite & Gibson, 1993).

### **Choosing Aged Care**

Chow (1994) suggests that preference to work in a chosen nursing speciality may be influenced by a person's education. Limited numbers of aged care nurses, along with limited numbers of instructors with adequate academic preparation to teach gerontological courses, and increasing numbers of older people requiring nursing care have important implications for nurse educators and health care providers (Timms & Ford, 1994).

Robertson and Cummings' (1991) study describes recognition from patients, families, and friends, role modeling, geriatric education early in nursing school, flexibility of work schedules, autonomy, and exposure to geriatric theories as a few reasons why nurses choose to practice in long-term-care settings. Jones et al., (1987), argue that a relationship exists between work satisfaction and the nursing shortage in nursing homes. They suggest that when seeking employment, it is more difficult to assess the intrinsic requirements a new job will bring, thus nurses turn to extrinsic factors such as flexible hours before accepting an offer of employment.

Findings from one study on why nurses are reluctant to work with the elderly elicited statements that the client has no appeal, is “heavy”, and their responses are “too slow” (Collins & Brown, 1989). Smith (1992) also found that older patients were rated by student nurses as generating a high physical workload and having poor learning potential for students. She suggests that the heavy physical nature of work with older people leaves nurses with little time for considering individuals. Low status was also found to be part of the image of aged care nursing (Pursey & Luker, 1995). In a qualitative study of the expertise required in gerontological nursing, Reed (1994) found the nurses believed the researcher would find the work place “boring” and the work “uninteresting.”

### **Implications**

The present research which examines aspects of aged care nursing is inconclusive and often contradictory. The literature is predominantly concerned with nurses’ attitudes to aged care and has also focused on education in gerontology and its influence on ageism. There has also been a tendency to focus on the experience of nurses in other areas of practice. The Australian Government National Review of Nurse Education in the Higher Education Sector (1994, p. 271) acknowledges that “the Committee was aware that policies on nursing education in higher education need to be sensitive to the range and diversity of the needs which health services must meet.” However, in the chapter titled “Nursing for all Australians” it failed to include aged care in those areas of nursing listed as needing health services - mental health, midwifery, rural and remote, Aboriginal and Torres Strait Islander, multicultural nursing and women’s health.

In Australia, the proportion of people aged 80 and over is increasing and it is this group who are the most intensive users of frail aged services (Mathur, 1996). The recruitment of appropriately qualified aged care nurses to meet workforce needs is a present day imperative. Nursing research which contributes to and expands the knowledge base of aged care nursing itself, is required in the development of strategies to attract registered nurses to that area of practice.

The phenomenological approach to nursing research, with its emphasis on the meaning of lived experience, provides a close fit conceptually with aged care and with the types of questions that emerge from aged care nursing. Beck (1994a, p. 501) suggests that phenomenology and clinical nursing practice parallel each other in a number of ways; there is an emphasis on observing, interviewing and interacting with clients, the use of self as a data collection instrument, the social nature of the research act, and the holistic perspective of human phenomena.

A phenomenological study of aged care nursing which accesses the “real life” experiences of aged care nurses in the Australian culture, will yield new insight and understanding of nurses’ experience of caring for the elderly in the nursing home environment.

### **Summary**

A considerable number of studies suggest that nurses hold negative attitudes towards aged care nursing. This may be a reflection of widespread negative stereotyping of old age in society generally. However, there is conflicting evidence about the benefit of present educational interventions in promoting more positive feelings towards older people. Several studies have identified factors that

correlate with nurses' attitudes towards elderly people. These include age, gender, ethnicity, and education.

Literature suggests that negative attitudes towards older patients has prejudiced the quality of the relationship between the elderly and the nursing profession. Older patients have expressed their experience of nursing care in terms of loss of identity, autonomy, power, privacy, control and space. Other research has indicated that patients want nurses to treat them with kindness, sympathy, comfort and communication alongside competent, scientific medical knowledge, technical excellence and skilled efficiency. Nurses experience negative feelings from situations in which they are not able to deliver the kind of care that is best for the client. Other experiences of aged care nursing include time constraints which prevent them from spending "caring time" with residents, and emotional labouring which may be a factor in nursing burnout.

Desired personality characteristics of gerontological nurses include acceptance, flexibility, respectfulness, consideration, tolerance, sense of humour and empathy. Other characteristics that have been described as having a positive impact on clients' health-related behaviour are optimism, vitality, maternal thinking and, in order to act as patient advocate, a sound professional identity and a high level of self-esteem and self-confidence.

The study of caring in nursing practice has found that there is a distinction between basic nursing care and technical nursing care. It is argued that basic nursing care is the essence of aged care nursing. The elements of caring, theoretical knowledge, decision making and evaluation, require intelligence, training and experience for their full development.

According to recent studies, there are a variety of reasons why nurses choose to practice in long-term-care settings. They include flexibility of work schedules, autonomy, recognition from patients, families and friends, role modeling and exposure to geriatric theories. Reasons why nurses choose not to work in gerontology include the high physical workload, no client appeal, low status and poor learning potential.

The growth of the elderly population and the educational needs of nurses to provide care for that population is an international concern. Much of the research into aspects of aged care nursing in the nursing home setting is conflicting or limited in scope. Australia has an aging population and changing health care needs, with implications for the chronically ill and frail aged who will need quality nursing home care. The time is ripe for further qualitative research into the perceptions, beliefs and characteristics of aged care nurses.

## **CHAPTER THREE**

### **Methodology**

#### **Introduction**

This chapter begins with descriptions of the research design, sample selection and access, the profile of the informants and the development of the demographic data questionnaire and the interview guide. Bracketing, in-depth interviews, the pilot study and the procedure are then discussed. Data collection and computer aided analysis are examined. The last part of the chapter is concerned with credibility, fittingness and auditability, ethical considerations, and a summary.

#### **Design**

Qualitative research was considered the most appropriate research design to answer the question: What is it like to be an aged care nurse? Some of the characteristics of qualitative design listed by Janesick (1994, p. 212) are:

- It is holistic. It looks at the larger picture, the whole picture, and begins with a search for understanding of the whole.
- It refers to the personal, face-to-face, and immediate.
- It is focused on understanding a given social setting, not necessarily on making predictions about that setting.
- It requires the researcher to become the research instrument. This means the researcher must have the ability to observe behaviour and must sharpen the skills necessary for observation and face-to-face interview.
- It incorporates informed consent decisions and is responsive to ethical concerns.



- It incorporates room for description of the role of the researcher as well as description of the researcher's own biases and ideological preference.
- It requires ongoing analyses of the data.

Phenomenological method is inductive and descriptive in its design.

Phenomenology provides a general framework for qualitative research approaches and was chosen for this study because it is ideally suited to evoke, describe and elaborate the experience of aged care nursing for nurses, from their own perspective.

The emphasis in phenomenological research is on the meaning of lived experience. Other people's experiences and reflections on their experiences are "borrowed" so that the researcher will be better able to understand the deeper meaning or significance of an aspect of human experience (Van Manen, 1990).

The focus of phenomenological inquiry, then, is what people experience regarding some phenomena and how they interpret those experiences (Polit & Hungler, 1995).

According to Crotty (1996, pp. 158-159) the phenomenological method involves five steps:

Step 1. Determine as precisely as possible what phenomenon we are focusing on.

Step 2. Consider the phenomenon precisely as phenomenon.

This requires that we:

- lay aside, as far as we can, all ideas, judgments, feelings, assumptions, connotations and associations that normally come into view for us when we think of this phenomenon.
- open ourselves to the phenomenon as the object of our immediate experience.

- Step 3. Describe what has come into view for us.
- Step 4. Ensure the phenomenological character of this description by looking closely at the phenomenological description and asking whether it originates solely in the experience of the phenomenon, or whether it has come from some other source.
- Step 5. Determine the essence of the phenomenon, ie. the element or elements in the phenomenon as phenomenon that make it precisely what it is.

In this study the subject is referred to as the informant or the participant (Field & Morse, 1990). Purposive sampling was used to select participants according to the selection criteria. Data were gathered in semi-structured, face-to-face interviews and the resulting verbatim transcripts were analysed using phenomenology to identify thematic structures of the experience of aged care nursing. The QSR NUD•IST (Non-numerical Unstructured Data Indexing Searching and Theorising) qualitative data analysis software package, developed by Thomas Richards and Lyn Richards (1994) was used as an analysis tool. This computer package is designed to aid researchers in handling non-numerical and unstructured data in qualitative analysis by creating an environment to store and manage a textual and non-textual document database. It enables the user to explore, search, edit and retrieve the text, to write and edit memos about the documents and to create an index database for managing categories.

### **Sample Selection**

The population for the study was that of registered nurses currently practicing clinical nursing in nursing homes. Purposeful sampling was used for the selection of informants. This method of sampling selects participants based on

their particular knowledge of a phenomenon for the purpose of sharing that knowledge (Streubert & Carpenter, 1995). Knowledge of the phenomenon of aged care nursing was affirmed by the selection criterion that required the nurse to have worked in aged care for a minimum of 12 months. Morse (1991b) suggests that a good informant also has the ability to reflect, is articulate, has the time to be interviewed and is willing to participate in the study. These requirements were outlined during the telephone contact with the Directors of Nursing who were asked to discuss the study with appropriate staff members at the nursing home and ask for volunteers. A list was provided for the potential participant to enter his or her name and home telephone number for subsequent contact by the researcher. The registered nurses who volunteered to participate in the study perceived themselves as fitting the selection criteria.

The criterion of adequacy is attained when sufficient data have been collected that saturation occurs (Morse, 1994). In this study the researcher recruited an additional three participants after conducting the original 15 interviews, in order to ensure saturation.

Extreme or deviant case sampling focuses on cases that are rich in information because they are unusual or special in some way (Patton, 1990). Using theoretical sampling, the researcher looks for negative cases to enrich the emergent model and to explain all variations and diverse patterns (Morse, 1994). Theoretical sampling refers to sampling on the basis of concepts that have proven theoretical relevance to the evolving theory (Strauss & Corbin, 1990). In this study's original purposive sample, all participants were Caucasian and female. It was conjectured that a greater understanding of the experience of aged care

nursing would emerge by including a male registered nurse and an Asian registered nurse. Using theoretical sampling, such informants were subsequently approached and enlisted to participate in the study, their names having been taken from the original lists.

### **Access to the Sample**

Telephone contact was made with the Directors of Nursing at eight nursing homes, all of which had a minimum of 60 residents and were in the Perth suburban area. The nursing homes were chosen from the list of licensed nursing homes provided by the Health Department of Western Australia. The research topic was outlined to the Director of Nursing and her cooperation was elicited in recruiting volunteer informants. An assurance was given that the name of the nursing home from which the participant came would not be recorded in the study and a pseudonym would be used for any references made to it in the interview. A letter confirming the arrangements (see Appendix B) was sent by the researcher to the Director of Nursing on the day of the telephone call, enclosing a list for the volunteer informant to provide his or her name and home telephone number. A stamped, addressed envelope for the return of the list to the researcher was provided.

All of the eight nursing homes responded positively to the telephone contact, and five returned the list of volunteer informants. From the lists, 15 registered nurses were contacted by telephone and, following a brief, general outline of the research topic, arrangements were made for the interview. A further

three registered nurses were recruited through the Nurse Manager at one of the nursing homes which did not return the list.

### **Profile of Informants**

The ages of the informants ranged from 27 years to 60 years. Of the 15 informants, 14 were Caucasian and one was Asian; 14 were female and one male. The educational background of the majority (13) comprised a Hospital Based Diploma; only two had a Degree in Nursing. To the question: "Is aged care nursing your area of first preference?" eight of the participants answered "yes" and seven answered "no". Years of practice as an aged care nurse ranged from 2½ to 31 years, with an average of 12 years. Five of the registered nurses were currently in full time work and ten worked part time.

### **Demographic Data Questionnaire and Interview Guide**

A questionnaire for demographic data (see Appendix C) was designed to generate information which was potentially relevant to the analysis of the qualitative data. Questions which may have been seen to be not politically correct, such as marital status, were avoided. None of the informants objected to or refused to answer any of the questions, which included: gender, age, country of birth, first preference, full time or part time, years of practice as aged care nurse and nursing education.

The simple interview guide (see Appendix D) acted as a prompt and consisted of four or five general issues considered central to aged care nursing; for example, how the participant came to work in aged care, the rewards and difficulties, a typical and an atypical shift, the essence of aged care nursing, and

what they saw as keeping them going. Informants were asked to share their thoughts, feelings, perceptions and the circumstances that they associated with aged care nursing. Although interviews should be guided by a tentative interview schedule, the interviewer must identify a proper balance of structure and flexibility. The format, timing and sequence of questions may change as the data collection process continues (Sorrell & Redmond, 1995).

The researcher had identified and articulated (bracketed) her own inherited understandings of the experience of aged care nursing (see Appendix A). Questions which would lead to answers validating the researcher's ideas and beliefs were avoided. The guide allowed for recursively defined questioning and acted as a memory jogger to cover certain concerns. It was also used to prevent the interview going off on a tangent; however, an interrogative style of interviewing was rigorously avoided. One of the most significant aspects of the use of interview schedules in in-depth interviewing is that there is no set of preconceived, structured questions. The asking of questions is in no pre-set or fixed order (Minichiello, Aroni, Timewell & Alexander, 1995). Generally the questions employed in this study flowed from the course of the dialogue and not from a predetermined path, thus providing a more valid explication of the informant's experience of aged care nursing.

### **Bracketing**

Qualitative research is ideologically driven; there is no value-free or bias-free design (Janesick, 1994). In order to identify the data in pure form, free from extraneous judgements, the process of bracketing is carried out (see Appendix A).

Bracketing describes the act of suspending one's various beliefs in the reality of the natural world in order to study the essential structures of the world (Van Manen, 1990, p. 175). According to Crotty (1996) it is an endeavour not to impose one's understandings and beliefs on the data.

Early in the study, the researcher identifies and articulates his or her own biases and inherited understanding of the phenomenon. A self-conscious endeavour is made to suspend preconceptions and presuppositions so that themes emerging from the data are free from the imposition of judgments. All ideas, feelings, associations and connotations are laid aside in order that the researcher is open to the phenomenon as the object of immediate experience. Explication of personal beliefs makes the investigator more aware of the potential impulsive judgements that may occur during data collection and analysis based on the researcher's belief system rather than on the actual data revealed by participants (Streubert & Carpenter, 1995). Beck (1994b) suggests that it is impossible for a researcher to be completely free of bias in reflection on the experience being studied but it is possible to control it.

### **In Depth Interviews**

Using a semi-structured model of interviewing enabled the researcher to follow a semi-recursive, conversational technique and by doing this, allowed the informants to describe their individual experiences of aged care nursing authentically and fully. In this way, the researcher can gain a holistic understanding of the experience that forms an important part of the informant's day-to-day existence (Sorrell & Redmond, 1995). The broad topic of aged care

nursing and issues within it guided the open-ended questions, but flexibility and the natural flow of conversation prevailed. Open-ended interviewing allows the researcher to follow the participant's lead, to ask clarifying questions, and to facilitate the expression of the lived experience by the participant (Streubert & Carpenter, 1995).

An attempt was made to create an empathetic atmosphere so that interpersonal familiarity and rapport could be established. The researcher assumed the level of the informant and engaged in a conversation with "give and take" and empathetic understanding. This makes the interview more honest, morally sound, and reliable, because it treats the informant as an equal, allows him or her to express personal feelings, and therefore presents a more "realistic" picture (Fontana & Frey, 1994). The skilled interviewer, as the research instrument, uses responses of the participant to guide data collection, probing for further information as needed for depth and clarity (Sorrell & Redmond, 1995). Patton (1990, p. 290) states that the fundamental principle of qualitative interviewing is to provide a framework within which informants can express their own understandings in their own terms.

The researcher usually introduced the topic of aged care by asking: "Tell me how you came to be working in aged care". Thereafter the conversation was allowed to progress according to the informant's responses. Long pauses were deliberately allowed so that the informants could fully express their feelings and thoughts from their own perspective. The researcher also encouraged the informants not to stop until they felt that they had discussed their feelings as completely as possible. When the researcher perceived the responses to be wholly



divergent from the issue of aged care nursing, transitions were used to refocus the attention to the topic. Transitions are a means of shifting the conversation to another issue or topic by connecting something the informant has said with the topic of interest to the interviewer (Minichiello et al., 1995).

Probing questions were framed using language that reflected the informant's language, and were most often in the form of what Minichiello et al., (1995) call the nudging probe. For example, repeating a phrase the informant has used, as a question, "'Fell into it'?". Using this reflexively defined interview process enabled the researcher to clarify and seek elaboration until the informant's meanings were understood. The common experiential background of researcher and informant enhanced understanding and empathy. Merton (cited in Minichiello et al. 1995, p. 182) argued that insiders have a special knowledge of their own group, that they are "endowed with special insight into matters necessarily obscure to others, thus possessed of a penetrating discernment."

### **Pilot Study**

To evaluate the data collection techniques and the effectiveness of the interview guide, a pilot study was carried out prior to the main data collection. Pre-interviews were conducted with two selected informants similar to those aged care nurses who participated in the main study. The data from these two interviews was not used in the main study.

