An Exploration of the Psychosocial Needs of Older People in Extended Care Settings: a Qualitative Study

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Declaration

I hereby declare that this work is my own and has not been previously submitted for degree or any other qualification. Where reference is made to the work of others, due acknowledgement is given.

Signed……..

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Abstract

Recent demographic projections indicate significant increases in the number of older people across Europe. This population shift requires appropriate responses by health and social care systems. An important challenge is to ensure that the years added to life are healthy, active and productive. Thus, research must make a concerted effort to enhance independent living through the exploration of measures which promote and maintain optimum health and quality of life among older persons in extended care settings.

The purpose of this research was to explore psychosocial needs among older persons in extended care settings in Ireland. The research design was guided by a grounded theory approach based upon the principles of symbolic interactionism. The sample consists of caregivers and residents from two publicly funded extended care settings in the South of Ireland. Employing a theoretical sampling strategy, data were collected by means of semi-structured interviews and focus group discussions. A theory was then constructed from the emergent concepts within the data.

Findings show that specific psychosocial determinants are acknowledged by residents and caregivers as being intrinsic to quality of life and well-being among older persons in extended care facilities. The importance of psychosocial well-being among residents of extended care facilities was highlighted by the service-users as the data demonstrate how effective coping skills, positive adaptation and an optimistic internal locus of control can promote psychosocial well-being by reducing the impact of negative life events and optimising present circumstances. Furthermore, residents and caregivers either directly or indirectly referred to the multifaceted value of social interaction to the psychosocial well-being of older persons in receipt of extended care services. However, a number of barriers exist which must be addressed to ensure the optimal quality of life and well-being of older persons in extended care facilities. Arguably, these barriers may be reduced through effective communication amongst caregivers, residents and families as findings show that communication and fundamental human interaction are the most lucrative means of assessing and

subsequently fulfilling the heterogeneous psychosocial needs of older people residing in extended care settings.

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Also, this study would not have been possible without the generosity of the staff and residents of the study sites, a most sincere thank you to all who participated.

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List of Abbreviations

CAQDAS	Computer Assisted Qualitative
ACT	Activity in Care Training
NRA	Nurse Respondent Site A
NRB	Nurse Respondent Site B
HCAA	Healthcare Assistant Site A
HCAB	Healthcare Assistant Site B
CNMA	Clinical Nurse Manger A
CNMB	Clinical Nurse Manger B
RRA	Resident Respondent A
RRB	Resident Respondent B
I	Interviewer

Chapter 1
Introduction

1.0 Background

Research into health in later life has been dominated by a biomedical approach (Bowling and Dieppe, 2005). As the practice of gerontology grows, the importance of understanding the psychosocial theoretical constructs that frame our practice intensifies. There has been continuous pursuit in all disciplines to move beyond the understanding of simple processes to understanding the complexities that exist in the social and physical world (McCormack et al., 2008). Research in ageing now looks to the oldest old and the greater challenges they face given the higher risk of loss across psychological, physical and social aspects of their lives (Baltes & Smith, 2002). While often overlooked, the psychosocial dimensions of health among older people are of paramount importance, particularly given the nature of change and adaptation associated with the ageing process. Significantly, it is conceded that the transition to an extended care facility constitutes one of the most difficult developmental challenges for older people (Baltes, 1996). Furthermore, psychological conditions are said to exacerbate physical conditions (Harwood et al., 1998). Thus, holistic care of older people in extended care settings must endeavour to facilitate optimum psychosocial well-being through the appropriate management of individual personal, social and psychological factors. Research exploring the subjective accounts of staff and residents currently experiencing such phenomena is most desirable in the endeavour for improved outcomes.

1.1 Context of this Study

Over the past few decades the prophesised demographic transformation has evolved from a distant prediction to a certain reality. Worldwide, the proportion of people aged 60 years and over is growing faster than any other age group (WHO, 2002). In 2005, the United Nations estimated that there were 690 million older persons worldwide, a figure that is predicted to double by the year 2025, and to reach nearly two billion by 2050. In Europe, the older population represents 17% of the total population; this figure is expected to increase to 30% by 2050 (Eurostat, 2007). The

National Census 2006 indicated that there were 470,000 older persons aged 65 years and over living in Ireland, portraying 11% of the country's overall population (Central Statistics Office, 2006). Furthermore, it is estimated that this figure will rise from 11% to almost 25% within the next 30 years, implying that almost one quarter of Ireland's entire population will be aged 65 years and over by 2036 (Central Statistics Office, 2004). Not only that, it is predicted that the most significant growth will occur among those aged 80 years and over (Commission of the European Communities, 2002; OECD, 2007), the reality of this prediction is already evident in Ireland with a 24.9% increase among those aged 80 years and over in the last ten years (Central Statistics Office, 2006).

This rapid growth in the "very old", coupled with the predicted decline in the economically active age groups (15-64 years), will result in substantial increases in dependency ratios, particularly the old age dependency ratio (Connell and Pringle, 2004). Although Ireland's current old age dependency ratio is low by European standards, it is projected to increase to almost 45.3% by 2050, more than double the 2005 figure of 16.5% (Eurostat, 1996). The significance of this demographic transformation is reflected by the substantial volume of literature which considers the increasing pressure on health services as a result of changing demographic profiles and subsequent inclines in the dependency ratio (Jacobzone et al., 1998; Commission of the European Communities, 2002; Polder et al., 2002; DOHC, 2008).

Functional ability is a key factor for individuals to maintain optimum independence and involvement in social activities (Christensen at al., 2006). Studies on changes in functional ability show that those aged 85 years or more experience the most deterioration (Bowling and Grundy, 1997; Avlund et al., 2003); inevitably impinging upon individuals' ability to carry out basic activities of daily living. The relationship between reduced functional ability and the need for formal or informal care is quite apparent as functional decline has been associated with reduced independence (Hoogerduijn et al., 2006). At present, approximately 5% of older people reside in extended care settings in Ireland. While the majority of international data claims that informal care could account for up to 80% of total care (Jacobzone et al., 1998), when one considers the reality of modern society this option is not always feasible.

The availability of carers is declining as more women, the traditional family carers, are now in employment outside the home thus, the demand for formal care will increase substantially (NDA/NCAOP, 2006). Despite predictions that advancements in biomedical therapies reduce the incidence of disability and mortality the need for extended care is expected to increase in developed countries as any reductions will not compensate for population ageing (Manton et al, 1993). The predicted increase in demands for extended care services will have repercussions on a number of levels, all of which will be reflected in government expenditure. Spending on health and long-term care is expected to account for 8.4% of GDP in 2050, while expenditure on pensions is expected to increase to 11.1% of GDP in 2050, from 4.6% in 2005 (Irish Government, 2006). The National Treasury Management Agency (2001) predicts that an additional annual Exchequer expenditure of approximately 7% of GNP will be needed by 2050 to maintain current levels of pension and health service provision. Expenditure on age-specific healthcare is predicted to increase in response to the growing life expectancy of frail older people, whose health care needs are greater due to the existence of co-morbidities (Polder, et al. 2002). Hence, despite the fact that increased longevity is one of the greatest achievements of the 20th century, it is perceived as a precursor to dwindling health and social budgets as a result of caring for dependent older persons (McMurdo, 2000). Thus, a concentrated effort is needed to reduce the cost associated with ageing, while at the same time ensure quality added life years.

1.1.1 Containing Expenditure; Promoting Well-being

Although greater numbers of individuals are reaching an advanced age in better health than ever before which, according to Costa & Lahey (2003) may be attributed to improved lifestyles, the notion that increased longevity is accompanied by increased morbidity is nevertheless a common conception (Layte et al., 1999; Bowling and Grundy, 1997; Blane et al., 2004). A recent report by the Organisation for Economic Co-Operation and Development (OECD) on the disability trends among older persons concedes that while the prevalence of disability rates have declined in recent years, population ageing and longevity will result in a greater proportion of older people with severe disability (LaFortune and Balestat, 2006). Jacobzone et al. (2000) assume a direct translation of trends in disability to formal care needs; this report subsequently recommends the implementation of initiatives which reduce or postpone

the onset of disability to alleviate demands on extended care services. These recommendations are warranted upon consideration of projections by the Economic Policy Committee which indicate that age-related public spending in Ireland will increase from 15.2% of GDP in 2005 to some 23.3% in 2050 (Economic Policy Committee and European Commission, 2006). Moreover, a national report on long term care reveals expenditure on long stay beds amounted to €429 million, approximately €58,000 per bed in 2005 (Department of Health and Children, 2008). However, it is acknowledged that a complex mix of physiological, psychological and social processes is involved in the onset and experience of disability, all of which may be modifiable through interventions designed to improve holistic health (Herman et al., 2005). Hence, there is evidence to suggest that the proportion of expenditure associated with age-related disability may be alleviated through appropriate and timely interventions. While the implementation of such interventions may have significant implications for the economy, the humanitarian gains are priceless.

1.2 Quality Added Life Years

Research into health in later life has demonstrated older persons' desire to continue living in their own home (Garavan et al., 2001). Furthermore, government initiatives such as the National Development Plan, continually strive for a continuum of health and social care services to facilitate older people to remain in dignity and independence in their own homes for as long as is possible or practicable (Irish Government, 2007). However, due to heterogeneity of the ageing process, the above goal can be short lived for a minority of older persons, as stated earlier approximately 5 per cent of those over 65 years of age reside in extended care facilities. The National Council of Aging and Older People (2000) assert that for those who can no longer be maintained in dignity and independence at home, extended care facilities must endeavour to provide care to such a standard that older people experience both health and social gain from the service.

Older people living in extended care may be regarded as being among the most vulnerable in our society by reason of the special supports and continuing care and assistance they need (Age and Opportunity, 2003). Therefore, it is contended that older people living in extended care settings should be cared for in such a way that they experience improvements in, not only their physical health, but also their

psychological health, to assure that their subjective quality of life is enhanced (Age & Opportunity, 2003). Thus, the transition to extended care seeks not only to promote and maintain quantity of life, but also quality of life. The issue of quality of life in extended care settings has been long standing, O'Connor and Walsh (1986) conducted research into the phenomenon in the mid 1980's, they concluded that the social environment of extended care facilities entails;

> "living a passive life in public places" (p.129).

O'Connor and Walsh (1986) further commend that quality of life needs to include;

> "the prevention of avoidable mental decline and the maintenance of physical and social function. The restoration of, or compensation for, loss of diminishing function is central to establishing the quality of life as the main theme of care" (p.129)

Furthermore, the National Health Strategy; *Quality and Fairness – A Health System for You* (2001) places value on quality of life, and the achievement of social gain in addition to health gain in later life. Therefore, in order to achieve optimum quality of life it is necessary to look beyond measurable health outcomes and look towards the broader determinants of health and well-being in old age.

1.3 Ageing and Health Promotion

A number of theories exist which attempt to define ageing and how best to experience it, however these theories lack consensus and many are contentious. One of the early theories on ageing; disengagement theory, adopted by Cumming and Henry (1961) was based on the premise that ageing was an inevitable process whereby individuals withdrew from their previous life roles and society in general (in Murphy et al., 2007). Alas, this perspective serves only to promote the marginalisation of older people in society. Alternatively, Havighurst constructed a more positive image of ageing through his acclaimed work on successful ageing and his subsequent activity theory. This theory commends the maintenance of individuals' participation in society as the foundation of successful ageing (Havighurst, 1963). This theory however, fails to acknowledge the transition to old age as a life process. In contrast, Atchley's continuity theory portrays life as a continuous process in which one adapts to one's

current life stage based on innate personal characteristics and the surrounding social world (Atchley, 1989). Therefore, continuity is dependent on societal and personal capacity to adapt and cope with life changes in an optimistic and fervent manner.

While some positive theories exist with regard to ageing, most are based on the assumption that the older population is comprised of a homogenous group of individuals. Thus, in order to highlight the heterogeneity of the older population, theories must reflect the diverse nature of older persons' circumstances and individual characteristics. The National Council for the Elderly (1994) conferred that,

> "Positive ageing is determined by how successful older people are in meeting their personal and social needs as determined by their individuality and their particular circumstances" (p. 2).

This definition appropriately acknowledges the heterogeneity of the ageing process. However, it was agreed that the universal prerequisite for positive ageing is "survival"; highlighting the imperative need to implement health promotion measures to facilitate the positive adaptation to changes that may occur in later life (National Council for the Elderly, 1994).

Although widely criticized for its idealistic portrayal of health and well-being, the World Health Organisation's definition of health as;

> "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".
>
> (WHO, 1946, p. 100).

clearly acknowledges the multifaceted determinants of health and well-being. Although now outdated and widely rejected, the above definition initially served to broaden the definition of health from that of isolated physiological processes, to interrelated biological, psychological and social processes. However, to define health in old age is controversial. It is contested that the above description of health is not universal and certainly not attainable, particularly among older persons, where age associated declines in physiological processes are inevitable (Smith et al., 2002; Grossman & Lange, 2006). Andersen and Burckhardt (1999) recognise that even in the context of ill health individuals can achieve an optimal state of wellness through

interventions aimed at enhancing basic constituents of well-being and secondary prevention. The literature puts forward many theories of what healthy ageing is (Cumming and Henry, 1961; Havighurst, 1963; Atchley, 1989; Rowe and Kahn, 1998; Baltes and Mayer, 1999; Valiant and Mukamal, 2001), some focusing primarily on physiological factors, others on psychosocial factors, as yet there is no consensus on what determines health in old age. Society is comprised of a heterogeneous group, thus all do not age at the same pace, nor have the same internal attribution styles, thus the ageing experience is extremely subjective and varies among individuals (Farley et al., 2006; Gilhooly et al., 2007). Despite acknowledgement of older persons' heterogeneity, it is accepted that minimum standards of practice must be agreed upon in order to ensure positive adaptation and optimum quality of life in old age (O'Shea, 2006). Nevertheless, in order for such practices to be successful they must be modifiable to reflect the heterogeneity of older persons needs.