The pilot study allowed the researcher to focus on particular areas of data collection that had not been previously practiced. One such area was the use of the audiotape. As the majority of the interviews were conducted at the informant's

home, it was found that the tape recorder should be used in battery mode to avoid having to use electrical extension leads and the participant's power supply. The ideal position of the tape recorder in relation to the speakers was also identified.

Additionally, the pilot interviews were used to test the questions asked in the demographic questionnaire and to resolve to produce them for completion at the beginning rather than the end of the interview.

The interview guide was also trialed during these interviews. A suitable question for introducing the subject of aged care nursing to the interview became evident. The influence of grandparents and other aged relatives or friends on the nurse's young life, and the death of nursing home residents emerged as key concerns. These two topics were raised in the interviews comprising the main data collection.

Other decisions made during the pilot study were an estimation of the interview time needed for the researcher and the informant to be satisfied that no new themes were emerging, how each party should retain a copy of the signed consent form, and arrangements regarding the follow-up interview. The pilot study also presented an opportunity for the researcher to begin to develop an approach which would allow the participants the freedom of open-ended responses and control of the sequencing and language of the interview. This initial time frame allows the researcher to begin to develop and solidify rapport with participants as well as to establish effective communication patterns (Janesick, 1994).

### Procedure

Eighteen registered nurses working in the nursing homes that were originally approached responded by listing their names and home telephone numbers for return to the researcher. All of the informants were contacted by telephone; one did not fit the criterion of clinical practice, two were unavailable at the time, and one telephone number was incorrect. A further four nurses were recruited, two to comply with the extreme or deviant case (see Sample Selection above), and two to further enrich and saturate the data. Of the 18 recorded interviews, two were used in the pilot study and not included in the main data, and one was too difficult to transcribe due to the frequent lowering of the voice by the informant and the inappropriate positioning of the tape recorder. The final sample size was 15.

During the initial telephone contact, the contents of the letter of information for potential participants (see Appendix E) were explained. These included selection criteria, tape recorded interview, confidentiality, rights of participation and the home and work telephone/fax numbers of the researcher.

If the informant confirmed his or her willingness to participate in the study, a time and place was arranged for the interview to take place. Choice of venue was made by the informant. Ten chose for the interview to be conducted in their home, two came to the home of the researcher, two chose the nursing home where they were working and one chose to be interviewed in a coffee shop close to her place of work.

Before the audiotape was turned on, the purpose of consent form (see Appendix F) was explained, there was some social discourse, and then the

demographic questionnaire and the consent form were given to the informant for completion. This provided a topic for discussion and an opportunity for the researcher to turn on the audiotape and introduce the opening question which was usually: "Tell me how you came to work in aged care?". The researcher allowed the interview to take a normal conversational form, according to the informant's responses. Support for those responses and the discussion of issues was conveyed both verbally and non-verbally by careful listening, an open posture and adopting a non-judgmental attitude. Useful and effective listening involves giving feedback to the informant in a normal conversational tone (Minichiello et al., 1995).

Avoiding leading questions, the researcher encouraged the participant to describe their experience as fully and deeply as possible. It was sometimes necessary to reassure the participant of the value of his or her responses. Questions from the interview guide were introduced only when appropriate or when the previous area of discussion appeared exhausted and there was a pause in the conversation.

Many of the issues in the interview guide were raised during the course of the interview without any prompting. The length of the interviews varied from 60 to 90 minutes.

As soon as practicable after the interview concluded, the researcher used a dictaphone to describe the informant and the setting, non verbal cues, and personal impressions and reflections on the course and content of the interview.

### **Data Collection and Analysis**

Data reduction preceded data analysis. Reduction is concentration on the phenomenon, becoming absorbed in it, and through bracketing, seeing it as if for

the first time (Oiler, 1982). It is known as reduction because it leads back to the source of meaning of the experience (Ray, 1985). The purpose of this reduction is to prepare for the analysis (Cohen, 1987). Data analysis began at the time of the first interview and thereafter was a continuous, ongoing process. Dictaphone field notes, made immediately after each interview, recorded the researcher's intuitions, interpretations and descriptions of the setting, the informant and the course and content of the interview itself. Memos were made and incorporated into the data. Contemplative dwelling was used to identify potentially significant statements. Contemplative dwelling is the "undistracted reading and re-reading of the descriptions with the intent to uncover the meaning of the lived experience for the subject" (Parse, Coyne & Smith, 1985, p. 19).

The procedural steps as described by Streubert and Carpenter (1995, p. 39) guided this phenomenological approach. They are:

1. Explicating a personal description of the phenomenon of interest.
2. Bracketing the researcher's presuppositions.
3. Interviewing participants in unfamiliar settings.
4. Carefully reading the transcripts of the interview to obtain a general sense of the experience.
5. Reviewing the transcripts to uncover essences.
6. Apprehending essential relationships.
7. Developing formalised descriptions of phenomena.
8. Returning to participants to validate descriptions.
9. Reviewing the relevant literature.
10. Distributing the findings to the nursing community.

Steps in the analysis of interview data (see Figure 1) included the following:

1. Bracketing occurred. The researcher's presuppositions and inherited and prevailing understandings of aged care nursing were identified and stated (see Appendix D).
2. All of the 15 audiotapes of the interviews were transcribed verbatim by the researcher. This provided an opportunity for researcher to become re-acquainted with the properties and character of each interview, and to facilitate immersion in the phenomenon of aged care nursing.
3. The transcripts and the data from the dictaphone recordings and memos were entered into the Q.S.R. NUD•IST qualitative data analysis database.
4. The transcripts were read and listened to simultaneously and memos made regarding the informant's tone, demeanour, language and implied meanings. The NUD•IST software package was used to manage, code, and index the documents.

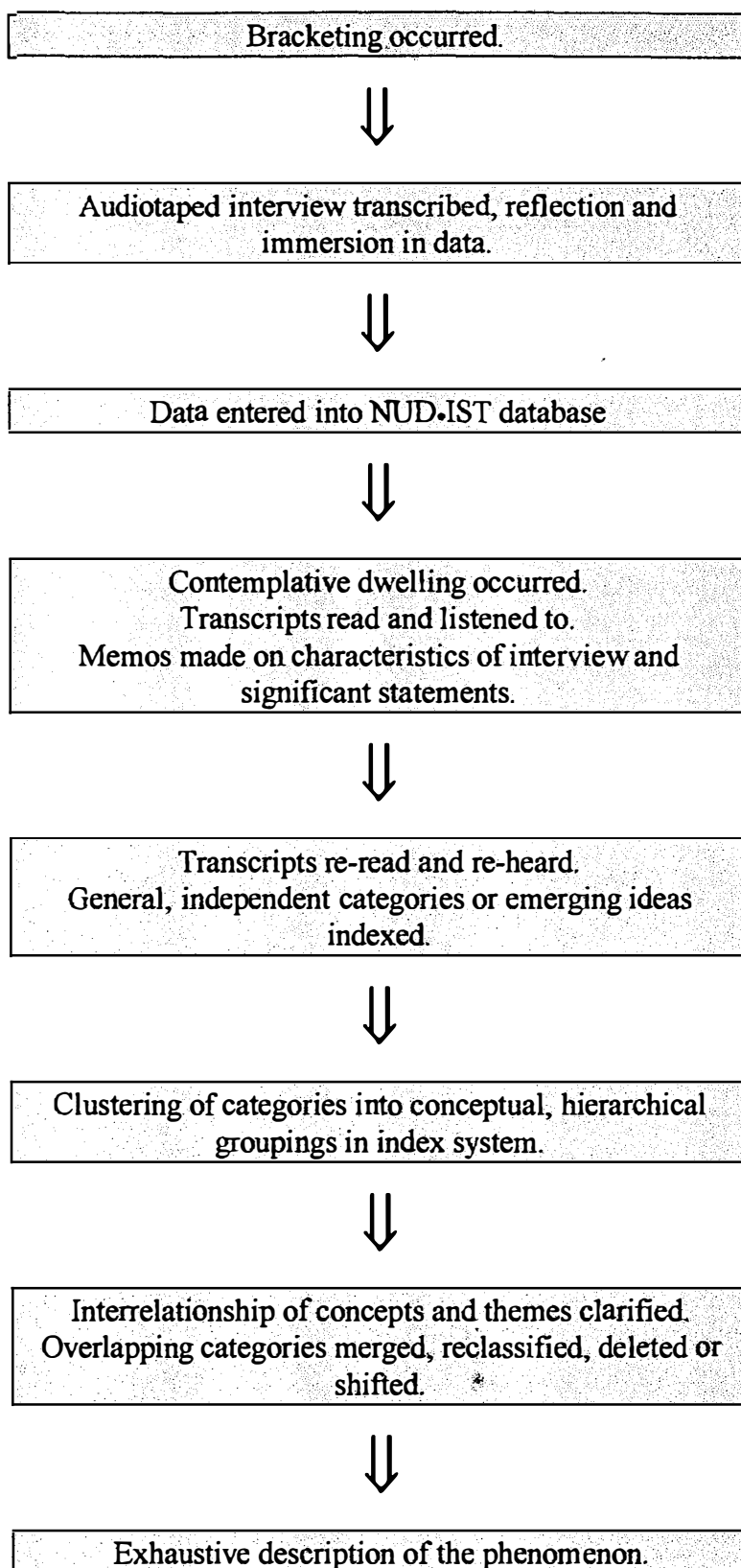
Actual analysis, corresponding to steps 5 and 6 of Streubert and Carpenter's (1995) procedure (previous page), was conducted using an adaptation of the Huberman and Miles (1994, p. 432) tactics for generating meaning. This framework is very compatible with computer-assisted methods of analysis.

The steps are:

- Noting patterns and themes.
- Seeing plausibility - making initial, intuitive sense.
- Clustering by conceptual grouping to see connections.
- Making metaphors, a kind of figurative grouping of data, to achieve more integration among diverse pieces of data.
- Making contrasts and comparisons to sharpen understanding by clustering and distinguishing observations.

- Partitioning or differentiating variables that have been prematurely grouped.
- Subsuming particulars into the general, shuttling back and forth between first-level data and more general categories.
- Factoring or moving from a large number of measured variables to a smaller set of unobserved, usually hypothetical variables.
- Noting relations between variables.
- Finding intervening variables.
- Building a logical chain of evidence to help a coherent understanding of the data set.

The second interviews were conducted by telephone. This follow-up interview enabled the informant to clarify and validate, or refute, themes, meanings, experiences and descriptions of aged care nursing, from the initial interview. The researcher documented comments made by the participants. Their comments were then incorporated into the final study report.



**Figure 1. Steps in Analysis of Interview Data**



### Computer aided analysis

Data analysis involves recognising significant statements, identifying meanings and reflecting on them across all participants to uncover themes. Data management methods should support recognition of categories and meanings found in the text and provide an easily accessible, reliable storage system with the facility to explore, code and retrieve textual links between concepts. The challenge is to make sense of massive amounts of data, reduce the volume of information, identify significant patterns, and construct a framework for communicating the essence of what the data reveal (Patton, 1990). Richards & Richards (1994) argue that computers can be used in the discovery and management of unrecognised ideas and concepts, and the construction and exploration of explanatory links between the data and emergent ideas, to make fabrics of argument and understanding around them.

The procedures of theory construction require above all a very flexible, very easy-to-modify database, that will shift, reorganise, undo, and backtrack to earlier states. This is because the process of constructing an understanding is tentative, involving the exploration and testing of hunches at all grain size levels, hanging onto them if they look good for now, throwing them away when they no longer fit, while maintaining the rest of the growing structure (Richards & Richards, 1994, p. 449)

The software system QSR NUD•IST version 3.0 was used to analyse data in this study. The package is designed to facilitate qualitative data analysis by managing documents, and by the processes of indexing, searching and theorising.

### **Assigning codes**

Codes or categories were developed from the audiotaped interviews themselves and from the transcriptions of the interviews. The initial codes were continually developed, modified, extended or deleted and, as analysis of the data proceeded, new codes emerged. For example, the categories “enjoyable”, and “happy” developed into the supporting sub-themes of “satisfaction” and “rewards”, along with the merged categories of “pleasant” and “happy.” This process is in keeping with the basic principles of the inductive reasoning methods, where there is a co-evolving development of incorporating emerging ideas into the collection and analysis of data (Minichiello, Aroni, Timewell & Alexander, 1995).

### **Indexing**

The initial and emerging codes were kept in an index system which allows the researcher to create and manipulate concepts and store and explore emerging ideas. For example, the original categories of “unpredictable”, “chaotic”, “busy” and “stressful” became sub-categories to the common theme of “stress.” The nodes or “places” where the codes were kept are organised into hierarchies, or trees, to represent the organisation of concepts into categories and subcategories (Crewes, 1994). Constant reading of the transcriptions resulted in the continued refinement and development of the indexing system until the point of saturation was reached.

## **Memos**

A memo is a text only file that can be written using Q.S.R. NUD•IST's editor and associated with a particular node or data document (User's Guide for Q.S.R. NUD•IST p. 32). The data from the dictaphone recording, which comprised the researcher's descriptions of the setting, the informant and the course and content of the interview, were stored at the document. Other memos concerning the informant's tone of voice, demeanour, language and implicit meanings were recorded as the transcriptions were being read and listened to.

## **Credibility, fittingness and auditability**

The issue of rigour in qualitative research continues to challenge researchers in the advancing paradigm shift from logical positivism to interpretivist inquiry (Koch, 1996). Leininger (1994) argued that because the purposes, goals, and intent of qualitative and quantitative research differ, different criteria are required to determine validity and reliability. Guba and Lincoln's (1985) "parallel" criteria for rigour mirrored those in quantitative research. They suggest that credibility be the criterion against which the truth value be evaluated, that fittingness is equated with applicability, and auditability relates to the consistency and confirmability of the research results. Validity issues in this study are based on the evaluation criteria of credibility, fittingness and auditability as described by Beck (1993), which are in turn based on the criteria proposed by Guba and Lincoln (1985).

## Credibility

Credibility in qualitative research measures how vivid and faithful the description of the phenomenon is. The informants, and also the readers who have had that human experience, should recognise the researchers' described experiences as their own (Beck, 1993).

The criterion of credibility will be addressed by referring to selected questions regarding the research design as proposed by Beck (1993, p. 265):

1. Did the researchers keep in-depth field notes regarding the researcher-informant relationships?

Immediately after the interview, the researcher recorded her thoughts and feelings regarding the appearance and demeanour of the informant, the characteristics and the content of the interview. These were then incorporated into the database. During the second interview, conducted by telephone, written notes were made regarding the informant's responses and comments. These were also included in the findings.

2. Were the effects of the researcher's presence on the nature of the data collected considered?

Early in the study the researcher identified and recorded (bracketed) her perceived biases and inherited concepts of aged care nursing (see Appendix D). However, the common experiential background of researcher and informant was perceived to enhance understanding between the two (Minichiello et al., 1995, p. 182).

3. Were the readers provided with rich excerpts from the transcripts or field notes?

All of the participants in this study received a full transcription of their interview and a preliminary analysis of findings, which included verbatim quotes.

4. Did the researcher validate the findings with the informants?

The letter which accompanied the transcript (see Appendix G) explained that the researcher would contact them by telephone within the next few days to discuss any changes, retractions or additions they may wish to make to the data. At the same time, the participants were asked whether the themes, meanings, experiences and descriptions which the researcher perceived to have emerged from the initial interview, adequately captured their experience of aged care nursing.

5. Did the researcher search for negative instances of categories or discounting evidence for tentative constructs (Field & Morse, 1985)?

In the study's original purposive sample, all participants were Caucasian and female. It was conjectured that a greater understanding of the experience of aged care nursing would emerge by including a male registered nurse and an Asian registered nurse. Using theoretical sampling, such informants were subsequently approached and enlisted to participate in the study, their names having been taken from the original lists.

6. Were data analysis procedures reviewed by a judge panel to prevent researcher bias and selective inattention (Morse, 1989)?

The descriptions, emerging themes, and the steps in the analysis were shared with the researcher's principal supervisor and co-supervisor, both of whom are experienced research nurses. It was originally intended that a third, independent, expert observer would be asked to analyse a randomly selected

sample of the taped interview, the results of which would be compared with the researcher's to establish reliability. However, Morse (1994, p. 231) claims that "this process actually violates the process of induction, because the first investigator has a bank of knowledge from conducting other interviews and from observing that the second researcher does not have." She goes on to explain that qualitative inquiry depends on insight which an independent investigator working from a limited data base cannot realistically be expected to have.

7. Do the readers view the findings as meaningful and applicable in terms of their own experiences?

At the follow-up interview, each of the 13 informants confirmed that the findings reflected their own experience of aged care nursing. None of the informants refuted or wished to retract or amend any parts of their transcript. All agreed that the findings accurately depicted their experience of aged care nursing. One of the informants wished to reiterate her experience of conflict in carrying out the doctor's orders when they were not in accord with her own view of what was in the resident's best interest. Another informant, who works in a facility which is dementia specific, expressed the belief that the maternal, nurturing aspect of aged care plays a large role in aged care nursing.

### **Fittingness**

According to Streubert and Carpenter (1995), fittingness is a term used to demonstrate the probability that the research findings have meaning to others in similar situations. The assessment of the fittingness of this study will be addressed by reference to selected questions proposed by Beck (1993).

1. Did the researcher establish the typicality of the informants and their responses?

Aged care nurses were recruited from six different nursing homes. The typicality of their responses was established by recognising the point at which no new information was forthcoming; that is, saturation of the data occurred.

2. Did the theoretical sampling result in a range of informants experiencing the phenomenon under study?

In this study, the researcher enriched the data and ensured saturation by recruiting an additional three aged care nurses after the original 15 interviews had been conducted. Theoretical sampling was used to recruit a male registered nurse and an Asian registered nurse. In the study's original sample, all participants were Caucasian and female.

3. Did the study results fit the data from which they were generated?

Data reduction preceded data analysis. Reduction is concentration on the phenomenon, becoming absorbed in it, and through bracketing, seeing it as if for the first time (Oiler, 1982). It is known as reduction because it leads back to the source of meaning of the experience (Ray, 1985). Contemplative dwelling was used to identify potentially significant statements (Parse, et al., 1985). The phenomenological analysis of the data lead to the identification of significant statements which were categorised, and patterns and relations between the categories were noted. The categories were then clustered into conceptual, hierarchical themes. Four core themes emerged from the data.

## **Auditability**

Streubert and Carpenter (1995, p. 313) refer to auditability as “the ability of another researcher to follow the methods and conclusion of the original researcher.” The audit trail encompasses all the decisions made by the researcher at every stage of data analysis. The issue of auditability in this study will be addressed using selected questions proposed by Beck (1993, p. 266).

1. Was a tape recorder or other mechanical device used to record the interviews?

All of the interviews were recorded using a tape recorder, and transcribed by the researcher verbatim. A dictaphone was also used to record the researcher’s impressions of the interview and the informant.

2. Was an in-depth description of the strategies used to collect and analyse the data provided to the readers?

Details of the data collection methods were described fully to the informants in a letter of information for potential participants (see Appendix E). Arrangements for the follow-up interview were discussed at the first interview, and again in the letter which accompanied the transcripts and findings mailed to the informants (see Appendix G).

3. Were the characteristics of the informants described and the process used to choose the informants?

The characteristics of the informants was described in the section titled “Profile of Informants” above. Similarly, the section “Sample Selection” above, describes the process used to choose the informants.

4. Were low inference descriptors, informants’ verbatim accounts, included to substantiate the categories developed during data analysis (LeCompte & Goetz, 1982)?



Extensive use of verbatim quotes is used in the chapter on data analysis and findings.

5. Could another investigator clearly follow the decision trail used by the researcher in the study?

The auditability of this study was enhanced by using NU•DIST computer analysis. As the analysis proceeds, the researcher can alter the index system without losing the references to documents supporting analysis at the textual level, and a log of what was done is added to the node memo. Thus each node has a documented history which helps in auditing the research process (Richards & Richards, 1994).

### **Ethical Considerations**

Permission to undertake this study was sought and granted by the Edith Cowan University Committee for the Conduct of Ethical Research.

A potential participant's inclusion in the study depended on the researcher securing informed verbal and written consent (see Appendix F). A copy of the consent form was kept by both the researcher and the participant.

A Letter of Information for potential participants (see Appendix E) informed participants of the nature of the research, its purpose, how the nurses were selected, the interview procedure, potential risks and benefits, means of assurance of confidentiality and the means of resolving questions. The participants were informed of the option to withdraw or modify the consent at any time during the research process. Process consent means that the researcher renegotiates the consent as unforeseen events or consequences arise (Munhall & Oiler, 1993).

Confidentiality was maintained by the use of codes and pseudonyms to identify demographic data, audiotapes and transcriptions. The consent form, which identified the participant, was kept separate from the main data in a locked cabinet. All transcribing of interviews was carried out by the researcher and no other person had access to the audiotapes. The computerised data base in which the data were stored was protected by a personal identification number known only to the researcher.

The confidential records of the study, including hard copy transcripts and field notes, will be archived at the Edith Cowan University library and destroyed by burning after five years. All audiotapes of the interviews will be erased at the completion of the study.

### Summary

Qualitative research, in particular phenomenology, was chosen as the most appropriate research design to gain insight into the lived experience of aged care nursing. Purposive sampling was used for the selection of 15 registered nurses currently working in nursing homes to participate in the study. Steps in the research process included the recruitment of participants, obtaining consent, arranging the interview and recording field notes. Semi-structured, in-depth interviews comprised the main source of data and these audiotaped interviews were transcribed verbatim by the researcher. The software system Q.S.R NUD.IST. was used to analyse the data employing an adaptation of the Huberman and Miles(1994) tactics for generating meaning. The ethics of the study were

considered and issues regarding credibility, fittingness and auditability were addressed.

## **CHAPTER FOUR**

### **Data Analysis and Findings**

#### **Introduction and Chapter Overview**

The purpose of this qualitative study was to interpret and describe the common, shared meanings of the experience of aged care nursing from the perspective of the registered nurse working in a nursing home. An open-ended, simple interview guide was developed, which consisted of questions to facilitate the description of four or five general issues considered central to aged care nursing. This served to guide the interview, but the conversation was unstructured and informal.

In this chapter, phenomenological analysis of the data leads to the identification of significant statements, which are coded (categorised). Patterns and relations between categories are noted, there is movement from a large number of categories to a smaller set, particulars are subsumed into the general and overlapping categories are merged, reclassified, deleted or shifted within the index system. These categories are then clustered into conceptual, hierarchical themes and the interrelationships of themes are clarified. Four core themes emerge. An audit trail is created to help a coherent understanding of the data set.

The findings include extracts of the transcribed interviews to illustrate the development of the themes and their properties as they emerged in the study.

### **The Phenomenological Analysis**

Phenomenology provides a general framework for qualitative research approaches. It was chosen for this study because of its emphasis on the meaning of lived experience and because of its aptness in describing and elaborating the experience of aged care nursing for nurses, from their own perspective.

As outlined in the previous chapter (p. 43), Streubert and Carpenter's (1995) procedural steps guided this phenomenological approach, and computer-assisted analysis of the data (steps 5 and 6 above) employed an adaptation of the Huberman and Miles (1994) tactics for generating meaning (p. 44).

Taped interviews of the 15 participants were transcribed by the researcher and entered into the data base of the NUD•IST qualitative analysis software package. This computer package enables the user to explore the documents and to create an index database for managing categories and themes. Also entered into the database, in the form of memos, were transcriptions of the dictaphone recordings that the researcher had made immediately after each interview. These described the researcher's intuitions, interpretations and descriptions of the setting, the informant and the course and content of the interview itself. The data were analysed using phenomenology to identify thematic structures of the experience of aged care nursing.

### **Data Analysis**

By listening to the audiotapes and reading the transcriptions several times, significant statements were identified and their meanings formulated. In total there were 779 significant statements categorised from the interview data (see

sample, Appendix H). These statements were stored at various nodes (sites) in the index system (see Appendix I). Each node was named to reflect the content of the significant statements, and represented a category. For example, those statements which described feelings such as “enjoyable”, “happy”, and “satisfying” were indexed at similarly named nodes. The data base was then searched for significant words using the search function. After confirming that the statements containing the words were significant, the results of these searches were merged with the corresponding nodes. For example, the results of a search for all statements which contained the words “pleasant”, “pleasing” or “pleasure”, were merged with the node “happy.” A search for the word “abuse” and an examination of the contexts of its use, revealed significant statements which were indexed at the nodes “stressful” and “unpredictable.” The merging of nodes is seamless; that is, a statement is not duplicated at one node. It is possible to store memos at the site of the node, and it was here that informal, full descriptions of the particular categories were kept. For example, in the memo at the node for “conflict” was the description: “This has turned into a node that houses maybe two types of conflict; professional conflict, where the nurse has conflict between her own personal views, standards, judgements and those of management, other staff or doctors and conflict between staff members, nurse and management, nurse and doctor.”

There were 26 categories tentatively identified when the initial coding was carried out. These were:

Rewards	Turnover
Status	Contribution
Unpredictable	Happy
Supported	Enjoy
Satisfying	Basics
Challenge	Rapport
Funding	Chaotic
Time	Self
Ethics	Perceptions
Documentation	Busy
Autonomy	Responsibility
Stressful	Hard Work
Conflict	Needed

These were grouped into 13 clusters of common themes using the tactics referred to above:

Rewards	Support
Satisfaction	Difficulties
Stress	Documentation, funding & Staff
Relationship	Empathy
Outcome Standards	Attitudes
Responsibilities	Doctors' Orders
Time	

For example, the categories of “happy”, “enjoy”, “needed” and “contribution” were subsumed into the theme “rewards.” The category of “positive perceptions” merged with “supported.” “Rewards” and “support” then became common themes, along with “satisfaction”, and formed the cluster of common themes supporting the core theme Gratification.

Categories such as “basics” and “hard work” became sub-categories to the common theme of “difficulties”, while “unpredictable”, “chaotic”, “busy” and “stressful” supported another common theme, “stress.” Similarly, “turnover”,

“funding” and “documentation” merged with the common theme incorporating those names. The cluster of themes, “stress”, “difficulties” and “documentation, funding and staffing” then, supported the emergent core theme of Non-productivity. All of the significant statements, categories and common themes represented constraints and obstacles to the participants’ productivity. None described experiences which assisted productivity.

The category “self”, which held significant statements pertaining to the nurses’ perception of his or herself within the context of resident care, was grouped with the category “rapport” and formed the common theme, “empathy.” Another common theme, “relationship”, resulted from the categories of “ethics” and “status.” Rapport then became the emergent core theme supported by the common themes “relationship” and “empathy.”

Conflict also emerged as a core theme. Subordinate to that were the common themes “attitude” (supported by the category “negative perceptions”), “responsibility” (“conflict” and “responsibility”), doctors’ orders (“autonomy”) and “Outcome Standards” (“challenge”).

Originally, the category of “time” appeared to make up a large part of the experience of aged care nursing. However, as data analysis proceeded, it became obvious that it overlapped both Non-productivity and Conflict. Nurses perceived that the lack of time had a large influence on the quantity of work they achieved, and at the same time they experienced personal conflict in the work they wanted to do and the time constraints.

From the significant statements, categories and common themes, therefore, there emerged the four core themes of Gratification, Non-productivity, Rapport



and Conflict. Thematic analysis of the data led to a description of the lived experience of the aged care nurse.

### **The Experience of Aged Care Nursing**

The common experiences of aged care nursing for the participants were expressed in terms of how they felt gratified or rewarded, the experience of their own productivity, their experience of personal and professional conflict and their perception of the rapport or connection they felt with the resident.

Gratifying experiences or rewards for contribution were expressed in many ways including feelings of satisfaction and enjoyment and a sense of collegial support. Allusions to non-productivity were made by referring to influences such as staff turnover and the use of agency staff, the unpredictability of the work including interruptions, chaos and stress, and resident characteristics. Similarly, the nurses all related feelings of rapport with the resident, often within the context of death or dying. Personal and professional conflict was experienced by all of the participants and the comprehension of “time” intersected both the experience of productivity and conflict.

The categories are described in detail, illustrated by using the words of the participants’ verbatim. The participants are identified using the codes P2 to P18, excluding P6, who was part of the pilot study, and P8 whose audibility during the recording of the interview was too poor for the data to be transcribed.

#### **Gratification**

**gratification**, n. the state of being gratified or pleased; enjoyment, satisfaction, pleasurable feeling (Oxford English Dictionary, 1989).

In the context of this study, gratification represents experiences that the participants perceived as rewarding or pleasurable. This theme emerged from the data which categorised significant statements expressing satisfaction, support and rewards. Many of the statements indexed at these nodes were also indexed at the node, rapport. The participants frequently spoke of the rapport they felt with the resident, simultaneously with expressions of gratification.

### Satisfaction.

Many participants couched the gratification they experienced in terms of a feeling of satisfaction. There were several sources of this feeling including the response of a resident.

It's the satisfaction of having someone who's quite demented being able to remember my name ... and the with-it people, I mean the satisfaction is just being able to hear from them, that they, they're comfortable or they enjoyed something... (P18)

Recognition by the nurse of his or her own contribution also played a part in promoting the experience of satisfaction.

And I must admit I get a lot of satisfaction when somebody's had a fractured femur and we get them on their legs again. I must admit I find that immensely satisfying. (P15)

That...is the satisfaction that I get, from making them happy and feeling as though I mean something, and that they mean something to me too. (P2)

Several of the informants spoke of the feeling of satisfaction coming as the result of an event, that of the death of a resident.

Because I think if you can care for somebody and their family ... that's probably one of the most wonderful things you can do for somebody old and ill...and when somebody dies well, I find, well, at

this stage of my career that [it] is ... probably one of the most deeply satisfying things you can do. (P15)

I always make sure that if you've got someone dying I bring the staff and show them the positions and I leave them looking nice; that gives me a lot of satisfaction. (P14)

One informant experienced a sense of satisfaction but questioned the notion that it was the result of any particular events.

It may not be a goal that I set out with at the beginning of the day to sort of do this and this, but I think basically, a lot of the things that give you the greatest satisfaction, are not perhaps that, you know, that doctor was called or that that happened for that resident, it's just the one on one, that sometimes just doesn't even get a name type thing. (P17)

#### Support.

Feelings of gratification were also evoked when the informants perceived that they were being supported implicitly by their colleagues. They described collegial support given in times of personal need and also the support they felt when working in a collaborative, team.

It's usually a shared thing as the, you know, the funny little quirks are shared too, that get you through the day. (P11)

[I] ... go and say hello to the girls that are there and just sort of talk about nothing and everything, and five, ten minutes and you come back again and that's it, you know, away you go. (P13)

Many experiences of reward were the result of being supported in a team situation.

And I think I had a lot of good vibes. I had staff tell me that they need someone like me there, that they appreciate my compassion and my, the fact that I'm fair, that I'm the only one who's champion for them. (P14)

You got to work together as a team, and so I think that's why I like to be out on the floor and help. (P4)

And it's a team thing because ...it's the whole team then that sort of feels quite sort of good about the whole thing in other words. (P13)

In other situations the informant needed to seek out the support and that also resulted in feelings of gratification.

...but we just ask or refer it to our level twos and 'What do you think is good for this and that' and stuff that someone's always there to boost you up, or when you don't feel that you're competent enough, you just have to ask them. (P12)

### Rewards.

Interaction with the residents was the richest source of reward for the participants. When an incident or a situation was perceived to be rewarding, it was often described using expressions like "enjoy", "a delight", "exciting", "beautiful" and "fabulous."

I enjoy the cut and thrust. I think, 'Oh now what's the day got for me?' I enjoy it. (P10)

As I say, I like old people. I find them fascinating and there's a great deal of joy from caring for them. (P15)

So we get these concert groups in and they'll play, and she just takes off, she just, oh, it's just such a delight it brings a tear to your eye almost. (P13)

But, that's [a correct nursing diagnosis], I think that's terrifically, um, it's quite exciting, I get quite excited when I hit the nail on the head. (P15)

I mean most of our residents are off night sedation, which is beautiful. (P7)

So that was, that was fabulous. I felt ... if I don't do anything for the next twelve months or ... if no-one says, pats on the back or anything like that, um, that, that one thing was worth sort of twelve months of sort of perhaps not, you know not getting any sort of pat on the back. (P17)

But she, she's a slapper and a pincher. But if you give her a kiss, the light in her face is worth all the slaps in a million years. (P15)

Other participants, however, were more restrained in their descriptions of rewarding events and used language which was more low key; for example "nice", "good", "encouraging" and "a privilege."

There's enough sort of, with this Alzheimer's, there's enough humour and love communicated for it to be rewarding. (P11)

He was so water logged you know, that his chest was rattly and there were so many secretions, we were having to suck him out. Now he's much more manageable, and he's learning to smile and that's nice. (P16)

It's surprising, just to see that improvement over two or three months, once they've settled into a nursing home, from someone who was really bed ridden and get them up and more involved, and mixing with other residents, I think that's really good too, you can see that difference. (P4)

And another thing too is like when a patient, resident's got, like we have cancer patient that has got terrible pain and then the pain is well controlled and you can talk to her, I feel really good. (P12)

So all the good comes. I mean it's not just, it's not just that you're sort of giving it to all these clients' families and that. You often get a lot back as well and it's learning both ways. So it is true, the more you give the more you get back. (P17)

And reassurance is usually in the tactile form ... and 'cause some of them respond so well ... it's encouraging ... (P11)

You're not just, um, washing a body. What you're doing is a, a, well basically it's an act of love, it's a privilege to do that. (P15)

### **Exhaustive Description of Gratification**

Aged care nurses experience feelings of gratification from delivering appropriate and effective nursing care in a familiar environment, from collaborative interaction with other staff members and from the residents themselves.