In recognition of Atchley's continuity theory one can appreciate the importance of maintaining an optimum state of health throughout the life course. Ideally this would entail making healthy life choices in youth and maintaining such behaviours throughout the lifespan into old age. However, as the previously dominant medical model of health focused on repair rather than prevention, health promotion initiatives are a relatively new endeavour. Of late, health care practitioners have looked to the more inclusive biopsychosocial model which emphasizes prevention as well as cure. This more inclusive model of health was initially thought to benefit the younger, healthier members of society in an effort to prevent ill-health and until recently the needs of older people were deemed unworthy of health promotion initiatives as it was perceived that they would not live to see the benefits of such efforts (Rowe and Kahn, 1998). In stark contrast, there exists an emergent body of evidence which reveals the remarkable capacity of older individuals to recover lost function (Christensen et al., 1996; Trappe et al., 2000; Calero-Garcia et al., 2007). Furthermore, it is hypothesised by Vass et al. (2005) that many of the clinical and social problems associated with functional decline can be improved though an holistic interdisciplinary approach to care thus improving active life expectancy. Therefore, it is inferred that proactive, individualised, holistic approaches to care are central to the endeavour of promoting optimal health and social gain among older persons as such an approaches are more

conducive to the chronic rather than acute needs of those residing in extended care settings.

1.4 Bio-Psycho-Social Being

While the traditional biomedical model of health and illness is dualistic; assuming that the body and mind are separate entities, the now widely accepted biopsychosocial model is holistic; a union of body and mind (Bernard & Kaupat, 1993). Rasmussen (1975) traces the philosophic origins of the biomedical model back three or four centuries when established Christian orthodoxy lifted the prohibition against physicians dissecting the human body as long as they did not presume to deal with man's soul, morals, mind and behavior (in Engel, 1978), thus the physical being was disassociated from the psychosocial being. However, psychosocial approaches are assuming increasing prominence as a means of achieving maintenance, promotion of health and secondary prevention through fostering healthy behaviours and adherence to them, reducing disability, promoting function and enhancing well-being and quality of life (Thompson, 2007). This increased attention on health maintenance initiatives is very much influenced by desires to alleviate the economic impact of ageing populations; nevertheless there is evidence to suggest the momentous benefits of such approaches for older person's holistic well-being (Glass et al., 1999). The Irish health promotion strategy *Adding years to life and life to years…A Health Promotion Strategy for Older People*, compiled by the National Council of Ageing and Older People, contends that extended care settings represent ideal environments for the implementation of health promotion initiatives such as physical activity programmes, with social activities and interaction being encouraged (Benner and Shelley, 1998). However, the negative depiction of extended care settings as environments where older people live passive lives without any autonomy or independence is a more widely accepted representation (Age and Opportunity, 2003). Furthermore, there appears to be dearth of literature which evaluates the current situation in gerontological practice in an Irish context.

As functional and psychosocial variables are known to be related, recognition of the fundamental role of psychosocial determinants to health and well-being in older age is crucial (Harwood et al., 1998). For instance, balance theories of health conceptualise equilibrium between body, mind and spiritual components of individuals and the

relationship of persons to their physical and social environment as being the foundation of optimum well-being (Albrecht and Devlieger, 1999). Furthermore, health research has accumulated considerable evidence in favour of the biopsychosocial perspective, with acknowledgement of multifaceted influences on health and illness being more apparent (Faltermaier, 1997). Moreover, a large volume of literature concerned with the relationship between ageing and cognitive function confirms that activity in old age involving physical, cognitive and social stimulation may protect against cognitive impairment and improve cognitive plasticity (Christensen et al., 1995; Seeman, et al., 2001). Such findings confirm the interconnected relationship between physical and mental health, and the interlaced biological, psychological and social determinants of holistic well-being. The interrelationship between physical and mental health is also evident in studies on physical activity and well-being among older persons with exercise programmes frequently being advised for older populations to minimise the effects of disability, which inadvertently produce positive psychological outcomes (Crone et al., 2005; Oida et al., 2003; Acree et al., 2006; Ellingson & Conn, 2000). It is postulated that because of the intimate connection between physical and mental health, many of the interventions designed to improve physical health may also promote mental health and vice versa (Herman et al., 2005).

Furthermore, there is much evidence to suggest that the social element of activity produces significant benefits. A study which aimed to ascertain correlations between social, productive, and physical activity and survival among older persons found that social and productive activities that involve little or no enhancement of physical fitness lower mortality as much as fitness activities do (Glass et al., 1999). This observation is significant as it suggests that activities that entail little or no physical exertion are also beneficial thus, a wider range of mechanisms, both physiological and psychosocial may be involved in the association between activity and well-being. Therefore, findings propose that besides physical fitness, activity bestows additional benefits through psychosocial channels. These results suggest the importance of alternative programmes of activity as a complement to exercise sessions for older persons residing in extended care settings. Although these studies only partly offer causal evidence, their outcomes underscore the close interrelationship between biological, psychological and social health among older persons and the need for

health maintenance initiatives that promote balance among these interrelated components of health and well-being. Indeed, there is consistent evidence to support the concept that social support has a positive influence on both physical and mental health (Cassel, 1976; Seeman, 1996; Seeman, 2001).

The above evidence supports the concept of facilitating holistic health by acknowledging the broader determinants of health such as psychological and sociological well-being as well as physical health. While involvement in meaningful activity is clearly instrumental to optimum quality of life and well-being, the evidence predominantly suggests it is the social interaction innate in such activities that is responsible for the greater outcomes. Thus, an exploration of the processes involved in achieving meaningful social interaction is warranted.

1.5 Rationale for the Study

While often overlooked, the psychosocial dimensions of health among older people are of paramount importance, particularly given the nature of change and adaptation associated with the ageing process. It is acknowledged that the transition to an extended care facility is one of the biggest challenges encountered as individuals develop along the ageing process (Baltes, 1996). Cervilla and Prince (1997) suggest that many of the innate occurrences of old age such as ageism, impairment, loneliness, and reduced social supports can result in poor mental health and general decline in well-being. Moreover, Anderson (2001) highlights how poor mental health can produce high levels of morbidity and mortality among older people. Accordingly, Anderson (2001) emphasises the importance of an interdisciplinary process which acknowledges the psychosocial, as well as the physical determinants of health. Thus, the iterative nature of complete biopsychosocial well-being is apparent; poor psychosocial health can contribute to poor physical outcomes, while negative life events such as the onset of disability can negatively impact on individuals' psychosocial health. Thus, holistic care of older people in extended care settings must endeavour to facilitate optimum psychosocial well-being through the appropriate management of personal, social and psychological processes.

However, older people in receipt of extended care services have more complex needs than previous generations, placing new demands on nursing staff. In particular,

increases in psychological morbidity imply a need for more holistic practices among nursing care staff. As the primary care providers to older people, nurses are held accountable for defining standards of care and increasingly, for delivering psychosocial care (Ryan, 2003). Thus, there is a need for continual competence and skill development among caregivers to cater for the evolving and diverse needs of this specialist client group. Until recently, modifications in the health care system were primarily geared to accommodate age-related declines in physical and cognitive functioning. As a result, personal goals and individual preferences of the older client base may have been neglected (Lockenhoff & Carstensen, 2004). While contemporary policy acknowledges the needs of our ageing population, there is evidence to suggest current practices are not always consistent with best policy guidelines and recommendations (Choowattanapakorn et al., 2004; Bowling &Dieppe, 2005).

As it is holistic, the biopsychosocial model is more complex than the biomedical model and practitioners must consider a multitude of factors in the endeavour for optimum health (Mackenzie et al., 2004), for this reason the entirety of the model is often neglected. Incorporating the complex physical, psychological and social dimensions into care practices necessitates more comprehensive assessments and diverse interventions that are not always achievable in today's healthcare service (Anderson & Burckhardt, 1999; Mackenzie et al., 2004). Such limitations of practice are understood to be exacerbated by disparities between the acute and chronic care services, which are perceived to be a result of the socialisation and subsequent marginalisation of older people (Ford & McCormack, 2000). Thus, the need to appropriately raise the profile of older persons is apparent. Older persons have an array of skills, wisdom and knowledge accumulated over the life course which materialize as invaluable contributions to the development of past, present and future societies. According to the Council of the European Union (2007) older people make useful contributions to society, forming intergenerational cohesions through social and cultural commitments to their families and communities. Thus, older person's right to accurate and timely services which facilitate optimal quality of life and well-being is reasonable. However, in reality the appropriate fulfilment of such rights is dubious; hence comprehension of the current situation in practice is warranted.

1.6 Research Question

How are older persons psychosocial needs perceived and subsequently met in extended care settings in Ireland?

1.7 Aim of the Study

The aim of this study is, to explore the psychosocial needs of older people in extended care settings in Ireland, from the perspective of both residents and caregivers.

1.8 Objectives of the Study

The main objective of the study is to explore the perceptions of staff and residents with regards to psychosocial well-being in extended care settings. Specific objectives are:

i. To explore the concept of psychosocial well-being among older persons in extended care settings.
ii. To identify key personal factors contributing to engagement in meaningful activity and its impact on the psychosocial well-being and quality of life of residents
iii. What personal factors influence residents' perceptions of psychosocial well-being and opportunities to engage in meaningful activity?
iv. To explore caregivers perceptions of psychosocial well-being among the residents
v. To identify practices which to facilitate psychosocial well-being and to explore the perceived effectiveness of these.
vi. To compare the perspectives of residents and caregivers.
vii. To consider the implications for best practice in psychosocial dimensions of healthcare for older people.

1.9 Definition of Relevant Terms

Older person

There appears to be a lack of consensus as to what the term older person denotes. To universally classify an older person, be it by chronology, social role or capabilities, is undoubtedly a complex task. However, for the purpose of this study it is necessary to clarify the connotation of the term as adopted throughout.

Chronological age is predominantly used as the criterion to define an older person with many developed countries accepting that the chronological age of 65 years instigates old age (WHO, 2008). As this study explores the experiences of older people in an Irish context, where it is accepted that the term "older person" refers to an individual aged 65 years or over, this classification shall be applied. Nevertheless, this definition is somewhat ambiguous upon considering the phenomenon of enhanced longevity and the apparent lack of a unilateral period of old age thus, for the purpose of this study it is intended that the term older person encompasses both the young old; aged 65-80 years and the old old; those aged 80 years and over.

Resident

Roach (2001) suggests that as the residential care setting becomes the older person's home, individuals who live in extended care facilities are called residents (Roach, 2001) . For the purpose of this study individuals in receipt of extended care shall be referred to as residents.

Extended Care

In this study, extended care refers to an institution that provides prolonged care or assistance to those unable to independently fulfil some or all of their personal needs.

Caregiver

For the purpose of this study, caregiver shall encompass all those involved in the provision of care in the facilities under exploration. Healthcare assistants, nurses and clinical nurse managers all facilitate and provide care within the extended care settings being explored, thus all are termed caregivers.

Psychosocial care

In this study, psychosocial care refers to practice which encompasses measures to facilitate individuals' needs beyond one's physical entity that is; one's psychological, social and emotional being, which intently leads to optimum psychosocial well-being.

Meaningful activity

For the purpose of this study, meaningful activity refers to any action/interaction, whether in group situation or in isolation, that has positive effects on individuals' psychosocial being.

1.10 Plan of Thesis

This thesis will be structured into the following chapters:

- Chapter one has introduced the study, outlining key issues pertinent to study's initial development.
- Chapter two reviews the existing literature surrounding the phenomenon under exploration.
- Chapter three outlines the research design, data collection and analysis procedures.
- Chapter four presents the findings of the study.
- Chapter five discusses the findings in relation to current practice and existing research.

1.11 Conclusion

The unprecedented phenomenon of population ageing is not without its challenges. Although Ireland's demographic transformation is more gradual than its European counterparts, projections suggest that the Irish population will soon follow this trend and become an ageing society as the current pattern of ageing demographic profiles will inevitably transcend into the contours of the Irish population. Be that as it may, Ireland will experience the challenges of population ageing, but with the advantage of observing and reflecting on the experiences of our neighbouring countries thus, with the privilege to adequately plan for the needs of our evolving older population. In this chapter the theoretically acknowledged benefits of adopting a biopsychosocial approach have been highlighted. However, in striving to promote optimum biopsychosocial well-being among older people in receipt of extended care, the reality of theory in practice must be explored. Consideration of ways to improve the quality of life of older people in extended care, beyond their evident physiological needs, motivated the conduct of this study. As acknowledged by Faltermaier (1997), such complex psychosocial variables may only be appreciated through the exploration of

subjective accounts from individuals who experience such phenomenon. Thus, an appreciation of individuals' unique perceptions derived from personal experience is fundamental.

Chapter 2
Research Evidence: A Review of the Literature

2.0 Introduction

This review of the literature will attempt to evaluate the implications of increased longevity and the importance of a proactive service approach to effectively combine added life years with optimum quality of life. Furthermore, this review will address the importance of psychosocial well-being among older people and factors which may affect its attainment. Literature from an international knowledge base will be reviewed as pertinent to the multidimensional phenomenon under exploration.

Contrary to the classic grounded theory approach (Glaser & Strauss, 1967; Glaser, 1978) a preliminary review of the literature was undertaken. This approach may be considered flawed by traditional grounded theorists who believe in delaying the review of literature until the point of analysis so as not to influence the generation of theory through preconceived thoughts derived from the existing literature (Glaser & Strauss, 1967; Glaser, 1978). However, as a novice researcher this overview of the literature was thought to be an essential component of the conceptual phase as it served to heighten awareness of existing literature, thus generating questions and inspiring the underlying principles of the study through the identification of deficits in the literature. Furthermore, it is acknowledged that nurse researchers unavoidably have certain assumptions secondary to knowledge gained through practical experience in the field being explored (Gerrish and Lacey, 2006). Hence, the notion of collecting data without any prior knowledge is idealistic. Furthermore, the knowledge acquired upon preliminary review of the literature proved invaluable, as it transpired to be an essential foundation for both the conceptual and the empirical phase of the study.

2.1 Search Strategy

Due to the multidimensional nature of the phenomenon under exploration, a complex and far-reaching search process was required to effectively address the pertinent research and locate material across a wide range of disciplines and associated bodies of knowledge. The review incorporated searches of bibliographic databases such as CINAHL (Cumulative Index to Nursing & Allied Health Literature), Blackwell

Synergy STM Collection, MEDLINE, Pubmed, SocINDEX, Psychology and Behavioural Sciences Collection, OECD, WHO and EHMA databases. For the purpose of the preliminary review, overarching key words and phrases such as "population ageing", "stimulating activities within older person settings", and "quality of life among older people" were employed. The above terms emanated from initial research into phenomena concerning older persons undertaken for the purpose of formulating and adapting the research proposal. The knowledge and insight attained during the subsequent empirical phase of the study facilitated the process of more specific searches to encompass terms such as "psychosocial well-being", "interpersonal relationships", "social interaction", "person-centred care", "continuing education", "health promotion", "practice developments" "attitudes" and "socialisation", all terms were combined with "older people". For the purpose of retrieving accurate and timely evidence based literature, it was initially proposed to include literature originating from the year 2001 and thereafter, however certain findings were limited as were the number of relevant studies retrieved, thus seminal work emanating from the period prior to 2001 were subsequently reviewed.

Material was sought which would reflect the factors influencing psychosocial well-being among older people in extended care, as evident from the analysis of the collected data. The review, therefore, had to be broad in its scope and range, choosing search terms which reflected the different issues and concepts that had emerged within the retrieved data. Thus, the search encompassed locating expert and seminal work in the fields of sociology, psychology, quality of life and gerontological nursing. Reference lists from review papers, book chapters and articles were scrutinized to maximise opportunities for sourcing relevant literature. Moreover, government reports, age specific organisations (Age Action Ireland and the National Council on Ageing and Older People) and library archives were accessed for key sources of "grey literature", specifically practice and policy developments and unpublished dissertations. Furthermore, the web sites of key organisations in the field of health service provision were also checked for relevant literature, in addition to seminal works by key authors recommended by peers and secondary to personal communiqué with experts within the field of gerontology. The majority of the literature emanated from Britain, Scandinavia, The Netherlands, North America and Australia. The following is a comprehensive review of the literature founded upon that retrieved

during the conceptual, preliminary review but, focused to a greater extent on the significant literature reviewed owing to empirical insight. That is to say, supportive themes which emerged during the preliminary review are evident due to their role as guiding principles yet; the main body of the review is reflective of the empirical phase as this literature was reviewed simultaneously with data collection and data analysis procedures. Therefore, this review of the literature encompasses critical analyses of literature pertaining to issues found to be relevant to the phenomenon under exploration, which are somewhat reflective of the concepts and categories derived from the study's empirical processes.

2.2 The Shift from Reactive to Proactive Healthcare

It is accepted that while the prevalence of disability rates have declined in recent years, population ageing and longevity will result in a greater proportion of older people with severe disability (LaFortune and Balestat, 2006). A complex mix of physiological, psychological and social processes is involved in the onset and experience of disability, which may be modifiable through interventions designed to improve holistic health (Herman et al., 2005). Manton et al. (2006) state that advancements in therapies and knowledge should be increasingly directed towards older persons to reduce disability associated with rising dependency levels and demands on extended care services. This sentiment echoes *The Plan of Action on Ageing*; one of its many aspirations to facilitate quality health care and support for older persons inclusive of preventative and rehabilitative health care (United Nations, 2002). While some losses in physical functioning and in some forms of cognitive ability are intrinsic to old age and thus inevitable, many loses associated with old age can be caused by extrinsic factors and are therefore modifiable (Rowe and Kahn, 1998).

The National Council on Ageing and Older People (1999) has acknowledged the value of health promotion initiatives as a cost-effective means of improving functional ability, thus preventing institutionalisation and loss of independence. However, this report also concedes that while the concept of promoting healthy ageing is widely accepted there is a lack of consensus as how to implement health promotion strategies for older persons. The shift in focus among older person nursing curriculum from geriatric nursing, which focuses on care of sick older people to gerontological

nursing; its core principle to promote optimum quality of life and wellness among older persons, emphasises the growing interest on optimising the normal process of ageing which encompasses biological, psychological and social perspectives (Wadensten, 2006). Hence, attentions are redirected to focus on the constituents of health and well-being, as opposed to ill-health. This is reflective of seminal work by Antonovsky (1979), Engel (1978) and Levine (1987) on salutogenesis, biopsychosocial health and quality of life respectively. Engel (1978) acknowledged the importance of biomedical therapies in identifying and treating illness, equally he conceded the medical model's incapacity to cater for the more personal, human, psychological and social aspects of health and illness; the caring rather than curing function of the health care practitioner (Engel, 1978). He posited an alternative biopsychosocial model of healthcare to integrate medicine into a holistic framework;

> "to include the psychosocial, without sacrificing the enormous advantages of the biomedical, approach' skills"
>
> (Engel 1977, p.131)

Furthermore, the work of Levine (1987) extensively rejects the biomedical model to virtue biopsychosocial being, honouring the work of Autonovsky to continuously question what causes salutogenesis rather than pathogenesis that is; what constitutes health rather than what causes illness. In doing so, he praises the concept of quality of life for its influence on medicine to acknowledge the wider dimensions of health and illness, which directs attention to the more complete social and psychological being (Levine, 1987). This proactive approach to care was significant to the health promotion movement of the late 20th century in addition to the shift to a more comprehensive approach to care. The combination of salutogenesis and quality of life catches the core components of the principles of health promotion where salutogenesis is the process leading to quality of life (Lindstrom, 1994; in Lindstrom & Eriksson, 2006, p242).

This seminal work is inherently significant to current social processes, as more proactive holistic approaches to health and well-being are now widely encouraged across all stages of the life process. However, there is little evidence to support the implementation and evaluations of such approaches within older person nursing. Furthermore, due to the inevitable declines in physiological processes and enhanced

vulnerability of psychosocial processes, it is considered that such theories and perspectives are especially fitting to the needs of older persons within extended care facilities. For instance, older persons within extended care facilities have chronic rather than acute needs and while there is an extensive body of literature which avows measures to maintain older persons' biological and physical processes (Stessman et al. 2002; Acree et al. 2006; Christensen at al. 2006; Farley et al., 2006), there is a comparably modest body of knowledge to support practices which nurture older person's salutogenesis; that is the broader determinants of health as proposed by Engel (1977). Without consideration of the older person's complete entity, the crucial balance between biological, psychological and social processes may not be achieved. Thus, it is reasonable to question how older persons' optimum well-being and quality of life may be adequately fulfilled.

2.3 Optimum Ageing; Optimum Quality of Life

The growing volumes of literature concerned with the concept of quality of life among residents of extended care facilities is reflective of the increasing desire to evaluate factors likely to affect quality of life in an effort to optimise individuals experience (OECD, 2005; OCS Consulting, 2004; Age and Opportunity, 2003) particularly for those with chronic conditions, where cure is unlikely (Moons et al. 2006). Thus, while advances in technology and standards of living have lead to increased quantity of life, greater emphasis is now being placed on assuring quality of the years added to life (NCAOP\DOHC, 1998). Furthermore, there is a considerable volume of literature on ageing which is centred on the concept of successful ageing and how it may be achieved (Rowe and Kahn, 1998; Baltes & Baltes, 1990, Valiant, 1990; Strawbridge et al., 2002). Some theories remain focused on biomedical approaches, whereas broader interpretations of the concept acknowledge the more inclusive biopsychosocial approaches (Bowling and Dieppe, 2005). Although widely accepted, the concept of successful ageing has been mostly applied to the "young old"; those who are active, independent and living in their own home (Rowe and Kahn, 1998). The concept of quality of life however, applicable to all age groups, extends to those in the latter years of life; aged 80 years and over.

A large proportion of the existing literature attempts to define quality of life and what it is composed of (Anderson & Burckhardt, 1999; Moons et al., 2006), however, it's

subjective nature has generated ambiguity regarding its definition thus, it is often depicted as an elusive multidimensional phenomenon (Borglin et al., 2005). On the other hand, it is understood that quality of life has the same basic constituents for all people. Although the relative importance of individual dimensions may vary depending on personal characteristics and circumstances (Anderson & Burckhardt, 1999), there appears to be general consensus that participation in meaningful social activity is a determinant of both health and quality of life (Browne at al., 1994; Farquhar, 1995; Albrecht and Devieger, 1999; Bowling et al., 2003; OCS Consulting, 2004; Murphy et al., 2007). Hence, it is understood that quality of life components surpass physiological processes and are inclusive of interrelated psychological and social processes (Levine, 1987; Brenner & Shelley, 1998; CSO, 2004; Banister, and Bowling, 2004; Borglin et al., 2005). Psychosocial factors are increasingly being recognised as important dimensions in quality of life of those in receipt of extended care services (Mackenzie et al., 2004). Hence, the incorporation of holistic care practices that facilitate the known constituents of quality of life is crucial to fulfilling the individual needs of those residing in extended care facilities. An important aspect in the facilitation of this process may be the ascertainment of elements instrumental to quality of life and well-being in old age.

2.4 Determinants of Health and Quality of Life

2.4.1 Social interaction

In a national correlational survey of the quality of life of older people aged 65 years and over living in their own home in Britain, Bowling et al. (2002) acknowledge the need for a multidimensional model; encompassing health, psychological and social variables, and social circumstances. This study is particularly significant in the psychosocial dimension of health care for older persons as, unlike other studies which focus on perceived health and functional ability, this study explores the broader components of quality of life. The findings, which were derived form a Quality of Life Survey Questionnaire, suggest an optimistic locus of internal control together with positive social capital leads to greater self-esteem, greater perceived self-efficacy, and thus influences independence, behaviour and ultimately well-being (Bowling et al., 2002). Thus, engagement in social activities is acknowledged as being a strong foundation in development of quality of life in later years. Comparably, Bowling et al. (2003) sought older persons' definition of, and priorities for a good

quality of life, findings show that having good social relationships was the most commonly stated determinant of quality of life. While the above findings may be limited as they are reflective of the perceptions of older persons living independently in their home, such findings are nonetheless invaluable to research on quality of life as it is a subjective concept that is often interpreted with much ambiguity. Furthermore, these findings are noteworthy to practice development leading to improved client outcomes as they highlight significant determinants of quality of life among older people thus, offer guidance and support to policy makers and practitioners in the endeavour to facilitate optimum quality of life among older persons, irrelevant of their place of dwelling.

In the United Sates, Nezlek et al. (2002) investigated psychological well-being in relation to daily social interaction among healthy older persons living in the community. Using a variant of the Rochester Interaction Record in addition to various measures of psychological well-being, (outlined in the summary of literature reviewed; appendix one) findings suggest that positive social interactions can enhance psychological well-being including life satisfaction and loneliness, in the same way low-level social engagement predicts intermediate declines in physical health and morale. This report strongly acknowledges the value of quality interactions on psychological well-being among spousal partners, however for those who were unmarried the quantity of interactions rather than the quality was most influential. Nezlek et al. (2002) consider that the quantity of interaction may be significant due to concerns of social isolation as frequent social interaction is psychologically rewarding. It is considered that the lack of qualitative content may contribute to the limited insight as to why the significance of the quality and quantity of social interaction varies among married and single older persons. Furthermore, Nezlek et al. (2002) assert that in the absence of random sampling, generalisation of the findings may be limited. Nevertheless, the intricate relationship between social networks and psychological health is well recognised, a clear association between participation in meaningful social activity, social supports, well-being and quality of life amongst older persons is evident (Browne at al., 1994; Farquhar, 1995; Albrecht and Devieger, 1999; OCS Consulting, 2004; Murphy et al., 2007). Durkheim's infamous writings on suicide are perhaps the most seminal accounts of the association between a positive social environment and psychological well-being (Lehmann, 1993).

However, not only does low level social engagement result in poor psychological well-being, it may also have an adverse effect on cognitive functioning. A recent longitudinal clinicopathologic cohort study conducted in the USA, which examined the association between loneliness and cognitive function among older persons residing in extended care facilities, found that while not the primary cause, loneliness contributes to an increased risk of developing dementia in later life (Wilson et al., 2007). Using a variety of scales outlined in appendix one, in addition to performing brain autopsy post mortem, Wilson et al. (2007) found the risk of Alzheimer's disease more than doubled among lonely older persons. What's more, loneliness was associated with lower level of cognition at baseline and with more rapid cognitive decline during follow-up. Although one of the limitations of this study may be its lack of qualitative inquiry to capture the subjective elements of this phenomenon, it's findings acknowledge the influence of social support on the multidimensional components of self, which ultimately determines individuals' holistic well-being. Furthermore, there is a growing body of evidence which clearly correlates low levels of social engagement and loneliness with intermediate declines in psychological health; including cognitive function, depressive symptoms, and morale (Bennett, 2002; Menac, 2003; Gulseren and Aysegul, 2005).

Furthermore, the above findings are all the more significant upon considering the profile of the older population in receipt of extended care services. Although the value of social interaction and social supports on quality of life and well-being among older persons is well established, it is important to consider older individuals' social circumstances. It is accepted that social networks diminish with age (Freyne et al., 2002); while at the same time the incidence of loneliness has been shown to increase, primarily due to loss of loved ones and the move to an extended care facility (Tijhuis et al., 1999). Although detailed information on the profile of those residing in extended care facilities is limited, it is reasonable to note the Department of Health's Long Stay Activity Report for 2006 which shows that the percentage of widowed persons increases with age (DOHC, 2008), while the percentage of residents aged 85 years and over in receipt of extended care services has steadily increased by 5.5% between the years 1999 and 2005 (DOHC, 2007). Thus it is reasonable to query the level of social support and extent of social networks retained by those currently in

receipt of extended care services. Consequently, upon acknowledging the value of social interaction and social support on psychological well-being in old age, the imperative need to consider changing social processes among older persons in receipt of extended care services is emphasised. Furthermore, the vulnerability of this client group's psychosocial well-being is accentuated upon consideration of older person's changing social networks as review of the consolidated evidence infers that the impact on psychosocial well-being may be momentous. Hence, the significance of meaningful and frequent interactions with staff and fellow residents may be considerable; extended care facilities must be responsive to the sensitive needs and changing circumstances of older people.