Experiencing a satisfying work environment was frequently described by the informants in terms of familiarity with the nursing home and the residents. They perceived that they knew well the environment and most of the residents. This perception made them feel comfortable with the routines of work and with the intimate relationships they had formed with most of the residents. The well known social and professional culture of the nursing home, the customs and rituals, induced an environment in which the nurse was not required to leave her psychological comfort zone. The course of the shift was usually predictable and very few threatening situations arose. This was seen by the informants as a factor contributing to the experience of satisfaction. One informant compared it to acute nursing by describing the long-term care of the resident as being the reason for satisfying experiences, as opposed to acute care where, often, outcomes of nursing care are not seen because the patient has been discharged. Another informant found it satisfying to work in surroundings that had, over the years, become as familiar as her own home. One nurse however, expressed feeling pleased when she experienced the novelty of nursing a resident who was on intravenous therapy, a situation which is not routine in nursing homes.

Several of the informants felt that nursing someone to his or her death, looking after them “body and soul”, was the most satisfying experience in aged care nursing. The successful application of the principles of palliative care was seen to be a large part of aged care and at the same time, a source of satisfaction to practitioners. In this situation, there appeared to be a component of “ownership” by the nurses of the resident’s state of psychological and physical well-being. Because of these feelings of proprietorship, the informants felt involved, responsible and depended upon, and often acted as resident advocate. These were roles that generated quite strong feelings of satisfaction and gratification.

Participants also experienced work satisfaction coming from being in control of the situation. This related mostly to successfully managing subordinate staff, delegating responsibilities when necessary, and working to a strategy. One of the informants felt satisfaction at the end of the shift if everything had gone according to her plan for the day.

Gratification also resulted from the support that informants felt they received from their colleagues. Many of the nurses worked in part time positions, so the opportunities for developing ongoing, strong collaborative relationships were often restricted to full time staff. These informants perceived that their colleagues were also their mentors; in one case the Director of Nursing had become a mentor to the nurse. Another cause for a informant to feel supported came from praise received from other staff members for their professional or personal attributes.

Concern for each other's welfare was also evident. One informant described feeling anxious about a coworker who had been on sick leave and, because they worked different shifts, was unable to find out about her condition. Other informants related accounts of their colleagues bringing in specially cooked food and confectionary for the staff.

Other instances of support involved collaborative decision-making or agreement among staff on a certain course of action. One informant described an incident in which she and her colleagues had resolved together that they would work less overtime and vowed to support each other in the pact. It was also gratifying for the informants to finish his or her shift knowing that, because the nurses had shared the work, there was a shared sense of accomplishment. Frequently one nurse would take on some of the workload of one of her colleagues if they had fallen behind for some reason. This resulted in a confirmation that all staff had a common goal and shared equally the achievement of that goal.

Many of the informants related anecdotes about small improvements in a resident's response which gave them feelings of reward. In another context the change could be described as insignificant, but this was not the perception of the informant. A particular source of gratification was care of the demented resident. It was in this context that informants spoke of being rewarded by a resident's smile, a comprehensible phrase or by the resident laughing. Gratification was also generated by the resident's appearance. One informant described how she felt pleased when she saw one of the people in her care looking alive and awake, with sparkling eyes. Several informants experienced feelings of gratification when a



resident recognised them as being somebody who worked in the nursing home and who cared for them.

When residents died in comfort and at peace, the informants expressed feeling pleased. Some of the nurses appeared reluctant to admit that they felt rewarded by the dignified death of a resident, but all of them acknowledge that to be the case. The common experience of nursing a person to his or her death then, was at once satisfying and rewarding.

### **Non-productivity**

**productivity**, n. capacity to produce; quality of state of being productive; production per unit of effort; effectiveness of productive effort, esp. in industry (Stokes, 1986).

The term is used in this study to describe the areas of practice that the nurses perceived as being work, usually practical and having tangible results, for instance physically moving an immobile resident, attending to residents' bowels or admitting a new client. The data which supported this theme were all statements describing constraints and obstacles to productivity. None of the participants reported experiences which promoted productivity.

The categories which formed the substructure of the theme of Non-productivity included "difficulties", "stress", and "documentation, funding and staff."

### Difficulties.

The participants' experience of the work load was, in every case, described as being busy, heavy, or physically or mentally exhausting. In one instance a registered nurse related an incident in which another staff member, whom she held in high regard, was overwhelmed with feelings of inadequacy.

I had a nurse in tears ... she was actually quite a level headed, she wasn't stupid, she was an organised girl. And she was in tears because she could not do it, she just could not do what was expected of her. (P7)

'Cause I know the work loading is really, to me, is quite heavy at times, um, you got to mix with your other nurse, or I have one-and-a-half nurses that I work with. (P4)

... the overall, you know if you've got eighteen residents, I think somewhere along the line it's just not physically possible for one person to sort of cover all the bases. (P17)

It's a mine field, it's a hell of a load. (P14)

I think a six hour shift is probably long enough for anyone to stand in a nursing home situation. Lifting, moving, dementias, you know. (P7)

Several participants commented on the increase in resident dependency and recalled times when the nursing home residents were far more independent. Two of the nurses remembered residents who were still driving their own car while they lived at the nursing home. The perception was that recent admissions were in the high dependency classification.

There are, what I've noticed over the years is the change in resident dependency and it's just got heavier and heavier and we're getting more and more dementia. (P16)

And each resident seems to be worse than the one before. They really do. And there doesn't seem to be any kind of 'No I'm not taking this person' because you've got to fill the bed. (P15)

But you see no one wants to do night duty, 'cause it's heavy ... and we have got very heavy residents. So it's physically, I actually, last year, actually added up how many lifts, transfers and moves we did and it was ninety-two, which is quite a lot, two people. (P7)

It's a very heavy industry, physically and mentally. So therefore, it stands to reason that there's going to be more injuries ... (P5)

Because it's, in many ways it's really too awful to be just a job. I mean it's incredibly draining, physically and emotionally. And perhaps the physical overpowers the other things. I mean you're so tired at the end of the day, um. Perhaps it's overpowering and I think you have to be committed to do it. (P15)

Some of the participants found the mental fatigue a greater factor in the work experience than others.

It's not physically exhausting, it's more mentally exhausting ... and you find sometimes when you're really busy, I can't sleep at night and I wake up and I think, oh, must remember to do this, you know, must remember to do that. (P13)

And, often I take on too much and I get to the end of the day totally spinning, thinking 'Now, have I done it all?'. (P18)

Many of the nurses strongly felt the busyness of the work.

And it's just go, go, go. So really those three nurses are one to eight, supposedly the RN's overdoing it. But it's just too much for the nurses. I mean, you've just got to bog in and do it. (P9)

Um, chaotic. It's the only way I can put it. ... I tend to find I'm running around like a headless chook quite often. (P18)

And things are just flat tack, you really have to make yourself go to the toilet, because there is really not time to go all the time. It sounds

stupid doesn't it? But you really have to make yourself have a drink and go to the toilet and have time out. (P7)

I mean you might have a couple admissions, you might have somebody who's fallen and fractured neck of femur and has to go X-ray and hospital and you might get something like about six doctors come in all at once, plus the phone ringing and all that. (P13)

### Stress.

Feelings of stress were a significant element in the experience of these aged care nurses. They reported that stressful conditions were a result of, among other things, resident care, the unpredictability of the work and interruptions to the work routine.

You've got inexperienced staff on and you've got everybody's bowels either bound up or running free. So the nurses are all in disarray. (P10)

An old fellow whacked me across the head, I can't even remember why. I just remember my glasses being broken and I can't imagine how I was going to get through the night without them or how I was going to drive home without them. (P15)

I drive to work on night duty and my biggest fear is fire, because we have a lot of people [who are] forgetful, dementia. I just feel the responsibility is just enormous. (P7)

[Opened bottles of morphine]...should be discarded in a month and nine months down the track we're still using it, wondering why somebody's not getting any relief, and I think if I keep on taking this on board I'm more stressed. (P14)

I find that a huge strain now, um, to try to, in a sense, protect the non-demented ones who may have severe physical illnesses but who are mentally, you know, mentally quite bright. (P15)

The death of a resident also presented as stressful to several of the participants. A painful or uncomfortable death was usually the reason for feelings of helplessness and inadequacy.

And I've just had hysterics over it, I've just gone down and burst into tears I've been so stressed out, how these people are dying. (P9)

This is distressing, is that they die today and tomorrow there's a new body in the bed. And I think that's very distressing for staff, or can be quite distressing. And it's distressing for the relatives because you're saying to them, 'When are you coming in to get their clothes and if you don't hurry up I've got to put them out in a bag'. (P10)

I get terribly, terribly distressed when people die in pain, in severe distress because there is no need for it. (P15)

I find some of the situations stressful but that's more to do with ... things that you'd like to see changed but you can't. (P17)

A sense of the unpredictability of the work was seen by the nurses as stressful. Frequently it was to do with visits from the auditors, but it was also part of the work culture and took the form of interruptions from other staff members, doctors and unforeseen resident needs.

Sometimes the confusion is frustrating, the way you can get the, you know, what's coming and there's nothing much you can do about it ... (P11)

So I sit in the car and meditate; lately I've gone in with a knot in my stomach wondering what's ahead of me. (P14)

That's a really stressful time when they come and start, the auditors come, and then they come through you three months later and have another go to see if you're doing it right. (P9)

Sometimes it is unpredictable, yeah, because you don't know what's going to happen. (P2)

Because you feel that you get it right and then, bang, next audit you get it wrong again, and they keep changing the rules. (P5)

Lots and lots of interruptions all through. You don't have time to be able to go and do what you have to do. (P13)

And then I find its a struggle, with all the interruptions and relatives and emergencies that happen. (P14)

What I find difficult is the continual interruptions, telephone, people ... . (P16)

It's [work] full of constant interruptions ... . (P7)

It's the stress. Yeah, I've had burnout. That's why I'm on medications. (P14)

Documentation, funding and staffing.

Other perceived influences on productivity were the interrelated areas of documentation, funding, staff turnover and agency staff. The informants all expressed negative views about paperwork, how it involved the Resident Classification Instrument (RCI) documentation which in turn impacted upon funding and the staffing of the nursing home. Two of the nurses, while acknowledging that it was unethical if not illegal, admitted taking documentation home to finish.

I mean the paper work is ludicrous. It is ludicrous. You'd think I was looking after somebody on life support with all sorts of other stuff, when I look at some poor old soul in end stage dementia. (P15)

I didn't go into nursing to write a nice piece of paper. (P17)

All this RCI documentation, toileting two hourly, I mean, get with it, who in the hell can toilet people two hourly? (P9)

The documentation in many instances caused the participant to work unpaid overtime. Many of the participants expressed a certain inevitability about working beyond the knock-off time.

That's why my eight hour day is turned into ten hour days. It's usually the paperwork that's holding me back. (P18)

And you literally, you're off duty at 3.30 and that's when you sit down, make yourself a cup of coffee and spend an hour writing up all your notes. (P13)

You know, at the end of the shift, when you're tired and you're really trying to go home, you think, 'God, we've got so and so and so and so on RCI'. So you then sit down and you have to write. (P7)

As well as influencing their productivity, the participants acknowledged the impact that the documentation was having on the resident care.

... because of all my paperwork I actually can't get out and see them [the residents] as I would like to do. (P16)

The RCI comes first, the SMT [Standards Monitoring Team] comes first. And really, nursing is taking a poor second to these other bureaucracies. (P5)

But still, my priority is to make sure that physical and emotional things are done to the residents out there first, they get first priority to more documentation. (P4)

The use of agency nursing staff for shift vacancies that had not been filled and to relieve nurses who were off sick, was a source of stress for those nurses who had to orient and work with agency nurses who were unfamiliar with the nursing home and its residents.

So you do all this orientation with them [the new staff member] as well, a whole day, ... and then two days later they say 'Oh she's not

coming back, she's not going to work here anymore'. Oh, all that time and effort wasted. (P13)

But when we get a registered nurse that hasn't worked in gerontics, ... they often end up in tears, crying. (P5)

Something dreadful's going to happen here before long because of the critical staffing. (P9)

I spend half the morning on the phone trying to get staff. And ... I think to myself, 'Hells bells, this isn't my job ...'. (P15)

It puts a lot of stress on everyone having agency staff. (P7)

There's just so much agency staff, there's no continuity. (P14)

And the whole nursing homes are going to be staffed by these people [agency staff] and I just don't know what's going to happen. Is it that much cheaper for them to have agency? (P9)

Funding for nursing hours is seen to be tight and there is the perception that the nursing home is running understaffed. Participants implied that their productivity would be improved with improved staffing levels.

Initially you have to fight for what you get. And it just seems to be that the money that's allocated for nursing runs out. (P7)

The other thing that is really awkward is the funding situation, because aged care seemed to miss out quite regularly. (P18)

They're all doing overtime and struggling, making do with less money and less hours, fewer hours, to help the organisation's budget. I mean, where does your responsibility begin and end? (P14)



### **Exhaustive Description of Non-productivity**

The experience of productivity is always seen negatively; none of the informants described any incident that promoted productivity. Generally, nurses' productivity was inhibited by difficulties with resident care, by feelings of stress, by what they perceived as unjustified time spent on documentation and by frequently having to work with new staff members or agency staff.

The informants perceived that, individually, they had too many residents to care for and too little time to deliver appropriate and effective nursing care. This led to feelings of inadequacy and frustration. Some were embarrassed that visiting relatives felt obliged to help take residents to the dining room or help with feeding at meal times. Some nurses reported feeling under pressure most of the time to "get through" the showers before lunch time or administer medications at the correct time. Other areas of resident care that caused difficulties included the frequency of toileting, attending to mobility and supervision of residents who wander.

Care of those residents with dementia was also perceived to jeopardise productivity. Dealing with incontinence, the inappropriate use of restraints and the lack of secure areas for "wanderers" were issues seen by some of the informants to influence the amount of work that they were able to accomplish. Many of the nurses experienced feelings of inadequacy when a truculent resident refused to collaborate in his or her care. On one occasion the resident was in pain but refused analgesia and the informant was unable to gain his co-operation. The complex behaviour problems in psycho-geriatric residents was described by one nurse as "the abnormal becoming the normal."

Another area which informants felt contributed to feelings of diminished productivity, involved having to use outdated equipment. A scarcity of continence aids and appropriate clothing for residents presented difficulties in the maintenance of standards of care. It was a common experience for the informants to feel that they were not able to achieve goals or reach their productive potential because of difficulties with the delivery of “hands-on” nursing care.

Many informants perceived that feeling stressed was a detrimental influence on their work output. Stressful situations arose when the nurses perceived that they were required to prioritise management and governmental directives over resident care. Some related feeling powerless when they were acting as resident advocate and were denied their request. Others thought that some of the people admitted to the nursing home were too dependent for the available resources and, as a consequence, the nurses were unable to meet expectations in their level of productivity. It was commonly perceived that there is a high rate of work related injury and trauma in aged care and observing other staff members experiencing ordeal was, in itself, a source of stress.

As with other experiences in aged care nursing, dealing with events surrounding the death of a resident figured prominently. Some of the informants described finding it stressful to look after relatives who had no insight into death and dying. Inadequate palliative care including pain management, and lack of debriefing for staff after a death also induced feelings of incompetence and ineptitude.

One of the major obstacles to productivity was perceived by the informants to be the burden of paperwork, including RCI documentation and detailed care

plans. All of the informants regarded it as excessive and unwarranted and a large part of the reason that they were unable to deliver better quality care to the residents. Not only did they have to spend time learning how to apply the RCI, but it was often completed incorrectly and as a consequence, nursing hours were lost. This induced a feeling of failure and a decrease in the staff morale. One participant felt punished by the RCI auditors when they amended the classification of a resident's dependency downward. Many thought the RCI to be ineffective in that it did not reflect a true picture of the care that a resident was receiving and another informant felt her efforts to be valueless because no one would read or consider what she had written.

A direct result of the classification of resident dependency is funding for nursing hours. The informants experienced strong feelings of frustration and anger at the staffing levels and composition in the nursing home. They perceived that there were difficulties in filling some positions and in retaining staff. There appeared to be a core of committed nurses but absenteeism was common, sick leave was not allowed to accumulate and most of the staff worked part time. As a result, working with agency or newly oriented nurses was a very common experience for the regular staff member. Some informants thought that agency nurses were uncommitted and their supervision was time consuming. They were unfamiliar with the special needs or idiosyncrasies of some residents, with the layout and routine of the nursing home and with their responsibilities. Their time devoted to their orientation and supervision was perceived to be another constraint to maximum productivity. One informant observed that staff turnover, the use of agency nurses and the high number of part time nurses was a serious

threat to the continuity of resident care and lead to an impairment in the quality of nursing care she was able to give.

### Rapport

**rapport**, a. reference, relationship; connexion, correspondence. Also, harmonious accord, co-ordination. Now freq. used of relations between persons (Oxford English Dictionary, 1989).

In this study, rapport is used to describe how the participant experiences his or her relationship with the resident. The data which supported this theme were statements which described that relationship, or those which expressed feelings that the participant experienced towards the resident.

The categories which formed the substructure of the theme of Rapport were “relationship” and “empathy.”

### Relationship

The relationships that the informants experienced with the residents were frequently described using loving, affectionate language. Many references were made expressing a familial sense to the relationship. A large proportion of the resident population has dementia and this influenced the kind of rapport the nurse felt.