2.4.2 Meaningful Relationships

It is proposed that the transition to an extended care facility may improve social outcomes and reduce the incidence of loneliness through increased opportunities for social interaction (Russell et al. 1997). Conversely, it is contended that the transition to an extended care facility can result in diminished social contacts whereby opportunities for socialisation occur primarily through interactions with staff (Mcgilton, 2002). Whatever the case may be, it is suggested that the concept of caregiver-resident relationships represents an underestimated resource for improving quality of life (Mcgilton, 2002; Stabell et al., 2004). Bergland and Kirkevold (2007) carried out a descriptive study which explores the significance of peer relationships on thriving and well-being among nursing home residents with varying cognitive ability in Oslo. Findings derived from field observations and interviews acknowledge the heterogeneity of the sample population and subsequently show that personal characteristics such as wishes and capacity to interact varied as did the significance of peer relationships to personal well-being. Nevertheless, involvement in peer relationships did serve to promote thriving for those who wished to interact. However, Bergland and Kirkevold (2007) acknowledge that many opportunities to form relationships are unsuccessful to the regret of the individual, the most significant finding being the caregivers potential to impact on whether or not social encounters developed into positive and meaningful interactions, particularly among those who were unable to from relationships themselves. Bergland and Kirkevold (2007) also note how individual caregivers' knowledge, skills and personal characteristics are

instrumental in creating and facilitating positive and meaningful interactions to promote thriving among residents.

A comparable observational study, also conducted in Oslo, describes the pattern of social interaction between nursing home caregivers and residents. Findings suggest that the caregivers' did not always maximise the potential of interactions with residents in so far as needs were often facilitated in the absence of significant communication or meaningful interaction (Stabell et al., 2004). Although Bergland and Kirkevold (2007) commend the role of caregiver in facilitating meaningful interaction with others, both Bergland and Kirkevold (2007) and Stabell et al. (2004) found the effectiveness of caregivers' role in facilitating meaningful interaction was very much dependent on knowledge and personal characteristics. While the possibility of the Hawthorne effect is questionable, both studies highlight the potential for inconsistent outcomes depending on caregivers' knowledge and personal characteristics. It is accepted that barriers in communication often arise through the socialisation of older people and a lack of understanding about the ageing process (Ryan, 2003). Hence, the implementation of measures to aid care staff to meet the broader psychosocial needs of residents may be warranted. Bergland and Kirkevold (2007) suggest how the caregiver may facilitate the introductions of themes of interests to residents as foundations for social interaction, which can then be elaborated through relating them to individuals' life experiences. However, it is contended that this method of interaction may only be successful upon formation of a dyadic relationship whereby information is shared between the caregiver and resident. McCormack et al. (2008) acknowledge the benefits of knowing the individual and their family in providing personalised care which appropriately addresses individuals' needs. Thus, the importance of facilitating positive relationships, not only among residents, but also between caregivers and residents is paramount. Hence, the imperative role of the therapeutic relationship in understanding the uniqueness of the older person is acknowledged, as is the fundamental role of the caregiver in facilitating one of the most significant determinants of quality of life and positive psychological health, that is social engagement (Bowling et al.,2003; Wilson et al., 2007).

However, it is not only staffing characteristics that influence social interaction and the quality of relationships formed, residents' characteristics and abilities may also be influential (Hubbard et al., 2003). In the United States, a cross sectional study conducted by Poon et al. (1992) formed the initial phase of the renowned longitudinal study; The Georgia Centenarian Study. This initial study examined the biomedical and psychosocial predictors of longevity and survival among centenarians. Findings suggest positive correlations between personal characteristics, wellbeing and longevity; attributes included optimism, meaningful social engagement, and the ability to cope with loss. Significantly, studies have shown that personal control, along with social support, are amongst the most important psychosocial predictors of morbidity, mortality, psychological well-being and quality of life (Rodin, 1986; Lane et al., 2000; Bryant et al., 2001).

2.4.3 Positive Internal Locus of Control

It said to reach a state of complete biopsychosocial well-being; an individual must be able to identify aspirations, to satisfy needs, and to adapt and cope with the environment (WHO, 1986). Treats to psychosocial wellness are largely dependent upon how older persons adapt to changing circumstances associated with growth and development (O' Neill, 2002). Various types of stress can threaten the individuals' psychosocial well-being; social stressors which may occur in the event of loss an element of one's social network through death, retirement, or relocation; as with the environmental stress associated with the move to an extended care facility, all of which contribute to psychological stressors such as fear and anxiety (Roach, 2001; O' Neill, 2002). Experience of stressful events has been associated with behaviour that is unfavourable to psychosocial well-being, thus the goal with any perceived stressor is continuous adaptation and the employment of effective coping strategies to preserve psychosocial well-being (Smith et al., 2003). Furthermore, there is evidence to suggest that a sense of personal control is intrinsic to one's biopsychosocial health, leading to greater self-esteem, greater perceived self-efficacy, thus influencing independence, behaviour and ultimately well-being (Valiant and Mukamal, 2001; Bowling et al., 2002; Bowling et al., 2007; Gilhooly et al., 2007). However, findings from the renowned Berlin Aging Study show that those age 85 years and over experienced fewer positive emotions, feeling others controlled their lives (Baltes and Mayer, 1999). Furthermore, there is a growing body evidence to support the incidence

of decline in autonomy and independence among older person's residing in extended care facilities (Stabell et al., 2004).

In a review of the literature on adaptive beliefs and behaviours, and perceived control over age-related decline occurrences, Lachman (2004) infers that adults with a low sense of control over age-related changes may be vulnerable to memory problems and physical disabilities in later life, in part, because they are not likely to use compensatory strategies or adopt preventative or remedial behaviours. Although many older adults assume they are too old to improve performance or functioning, or to make up for losses in areas such as memory or physical ability, it is contended that there is the potential to reduce declines in cognition and physical functioning by facilitating adaptive beliefs and thus behaviours about controllability over aspects of the aging process (Lachman, 2004). For this reason, promotion of the principles of autonomy and independence underpin many of the guidelines for improving the quality of nursing care and subsequent patient outcomes (Davies et al., 2000; Stabell et al., 2004; O'Shea, 2006); namely individuals sense of personal control; essential to psychosocial well-being (Ryan, 2003). Therefore, older persons' psychosocial well-being is largely correlated with how they adapt to changing circumstances (O' Neill, 2002).

2.4.4 Adaptation

Psychosocial development continues throughout the life span, physical and behavioral changes continually occur and contribute to the psychological development of the individual (Roach, 2001). Yet, it is how the individual adapts to each stage that dictates their continued psychosocial well-being. O'Shea (2006) maintains the provision of supportive environments, both physical and social, actively encourages greater independence and autonomy. A number of theories concerned with psychosocial development attempt to determine age related changes and how best to adapt to them. The theory of selective optimization with compensation (Baltes and Baltes, 1990; Baltes and Smith, 2002) offers a practical yet fulfilling approach to facilitate effective ageing. It is based on the premise that optimum ageing may be facilitated by individuals' ability to offset inevitable losses by selectively optimizing available internal and external resources, thus compensating for these loses by focusing on what one can do rather than what one cannot do. Thus, compensatory

mechanisms are focused upon; whereby new means are used to reach a goal when old means are no longer available, such adaptations become increasingly important in old age (Baltes and Smith, 2002). This theory echoes concepts portrayed in Atchley's continuity theory, which depicts life as a continuous process in which one adapts to one's current life stage based on innate personal characteristics and the surrounding social world (Atchley, 1989).

Furthermore, Antonovsky maintains that individuals with a strong sense of coherence will make sense of their social world as comprehensible, optimistic regarding one's ability to successfully manage the vast number of complex stressors encountered in the lifespan thus, motivating them to persist in the face of adversity (Antonovsky, 1987; in Albrecht and Devlieger, 1999). Similarly, the eight stage of Erikson's theory of personality development focuses on integrity versus despair in the final developmental task of the life span. This suggests older people may either accept the human life cycle and look back on their achievements with satisfaction, accept assistance if needed and can adjust, or substitute when loses occur. Alternatively, they may experience regret and despair; dissatisfied with past life, and ultimately fear death (O'Neill, 2002). This perspective, which acknowledges old age as a natural phase in the life cycle, is reflective of the theory of gerotranscendence which emphasises change and development. This theory sees the individual experience a new understanding of the self and relationship to others associated with decreased interest in superfluous social interaction (Tornstam, 1996; Tornstam, 2003). While Lockenhoff & Carstensen (2004) also acknowledge the focus in attentions to meaningful social interaction above frivolous interaction, Tornstam's (1996) notion that positive solitude becomes more important in later life is contradictory to much of the evidence highlighting the significance of social support (Poon et al.,1992; Browne at al., 1994; Farquhar, 1995; Albrecht and Devieger, 1999; Bennett, 2002; Menac, 2003; Bowling et al., 2003; Gulseren and Aysegul, 2005; Murphy et al., 2007). Furthermore, the theory of gerotranscendence has been criticized due to its underpinning principles, similar to disengagement theory, which do not adequately reflect the needs of the post modern heterogeneous ageing population (Ebel, 2000). However, Tornstam rejects these criticisms stating that disengagement is associated with social withdrawal, whereas gerotransendence acknowledges the need for social activity but also the greater need for philosophising and reflecting (Tornstam, 1996).

Nevertheless, it is the individual needs and wants of each unique older person that must be addressed, thus to facilitate adaptation to each stage of development, continuous assessment must endeavour to reflect and subsequently facilitate individual goals and priorities. Taking account of the residual strengths of the older person by assessing their interests and values may facilitate older persons' contribution to their personal meaningful and individual rehabilitative activities (Kivnick & Murray, 1997). Hence, adaptive approaches may assist in rehabilitative interventions, knowledge of which may support recognition of the individuals' potential beyond physical abilities, thus achieving optimal well-being. Therefore, continuity is dependent on societal and personal capacity to adapt and cope with life changes in a positive and fervent manner. Furthermore, understanding of the interrelated bio-psycho-social aspects of health and well-being is essential in facilitating optimum quality of life for older persons.

2.5 Psychosocial Care in Practice

Throughout the 21st century there is consistent evidence of healthcare professionals' continued adherence to the biomedical therapies (Bowling & Dieppe, 2005) and failure to encompass the broader determinants of health. In the 1960's it was argued that the culture of professionals and the needs and practices of organisations were among the main barriers to the achievement of health goals (Levine, Scotch and Vlasak, 1969, in Levine, 1987). Although the biopsychosocial model was developed to address the medical model's inability to encompass the psychosocial dimension of care, healthcare practices continue to receive criticism for their persistent focus on the physical self as with the biomedical model (Andersen & Burckhardt, 1999). Engel (1978) claimed that neglect of this important dimension of care was partly attributed to practitioners being *mechanical* in their approaches due to over reliance on the biomedical model. Barba et al. (2002) claims that older persons living in extended care settings enjoy few stimulating activities as care organisations work from a predominantly medical model, thus many of their residents' psychological needs go unmet. Therefore, it is accepted that a biomedical approach is not conducive to older person's well-being and quality of life. Alas, while there is a growing volume of evidence to support a more inclusive approach to caring for older persons (Orb et al.,

2001; Mackenzie et al., 2004; Wadensten, 2006) a review of the literature depicts current practices based on tradition rather than evidence.

Qualitative research, guided by a grounded theory approach, explores the experience of older person nursing care in Bangkok; findings show that while the nursing curriculum and rhetoric related to care of the older person is based on a holistic model, everyday practice appears to be consistent with the biomedical model (Choowattanapakorn et al., 2004). Findings portrayed the overwhelming task-orientated nature of care to the extent that unfinished tasks were cause for disciplinary action, whereas neglect of broader requirements, such as psychological needs, was acceptable. Although, derived from a culturally diverse health care system, these findings are momentous in the psychosocial dimension of healthcare for older persons as they highlight the need for greater acknowledgement of such determinants in fulfilling individuals' optimum well-being and quality of life. Nonetheless, disparity of economic, social and cultural environments across countries and regions gives rise to culturally unique practices, thus the need for evidence applicable to the Irish health care system is quite apparent.

Findings from a hermeneutic phenomenological study verify the occurrence of such practices in the Irish healthcare system (McCabe, 2004). In exploring patients' experiences as to how nurses communicate, McCabe (2004) found that patients believed nurses' actions were dictated by a need to fulfill tasks rather than communicate with patients. Thus, a task-centred rather than patient-centred approach to care was dominant. Although the transferability of these findings is limited as they are derived from an acute rather than an extended care setting, they are nonetheless significant as they are reflective of cultural practices in the Irish healthcare system. This inference is justified upon noting the context from which the data were derived as it is revealed that the study site was in fact a teaching hospital. Significantly, there is a large body of evidence to suggest that the prevailing philosophy of nurses and work practices greatly impacts on student nurses demeanour (Thomas, 1992; Ahmed and Kitson, 1993; Robinson and Hill, 1995; Ryan, 2003). Therefore, it is inferred that such practices are observed, learned and replicated by student nurses in their own practice, regardless of theoretical knowledge. Accordingly, it is considered that if task-centred rather than patient-centred approach to care is dominant in teaching

hospitals, it has presumably transpired into other healthcare services as nurses carry forward their knowledge and professional conduct into their postgraduate practice. The propensity for such learned behaviour is acknowledged by McCabe (2004) as she highlights literature which suggests that the professional socialisation of nurses results in task-centred rather than patient-centred practices (Telford, 1992; Graham, 1994; McColl et al., 1996). Thus, it is inferred that current practices may not appropriately meet services users' needs due to a preoccupation with customary tasks rather than human needs.

In recognition of the intrinsic role of effective assessment procedures to the provision of accurate and timely care, Worden et al. (2006) carried out a correlation study to examine the accuracy of assessment documentation of older person's needs in extended care settings in Britain. Findings reveal that many important domains, including mental health, were infrequently mentioned on the assessment documents (Worden et al., 2006). The most frequently covered items were the activities of daily living and physical care. In the psychosocial domains only two out of eight domains, 'activity pursuit patterns' and 'social contacts, relationships and involvement/psychosocial wellbeing' were found on just over 50% of the documents. Therefore, findings suggest the significantly high percentage of remaining assessments failed to appropriately evaluate individuals' psychosocial needs. There was also low coverage of the individual's pattern of activities and routines prior to admission, a lack of which may have implications for older persons continuity of self. While this data shows evidence of psychosocial needs being addressed in some cases, it highlights the lack of standardised assessments to include determinants of health and well-being beyond activities of daily living, thus the holistic well-being and quality of life of some residents may be poorly addressed (Worden et al., 2006).

Furthermore, little attention was paid to the wider uses of information derived from the initial assessment. This is in direct contrast to the USA where the Minimum Data Set/Resident Assessment Instrument (MDS/RAI), a systematic assessment, has been mandated for use in nursing homes (Worden et al., 2006), thus the need for standardised assessments which encompass all domains necessary for high quality care and optimum resident outcomes is evident. As findings were dependent on care settings willingness to respond to postal intervention, research sampling procedures

may give way to bias in so far as managers controlled the content of the data requested. For instance while, 71% of homes returned questionnaires only 49% returned assessment forms which might indicate that only homes with better established assessment systems wished to explicate their practice. Furthermore, data is reflective of the UK health services, therefore is not entirely amenable to an Irish context. Recent policy developments in Ireland have placed further emphasis on standardised holistic continuous assessment and the use of best practice and clinical governance (HIQA, 2008). National policy initiatives such as *Quality and Fairness* (2001) and *Adding years to life and life to years* (1998) emphasise the non-medical aspects of achieving optimum health potential; minimising the impact of disability and disease on older people (NCAOP\DOHC, 1998; DOHC, 2001; O'Shea, 2006). Nevertheless, the pervasive influence of the biomedical model in practice is quiet apparent. The above research conducted by Worden et al. (2006) has considerable relevance to practice development as findings clearly show that physical care currently dominates practice, often to the point where the broader determinants of health are overlooked.

While there is a considerable volume of evidence to support a more inclusive approach to caring for older persons, there appears to be a number of factors which influence the accomplishment of such practice. Incorporating the complex physical, psychological and social dimensions into care practices demands a more comprehensive assessment and diverse interventions that are not always achievable (Anderson & Burckhardt, 1999; Mackenzie et al., 2004). The implementation and outcomes of psychosocial interventions are influenced by a diversity of factors such as patient and family characteristics, the social environmental conditions such as the interpersonal skills, knowledge and staffing of healthcare professionals, structural issues and the environment; and cultural context such as philosophy of care and attitudes may be influential (Hubbard et al., 2003).

2.6 Factors Affecting the Facilitation of Psychosocial Well-being

The provision of care for older people is affected by the knowledge and views that staff and society have about the implications of ageing. Individuals' priorities when caring for older people largely depend on their personal and theoretical perspective (Wadensten, 2006). Conversely, Engel (1978) proposed that it is not one's

professional knowledge that permits them to cater for patients' psychosocial needs but rather one's basic interpersonal skills, empathy and social awareness and level of understanding. Roach (2001) defined some attributes of importance for gerontological nurses: the ability to form a therapeutic relationship with older people, appreciation of the uniqueness of older people, clinical competence in basic nursing skills, good communication skills and knowledge of physical and psychosocial changes that occur with age. The impact of caregivers' personal characteristics and social behaviour on patient outcomes is well documented (Castle and Engberg, 2007), as is the value of nurse patient interaction (Mcgilton, 2002; Arnold and Underman Boggs, 2003; Ryan, 2003; Stabell et al., 2004). However, it is the content and the manner in which the interaction is conveyed which dictates the outcome of this routine practice (Latter 1998), all of which may be influenced by the caregivers knowledge and perceptions of holistic well-being. It has been conceded that the broader determinants of health are often neglected due to nurses' preoccupation with physiological health and tendency to think in disease-specific terms (Andersen & Burckhardt, 1999). Therefore, the challenge for health care practitioners is to differentiate between gerontological and acute general nursing and to recognise that while physical care is important it is only part of the whole self, one aspect of holistic care. However, such challenges may be exacerbated by the absence of appropriate gerontological theory.

2.6.1 Knowledge and Continuing Education

In a review of seventeen traditional nursing theories, Wadensten and Carlsson (2006) assess the applicability of such theories to age-related care nursing. Findings suggest that these traditional theories fail to provide any guidance on how to care for older people and how to support them in the process of ageing. Moreover, it has been suggested that traditional conceptual nursing frameworks such as The Activities of Daily Living Model, Roper, Logan and Tierney (1976) used in practice, impede holistic care as such frameworks are based on observable, measurable behaviour and scientific tests. Despite its holistic intentions, the Activities of Daily Living model can lead to an emphasis on physical nursing problems in practice, as it is often the case that the intention of the model is lost in the pursuit of physical achievements (Aggleton and Chalmers, 1986; in Robinson and Hill, 1995). Hence, there is a need to develop a nursing care model that takes human ageing into consideration as individuals without age specific education may work from traditional nursing theories

which inadequately support the ageing process. Therefore, the need for specialist gerontological knowledge may be justifiable in the endeavour to accurately meet the individual needs of this specialist client group. The need for specialist education is further justified upon recognition of the dominant medical model and lack of emphasis on health maintenance interventions achieved through a more appropriate biopsychosocial framework of care (Bowling & Grundy, 1997). It was thought the inclusion of theoretical components relating to social science into the current curriculum would help nurses to understand that health status is related to a wide range of factors beyond the one's physical entity (Robinson and Hill, 1995). However, criticism of nurse education tends to regard competency training as leading to a role that is reductionist in nature as it fortifies task orientated, rather that patient-centred holistic care (Coffey, 2004).

The need for nurses to support and engage in continuing education practices is further highlighted in a seminal paper which reviews practice developments through the integration of theory to practice (Robinson and Hill, 1995). This review paper suggests that the new paradigm for nurse education is being prevented from fulfilling itself because of factors operating within the taught, hidden and wider curriculum. Robinson and Hill (1995) refer to the importance of the organisations ethos of care and role modelling, contending that the taught curriculum needs to be supported by a suitable hidden curriculum both within the educational and clinical setting. Furthermore, Robinson and Hill (1995) believe that role models who demonstrate integrated theory occurring in practice are vital to achieving evidence based practice developments. It is contended that the prevailing philosophy of nurses and work practices greatly impacts on healthcare assistants and student nurses demeanour (Thomas, 1992; Ahmed and Kitson, 1993; Robinson and Hill, 1995; Ryan, 2003). Latter (1998) suggests that continued adoption of the traditional biomedical model limits the scope of the professions ability, as junior staff and student nurses adapt to routine practice rather that initiating change through utilising their critical awareness of practices and evidence based knowledge. The taught curriculum of nurse education needs to relate to what students see and experience in both education and clinical settings, and ultimately, this needs to occur within a supportive social and political framework (Latter, 1998). Although the content of nurse education curriculum may be changing, it is how this knowledge is facilitated in practice which truly determines

evidence based practice. As the primary providers of care to older persons, nurses are held accountable for defining standards of care and increasingly for delivering psychosocial care (Ryan, 2003).

The Report of the Commission on Nursing articulates concern regarding conditions and staffing levels in some older person care settings which adversely impact on the quality of nursing care (The Department of Health and Children, 1998). Apart from the noteworthy effect on the standards of care, staffing levels also impact on the ability of staff to attend educational courses, an essential component in the attainment of positive patient and staff outcomes alike. Lack of professional development opportunities among older person nurses has been associated with work dissatisfaction and staff turnover (Arnetz and Hasson, 2007). The report also considers that older person nursing offers substantial opportunities for nurse led services. Hence, the advancement of post-registration education for nurses' practising in older person care services is important in relation to the development of clinical nurse specialist and advanced nurse practitioner in care of the older person. There has been much ambiguity surrounding the nursing role and its boundaries in the past, however advancements in nurse education, specialist knowledge and expending role boundaries is crucial to the creation of a more empowered and autonomous profession; further enhancing their valuable role within the multidisciplinary team (Latter, 1998; McCormack, 1998). However, it is acknowledged that both the number of courses and their participants are small when compared with the number and educational needs of nurses working in care of the older person (The Department of Health and Children, 1998). Furthermore, lack of standardised training for healthcare assistants may result in insufficient skills needed to address psychosocial aspects of care as the minimum required in-service training is specific to skills related to physical care, such as manual handling and lifting (Coffey, 2004). However, this deficit is gradually attenuating due to the growing volume of age-related care programmes, knowledge requirements for healthcare assistants and nurses, and health service standards nationwide (The Department of Health and Children, 1998; Coffey, 2004; National Council for the Professional Development of Nursing and Midwifery 2007; Health Information and Quality Authority, 2008).

2.6.2 Comprehensive Knowledge; Comprehensive Care

Alas, it is contended that while nursing curriculum advocates patient-centred care and biopsychosocial health, in reality the concept of psychosocial care is very often associated with psychosocial interventions such as cognitive behaviour therapy, psychotherapy and motivational therapy often restricted to the mental health and intellectual disability disciplines (Sarafino, 2006; Bradshaw et al., 2007; Brooker et al; 2003). While some evidence exists regarding effectiveness of psychosocial interventions in reducing the symptoms of dementia (Fossey et al., 2006), there remains a significant dearth of evidence which evaluates psychosocial care in older person nursing. However, findings from a quasi-experimental study which evaluates the effect of the implementation of workplace-based supervision for mental health nurses undertaking a programme of psychosocial education found that psychosocial intervention education can enhance knowledge outcomes for nurses who complete such courses and outcomes for the service users whom they work with (Bradshaw et al., 2007). Although these findings may be limited to the mental health discipline, they reveal how effective support and education may enhance learning opportunities for staff leading to enhanced psychosocial outcomes among service users. In gerontological nursing, appropriate education may direct attentions to the psychosocial theories of ageing which attempt to describe the ageing process and what ageing implies in terms of individual changes in cognitive functions, behaviour, roles, relationships, coping ability and social changes, thus may be useful in devising care that is conducive to older persons holistic needs (Schroots, 1996, in Wadensten, 2006). However, while a number of theories on ageing exist (Cumming and Henry, 1961; Havighurst, 1961, 1963; Atchley, 1989; Erikson & Erikson, 1986, 1997; Tornstam, 1989) these theories do not describe how holistic proactive care of the older people could be implemented (Wadensten, 2006).

In the absence of a clear description of what gerontological nursing entails, Kelly et al. (2005) conducted action research with a representative sample of thirty community gerontological nurses to develop a common understanding of the principles which underpin nursing older persons. Significantly all the participants agreed that the concepts of enablement, therapeutic intervention, health promotion and negotiated goals comprised the foundation of their practice, all of which are predominantly seen to be positively associated with the older person's psychosocial well-being.

Accordingly, gerontological nursing was described as a person-centred approach to promoting healthy ageing and the achievement of well-being, enabling positive adaptation to changing processes. It is accepted that this description is derived from nurses with specialist gerontological knowledge, therefore greater knowledge and insight into the needs of older persons may have contributed to the development of such person-centred, holistic principles. While specialist knowledge is desirable, it is not feasible for all staff members to have specialist education, for this reason the sharing of knowledge is essential (McCormack et al, 2008). Hence, there is an urgent need to incorporate such evidence based principles into clear polices which facilitate all members of the multidisciplinary team to facilitate optimal ageing.

In a prospective, non-randomized controlled study, Arnetz and Hasson (2007) evaluated the effects of an educational intervention in two extended care facilities in Sweden and found improvements in competencies specific to older person care through multidisciplinary peer group interventions devised specifically to meet identified deficits in knowledge of staff. Hence, the value of the multidisciplinary team in providing accurate care to meet diverse and evolving needs must not be underestimated. While staffing characteristics inevitably impact on healthcare outcomes, accurate and timely care is dependant on a number of interrelated concepts, including organisational factors.

2.6.3 Staff and Organisational Factors

A qualitative descriptive case study carried out in the UK, which explored the impact of health and social care organisational structures on older persons' experiences of whole systems found that general services fail to understand the complexity of need associated with advancing age (McCormack et al., 2008). McCormack et al. (2008) propose that the divide that exists between generalist and specialist services may lead to inadequate care underpinned by poor collaboration among the multidisciplinary team. Findings from this study highlight how effective communication is essential to care provision that is reflective of older persons' individual needs. While McCormack et al. (2008) commend the significance of maintaining psychological well-being through promoting personal autonomy and client involvement in the planning of care, they found that older people felt disempowered by the system of care delivery which they felt did not include them in decision making; providing "routinized" care rather

than individualised care. Although the above study specifically looks at the older persons' journey through the whole care system it is applicable to specialist areas of practice. For instance, the extended care setting is a component of the whole system whereby a receptive interdisciplinary approach is necessary for the provision of accurate and timely care. Hence, the above findings highlight the tendency to provide standardised care in spite of older persons' heterogeneous needs.

Upon recognition that existing services fell short of providing appropriate, timely and co-ordinated care for older people, Reed et al. (2005) conducted a literature review to explore integrated care for older people. This review concedes that older people have complex and interacting needs, which often necessitate treatment and care from a range of professionals and carers, services and agencies at the same time, thus inadequate use of available services led to poor patient outcomes associated with greater costs. The value of the multidisciplinary team and collaborated service provision is well documented as role boundaries begin to merge (Latter, 1998; Reed et al., 2005). Professional relationships provide a unique opportunity to approach client care from a holistic perspective by drawing on the expertise of various disciplines (Underman Boggs, 2003). McCormack et al. (2008) praises the concept of integrated care contending that without it healthcare systems will support services that are organisationally focused rather than person-centred. Hence, McCormack et al. (2008) acknowledges the significant impact of individual and organisational system factors on care processes and outcomes.