And if you tried ... to interact in a loving spirit, in a kind spirit, and tried to connect with that same part of them, then ... that's what you drew forth from them. (P16)

[The residents with moderate to severe dementia] are all their own personalities in one way or the other ... so they are very much people and that's how you see them. (P11)

Even though it's the most difficult ward, because I like the residents, I've got to know them. I know their little quirks, I really love them. (P9)

... it seems more like family ... over there, and you're not just an item or, you know, nil person. (P13)

... I count them as part of my sort of extended family and you get very attached to their family as well and that. (P4)

The relationship involved a duality of feelings, however. The rapport that was felt by the nurses was neither total nor consistent.

... there are some people you like and there are some people you don't like so there's some residents that you really care a lot about and there's some residents ... that don't like you. (P17)

I mean, I love them. I express that love and I care for them. But there are times I get frustrated and tired, go into the treatment room and say, 'Shut up, shut up, shut up!'. (P14)

Once again the death of a resident was felt strongly by the participants.

Many of them spoke as if a member of the family had died, or a friend.

But I think you do get to love some of them that you've had for a long time. Especially when they go, you really feel it. (P10)

... I'll be sad when they die because I will have lost, um, a friend. (P15)

I think that for me that's the difference between the aged care and taking care of patients in the hospital, 'cause once they were up and discharged they're off. But with this one they continuously there until they die. (P12)

### Empathy.

Comments about the type of rapport felt by the nurses with the residents, involved descriptions of understanding and putting themselves in the resident's

situation. Sometimes the nurse would actively engage in this role as a therapeutic measure, and other times there appeared to be a rapport with the resident which had developed naturally, from a non-professional perspective.

I enter into their world with them [the residents with dementia] and you can respond that way and you get a rapport. (P18)

I can empathise with the older people on their likes, their dislikes, their expectations, the things that they will accept, the social mores really. (P3)

Try and do whatever you think that, if that was your mother, or something or other, what they would like, and work it out that way. (P13)

And I sort of felt as I got older and more compassionate I suppose, and more able to see that this ... person I was caring for ... was somebody's mother, father, whatever. (P15)

They've done the hard grinding, they've invented the wheel, ... and that's where you could find a lot of use for the minds of a lot of the old people. (P18)

That's just my experience, that there's always, even in the seemingly, I say seemingly, most unlovable person there, with lots of behaviour problems, there's always something that you can actually focus on, and remember each time you go to that resident, that actually changes the focus so that you're not dealing with a difficult person, or a behaviour or something, that makes that person come real for you in a real way. (P16)

### **Exhaustive Description of Rapport**

All of the participants in this study described having a unique relationship and feelings of empathy with residents of the nursing home. Many spoke of a sense of family within the home environment, linking stories of their own mothers or grandparents with accounts of interactions with the residents. Several of the

nurses based the quality of their nursing care and that expected of their subordinates, on what they thought their aged mother or father would have deserved. They experienced deep involvement with both the resident and the resident's family. One informant described them as her extended family and another said she often thought of them as her children. Demonstrations of physical affection such as hugging and kissing were common, even with residents who were perceived by the informant as being unlovable and socially undesirable. Informants indicated that they were prepared to advocate for the resident and to defend his or her rights to good nursing care. One of the nurses felt strongly about having the resident die at the nursing home rather than in hospital, if there was an option available. Two of the informants reported attending the funeral of a resident with whom they had had a special relationship and another had brought her children in on several occasions to meet some of the people living in the nursing home. Generally, informants believed that the aged deserved to be cared for by competent professionals. Other feelings that the nurse felt for the resident included respect, admiration for past contributions and mutual trust.

Feelings of empathy were also part of the aged care nurse's experience. These feelings ranged from appreciating the changed circumstances of a newly admitted resident, to intuiting the health of the resident who is well known to them. When the resident exhibited sufficient trust in the informant to discuss their wishes after death, or, in one case, a resident's unpreparedness for death, the nurse experienced profound feelings of intimacy and empathy. Several nurses, experiencing the intimacy of the relationship, said goodbye to the dying resident privately. Also shared were humorous situations, spiritual convictions and times

when the resident was fearful of pain. One of the informants believed it would be frightening to be faced with a new carer every day, another felt the distress of someone with dementia who had been pushed over by another resident. Nurses felt the individuality and uniqueness of all residents, including those with dementia who no longer had any of his or her former personality traits. Many informants felt that, because of their experience and the length of the relationship, they had insight into the special needs of those in their care.

### Conflict

**conflict**, a. a mental or spiritual struggle within a man. The clashing or variance of opposed principles, statements, arguments etc. *Psychol.* The opposition, in an individual, incompatible wishes or needs of approximately equal strength; also, the distressing emotional state resulting from such opposition (Oxford English Dictionary, 1989)

In this study, conflict describes feelings of ambivalence arising from various experiences. These include compliance with Resident Outcome Standards, acknowledging conflicting emotions regarding the aged and aged care nursing, perceived responsibilities differing from directives, and assessments which are opposed to the doctor's.

The categories which supported the theme Conflict contained those statements describing Resident Outcome Standards, participants' attitudes, events in which the nurse perceived he or she had certain, specific responsibilities but found them contrary to policy or practice, and disagreement with doctors' orders.



### Resident Outcome Standards.

The Resident Outcome Standards are outcome measures developed as a guide to good practice and improved standards in nursing homes. These stipulate the obligation of nursing homes towards their residents under common or civil law and are comprised of 31 standards, including such aspects as privacy, dignity, independence and freedom of choice (Commonwealth of Australia, 1987). The standards in nursing homes are regularly checked by the visiting Standards Monitoring Team. Many nurses experienced a sense of frustration and personal conflict in trying to deliver what they perceived as good nursing care, and, at the same time, maintaining the Resident Outcome Standards.

I find it is also very difficult to draw that very fine line between professional practice and the fact that these people are living in now what is their own home. (P3)

But they have this obsession with home-like environment, but yet we're delivering hospital-like care. (P15)

And sometimes it's difficult striking a balance between giving a resident some individual rights or a bit of freedom ... (P11)

The protection of the non-dementing residents from those who have dementia was seen by the participants to be a cause of conflict. They questioned how the rights of the dementing resident impinged on other residents.

... one thing I hate about aged care at the moment ... is mixing dementias with frail aged. ... It just doesn't work. It drives the frail aged absolutely demented to have a demented person come in and go through what possessions they still have. (P7)

[It is] extremely difficult ... to care for the ones that aren't demented in a satisfactory manner when you've got so many that are demented

that make noise, rummage in their stuff, whose continence habits aren't crash hot. (P15)

### Attitudes.

Participants expressed ambivalent attitudes towards the residents and the practice of aged care nursing and this was a source of personal conflict for them. They felt deeply involved with those aged people in their care, and, at the same time, harboured persistent thoughts of leaving aged care practice.

I mean, I, I some of my residents, I can't stand them, I really can't. And I think, 'But you're not there to like or dislike them and you have to care for them to the best of your ability'. (P15)

... but I know I'm enjoying doing what I'm doing with the residents because I've already known them, but there are times that you feel bored with what you're doing. (P12)

Disillusioned again, and I've got to ask myself why I keep coming to this point. (P5)

I'd get out of all this stuff ... and lots and lots of others feel like that and who's at the end of all this? Poor old people. (P15)

And I really don't know why I stay there. (P9)

### Responsibilities.

There were many descriptions of incidences when the nurse experienced a dilemma in carrying out her responsibilities, because they did not fit within the framework of his or her own standards and values. Frequently this was in the context of resident care.

And I found that we were hauling her out of bed against her wishes, to sit her up for breakfast because the rule said that everyone had to be sitting up for breakfast. I said, 'Personally, I'm not going to do this anymore'. (P7)

You know if I'm really honest we used to think, 'Well how do we feel? Will we do him [an abusive resident] now or will we do him in the morning?' (P10)

Because a little old girl who can't really communicate ... has no say in the matter. If she doesn't want to take her pills, she can't say no. 'Here you are'. (P3)

You know, you've got someone in the shower and a doctor comes in [and] you don't want to leave this person sitting in the shower ... and you know you want to go because you want him or her to write up this or that, or you want to talk about this or that. (P17)

Conflict was also experienced by the participants when they perceived that some of the requirements of administration were inconsistent with common decency or justified expectations of the staff.

A lady dies on Friday and on Saturday morning there was somebody in her room. ... I mean I know no disrespect was meant, but it's as if, 'That person's gone, just fill it up with another one'. (P15)

The hardest thing to do is to stand back and rehabilitate somebody, whether it's mobilising or just whatever. (P3)

[I] don't think staff should have the right to accept that they're being punched and, what do you do with them? Do you chemically restrain them, do you physically restrain them? (P7)

But I think it's rude to sort of want money because of someone's natural [grief]. (P15)

And I've sort of reached the point where I don't want to be responsible for their [untrained staff] actions any more. (P7)

They [RCI auditors or SMT] are ... very, very necessary. But they're not perceived as that, so you get this dilemma or paradox of the system being implemented, which is sorely needed. (P5)

I'm actually level two/three you know and yet I look at my duty statement and think, 'Am I allowed to do it?' (P14)

### Doctors' Orders.

The nursing diagnosis and assessment of a resident's condition were often seen to be in opposition to the doctor's. This was another area of practice which caused conflict.

I'd finally got a doctor to come in and he actually said to me, 'Well, what do you want me to do?' I said, 'Get her off all these medications, this person is dying, she's not capable of really taking these medications'. (P9)

I have some conflict with the amount of medications that is given. (P16)

There are some GPs who quite happily have a patient taking nine, ten pills at a time. I mean that is appalling. (P3)

One man has eighteen pills at eight o'clock. Who wants to have eighteen pills at eight o'clock when you're eighty? ... Now I ask you, what quality of life does that man have? (P7)

When people come into nursing homes every medication they're on should be stopped immediately for 24 hours to see what the heck happens. (P15)

And I said to the doctor, who was an old one, he'd ordered Pethidine as an analgesic, I said, 'But she's dying, I really feel maybe we could have morphine'. 'Oh no, no, no, no, no, we won't have morphine, cutting it fine'. (P9)

### Exhaustive Description of Conflict

The experience of conflict is common in aged care nursing. The participants in this study expressed feelings of duality in maintaining Resident Outcome Standards, their emotional attachment to the residents and their view of aged care

nursing, ambivalent feelings to do with nursing responsibilities, and their assessment of a resident's needs as opposed to the doctor's.

Most of the informants reported struggling to provide "hospital-like" care within the parameters of the Resident Outcome Standards. It was felt that many of the standards were breached because the nursing home provided integrated care for demented and non-demented residents. This caused the nurses to feel powerless to provide privacy, dignity, and protection of property to those residents who were cognitively unimpaired. Instances of someone with dementia rummaging in another resident's belongings, of wandering into the wrong room, and of shouting and calling out when a nearby resident was dying were common. Other issues were to do with resident security. The informants felt frustrated because they wanted to comply with the Outcome Standards that state that the resident should enjoy a variety of experiences, but at the same time be safe. The nursing home facilities, in all cases, did not allow dementing residents to wander outdoors in a secure area, and nurses reported that they did not have the time to supervise them in a one-on-one situation. The use of physical or chemical restraint also caused feelings of conflict. They were unable to provide freedom of choice for those residents who could not communicate non-compliance if they did not want to get out of bed, have a shower or take their medications. In some cases it was the system that frustrated freedom of choice. This was the case when a resident had to choose a meal from a menu, for the next day. If the next day the resident no longer wanted that particular choice, it was not able to be changed. The standard for the residents' social independence was not perceived to be realistic or achievable.

Several informants said that they wanted to deliver professional nursing care but were constrained by the requirements of a home-like environment. One nurse said she found it difficult to work in a room space that was cluttered with personal property like the large TV and stand, large armchairs, and too many ornaments on the bedside table.

The Outcome Standard that had the objective of health care, however, was the greatest source of conflict for the participants, particularly in the area of pain management. They reported feelings of inadequacy when a resident was unable to communicate the extent of his or her pain, when what they perceived as appropriate pain relief was not ordered by the doctor, or when other staff members had opposing pain management practices.

Participants experienced conflicting emotions towards both the resident for whom they cared, and the practice of aged care nursing itself. Many informants felt affection for the resident, but at the same time were frustrated, angered and impatient with their behaviour, particularly that of abusive residents. They often had to verbalise this resentment to other staff members, or privately in the treatment room or staff toilet. This provoked feelings of guilt; an acknowledgment that the participant did harbour such feelings, coupled with the recognition that the resident did not deserve to be thought of in these terms. One informant excused a resident for his abusive behaviour, but simultaneously felt deeply offended. Several informants feared that they would react overtly to a stressful situation and feel regret after.

Another source of conflict involving attitude originated in the perception that there was no status in aged care nursing, and that older people were not

valued by society. One nurse reported that the nursing home had employed two graduate nurses, but the reason they had applied for a position in aged care was that they could not find employment elsewhere. This prevailing view resulted in decreased self esteem for other staff members. Also, the recent pay increase of 10% for the public sector nurses was seen as discriminating against aged care nurses who were excluded because they were in the private sector. The general perception was that the majority of the nurses did not want to work in aged care and that burnout was common.

Conflict also arose when the informants felt that their responsibilities involved practices that were not in accord with their personal standards and values. Frequently this involved resident care being subordinate to the routine of the nursing home, including getting the resident out of bed for breakfast and showering by a certain time of the morning. The requirement that nursing home beds be filled as quickly as possible after a death, also produced feelings of unresolved grief in the nurses. There was also a dilemma in carrying out the “passive” responsibilities such as reading the care plans (often very detailed and involved) or sitting with a resident, at the expense of the more “active” work like direct nursing care or the medication round. Some of the informants were annoyed that their colleagues did spend time reading care plans, but at the same time wished that they had the time to do so. It was perceived that management expected them to attend to the residents’ physical care before their psychological care.

Staffing ratios and qualifications presented conflicting thoughts for the informants. One nurse did not wish to be responsible for other staff members, the

Assistants in Nursing (AIN), who had no qualifications, while others wished that the AINs were allowed to perform some nursing duties like giving suppositories and doing simple dressings. All of the informants felt that the quality of nursing care was being compromised by the use of untrained staff, many of whom had worked in the nursing home for many years and were very resistant to change. While recognising the value to the individual of part time work, informants generally believed that this caused problems with continuity of care, communication and difficulties with developing a stable relationship with the residents.

Informants also experienced conflict with doctor's orders. This usually involved palliative care, when the informants had made an assessment of the particular needs of a resident for pain relief, and this was opposed by the doctor. One nurse expressed feelings of frustration and anger when a doctor refused to get the palliative care team in, and several reported instances of the doctor refusing to give adequate analgesia. This occurred between staff members as well. The participants felt strongly that they were acting as resident advocate in an adversarial situation with a doctor who they perceived to be unknowledgable and uninterested in aged care.

### Time

In these findings, time was described as a large part of the aged care nursing experience. It overlapped and intersected the core themes of Non-productivity and Conflict.



Each of the participants mentioned time in the context of how it affected their productivity and how it was a source of conflict. In the case of productivity, all participants believed that they did not have enough time to achieve their productive potential. Similarly, many spoke of not being able to spend time (excluding time spent carrying out tasks) with the resident because of other responsibilities with more tangible outcomes.

Most of it gets back to time, if you haven't got enough time to do a job properly, whether it be feeding or changing residents in time. (P11)

I don't feel that I do my job properly, because I'm so rushed the whole time. (P7)

The atypical day would be more where it runs smoothly and I have time to sit down and chat with a dozen residents. (P18)

... residents get upset, they want to talk to you, things happen, you want to spend time with them and often, you know, you feel as though you can't. (P2)

I mean they may not be dying, but they will say to you, 'Don't leave me'. And you have to because you haven't got time to stay with them. (P15)

### **Exhaustive Description of Time**

The overwhelming experience of the aged care nurse was a lack of time. The informants believed that it was a very desirable and important part of aged care nursing to spend time with someone who was dying, or reassuring a confused resident. Many of the participants thought that the nursing home residents experienced loneliness and regretted that they were unable to relieve that by sitting with them, or chatting to them. They reported that the only time they had to

chat was when they were showering, toileting or feeding a resident. Time was also unavailable for listening to residents, mobilising residents, attending to incontinence, and for following up non-urgent requests. If the informant did spend some time with a resident, they found themselves preoccupied with thoughts of what they still had to do, which detracted from the quality of that time. This was a very unsatisfying experience for them.

Some of the situations perceived as contributing to the lack of time included paperwork, orientation and supervision of new and agency staff, chasing up doctors' prescriptions, inefficient systems (medication round), meetings, and interruptions.

There were various responses to the experience of working unpaid overtime. All of the informants reported working overtime, either by staying late after a shift, or by coming on early for a handover or to catch up on the resident notes. However, some thought this to be part of the job and appeared to accept it as such, others thought it unprofessional but did it all the same, and other informants worked overtime and deeply resented it.

Inadequate time resulted in the perception that the quality of nursing care was being compromised and this induced feelings of conflict and decreased productivity.