Management and organisational structures are intrinsic to the quality of life of those living in extended care facilities (Murphy et al., 2007). The impact of the organisational issues at macro level on the individuals' outcomes at micro level is well documented (Currie et al., 2005). Reed et al. (2005) found that societal and organisational strategies impacted on health outcomes for older persons. Furthermore, Latter (1998) acknowledges the combined input of micro, as well as macro influences on implementing change and practice development initiatives, thus consensus and support at an individual level; encompassing both service users and services providers contribution, and structural change at a more macro level; including the development of best practice polices and guidelines are mutually essential components. McCormack et al. (2008) further highlights the need for care managers to ensure

accurate assessments and subsequent interventions and to advocate on behalf of the patient to ensure they received the most appropriate care. Moreover, McCormack et al. (2008) found the absence of a strong relationship with a primary carer resulted in many older people feeling vulnerable and unsure about their plan of care; the patients often did not know what was happening to them nor understood the rationale underpinning decisions and actions (McCormack et al., 2008). The limited information made it difficult for them to challenge the existing system. This evidence is consistent with the literature supporting patient empowerment and person-centred care which suggests person-centred initiatives designed to give power and autonomy to residents over their physical and social environment are prerequisites in facilitating optimum well-being among older persons (McCormack 2004; Bennett, 2006; O'Shea, 2006). Identifying and allowing for the articulation of identities of older people has the potential to inform organisations and policies that better respond to the older persons' unique situation (Bennett, 2006). However, capacity to involve older people in the planning of their care may be dependent on how older people are socialised.

2.6.4 The Socialisation of Older People

It is the role of the health care provider to advocate for patients' rights of autonomy and independence; maximising their opportunities for improved physical health, supportive social conditions and opportunities for personal growth through the provision of appropriate care and information (Underman Boggs, 2003). A press release by The Irish Human Rights Commission (2005) expressed concern that individuals residing in extended care facilities may be particularly vulnerable to human rights violations as standards are dictated by physical conditions, and are thus rarely inclusive of broader quality of life or social gain issues. Factors such as discrimination and marginalisation may impede the fulfilment of individuals' human rights. Goffman (1968) contends that every society has stereotypical expectations about how individuals ought to be (Porter, 1998). Ageing has traditionally been thought of as a period of decline, loss and dependency (Reed and Clarke, 1999; Nilsson, et al. 2000; McMurdo, 2000). Ageism may construe the application of assumed homogeneous age-based characteristics to an individual, regardless of that individual's actual personal characteristics (Macnicol, 2006). Hence, it is regrettable that the socialisation of older people largely conjures a negative image of ageing; that

of a homogenous group, frail and highly dependent and thus a burden on society (Ryan, 2003; Lovell, 2006; Castle and Engberg, 2007).

> "Our society sees the growing number of older people more as a demographic problem than a demographic bounty"
>
> (O'Shea, 2006 p.3)

Resistance to accept the humanitarian implications of ageing within the political environment leads to marginalisation of older people (Baltes & Smith 2002). In a recent position paper, O'Shea (2006) contends that continued emphasis on the financial implications of ageing populations representing older people as a burden on society, will inevitably contribute to the marginalisation of older people. O'Shea (2006) recommends a new strategy for older people whereby all government policies are "age proofed" to remove discrimination against older people, with the development of clear and consistent legislation on the rights and entitlements of older people. However, such policies may result in mere transcripts if stereotyping and negatives attitudes continue to permeate society, which according to Scrutton (1990);

> "restrict the social role of older people, structure their expectation of themselves, prevent them achieving their potential and deny them equal opportunities" (p.13).

Furthermore, stigma and ageism are two phenomena that together greatly affect assessment of the older people and their subsequent health care. Awareness of the impact of these phenomena can assist healthcare providers and, specifically, nurses caring for the older people to provide holistic care (Herrick et al., 1997). Hence, the issue is not the individuals' impairment but societal and organisational structures that may impede individuals' potential. The relationship between impairment and disability depends not just on the severity of the underlying pathological processes but also on host-environment interactions including therapeutic, social and other interventions, as well as the expectations of society (Bond et al., 1993). Barrett (2006) makes a case for the examination of the social context of frailty in later life as a dynamic social phenomenon. Barrett (2006) differentiates between disability and frailty, and contends that while disability is resulting from specific impairments, frailty is associated with a multitude of interrelated individual and environmental factors. Nevertheless, as with other authors of critical gerontology, Barrett (2006)

acknowledges the negative effects of social structures on adult ageing, maintaining disabilities can be exacerbated or even created by societies disabling processes, such as stereotyping and stigmatisation of minority groups (Albrecht & Devlieger, 1999; Imrie, 2004; Biggs, 2004). Therefore, the attitudes of healthcare providers may be influential to client assessment and subsequent outcomes.

In a paper which explores stigma and ageism and their potential and actual influences on assessment and interventions for older people, Herrick et al. (1997) present strategies for overcoming the impact of stigma and ageism to assist healthcare providers to advocate for clients. This paper maintains that healthcare providers must be aware of their own attitudes toward ageing which may unconsciously contribute to stigma and ageism. Crucially, when assessing older persons, healthcare providers must avoid separating the mind from the body (Herrick et al., 1997).

The collective nature of stigma means that those who associate with the stigmatised victim also are stereotyped (Herrick et al., 1997). Age and Opportunity (2001) concede that negative attitudes and stereotypical notions can signify that,

> "the act of caring for a dependent or vulnerable older person becomes regarded as a low prestige, low priority, occupation by both health professional and society in general" (p.12).

Ford & McCormack (2000) acknowledge the societal influence on gerontological nursing and its resultant impact on service provision; such as perceptions of under developed services for older people influence how individuals including health care professionals think about nursing older people. It is suggested that the low status afforded to older people by society deprives a large proportion of them of a fair share of social resources (Age & Opportunity, 2001). For instance, many extended care facilities remain inappropriate in design and reflect the poor status in which care provision for older people was viewed in the past (Coffey, 2004; Stabell et al, 2004). O'Shea (2006) further highlights the discrepancies relating to appropriate and timely polices for older people, stating that much of the frameworks which inform current policy are dated, thus the service in is need of great reform in order to effectively meet the evolving needs of this heterogeneous client group. According to the National Council on Ageing and Older People (2005) institutional policies and practices that

fuel negative stereotypes about older people, which reduce their life satisfaction and undermine their personal dignity, must be eradicated. Thus, the importance of empowering older people to determine and subsequently fulfil their personal needs is paramount, aspiring to create practice that is needs driven rather than society driven.

2.7 Need for Reform

The complex and dynamic nature of society demands a certain degree of flexibility from health service organisations, thus nurses must be flexible in their approach to care and willing to take on new roles and responsibilities (Williamson, 1998). The implications of demographic transformations call for a revised approach to caring for older persons, facilitating optimal health and well-being. In an era where longevity is celebrated and seen as one of mankind's greatest triumphs, society fails to appropriately acknowledge those that actually achieve it (MacGregor, 2003). The above literature suggests that current health care systems are not conducive to the ongoing health needs of older persons as emphasis appears to be on cure rather than rehabilitation and optimisation. Furthermore, McCormack et al. (2008) acknowledges that many policy developments in healthcare practice are not transcending into clinical practice; highlighting the need for greater integration and clinical governance.

2.8 Summary

The above literature constitutes an appraisal of leading studies on quality of life and factors which affect the attainment of optimum quality of life in old age. Upon evaluation of the literature, it is apparent that there is a large body of evidence which supports the notion that quality of life determinants surpass physiological processes and are inclusive of interrelated psychological and social processes. Indeed social processes are shown to be amongst the most influential determinants associated with improved physical and cognitive functioning as well as quality of life. While the promotion and maintenance of physical processes is undoubtedly invaluable, the literature suggests that older persons within extended care facilities have chronic rather than acute needs and while there is an extensive body of literature which avows measures to maintain older persons' biological and physical processes there is a comparably modest body of knowledge to support practices which nurture the broader determinants of well-being and quality of life in old age. Furthermore, the imperative role of the psychosocial determinants of well-being and quality of life in old age is

recognised as the literature suggests the heightened vulnerability of older persons' psychosocial well-being given the higher risk of loss across psychological, physical and social aspects of their lives. Hence, the instrumental role of caregivers as facilitators within extended care settings is apparent, as is the universal need for heightened sensitivity to the holistic implications of the ageing process. The literature avows the fundamental role of the therapeutic relationship, coupled with practice development initiatives which aim to incorporate evidence based practice; specific to older persons needs, into gerontological nursing. However, the literature proposes that the theoretical constructs which virtue innovative holistic practice often fail to descend into gerontological practice, resulting in care that is not conducive to older persons needs. Furthermore, the need to distinguish between the priorities of acute general nursing and those of gerontological nursing is evident as the literature suggests the lack of appropriate definition as to what gerontological nursing entails, together with a poor understanding of the ageing process results in the care that is service focused rather than person-centred. Hence the need for multidisciplinary cohesion together with an amalgamation of policy makers, practitioners and service users to review and reform current practices within older person nursing is apparent. While the significance of biopsychosocial care in the attainment of optimum quality of clearly explicated within the literature, the apparent failure to incorporate the psychosocial components of health and well-being into gerontological nursing is unmistakable. Hence, the endeavour to ascertain how are older persons psychosocial needs perceived and subsequently met in extended care settings in Ireland is justified.

The findings of this review have implications for nursing practice whereby the elucidation of international practices in the psychosocial dimensions of gerontological nursing highlight potential for reform among Irish practices. At the same time, the literature highlights the need for greater insight into the Irish situation; nevertheless appreciation of international literature facilitates the establishment of culturally sensitive practice developments through local research endeavours.

Appendix one provides a detailed summary of the key literature appraised through-out this review.

Chapter 3
Methodology

3.0 Introduction

This chapter outlines the methodology which guided this research process; rationale for the choice of methodology and subsequent methods will be provided. Preparation for the fieldwork inclusive of decisions regarding sampling procedures, piloting, methods of data collection and data analysis will be made explicit. Relevant ethical considerations pertaining to this study will also be addressed, as will methodological limitations and issues of scientific rigour. Thus, each stage of the research process, from the conceptual to the empirical, is elucidated.

The decision to adopt the chosen research approach is fortified upon acknowledging the methods and procedures utilized in the pertinent literature reviewed. A number of key pieces of literature reviewed were derived from the application of quantitative methods (Bowling et al., 2002; Nezlek et al., 2002; Wilson et al., 2007; Arnetz and Hasson, 2007), while extremely valuable data, it is considered that deeper insight, necessary for the comprehension of the intricate variables involved in the phenomenon under exploration, may be best achieved through acquiring subjective reports from those who experience it (Faltermaier, 1997). Furthermore, it is considered that a number of the quantitative findings were limited due to their lack of subjective insight. Conversely, a proportionate amount of germane literature was derived from qualitative approaches (Choowattanapakorn et al., 2004; Bergland and Kirkevold, 2007, McCormack et al., 2008). Whether employed in across method triangulation or in isolation, it is considered that qualitative approaches were most suitable to the exploration of such phenomena. Nursing research seeks to help practitioners' discover, interpret and understand the varied context of nursing practice (Morgan and Drury, 2003). Whilst a quantitative approach undoubtedly contributes towards the knowledge base of nursing practice, Morgan and Drury (2003) suggest its procedures may be insufficient in providing insight into the complexity of human behaviour, human experience, or the health-illness continuum, let alone acknowledging the relationships between them.

The preceding literature addresses some recent policy advancements and recommendations in older person services, thus highlighting the growing need for research which appropriately seeks to understand current situations in practice, thus allowing for the transition of evidence based policies and guidelines from mere polices into tangible practice. In order to effectively determine best practice policies and guidelines that can feasibly be executed in practice, the attainment of the perspectives of those who are most impinged upon is paramount. It is equally important to gain such perspectives in a manner that is reflective of the social context in which the phenomena occur. Qualitative approaches to research are commended for their ability to portray such precious subjective insight (Pope and Mays, 1995; Faltermaier, 1997). Thus, the qualitative methods and procedures perceived to be most constructive to the exploration of the psychosocial needs of older people in residential care settings are discussed.

3.1 Development of a Conceptual Framework

While the conceptual underpinnings provide the essential foundations for any research process, a traditional conceptual framework, derived from an extensive review of the extant literature, was not utilized for the purpose of this study. According to Bowling (2002) conceptual frameworks consist of systematic propositions which enable the explanation and prediction of the phenomenon being explored. However, in the conduct of qualitative research, concepts and theories are usually inductively derived from the collected data (Bryman, 2004). The appropriateness of a conceptual framework must therefore be questioned as it predetermines concepts for exploration, thus restricting the scope of interpretation so that potentially significant issues may be overlooked. In the absence of a traditional conceptual framework this study was guided upon recommendations from experts in the field, knowledge derived from a brief overview of the literature and pilot interviews, in addition to consideration of the context of the phenomena being explored.

Furthermore, the strong foundations of the chosen approach contribute to a sound yet open and flexible framework for the conceptualisation of theory. A symbolic interactionist framework implies exploring the social world through understanding social actions and interactions in terms of the meanings that those actions have for individuals (Porter, 1998), while a grounded theory framework suggests an integrated

set of concepts that provide a thorough theoretical explanation of social phenomena (Corbin & Strauss, 1990). Thus, the epistemological assumptions of the chosen approach provide focus, emphasising aspects of social processes for exploration that may otherwise have been overlooked. Furthermore, it was thought that these theoretical influences form a strong medium to address the multifaceted concept of psychosocial well-being among older people in extended care settings. Hence, the conceptual framework, provided by the origins of the chosen grounded theory approach is particularly congruent. Thus, rather than utilising a traditional conceptual framework, a framework for discovery was adopted using the above sensitizing concepts. According to Bulmer (1954);

> "A sensitizing concept gives the user a general sense of reference and guidance in approaching empirical stances" (p.7)

Hence, as the adopted qualitative approach pertains to the process of grounding the concepts in the data, the formation of refined concepts will be evident in the subsequent chapters, which explore in detail, the themes arising from the constant comparative method applied throughout the study. Therefore, the conceptual framework evolves in accordance with the research process.