### **Verification Interviews**

Follow-up interviews were conducted to clarify and validate data from the initial interviews. All of the participants in the study were sent full transcriptions

of the interview and a summarised copy of the findings. Also enclosed was a letter explaining that the researcher would telephone to verify that the themes, meanings, experiences and descriptions which the researcher perceived to have emerged from the initial interview fitted with the informant's own experiences (see Appendix G). They were invited to make any changes to their observations, to add to them or to retract any statements if they wished.

None of the informants refuted or wished to retract or amend any parts of their transcript. All agreed that the findings accurately depicted their experience of aged care nursing. One of the informants wished to reiterate her experience of conflict in carrying out the doctor's orders when they were not in accord with her own view of what was in the resident's best interest. Another informant, who works in a facility which is dementia specific, expressed the belief that the maternal, nurturing aspect of aged care plays a large role in aged care nursing. This secondary data was recorded and used in the study.

### **Summary**

Phenomenological analysis of the interview transcriptions, using the computer software package NUD•IST, resulted in first level data comprising 26 categories. In a series of stages including shuttling back and forth between first-level data and more general categories, merging, clustering and reclassifying, 13 common themes were identified. These supported the four emergent core themes: Gratification, Conflict, Non-productivity and Rapport. Common themes supporting Gratification were "satisfaction", "support" and "rewards"; those supporting Conflict were "Outcome Standards", "attitudes", "responsibilities" and

“doctors’ orders.” The theme of Non-productivity was supported by “difficulties”, “stress” and “documentation, funding and staffing”, while the sub-themes of Rapport were “relationship” and “empathy.” The sub-theme of Time intersected both Non-productivity and Conflict.

## **CHAPTER FIVE**

### **Discussion of Findings**

#### **Introduction and Overview**

In this chapter, the findings from the study are discussed and the identified themes and their proposed linkages and relationships are depicted in a conceptual framework. The limitations of the study are outlined and the implications and recommendations are presented. Possible future research is suggested.

Descriptions of the phenomenon of aged care nursing characterise the experience as complex and ambiguous, but with interwoven threads of common meanings for individual nurses. The four emergent core themes of Gratification, Non-productivity, Rapport and Conflict are discussed within the context of the supporting sub-structures.

Gratification describes feelings of satisfaction from nursing outcomes, support by colleagues and rewarding experiences from interactions with residents.

The theme of Non-productivity involves constraints and obstacles to work output. These were seen by the participants to be difficulties with direct resident care, feelings of stress, and paperwork and staffing issues.

The experience of Rapport is discussed with the sub-themes of the relationship the nurse enjoyed with the resident, and the strong feelings of empathy.

The core theme of Conflict is then examined. Emotional conflict resulted from attempts to comply with the Resident Outcome Standards, the ambivalent

feelings that nurses held towards the residents and the practice of aged care nursing, opposing standards of nursing care, and opposition to doctors' orders.

Time is a sub-theme which intersects the themes Conflict and Non-productivity. This relationship is explored and discussed.

### **Gratification**

The findings of this study suggest that the aged care nurse experiences feelings of gratification from three main sources. One of these involves nursing outcomes which are satisfying for the nurse, sometimes because of a rehabilitative success and often from the pain-free and dignified death of a resident. Another source of gratification was perceived to be the collegial support that the participant experienced from AINs, domestic staff and peers. Thirdly, resident interaction which provided rewarding experiences for the informants induced feelings of gratification.

### **Satisfaction.**

Many of the descriptions the informants gave were anecdotal, that is they involved an incident which had given the nurse feelings of satisfaction or joy. These incidents usually referred to events concerning residents, particularly those who were close to death. Aged care nurses have a particular view of death. Unlike most other nurses and, probably, most other people in the community, every one of the nurses had seriously thought about death and did not see it as threatening, but rather as an inevitable outcome for all of the people they care for. Because of the nature of the nursing home population, nurses' exposure to the death of a resident is not an uncommon event and, provided it is pain free and dignified,

many informants expressed satisfaction in being involved. One nurse described it as a privilege. This finding is not in accord with a quantitative study of nursing staff (including nursing aides/orderlies) at a large continuing care and rehabilitation hospital in Canada (O'Hara, Harper, Chartrand & Johnston, 1996). They found that being negatively affected by patient death is common in this setting.

Many of the nurses in this study were older women. Some had experienced the death of a family member and in discussing death in the context of the nursing home, raised the subject of the death of a close relative. The two events seemed linked in the nurses' experience, one was not separate from the other. This raised the point that the aged care nurse has a special relationship with his or her resident. The uniqueness of this relationship may be because the resident is in his or her care for longer than hospitalised people and because the person is most probably going to end his or her life in the nursing home.

A satisfying experience for the informant frequently involved being part of a resident's response. This was particularly evident when the resident had dementia. Small changes for the better in the person's cognitive behaviour resulted in disproportionately large feelings of satisfaction for the nurse. Informants described events such as the resident's use of a short but complete sentence, signs of recognition of the nurse by the resident, and outward displays of enjoyment. This is in agreement with a study into the retention of nurses in long-term care, which found that one of the factors that satisfy nurses is recognition from patients (Robertson, Herth & Cummings, 1994). In a quantitative study conducted in New Zealand by Glasspoole and Aman (1990, p. 12) it was found that "an

overwhelming majority of nurses reported feeling satisfied working with elderly people.”

Satisfying experiences were also found in the informant’s acknowledgment of his or her own contribution, frequently to the rehabilitation of a resident after a fall which resulted in a fracture. These were more tangible events than those described above and are possibly much closer to the satisfaction felt by nurses working in the acute sector. Blegen (1993) found satisfaction to be strongly correlated with commitment.

One of the participants experienced a sense of satisfaction unrelated to any particular event, which implies that aged care nursing is generally satisfying. This is not in agreement with the results of several studies which have linked satisfaction to criteria such as autonomy, interpersonal relationships, task achievement, personal growth and management style (Cohen-Mansfield, 1989; Lucas, 1991; Sowell & Alexander 1989).

#### Support.

The collegial support experienced by the informants also resulted in feelings of gratification. Some nurses reported sharing esoteric experiences with other staff members; several others thought that, because of the physical and emotional demands of the work, it was necessary to give support to their colleagues, for example by taking on part of their workload if necessary. Chappell and Novak (1992) found that social support at work can assist in dealing with perceived job pressure. Other informants’ experience of support came from working in a team situation. In their quantitative study on situational support for nurses, Brooks, Wilkinson, Bott and Taunton (1993) found that, among other variables, group



cohesion functioned as a support mechanism. It may be the commonality of work experience that contributes to feelings of support among aged care nurses, a type of “unity-in-adversity” culture. Collegial support was felt by most of the nurses. Where does this particular brand of support emanate from? There are many tasks to do with aged care that are unpleasant. Showering a resident in a communal shower, often with poor ventilation so that it is stuffy and hot, in a bathroom not designed to accommodate shower chairs or trolleys, with pressure from other staff members who may also have “eight showers before morning tea” and need the bathroom, can be stressful and exhausting. The registered nurses in this study had residents to shower as well as responsibilities like the medication round and dressings. Another unpleasant task is attending to residents’ bowels. It is common for the generation who are now in their 80s to have dysfunctional bowels. Registered nurses are the ones who give suppositories. Nursing assistants are not allowed to and there are few Enrolled nurses working in nursing homes. One informant in this study said she worked with an Enrolled nurse who refused to give suppositories or take on any work over and above the level of the nursing assistants. From giving aperients to administering suppositories and frequently dealing with the results, the nurse has constantly to deal with residents’ bowels.

According to Hansen (1995), work-related aspects of support are one of the key themes driving collegiality. It may be that the work is, as one informant put it, “really too awful to be just a job.” It may be that collegial support has evolved as a necessity, and that nurses could not get by without it, as tenuous as it is in some cases. Certainly aged care is seen by some practitioners as being lower in status than all other areas of nursing (Pursey & Luker, 1995). Several of the informants

in this study described how they were not really proud of working in a nursing home. All of these statements were made using the past tense however. Nine of the nurses answered yes to the question in the demographic, "Is aged care your first preference?". However, during the interview, all of these informants indicated that it was accidental or by default that they had started working in aged care. This suggests that, although they did not choose to work in a nursing home initially, it had become their preference over time.

### Rewards.

The participants paid recognition to the nursing home residents as they described what caring for the frail aged is like. Interaction with the residents was the richest source of reward and, in describing those moments of gratification, the nurses spoke with real enthusiasm. One nurse commented, "... the light in her face [after a kiss] is worth all the slaps in a million years." This aspect of aged care nursing was categorised by Nolan and Grant (1993) as "essentially psychological", referring to the maintenance of a resident's mood and self-esteem, and half of the nurses in that study described interpersonal responses as the most interesting aspect of their work.

There is no doubt that nurses believe aged care nursing to be hard work (Peisah, 1991; Smith, 1992), and it is possible that the value of the rewards is exaggerated because of the contrast between the physical and emotional effort and the repayments for that effort. The participants in the study however, exhibited sincere appreciation and pleasure in caring for the frail aged; most of them implied that, in non-monetary terms, they were compensated for their labour.

The data which supports the theme of Gratification strongly suggests that the rewards of aged care nursing are modest and undramatic. Typically, the resident care in nursing homes is custodial or palliative. There are few real emergencies; life and death situations occur in an environment in which death is expected, so the potential for heroic action is diminished. However, the participants in this study found the end-of-life care for nursing home residents satisfying, supported and rewarding. It is possible that, because of the esoteric nature of their feelings of gratification, their true meanings may only be understood by others engaged in caring for the aged.

### **Non-productivity**

A large part of the experience of aged care nursing for participants in this study was work; that is, practical activities like lifting, dealing with demented residents and attending to residents' bowel elimination. Most of the nurses had comparable roles, duties and responsibilities and similarities were found in the context of their work as well as the management of the work load. Factors affecting their productivity included difficulties with resident care, stress, and the interrelated areas of documentation, funding and staffing levels. All informants described their productivity in terms of obstacles to achieving optimum output. None of the nurses described experiences which promoted productivity.

### **Difficulties.**

As well as being unpleasant, much of the work is physically hard. Lifting and transferring immobile residents and just being on your feet all day is tiring, especially when there are time constraints. Many of the informants reported not

having enough time for morning tea and even lunch breaks. Nurses described their work as being heavier than in the past because of the change in the dependency of nursing home residents. The vast majority of residents are concentrated in the higher dependency levels, and from 1990 to 1994 that group increased by 10% (Mathur, 1996). Most of the nurses in this study were females over the age of 40 and had been working in aged care for an average of 12 years. Many of them reported chronic back injury. It is not surprising therefore that the findings reveal that they perceived the work as heavy. One nurse reported tallying up 92 lifts in one night shift which, even for a young male, could be described as heavy. It has been suggested that feeling depleted and pessimistic has a negative influence on commitment and caring (Hover-Kramer et al., 1996).

Many nurses reported that they feel emotionally and physically drained by the work. This aspect was related to the care of those residents with dementia as well as the busyness of the work. Answering an often repeated question and maintaining a constant, reassuring manner were found to be merciless and emotionally exhausting. James (1989) described this as emotional labour, defining it as any labour involved in dealing with people's feelings. Emotional labour is a sizeable component of health care work, and makes considerable demands on those delivering health care (Phillips 1996). This would apply in particular to nurses working in nursing homes because agitation behaviours occur in a large percentage of persons with dementia (Snyder, Egan & Burns, 1995). These repetitive, relentless behaviours were a source of feelings of failure, of not making any headway, and of decreased productivity. The repetitive nature of the tasks also contributed to experiencing a sense of inadequacy.

Several other informants reported having difficulty “turning off” at the end of the shift and found themselves thinking about what they may have forgotten to do. Many telephoned their workplace after they had gone home to check that certain things had been done. This was such a frequent occurrence in one case, that the informant’s husband went “ape.” The nursing home environment is typically busy and the registered nurse has many issues to deal with, which not only keep her physically busy but mentally busy as well.

The structure of the facility also had a bearing on how productive the participant was. Many nursing homes are converted houses, and even the purpose-built nursing homes are usually older than 20 years. The rooms are small and often crowded with the resident’s personal furniture, including in some cases, a larger than hospital-sized bed, a television and a bedside table. Few of the nursing homes have single rooms as a rule, so the area is made even more unworkable with two or more people living in it.

### Stress.

For many years nursing has been acknowledged to be a stressful occupation (Firth, McKeown, McIntoe & Britton, 1987). The term has been used so often in conjunction with nursing that one informant in this study was reluctant to use it, calling it cliched. It is not surprising then that many of the other informants did use it to describe their experience of aged care. Stressful situations in the nursing home environment are common place. Cullen (1995) in her consideration of nurse burnout, argues that the nurse experiences the death of a patient as a personal failure, because the outcome that she considers positive (free from pain and fear, inclusive of acceptance and closure by patient and loved ones) is negated or

trivialised by society. Stressors such as death, pressure and feelings of inadequacy exist on a daily basis. Many of the participants have not upgraded their qualifications; only two of the informants had degrees in nursing. Gaps in knowledge would be stressful, particularly as the acute hospitals are sending back much earlier than previously, patients who have had surgery for fractured neck of femur or have been hospitalised for other similar emergencies. One nurse was caring for a resident on intravenous therapy, and there were several residents on gastrostomy tube feeding.

Resident care, the unpredictability of the work and interruptions to the work routine were reported as generating stress which affected productivity. Some of the situations were very common and occurred regularly, like dealing with faecal incontinence. One informant, when asked what she thought the essence of aged care was, replied with a wry smile, "Smelly." Several other nurses described incidences of verbal and physical abuse by the resident, but implied that, although they found it stressful, they accepted abuse as part of the job. Research in the US has shown that 25% of nursing home residents display significant physical aggression (Burgio, Jones, Butler & Engel, 1988). Other situations causing stress were related to the events surrounding the death of a resident. Nurses felt very angry when a resident died in pain, or without somebody being with them. Since death is common in nursing homes, it could be assumed that the nursing environment would be specialised in providing excellent care for the dying. The collective experience of these nurses does not bear out that assumption.

Some nurses found their productivity to be hindered by the constant interruptions to their work. These included telephone calls, doctors' visits,

unpredictable events like accidents and even in-house education sessions. This indicates that the nurses are unprotected from interruptions and this could be related to staffing levels.

#### Documentation, funding and staffing.

The documentation of patient care is a routine component of nurses' work and can consume excessive amounts of nursing time (Deane, McElroy & Alden, 1986). In Australian nursing homes, the RCI was introduced by the Federal Government in mid 1987 to provide the basis for a system of funding (Mathur, 1996). Under this funding arrangement, residents are classified into groups on the basis of their care needs, and the paperwork which this entails is seen by participants in this study to be one factor preventing them from doing "real nursing." One of the nurses estimated that, of the seven-and-a-half hours that she spent at work, three hours were spent on paperwork. Many of the informants worked unpaid overtime in order to catch up with the documentation and several nurses worked on it at home. Twelve of the 15 informants in this study referred to the burden of documentation, believing it to be a threat to nursing practice. In a study in the US, Morrissey-Ross (1988) found that some nurses believed that the increase in paperwork jeopardised the value system of nursing. It has been suggested that computer technology may alleviate the burden of paperwork in the future (Congdon & Magilvy, 1995; Merkouris, 1995).

Because Government funding of nursing hours is geared to the RCI, any mistake or oversight in the completion of this document directly affects the staffing levels, which is seen to be another influence on productivity. The time taken orienting new staff who do not stay, the difficulties working with agency

nurses and under-staffing are also perceived by the informants to be barriers to improved productivity. The frequent use of agency staff relieving sick nurses or those on holidays, or when a position was vacant and could not be filled, became a real difficulty for those left to cope, sometimes, alone. One of the nurses described being the only regular staff member on a shift of eight nurses. The rest were agency staff.

### **Rapport**

Each of the informants in this study described feelings of rapport with the resident as being a large part of their aged care nursing experience. There were many references throughout the data to the participant's own mother or grandmother, comparing the resident to them, and suggesting that their care was or would be equivalent. Several of the nurses described the relationship as having a familial sense.

They described their feelings for the resident using loving, affectionate language, which implied a respect and honesty.

### **Relationship.**

Smithers (1992) found that frequent staff turnover limited the clients' ability to form relationships with staff. The nurses in this study had been practicing in aged care for an average of 12 years.<sup>4</sup> Most of them had worked at their present nursing home for more than four years. It was apparent that during this time they had formed intimate relationships with many of the residents. Pressure areas and skin care was one aspect of aged care that concerned one participant in particular. She had designed and made special articles of clothing to



help prevent skin tears. This was an example of how the nurse becomes personally involved with the resident. Another illustration of this was given by a participant who described one of her colleagues regularly cooking kangaroo stew at home for a resident who was accustomed to eating kangaroo meat. Buckwalter, Smith and Martin (1993) found that there is often a power struggle between residents and staff. Stirling & Reid (1992) observed that nurses exercised control over patients in the care giving process and Shield (1990) cited the use of a diminutive version of a resident's name as an example of asserting dominance. In this study however, there was no indication that the relationship was hierarchical or there was any sense of control by the nurses of the resident. All spoke of their relationship with the residents with affection and appeared to experience the relationship as being equal. Powers (1992) and Smithers (1992) both noted that warm relationships between staff and residents do exist.