3.2 Personal Perspective on Research

The presence and consequences of the researcher in the exploration of phenomena is a significant aspect of interpretative research (Clarke, 2005). In stark contrast to the writings of Emile Durkheim (1938; in Lehmann, 1995) and Glaser and Strauss (1967), which claim that all preconceptions must be eradicated in the search for empirical knowledge, it is now accepted that researchers values and personal perspectives are intricately related to the research process, as s(he) is an integral part of the world under exploration, from which total detachment is impossible (Strauss and Corbin, 1994; Thornburgh, 2003). Furthermore Cutcliffe (2000) contends that denying access to a researcher's prior knowledge;

> "is likely to limit the depth of understanding of the phenomenon and impose unnecessary, rigid structures" (p.1480)

Bowling (2002) maintains that values are innate in social science, from the inception of the research hypothesis to it's synthesis as a viable study. While objectivity and neutrality are key factors in minimising the risk of bias, ontological realism acknowledges the researcher's beliefs and disciplinary background and accepts that research cannot be value free but reflexive, whereby personal perspectives are made transparent (Ritchie and Lewis, 2003). Annals (1996) maintains that the selection of methodology is intrinsic to the researcher's philosophical beliefs, while Polit and Beck (2008) concede that genuine interest in and awareness about the selected research topic are significant rudiments to a productive study. As a healthcare practitioner with a keen interest in care of the older person, the development of practice that is reflective of service users' holistic needs is an ardent personal objective. In addition, insightful underpinnings derived from personal experience in the field under exploration lend a certain degree of empathy to the context and participants of the study thus ease of entry into their social world. Hence, the decision to adopt a qualitative approach was instinctive; it's inherent belief that reality is constructed from human perspectives, individuals' interactions and shared meanings of given phenomena (Cutcliffe, 2000). Thus, qualitative research is suited to the complexity of modern human phenomena which warrants the use of more flexible research designs.

3.3 Overview of Methodology

The choice of research design and subsequent methods is dependent upon the aims, objectives and nature of the study. Mays and Pope (2000) contend that regardless of the approach, all research should attempt to represent that reality rather than to attain "the truth" (p. 51). Nevertheless, the philosophical underpinnings, as well as the strengths and limitations of each approach should be considered when selecting a methodology that most appropriately addresses the research problem (Morgan and Drury, 2003).

> "Qualitative research is concerned with the process of understanding, based on distinct methodological traditions of inquiry that explore social or human phenomena: it entails building complex, holistic pictures, formed with words, and reporting detailed views of informants, obtained in natural settings" (Creswell, 1998, p.15).

Quantitative research, in contrast,

> "…deals with quantities and relationships between attributes: it involves the collection and analysis of highly structured data in a positivist tradition" (Bowling, 2002. p194).

Hence, quantitative research seeks to show statistical associations or cause and effect relationships, while qualitative research centers on describing or illuminating social phenomena and human experience (Fade, 2003).

Thus the type of evidence desired and the context in which it occurs greatly influences the paradigm of inquiry. While the possibility of using an experimental design involving a randomised control trial was contemplated, given that their fixed design requires a developed framework or theory, advanced knowledge of what to look for, and extensive pilot work to establish what is going to be feasible (Robson, 2002), such an approach was deemed unsuitable. In order to appropriately capture the intricacy of issues perceived to be most pertinent to psychosocial well-being among residents of extended care facilities a certain degree of flexibility was necessary. Furthermore, many aspects of health care are not amenable to scientific design (Clark, 2004), while randomized control trials may determine which activities best enhance quality of life, they fail to provide a holistic portrayal of the complexity of human behaviour and human experience. Thus to explore the psychosocial factors that influence health and well-being, it is useful to look beyond outcome scores to the individual experiences of older people and the staff who facilitate their well-being. While there certainly is a place for measurement in nursing practice, it is best reserved for areas that do not require detailed descriptions of vulnerable life experiences (Myers 2000).

The aim of this research is to explore the psychosocial needs of older people in extended care settings in Ireland; an extremely subjective and temporal phenomenon. To objectively fulfil this endeavour the study aims to encompass the perceptions of caregivers and residents, to ascertain their meaning of psychosocial being and factors which influence it. Such complex human phenomena require methods of inquiry which yield greater insight into meanings, experiences and perceptions of the population under exploration (Pope and Mays, 1995). These complex and individual

variables can only be explored effectively by adopting an approach that is flexible and conducive to the holistic, biopsychosocial components of human experience. Polit and Beck (2008) suggest that the research approach is naturally derived from the implications of the chosen research question, that is; how are older persons psychosocial needs perceived and subsequently met in extended care settings in Ireland? It is widely recognised that social science methods; qualitative approaches, are most appropriate to the study of such phenomena (Faltermaier, 1997; Pope and Mays, 1995). Holistic by nature, qualitative research permits in-depth descriptive accounts of diverse human phenomena (Cormack, 2000). A qualitative framework provides a foundation for the production of data through a variety of sources and means, whilst offering an interpretative flexibility that is both reflexive and reactive to the concepts and theories which emerge from the data (Morgan and Drury, 2003, p.5). The goal of qualitative research, as described by Polit and Beck (2008) is,

> "to develop rich understanding of a phenomenon as it exists in the real world and as it is constructed by individuals in the context of that world" (p.220)

Qualitative approaches to research facilitate the identification, interpretation and provision of meaning; appreciating the complexity of phenomena through acknowledging the dimensions and the contexts in which they occur and how individuals may react towards life events (Morgan and Drury, 2003). Furthermore, Faltermaier (1997) maintains that qualitative methods are valued for their focus on the whole person in their social world, and their endeavour for subjective reports and experiences revealing unanticipated meanings and connections. Therefore, in light of the extant literature and the intended outcomes of this study, a qualitative approach to research was considered most appropriate. Thus, it is apparent that the virtues of qualitative research are more conducive to achieving the objectives of this study; the attainment of the individuals' unique perspectives being foremost. Hence, the choice of paradigm was thoroughly contemplated in order to assure fit and sensitivity to both the objectives and context of the study.

3.3.1 Epistemological Considerations

As the research aims to generate knowledge about human phenomena and social processes, a grounded theory approach, epistemologically derived from symbolic

interactionism, was deemed to be most appropriate. Symbolic interactionism explores the process of interaction between people's social roles and behaviours (McCann and Clark, 2003). Hence, the decision to adopt a grounded theory approach is further justified upon recognition of the reasons for and influences on its development; highlighting its guiding principles which underpin the contemporary qualitative methodology. In the early 20th century George Herbert Mead sought to bridge the divide between psychologism and sociologism with the aspiration to attain greater understanding of the social world (Goulding, 2002). Inspired by the works of W.I. Thomas and Charles Cooley and their idea's concerning *definition of the situation* and the *looking glass* respectively, Mead postulated the social nature and origin of self, arguing that individuals come to understand collective social definitions through a socialising process and interaction with the environment (Annells, 1996). Mead proposed the inherent use symbols in the expression of human social processes, language being a significant symbol signifying a certain meaning in the development of human experience (Mead, 1962). As the study aims to explore the perceptions of residents and staff, the concepts of language, communication and interactions are considered central to the process of inquiry. Furthermore, in attempting to understand the human phenomena and social processes which underpin the research question, the symbolic interactionist propensity to explore individuals' perceptions of the world around them based on their interactions with others, and how such interactions affect the self was considered pertinent to this study.

Blumer further developed the philosophical position and coined the term symbolic interactionism, which emerged as a form of social theory with distinctive epistemological implications (Annells, 1996). According to Annells (1996) symbolic interactionism is both a theory about human behaviour and an approach to enquiry about human conduct and group behaviour however; it is a micro-sociological theory concentrating on the dynamics of interaction between the individuals and the relationship between individual perceptions, collective action and society. Thus, its aim is to explain social actions and interactions in terms of the meanings that those actions have for individuals (Porter, 1998). An act only becomes symbolic if there is shared meaning attached to it, often arising from active interpretation and socially constructed assumptions (Mead, 1962), hence we interpret what is going on around us and act on the basis of the interpretation that we make. Blumer (1969) acknowledges

the significant influence of human interaction in the formation and maintenance of social structures, highlighting the importance of interpreting individuals' perceptions in understanding social processes such as that currently under exploration.

Therefore, symbolic interactionism as an approach to enquiry and as a theory, was thought to facilitate the appreciation of how social processes within the extended care facility impact on the psychosocial well-being of residents. It is considered that an understanding of current practices, founded upon human actions and interactions, is essential for the progression of practice, hence improved patient outcomes. Thus, through comparative analysis of the views of the service users and the service providers, it is anticipated that interpretation of the subjective accounts from a symbolic interactionist perspective will contribute to the conceptualisation of a significant theory founded upon shared meaning.

Symbolic interactionism influenced the thoughts of the discoverers of grounded theory, Barney Glaser and in particular, Anselm Strauss. Such writings heightened Strauss's awareness of the need to conduct research which accurately portrays social phenomena, to construct theory that is grounded in reality and to capture the dynamics of human behaviour in their construction of social reality (Strauss & Corbin, 1990). According to Goulding (2002) the main impetus in the formation of an alternative qualitative approach was to eradicate the disparity between theoretically "uninformed" empirical research and empirically "uninformed" theory by grounded theory in data. Indeed, Glaser and Strauss (1978) sought to discover a method of inquiry appropriate to the exploration of social science, rejecting the notion of "theory generated by logical deduction from *a priori* assumptions" to develop a rigorous method of inquiry that inductively generates theory from data (p.3). Thus, informed by the interactionist philosophy, grounded theory's forte is that conceptualisations are grounded in the empirical work (Orona, 1990). According to Morse and Field (1995) the process of generating grounded theory is "both hierarchical and recursive" as systematic categorisation of data is essential prior to the process of theorising patterns from the emergent categories (p.157). Thus, the method is iterative rather than a linear process as the generation of theory depends upon constant comparison of the data collected at each stage of the research process, hence data collection and analysis occur simultaneously.

Such definite characteristics are believed to be most fitting to this study aims and objectives. Adopting a grounded theory approach lends a certain degree of flexibility, whereby in the event of significant themes emerging from the initial data, further inquiry can be made in order to evaluate the situation and develop a theory, reflecting the reality of human phenomena. Informed by the interactionist school of thought, it is anticipated that this approach will result in a deeper understanding of the phenomenon, through providing a more extensive and comprehensive portrayal of the phenomenon from the perspectives of those who experience it.

Corbin and Strauss (1990) highlight significant principles occurring from the philosophical and sociological orientations of grounded theory. For instance, the significance of change as;

> "phenomena are not conceived of as static but as continually changing in response to evolving conditions" (p.5)

Therefore, it is acknowledged that theories are a product of a specific time, place and person and thus will be interpreted by those who are time and context-bound (Daly, 1997). Grounded theory explains what is actually happening in practical life at a particular time, rather than describing what should be going on (McCallin, 2003). It is particularly relevant to this research as an understanding of present circumstances is essential for the facilitation of future amendments. Furthermore, this approach is conducive to the evolving nature of this study in the sense that the research process is less predetermined and the design develops as the research proceeds.

In addition, Corbin and Strauss (1990) contend that;

> "grounded theory, seeks not only to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions" (p.5).

This principle was thought to be particularly conducive to the exploration of this phenomenon as individuals in extended care settings may have experienced great change, not only in their place of dwelling, but also in their surrounding social world. Thus, such an approach may assist in the appreciation of how individuals adapt and

perceive such changing circumstances and the subsequent impact on one's psychosocial well-being.

Hence, it is understood that the grounded theory approach is suited to the exploration of micro issues rather than macro issues (Gerrish and Lacey, 2006). Developed by sociologists, this approach was deemed suitable for this study to enhance understanding of the broader sociological aspects of nursing and life in extended care settings. More specifically, grounded theory is rooted in the symbolic interaction tradition of social psychology and sociology (Chenitz & Swanson, 1986), thus it is considered ideal for the exploration of psychosocial issues. Furthermore, in an effort to generate theory which facilitates the development of guidelines and polices that are reflective of individuals' actual needs, focus on the individual was foremost. Therefore, central to the enquiry was a desire to understand individual conduct with or without the involvement of interaction with others; hence focus is on the individual and the individual in the social context. The desire to reveal the perspectives of the participants in an effort to ascertain the current sociological position of the setting is very much in keeping with symbolic interactionism. According to Benoliel (1996) grounded theory research focuses on "the social psychological processes" of people undergoing a period of change or adaptation, and to a variable degree, on the environmental circumstances influencing the experience (p.413). Thus, theory is inducted from the interpretations of the participants' word; generating a timely theory of social reality. Therefore, grounded theory's inherent measures to minimise the influence of extrinsic factors are imperative in the endeavour for apt interpretations of a complex and extremely subjective phenomenon. Hence, grounded theory, informed by the interactionist's school of thought, is ontologically and epistemologically congruent to the phenomenon being explored. However, since its establishment as a research approach, grounded theory has been subject to various interpretations thus, the need to adopt an approach most suitable to the aims, objectives and context of this study was apparent.

3.3.2 A Tailored Approach to Grounded Theory

There appears to be general consensus that since its inception grounded theory has undergone many transformations that have distanced it from its symbolic interactionist roots; with its emphasis on behaviour grounded in social and symbolic

actions (Cutcliffe, 2000; Goulding, 2002). Classic grounded theory method, critical realist in philosophy and objectivist in perspective, is firmly grounded within a postpositivist paradigm of inquiry. Alternatively Strauss' modern take on grounded theory is relativist in ontology, subjectivist in epistemology and acknowledges the interactive role of the inquirer, thus can be clearly correlated with a constructivist belief system (Annells, 1996). Yet, the constant comparison of the data to develop concepts and categories; the gradual abstraction of the data from descriptive level to higher order theoretical categories, theoretical sampling, theoretical memos and saturation of data are features that remain constant regardless of the version adopted (Goulding, 2002). Thus two versions of grounded theory have emerged and while one was considered more favourable to the aims and objectives of this study, both editions are regarded as influential to the current study. Popay et al. (1998) censure the rigid adherence to a specific research design, and instead argue that,

> "...the hallmark of good qualitative methodology is its variability, rather than its standardization..." (p. 346).