Despite many of the informants feeling at times unproductive, angry and stressed, they all had a special relationship with the residents, they had grown to love them. The care given in some cases, when the resident is highly dependent is very intimate. One informant commented that she "wouldn't just sit there" if some stranger was going to do something to her which involved that level of intimacy.

#### Empathy.

Perhaps because of the maturity of the participants in this study, many felt that they empathised with the residents. This ranged from "knowing" the type of cooking that the resident would prefer to being able to share the experience of someone who is close to death. Jansson, Norberg, Sandman and Astrom (1995)

found that nurses in dementia care were able to place themselves in the patients' situation and to grasp the meaning of the experience from the patient's point of view. However, May (1995) argues that talking with patients in order to discover hidden aspects of their private character is intrusive and assumes that real problems are solved. In another study it is suggested that a high level of empathy in the nursing staff is needed in order to establish verbal and non-verbal contacts with the residents (Astrom, Nilsson, Norberg & Winblad, 1990). They suggested that a fruitful relationship between nursing staff and the demented patient is more probable if the nurses are empathetic. However, Salmon (1993) identified low frequency and poor quality interaction between residents and staff as a common feature of long-term care settings. It has also been proposed that nurses and the nursing home environment encourage institutionalised behaviour in residents, making it more likely that they will participate willingly in the nursing home's treatment process and daily routines (Donnenwerth & Petersen 1992; Stirling & Reid 1992).

### **Conflict**

Each of the informants in this study experienced some form of conflict. For many it came from attempting to comply with the Resident Outcome Standards, others felt ambivalent about the residents as well as the practice of aged care nursing. From almost all of the participants there was an air of hostility towards management, doctors and occasionally other staff members.

### Resident Outcome Standards.

Dilemmas in nursing home life arise when individual desires conflict with organisational expectations such as where and when the resident eats, sleeps, bathes and interacts with others (Norburn, Nettles-Carlson, Soltys, Read & Pickard (1995). One aspect of the conflict nurses experienced with Outcome Standards was described by Shield (1990), who found that they were not clear on whether the nursing home was a “home” and as such functioned with the notion that individual residents could make decisions about how they wanted to live, or if the nursing home was an institution, functioning under the medical model where clients did what was good for them as determined by their physician. The nurses in this study believed that the nursing home was home for the residents and endeavoured to create an environment where the Outcome Standards could be implemented and maintained. Conflict arose because they were often unsuccessful. One reason for this is that the age and the layout of the nursing home made difficult attempts to create a home-like atmosphere in conditions that were far from home-like. There is often insufficient space to manoeuvre wheelchairs, shower chairs, or to effectively transfer a resident from bed to chair. Several other Outcome Standards were not able to be complied with. One was pain management, where it was common for the informant to have to care for a resident who was not covered adequately for pain. Another was attempting to ensure the privacy of residents when other residents with dementia was a wanderer. This was also a threat to both of the residents’ safety.

### Attitudes.

The attitudes towards demented patients held by the nursing staff also give rise to feelings of conflict. There appear to be some feelings of guilt associated with informants verbalising their dislike of aged care nursing. Opportunities for personal expression of distress or frustration are curtailed, however overwhelming or disgusting the nurses find the task in hand. Many of the nurses in this study followed up such expressions with excuses or reasons why they felt antagonistic. Several of them indicated that they wanted to leave aged care; at the same time these nurses had been working in aged care for many years. Salmon (1993) found there was virtually no relationship between nurses' attitudes and the quality of their interactions with elderly clients but Buckwalter et al., (1993) suggested that wide spread ageism in the community had an effect on care received by elderly people in institutions.

### Responsibilities.

It appears that there is often tension between what the nursing home management want and what the nurse wants to do. The management want to fill a bed as soon as the occupant has died, whereas nurses would like to see the bed remain empty for a time to allow the staff to grieve. The registered nurses are expected to be responsible for the actions of assistant nurses who are untrained and, as one participant put it, recruited "off the street." This sits very uneasily with the registered nurses who see it as an unfair expectation. Simple areas of resident care become a dilemma for the nurse, such as turning an abusive resident in the night. They acknowledge that the resident should be turned, but rationalise that with fear of the consequences should he become violent. Hermann (1984)

observed that care for patients suffering from dementia often leads to ethical dilemmas in the staff.

#### Doctors' Orders.

The nurse's perceptions of best resident care is frequently at odds with that of the attending General Practitioner (GP), particularly in the areas of medications and pain control. This predicament was called "moral discomfort" by Wurzbach (1996) in her study of aged care nurses' moral choices. The participants faced moral discomfort when they believed they had not done as the good nurse would, when they were in situations where there was nothing they could do for the resident, or when futile treatment was ordered. Nurses seem frustrated that although they are closest to the resident, have an intimate knowledge of his condition and are caring for him 24 hours a day, their opinions on the most appropriate course of action are often in conflict with the doctor's. Jansson et al., (1995) found that the prime concern of dementia care nurses was to understand the resident's experience and wishes, and decide what is good for them. Some of the informants did successfully argue their case, but all indicated that it was difficult and mostly impossible to make the doctor change his mind once it was set on a certain course of action. Previous research has shown that nurses are often acting as the resident advocate in an adversarial situation with the doctor (Segesten, 1993). It has also been argued that nursing practice enables nurses to be aware, to a far greater degree than doctors, of the social and environmental factors that impinge upon health (Brown & Seddon, 1996).

The medication round was also seen to be a problem. Many of the participants were concerned that the resident was being over-medicated. In one

case, 18 pills were given at once, to an 80-year-old resident. Many of the nurses had taken action to attempt to have this level reduced; some had succeeded. One participant spoke about night sedation and her residents, how the residents were given a hot drink and what might be described as alternative therapy to aid sleep. Previous research has indicated that aged care nurses rate behavioural treatments above pharmacotherapy for residents with dementia (Burgio, Hardin, Sinnott, Janosky & Hohman, 1995).

Nurses are subordinate to the GPs within the nursing home hierarchy and there are legal limits on their powers of decision making. At the same time they act as resident advocate when they perceive, for instance, that pain control is inadequate. Generally they do not see the doctor as a collaborator in the palliative care of the resident. Nor do they perceive their adoption of an advocacy role as being part of a power struggle (Porter, 1992). Participants in this study appeared to consider the residents' care to have importance above all else. Many of the informants perceived the doctors to be disinterested in aged care. The Committee of Inquiry into Medical Education and the Medical Workforce (1988) found general practitioners failed to discuss medications and conditions adequately and were disinterested in illnesses affecting the aged.

### Time

Central to the participants' experience of aged care nursing was their experience of time, or more precisely the lack of time. Nurses believed that it was the reason that they were unable to spend "quality" time with residents and families who were distressed or lonely (Casey & Holmes, 1995). They perceived

this part of their nursing care to be as important as tending to the physical needs of the residents and many of them found difficulty in prioritising psychological care over physical care. Participants in a phenomenological study by Milne and McWilliam (1996), described these two aspects of caring time as “being with” and “doing to/doing for.” Some nurses, while acknowledging that being with time was valuable, felt distracted by doing to/doing for tasks which had to be done. However, apparently carrying out other more routine tasks is also jeopardised by lack of time. Nurses participating in a quantitative study into position changes for residents in long-term care indicated that time was a major problem preventing compliance with turning schedules (Helme, 1994). All saw the lack of time as an impediment to productivity. This was also the finding in a phenomenological study of the work of oncology nurses by Deatruck and Fischer (1994). Here they describe time as a central metaphor in the descriptions, enabling or detracting from the quality and quantity of the work. Hogston (1995) and Clarke and Wheeler (1992) also found that hospital based nurses perceived time to be a luxury and that lack of time endangered the psychological care and the development of interpersonal relationships with patients.

### **Conceptual Framework**

In summary, aged care nursing is described by its practitioners as comprising gratifying experiences, non-productive experiences, conflicting experiences and experiences of rapport. The way aged care nurses experience time overlays both non-productivity and conflict. A conceptual framework (see

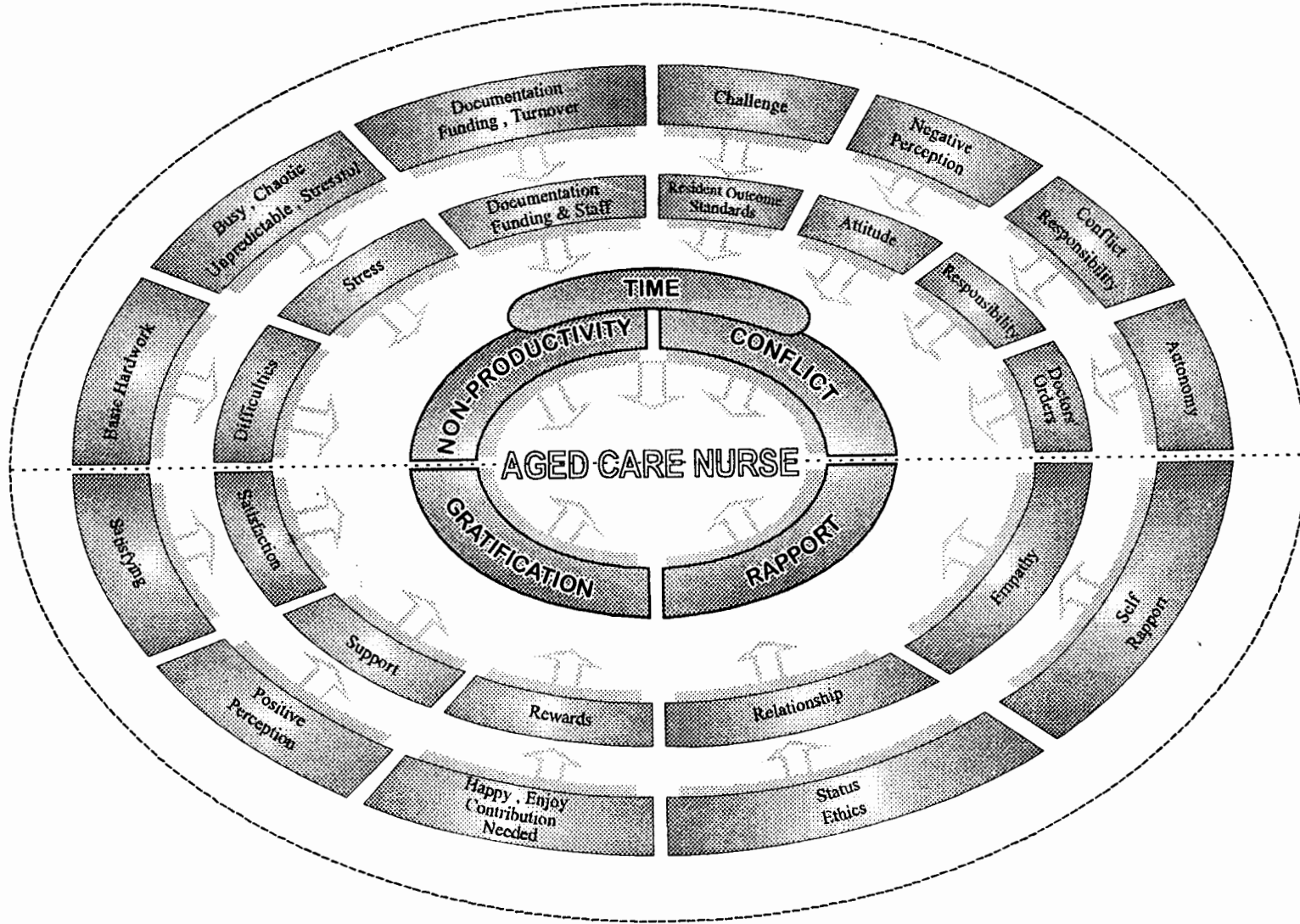
Figure 2) has been constructed to clarify the proposed linkages and relationships between the concepts.

The lived experience of the aged care nurse is represented by the area bounded by the perforated line. External influences are not completely excluded, nor is aged care nursing a “sealed-off”, isolated experience. There is interaction at the interface of aged care nursing and other life experiences. Central to the experience is the aged care nurse him or her self.

In gross terms, the experience can be divided into positive (the lower part of the model) and negative (the upper part) aspects. This division is also relatively insubstantial and undefined, as represented by the horizontal, dotted line. The core themes (beliefs, perceptions) of Gratification and Rapport comprise the positive portion and, it can be speculated, form the basis of the experience, the reason why nurses persist with the experience. The negative themes of Non-productivity and Conflict make up the remainder, together with the overlapping sub-theme of Time.

The major themes are supported by the surrounding minor, but contributory, categories on the perimeter of the experience. These in turn support sub-themes closer to the heart of the experience. Each of the categories and sub-themes contribute to the essence of the experience and each eventually impinge on the beliefs and perceptions of the aged care nurse.





**Figure 2.** Conceptual framework: Experience of the aged care nurse.

### **Limitations of the Study**

The sample group was a purposive sample, rather than a random sample; therefore the perceptions of the aged care nurses interviewed cannot be generalised to other aged care nurses. Generalisation of phenomenological studies is based on similar meanings rather than an exact duplication of essence (Field & Morse, 1990).

The range of experiences examined was also limited to registered nurses who perceived themselves to be able to articulate their experience and who responded to the request for participants. The results may also have been affected by the self-selection process, since participation was voluntary, and may represent those nurses who feel strongly about certain issues related to aged care. Also, the perspectives of registered nurses who work in hostels for the aged, rural nursing homes, hospital-based extended care and community aged care were not included.

### **Implications for Aged Care Nursing**

These findings have several implications. They confirm the results of other studies (some of which date back many years) into various aspects of aged care nursing. The elements of satisfaction, stress, time and staffing levels in nursing homes have been explored before in the context of recruitment and delivery of care. However, less has been described with regard to the gratification which is the experience of aged care nursing, the positive rapport the nurse has with the resident, and feelings of conflict within the nursing home culture. Administrators should be more cognisant of the influences, both positive and negative, in the daily experience of aged care nurses. A sharper insight by employers would lead

to a greater appreciation of the benefits and burdens of aged care and hence a more focussed and effective recruitment strategy.

The themes that emerged from this study place an emphasis on the duality of aged care nursing. Aged care nurses do have gratifying experiences that embrace feelings of satisfaction, support and reward. At the same time they experience inner conflict. This arises from both the practice of and their attitudes to aged care nursing. This study gives voice to the participants as they describe their feelings and perceptions. Considering the projected increase in demand for aged care, it would be prudent for the aged care industry to develop a comprehensive, research based strategy for attracting registered nurses, which recognises the essential nature of age care.

### **Recommendations**

By directing attention to the themes which emerged from this study and hence developing a greater understanding of aged care nursing, administrators of nursing homes will be in a better position to address staff shortages. A similarly enlightened approach to the education of undergraduate nurses may assist in turning the tide of opinion in the direction of aged care.

It is apparent that the staffing levels in nursing homes are perceived by regular staff to be too low, inhibiting optimal productivity. Ideal staff numbers would allow more time for being with the resident and would also minimise the use of agency nurses. Providing more time for one-to-one interaction would enhance the development of a richer and more meaningful relationship with the resident. To date the Commonwealth Department of Health and Family Services

has no recommended staff-to-resident ratio for nursing homes. Funding is made on the basis of resident dependence, and Directors of Nursing have discretion in deciding staffing mix and levels.

Streamlining documentation is another imperative. The detail and complexity of the present paperwork is felt by the nurses to be unnecessary and extreme. It is also necessary to address the causes of conflict, such as the difficulties in complying with the Outcome Standards, the delegation of responsibilities and the doctor/nurse relationship. The opportunities for rewarding and satisfying experiences should also be expanded. Past research has demonstrated that this is a factor in the retention of aged care nurses. Finally, if the future demand for aged care services is to be met, it is critical that the education of student nurses now at university, rates aged care equally with other fields of nursing practice.

Successfully attracting nurses into aged care, and promoting a nursing home culture that enriches the experience, will ultimately lead to better resident care.

### **Future Research**

The understanding of aged care nursing which has been gained from this study is based on the perspectives of the practitioners. The emergent themes and the conceptual framework within which they are presented and described will serve to inform further work by others in this field. Specifically, such research needs to explore samples in other long-term care facilities including hospital based extended care, rural nursing homes and community based aged care.

Comparisons of the experiences of aged care nurses from different ethnic backgrounds, and also those of male nurses would be beneficial.

Further research is also needed into the effects on the nurse of the death of a nursing home resident. Many of the informants described their experiences of reward and satisfaction in terms of the death of one of their residents, and unlike previous research into the effects of death on staff in a long-term care hospital (O'Hara et al., 1996), the nurses in this study saw a resident's peaceful, pain free death as a desirable nursing outcome.

The following further studies are also recommended:

- Research into developing a nursing home environment which adds to and amplifies the staff's experience of satisfaction, support and reward.
- Research into methods of combating negative perceptions of aged care among undergraduate nurses.
- Time management studies of the registered nurse working in a nursing home.
- Research into optimum staff to resident ratios in nursing homes.

### Conclusion

Phenomenological analysis has revealed a view into the meaning of aged care nursing as experienced and described by the nurses in this study. Four major themes emerged as being central to the experience of aged care nursing - Gratification, Non-productivity, Rapport and Conflict. The nature of aged care nursing is both complex and ambiguous but nurses have readily identified the interwoven threads of the experience. While constraints and obstacles to productivity and personal and political conflict may be seen as the negative

aspects of aged care, these experiences were relieved by uplifting events described within the framework of resident care and rapport and collegial support.

Gratifying experiences arise when there are satisfying outcomes to nursing care, when the nurse feels supported by her coworkers and when she is rewarded during interactions with nursing home residents. Descriptions of gratification may appear relatively insignificant outside the context of aged care, but for the nurses in this study they comprised a substantial part of the positive experience.

Similarly, there are strong feelings of rapport with nursing home residents. These are described within the framework of the relationship that the nurse enjoys with the resident, and the powerful feelings of empathy that are experienced.

Another large part of the aged care experience is work. This study uncovered three factors which acted as inhibitors to work output or productivity. These involved the physical difficulties with resident care experienced by the nurses, stress caused by unpredictable events and interruptions, and paperwork and staffing levels. There do not appear to be any factors in the experience of the aged care nurse which enhance productivity.

The fourth theme in the experience of aged care nursing is conflict. In this study it represented the distressing state of mind experienced by the nurse, which resulted from incompatible aspirations and needs. Practicing to the Resident Outcome Standards in many instances conflicts with good nursing care. There are ambivalent feelings towards the residents and aged care nursing. Some directives by management are in conflict with individual nurses' standards and values, and they are caught in an advocacy/adversary role with the doctors.

Time is central to the experience of aged care nursing. Its lack detracts from both the quality and the quantity of the work. Nurses are torn between providing “being with” caring time and “doing to/doing for” caring time.

Future investigation is required to increase the depth of understanding of aged care nursing and to determine how to create a nursing home environment which enriches the experience of both nurse and resident.

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**APPENDICES**

## Appendix A

### Bracketing Memo

#### A description of the researcher's own experiences and preconceptions.

I had been many years out of the paid work force; married to a farmer a week after I finished my nursing training, I raised children and worked on the farm for nearly 20 years. In order to get back into nursing, I had to do a six week 'refresher' course. The theoretical aspect of nursing presented no problems but practically I did not feel confident enough to apply for work at an acute hospital. So began my employment in nursing homes.

During the early stages of work in a nursing home, I formed the opinion that it was a refuge for some registered nurses who were as under-confident as I, and who did not want to take on further study or professional development. The career structure had recently been introduced at that time.

I also experienced at first hand how physically hard the work was, how emotionally draining it could be and how rewarding it was on a very personal and intimate level. I became very fond of many of the nursing home residents and felt a unique bond with my nursing colleagues. Esoteric humour and camaraderie seemed to be central to their daily impetus. I found them to be very patient, loving and genuinely concerned for those they cared for. Many of them were the breadwinners of the family, none appeared to come from wealthy backgrounds. Most of them would give more than they were required to by management, would go beyond the call of duty. This may be by staying well beyond their knock-off time, by taking residents' washing or mending home, by shopping for the residents' clothes or by bringing home-cooked food in. This was all done quietly and without fuss; they expected no accolades and they appeared to consider it part of the job.

However I did come to think that many of them were resistant to change. A lot of the registered nurses were older, over 40 years, and had no desire to convert their hospital-based diploma to a nursing degree. In fact they would take a stand against university trained nurses, and defend their own experiential background. I thought they felt threatened by better educated nurses.

I also perceived that they did not see themselves as having equal status as registered nurses who were working in the acute hospitals. Aged care was definitely a poor relation to other areas of nursing, and those who worked in aged care were seen to be professionally inferior.

I worked at several nursing homes during the next few years, and my views concerning aged care nursing were strengthened.

Then I was employed as Nurse Manager at a nursing home. It was when I was in this position, closer to the nurses and often acting as a confidant or counsellor, that my beliefs about the work culture in aged care, and the type of person it attracted were reinforced. I also found that it was difficult to recruit registered nurses into aged care.

So I begin this research with inherited understandings, opinions and beliefs about aged care nurses and nursing, which have their genesis in personal experience. I identify and bracket them as follows:

- Aged care nursing is physically hard work and emotionally draining.
- Aged care is frequently a last resort for nurses who have not kept up with further education, are older and under-confident in their abilities.
- Humour and relationships with colleagues are what keeps aged care nurses going.
- Aged care nursing attracts people who are giving, patient and self-sacrificing by nature.
- Aged care nursing does not enjoy an equal status to nursing in the acute sector.
- Working in aged care requires a narrower knowledge base and less technical know-how than acute care.

Given the implications for nursing of our aging population, I believe that it is important that we identify the rewards and difficulties of aged care nursing so that we can use this knowledge to develop new strategies to encourage registered nurses to make it a career choice.



**Appendix B****Letter of confirmation to Director of Nursing**Christine Martin  


Director of Nursing  
Nursing Home

Dear

Many thanks for your offer to help me recruit volunteers for my research.

As we discussed, I need registered nurses who have been working 'hands-on' in aged care for at least 12 months and who will agree to a tape-recorded interview lasting about 1 - 2 hours and a follow-up, perhaps by telephone, of maybe 10 or 15 minutes. The interview can take place where ever the participant prefers - my place, their place, coffee shop, over lunch, dinner or breakfast. It will be a very relaxed discussion, one that I hope will be enjoyable for the volunteer; a chance to tell a good listener about the unique experience of aged care nursing, the rewards and difficulties. I 'job-share' at the moment, week-on/week-off, so I am available for the interview pretty much any time.

There is no preparation necessary for the interview, it is not a test of knowledge. The data will be treated in the strictest confidence, the nurse's identity will remain anonymous and there will be no record of the individual nursing home from which he/she has been recruited.

Enclosed is a copy of the proposal and a form for listing names and home telephone numbers of the volunteers. I would appreciate it if you would return the list to me in the s.a.e. enclosed.

Thank you so much for your generous approach to my study - I am well aware that researchers can be a bit trying at times! When it is finished at the end of this year, I will post out a copy of the thesis.

Yours sincerely

Christine Martin

## Appendix C

Demographic Information

Gender M or F

Age

years

Country of birth ✓

1. Australia

2. Elsewhere

*Please specify:* \_\_\_\_\_

Primary language ✓

1. English

2. Other

*Please specify:* \_\_\_\_\_

Is aged care nursing your area of first preference? Y or N

Are you presently employed working ✓-

1. Full time

2. Part time

Years of practice as an aged care nurse

years

Duration of practice in present employment

Previous working experience:

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**Nursing Education** ✓

Hospital Based Diploma

Degree in Nursing

Post Basic Courses

Post Graduate Qualifications

Please specify:

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Please specify:

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---

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State or Country where nursing education received:

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Any further relevant information or suggestions:

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*Thank you for your time and co-operation in filling out this form.*

## Appendix D

### Interview Guide

*Participants will be asked to share their thoughts, feelings, perceptions and the circumstances that they associate with aged care nursing.*

*A sample of prompts may include the following:*

How have you come to work in aged care?

What is a typical day/shift like for you? (With questions to facilitate the breadth and depth of the description.)

What is an unusual day/shift like for you? (With questions to facilitate the breadth and depth of the description.)

What parts of your job are particularly rewarding?

What parts of your job are particularly difficult?

What in your surroundings (including people) keeps you going?

Describe an incident that you think captures the essence of what aged care nursing is all about.

Is there anything else which you think may be important for me to know?

## Appendix E

### Letter of Information for Potential Participants

I am conducting a study on the lived experience of the aged care nurse and I would appreciate your participation. The study will be conducted over an eight week period, your time commitment will involve one or two hours for the first meeting and possibly less than that for the follow-up meeting.

You were selected as a potential participant because you have met selected criteria. That is, you are currently registered with the Nurses Board of Western Australia, are practicing in the clinical stream at a nursing home and have worked in aged care for more than 12 months.

If you agree to participate in the study it will involve an interview which will be tape recorded. The interview is expected to last approximately one to two hours. You will be asked to describe the meanings and qualities of the experience of aged care nursing. There is no need to undergo any preparation for the interview. The interview will be conducted at a mutually agreed time and setting. The benefit to you in participating is you have the opportunity to express your thoughts about the experience of aged care nursing, which will be incorporated into the findings of the study. This will contribute to the study of the unique experiences of the aged care nurse.

All responses given in the interview will be kept confidential. The tape recording of your interview will be identified by a code only. The index of names to the code will be kept secure at all times. Once the study is completed, the name/number code will be destroyed and the tape will be erased. Your identity will remain anonymous when the research report is written.

Your participation in the study is voluntary. You may refuse to participate without being penalised and you also have the right to withdraw from the study at any time without penalty.

You may contact me at any time to ask questions regarding the study or your rights as a participant. I may be contacted at home on [REDACTED] or at work on (09) 386 3240. If I am unavailable at home you may leave a message on the answering machine, or send a fax on the same number.

Thank you in anticipation,  
Yours sincerely

Christine Martin

**Appendix F****Written Consent Form**

**Study Title:** A Phenomenological Study of the Lived Experience of the Aged Care Nurse.

**Investigator:** Christine Martin.

Ms Martin is a registered nurse studying the lived experience of the aged care nurse. Her purpose is to describe and interpret the essence of the experience and to generate new meanings of the nature of aged care nursing from the practicing nurse's perspective. In-depth, face-to-face interviews will be conducted that will take one or two hours of my time and probably less than that for the follow-up meeting. I understand that the interview will be tape recorded by the investigator.

I know that my participation in this study is strictly voluntary and I understand that there will be no health risks to me resulting from my participation in the research. I understand that I am free to refuse to answer any specific questions. I also understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

If I have any questions about the study or about being a participant, I know I can call Ms Martin. I may reach her at home on [REDACTED]  
[REDACTED]

I agree to participate in this study and I have received a copy of this consent form. I understand that the information may be published, but my name will not be associated with the research and my identity will not be revealed at any time. I have also been assured that the tape will be erased once the study is completed and all other data will be kept in a secure place and destroyed five years after the completion of the study.

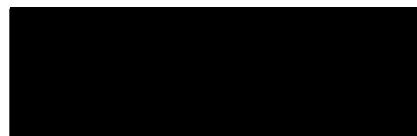
Participant's Signature: \_\_\_\_\_

Investigator's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Appendix G****Credibility - Covering Letter**

Christine Martin



Informant  
Address.

Dear

I am sorry that it has taken me so long to get back to you after our meeting, the study is taking a lot more time than I ever dreamed.

I am enclosing the transcript of our interview and a draft of the findings. You may remember I said I would get back to you after I had analysed the data.

You are coded as [redacted] in the transcripts and you are (P) in the findings. There may be names and places in the transcript that identify you or other people, so you might like to destroy it if you like, or keep it safe anyway.

I will call you in a few days to check whether you would like to add to what you've said, or maybe change what you said, or correct my interpretation of what you've said.

Your interview, and in fact all the interviews were fantastic - such a rich source of data. I really felt privileged to have the nurses share their thoughts with me.

Thank you once again for your help

Regards,

9 November, 1996

## Appendix H

Significant Statements Sample

```

*****
(3 1 3) /Experience/work/chaotic
*** Definition:
Cut from node (3 3 3) .
+++++
+++ ON-LINE DOCUMENT: ALEX
+++ Retrieval for this document: 16 units out of 1071, = 1.5%
*Alex 686
++ Text units 687-688:
Um, chaotic. It's the only way I can put it. Um, a typical day for me 687
would be coming in, checking to see if we have enough staff, and 688
++ Text units 691-692:
and then it starts from there. You have, I tend to find I'm running 691
around like a headless chook quite often. Um, trying to tend to all 692
*Alex 699
++ Text units 703-704:
wards. Which means my 7 to 3.30 shift is quite often a 7 til 5 or 6 703
shift. Because there just so many little things to do. Um, I will have 704
++ Text units 742-746:
then address the pain. So you have all those thoughts going on and 742
now I'm not confined to certain wards areas here, there are 80 743
residents in this nursing home and I find that I'm thinking of all 80 744
residents. And I'm trying to remember who's round he place and 745
who's got what and who needs something doing for them. 746
*Alex 751
++ Text units 756-760:
has to be taken in as part of the day. And, often I take on too much 756
and I get to the end of the day totalling spinning, thinking now, have 757
I done it all. And I'll even go home sometimes and suddenly 758
remember sometimes, I have to ring back. Say, I haven't done this, 759
or will you do that. Um, but that's because of the position I'm in. 760
+++++
+++ ON-LINE DOCUMENT: BELLE
+++ Retrieval for this document: 3 units out of 669, = 0.45%
*Belle 6
++ Text units 20-22:
they're aloud to be given. Sometimes the confusion is frustrating, 20
the way you can get the, you know, what's coming and there's 21
nothing much you can do about it within the facilities. 22
+++++
+++ ON-LINE DOCUMENT: BRIE
+++ Retrieval for this document: 15 units out of 1275, = 1.2%
*Brie 121
++ Text units 122-125:
Very busy. Lots and lots of interruptions all through. You just 122
don't have enough time to be able to go and do what you have to 123
do. It's always in the back of your mind, I've still this to do, that to 124
do. And it all evolves eventually at the end of the day, but it is 125
*Brie 217
++ Text units 218-222:
No, no. A real hectic, hectic shift. I mean you might have a couple 218
admissions, you might have somebody whose fallen and fractured 219
neck of femur and has to go X-ray and hospital. And you might get 220
something like about six doctors come in all at once, plus the phone 221
ringing and all that. And you literally, your off duty at 3.30 and 222
*Brie 954
++ Text units 977-982:
lots of feeds to do so we do some feeds. So it's sort of, you're on 977
the go all the time, sometimes it's all the same thing that you're 978
doing every day maybe, you know, when there's not much sort of 979
change but then all of a sudden the whole place just goes berserk 980
and you know, you don't know whether you're coming or going sort 981
of thing so it sort of evens itself up really in the long run. 982
+++++
+++ ON-LINE DOCUMENT: PORTIA
+++ Retrieval for this document: 5 units out of 929, = 0.54%
++ Text units 216-220:

```



## Appendix I

Coded Transcript Sample

(1) /base data  
 (1 1) /base data/nsg home  
 (1 1 1) /base data/nsg home/Nymph  
 (1 1 2) /base data/nsg home/idyll  
 (1 1 3) /base data/nsg home/llama  
 (1 1 4) /base data/nsg home/sledge  
 (1 1 5) /base data/nsg home/arab  
 (1 1 6) /base data/nsg home/onyx  
 (1 2) /base data/age group  
 (1 2 1) /base data/age group/20s  
 (1 2 2) /base data/age group/30s  
 (1 2 3) /base data/age group/40s  
 (1 2 4) /base data/age group/50s  
 (1 2 5) /base data/age group/60s  
 (1 3) /base data/preference  
 (1 3 1) /base data/preference/yes  
 (1 3 2) /base data/preference/no  
 (1 4) /base data/employed  
 (1 4 1) /base data/employed/fulltime  
 (1 4 2) /base data/employed/parttime  
 (1 5) /base data/practice yrs  
 (1 5 1) /base data/practice yrs/up to 5  
 (1 5 2) /base data/practice yrs/5 to 10  
 (1 5 3) /base data/practice yrs/10 to 15  
 (1 5 4) /base data/practice yrs/15 to 20  
 (1 5 5) /base data/practice yrs/20 to 25  
 (1 5 6) /base data/practice yrs/25 to 30  
 (1 6) /base data/education  
 (1 6 1) /base data/education/degree  
 (1 6 2) /base data/education/diploma  
 (2) /how?  
 (3) /Experience  
 (3 1) /Experience/work  
 (3 1 1) /Experience/work/basics  
 (3 1 2) /Experience/work/turnover  
 (3 1 3) /Experience/work/chaotic  
 (3 1 4) /Experience/work/stressful  
 (3 1 5) /Experience/work/unpredictable  
 (3 1 6) /Experience/work/documentation  
 (3 1 7) /Experience/work/funding  
 (3 1 8) /Experience/work/difficulties  
 (3 2) /Experience/conflict  
 (3 2 1) /Experience/conflict/time  
 (3 2 2) /Experience/conflict/challenge  
 (3 2 5) /Experience/conflict/discord  
 (3 3) /Experience/colleagues  
 (3 3 1) /Experience/colleagues/positive  
 (3 3 2) /Experience/colleagues/negative  
 (3 4) /Experience/self  
 (3 4 1) /Experience/self/about  
 (3 4 1 1) /Experience/self/about/ethics  
 (3 4 1 2) /Experience/self/about/status  
 (3 6) /Experience/gratification  
 (3 6 1) /Experience/gratification/satisfaction  
 (3 6 2) /Experience/gratification/supported  
 (3 6 3) /Experience/gratification/rapport  
 (3 6 4) /Experience/gratification/enjoy  
 (3 6 5) /Experience/gratification/responsible  
 (3 6 6) /Experience/gratification/autonomy  
 (9) /Speakers  
 (9 1) /Speakers/Alex  
 (9 2) /Speakers/barbara  
 (9 3) /Speakers/Belle  
 (9 4) /Speakers/Brenda  
 (9 5) /Speakers/Brie