Hence, Popay et al. (1998) value flexibility, adaptation and redesign of the approach as applicable to the evolving dimensions of the study. While this study was guided by the general principles of grounded theory one particular version was not systematically adhered to, rather features were adopted from both adaptations as applicable to the context of the study. Nevertheless, Strauss's emphasis on how individuals actively respond to events which they encounter, the focus of his work being social situations and identities developed through interaction was greatly acknowledged (Goulding, 2002), his approach was deemed more appropriate to the exploration of this phenomenon, and therefore his guiding principles take precedence and are widely evident throughout this study.

Nevertheless, it is the foundations of grounded theory that strengthen it's attractiveness as an approach in exploring social issues such as the current phenomenon. While the approach has transformed and taken on different forms since its origin, its roots remain unchanged and thus influential. The pragmatist influences on the principles of symbolic interactionism infer that meanings of phenomena are to be found embedded in relationships in society (Clarke, 1990). Thus, the power of

interaction itself is central to the paradigm and so perceived to be suitable to the phenomenon under exploration as from inception it was probable that the concept of interaction would be a significant feature, not only in the study findings but also in the methods of enquiry. This logic is apparent on consideration of the sample population, hence the importance of appropriate interactive methods of enquiry.

3.4 Setting

In order to increase the transferability of the findings, two publicly funded care settings in the South of Ireland located approximately 38 kilometres apart were chosen as research sites. Furthermore, the use of two research sites increased opportunities to recruit sufficient participants as the potential for recruitment was perceived to be limited; predominantly the feasibility of staff members participating was somewhat restricted on account of the time required to allow for data collection methods as personal obligations or organisational factors often determined individuals' participation. The accessibility of the study sites was significant due to the study's restricted time frame together with the frequency of visits required throughout, thus identifying sites within relatively close proximity proved invaluable for the purpose of time management. The selection of two research sites also enhances the comparative nature of the grounded theory approach. Furthermore, in reducing opportunity for bias it was assured that the researcher had no personal or professional obligation to either of the research sites other than to fulfil the objectives of this study.

In light of the study's aims and objectives the two community hospitals chosen offered some form of stimulating activity (co-ordinated by local staff members) for their residents. Furthermore, both sites offered a combination of rehabilitation, respite and extended care services however, residents in receipt of intermittent care such as rehabilitation or respite were not invited to participate in this study. The exclusion of this cohort can be justified in acknowledgement of the aims and objectives of the study; to explore the perspectives of those in receipt of extended care. Thus, the inclusion of those in receipt of intermittent care would only serve to weaken the findings as their experience of extended care would be somewhat sporadic. Therefore, their experience of psychosocial stimulation would be inapt to this study.

3.5 Access to Sample

According to Woods and Roberts (2003) planned, diplomatic negotiated access to research sites and participants is a crucial component of the research process. Prior to the commencement of the study ethical approval was sought and subsequently granted by the relevant authorities (Appendix 2 & 3). A letter requesting permission to carry out the research accompanied by information regarding the proposed study was sent to the hospital managers (Appendix, 4a), the directors of nursing (Appendix, 4b) and to the unit managers of each site (Appendix, 4c). A meeting was then arranged with these "gatekeepers" which served to establish good rapport with the study sites, in addition to personally responding to any queries or concerns expressed. The established rapport with "gatekeepers" proved invaluable in the subsequent stages of the research process as supportive management structures facilitated access to the study participants in addition to the use of facilities such as private rooms for interview purposes.

Once access to the study sites was granted, the clinical nurse mangers of each unit were requested to distribute information leaflets to potential participants (Appendices 5a-5c) and letters inviting them to participate in the study (Appendices 6a & 6b). Similar letters and information leaflets were later devised for the purpose of recruiting participants through theoretical sampling. Participants were invited to take part in the study by letter and were not directly contacted by the researcher until they had expressed a desire to partake. The clinical nurse managers of the units served as gatekeepers and mediums for this indirect communication. All documents intended for residents were formatted in larger font size to accommodate any potential visual impairment.

3.6 Sampling and Planning Issues

The use of a focused sample is recommended in the application of grounded theory to ensure the sample frame consists of individuals with experience in the phenomenon under exploration to reveal the situated, contextual, core and subsidiary social processes (Cutcliffe, 2000). Identification of each person in the accessible population is essential to maximise opportunities for the most favourable sample to represent the phenomenon under exploration (Burns and Grove, 2003). Hence, eligibility criteria were essential in recruiting participants that would be able to provide insight into the

phenomenon under exploration. The gatekeepers of the study sites were provided with a copy of the eligibility criteria from which a list of all potential participants was devised (Appendix 7). The identified population were then invited to participate by means of letters accompanied by information leaflets (Appendices 5a-6b). Hence, sample selection was determined by the institution's admissions policy, residents' profiles and by residents' and staffs' willingness to participate.

The initial sampling was purposive, so that selected participants had the capacity to provide relevant data for the phenomena being studied. Although the grounded theory approach generally stipulates the application of theoretical sampling (Glaser & Strauss, 1967; Becker, 1993), the need for initial purposive sampling is condoned for the purpose of generating adequate data to direct subsequent sampling processes (Cutcliffe, 2000). Hence the nurse population were selected for the purpose of the opening sample. It was considered that this populations' central positioning within the multidisciplinary team, in addition to their inherent knowledge of the facility's residents, would generate the profound data required to determine the ensuing direction of the study and subsequent sampling needs. To minimise the risk of bias, staff members willing to participate were randomly selected from the initial purposive sample. For the purpose of understanding the staff nurses perspective of the current phenomenon, focus group discussions were deemed most appropriate. While it was anticipated to have no less than five attendees for each discussion, sampling proved difficult. Invitations to participate in the study were extended to staff nurses eligible to take part. While Sim (1998) recommends that eight to twelve participants is idyllic for focus group discussion he concedes that smaller groups comprised of four to six participants is also acceptable. While a total of 10 nurses' from each study site were willing to participate, arranging a suitable time when all participants could attend was met with great difficulty. The main issue being the difficulty in attending during participants free time due to personal commitments. Thus, it was benevolently agreed by management that the discussion would take place during work hours with relief of one hour given from ward duties or time owed to participants who attended in their free time. Out of the ten staff nurses who initially agreed to take part, five attended from site "A" while four attended from site "B", some staff members could not attend due to low staffing levels secondary to absenteeism on the day of the discussion. A similar pattern occurred when theoretical sampling of the clinical nurse managers

occurred, of eight managers eligible to take part from each site only four attended. The reason being that the majority of the wards had one nurse manger on duty at a given time; those not on duty the day of the discussion were not willing to participate in their free time due to personal commitments.

In recruiting members of the resident population every effort was made to ensure their well-being remained paramount. Gerrish and Lacey (2006) highlight that every recipient of healthcare is in some way vulnerable, when carrying out research involving older people thoughtful consideration to humanitarian issues is foremost. Thus, when recruiting residents to partake in this research precedence was given to their human rights, biopsychosocial needs, comfort and overall safety. The opportunity for introductions and time to respond to any queries or concerns was availed of upon receipt of confirmation from the clinical nurse managers regarding residents willing to participate in the study. The benefit of personally meeting with participants prior to the interview process was acknowledged as this initial introduction served to promote a more relaxed atmosphere between the researcher and participant owing to the eradication of uncertainties through providing adequate information in a relaxed and cordial manner. A time suitable to the participant was then organised to hold the interview, in some instances the residents wished to continue the conversation at the time of introductions, thus following a complete explanation of the process and having ascertained their comprehension, informed consent was obtained in the presence of a nurse witness. Invitations to participate in the study were extended to all residents eligible to take part via the nurse managers in both study sites. While six residents expressed willingness to participant in site “A”, five residents of site “B” agreed to participate, one of which later withdrew their desire to take part. The resultant sample consisted of 5 men and 5 women which, although balanced, was completely coincidental. Furthermore, it was expected to have a larger representation of woman as they comprised the greatest proportion of residents in both study sites. However, due to cognitive impairment, ethical and legal considerations rendered many of the residents incapable of giving their informed consent thus, in respect of their human rights these residents were excluded from the sampling frame.

In keeping with grounded theory, the analysis of the data obtained served to indicate the future direction that sampling should take, thus theoretical sampling followed. Theoretical sampling is defined by Glaser and Strauss (1967) as;

> "the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges"
>
> (p.45)

The initial sampling was derived from a relatively substantive group which evolved through the application of theoretical sampling. According to Charmaz (2006) theoretical sample allows for clarity and generality as sampling extends across substantive areas. Thus, engaging in theoretical sampling can raise the emerging theory to a more formal level, thus increasing its transferability. Therefore, although a substantive theory was originally anticipated it is thought that the broad sampling frame may be conducive to a more formal theory, applicable beyond the immediate context of this study.

According to Cutcliffe (2000) theoretical sampling is favourable to the complete understanding of the phenomenon. Hence, as the fieldwork and interviews progressed the need to collect data from additional sources became apparent. For instance, it was initially proposed that a total of five residents, and seven staff nurses from each site would constitute the sample, giving an overall total of 24 participants. However, following the pilot focus group session attended by staff nurses of a hospital for older people, unrelated to the study sites, the invaluable role of healthcare assistants was made apparent. As a result, the sampling frame was revised to include 5 healthcare assistants from each site. It was decided that the inclusion of healthcare assistants was essential to the exploration of this phenomena; their contributions to both physical and psychological needs of residents in the extended care settings is widely acknowledged (Barba et al., 2002; Coffey, 2004; Atwal et al., 2006). However, in order to limit the potential of disparity, arising from varying experience or educational levels, it was decided to limit participation to those who were employed in the setting for a period of six months or more and to include only healthcare assistants who possessed FETAC qualifications. While 5 out of 9 healthcare assistants invited to take part were successfully recruited from one site, the other had a limited number of FETAC

accredited employees; of 7 healthcare assistants invited to take part only one was willing to participate, hence the representation of healthcare assistants is unbalanced across the study sites.

Furthermore, following comparative analysis of the staff nurses' focus group sessions, it became evident that issues pertaining to management permeated the data. As a result clinical nurse managers were recruited from each site to take part in additional focus group sessions to further explore the emerging categories and relationships. The addition of clinical nurse mangers to the sample was significant as it was thought they could provide insightful accounts due to their medicating role between the ward staff and higher governing authorities. Also, as individuals directly involved in the provision of activity (formal or informal) were frequently referred to in the data, one activity personnel from each site was recruited to provide insight into this aspect of care. Hence, theoretical sampling allowed for the pursuit of unanticipated realms, enabling a more inclusive exploration of the phenomenon.

While sampling was guided by the data and emergent concepts, time was also an element as the study was restricted to a specific time frame for completion. Thus, to ensure significant concepts could be explored within the timeframe, the predominant and noteworthy emergent categories were given priority and sampling ceased upon saturated of these categories. Theoretical saturation was further confirmed upon attainment of the perspectives of all available staff and residents related to the phenomenon and emerging concepts, thus no further immediate avenues of inquiry remained.

3.7 Eligibility Criteria

While a broad sampling criteria was adopted to include individuals from four separate groups; (Clinical Nurse Managers, Staff Nurses, Healthcare Assistants and Residents) it was intended that all the staff groups would be comprised of homogenous population to control for extraneous variables. Conversely, a heterogeneous resident sample was desired to represent the varying perspectives of this population group, hence any individual residing in the setting for a period of six months or more was invited to participate. However, for ethical reasons those with severe cognitive impairment were not included.

Therefore, for the purpose of meeting the studies objectives the following criteria applied:

- Residents must be aged 65 and over
- Residents must be in a state of reasonable mental health in order to understand the full implications of involvement in the study and to provide legitimate informed consent. This will be assessed using the abbreviated mental test score (AMTS) (Hodkinson, 1972).
- Residents must be in receipt of extended care for a period of 6 months or more.
- Staff must be working in the extended care units for a period of 6 months or more.
- Staff must have some involvement in the activities provided (participant or observer).
- Healthcare assistants must process the appropriate FETAC level 5 qualifications.
- Both men and women are required for equality of sampling.

Exclusion criteria include:

- Those with cognitive impairment to the degree that it would render them unable to provide valid consent to participate.
- Those in receipt of respite care, rehabilitation or any form of intermittent care

3.8 Pilot Interviews

Although not a typical step in the qualitative research process, it was decided to carry out pilot interviews with two older persons living in an extended care setting and also a pilot focus group session with staff nurses working in a separate extended care setting. Both settings were independent of the study and had no affiliation with the academic or clinical settings involved in the research. The interviews with residents were piloted in order to ascertain the feasibility of the approach and its suitability to an older respondent. Furthermore, the exercise heightened personal awareness of the value of good interpersonal skills, particularly where sensory impairment may be present. Two residents from a private nursing home, with whom the researcher has an amiable relationship agreed to participate. The focus groups were also piloted with a

group of nurses working in a care of the older person setting independent of the sample population.

The decision to perform pilot interviews proved invaluable in terms of quality enhancement as the piloting process served as a trial run and personal critique. Upon reflection, areas where personal gestures or statements may have influenced the generation of data through leading questions and interpretations were acknowledged Thus personal subjectivity and candour among participants were scrutinized in an effort to reduce potential for bias in the subsequent interviews. Furthermore, this additional step was thought to be a fortifying component to the study as it served to reveal further concepts for exploration in the actual interviews, thus instrumental to the construction of the interview topic guides. It also served to highlight further population cohorts to be included in the sample. It had been initially thought to include residents and staff nurses in the sampling; however the significant role of the health care assistant in the provision of holistic care became evident in the pilot focus group discussion, thus this cohort was added to the initial sample. The fundamental role of these members of the multidisciplinary team is acknowledged in the literature. Hence, the pilot interviews served to highlight areas significant to the phenomenon under exploration thus augmenting the initial topic guides in addition to enhancing the researcher's interview skills.

3.9 Data Collection

The complexity of phenomena explored in the qualitative paradigm necessitates the utilisation of methods that ensure a close proximity to the information sources (Morgan and Drury, 2003). Thus qualitative methods that are sensitive to individuals' subjective experiences, perceptions and meanings, are required (Sim, 1998) Furthermore;

> "as the purpose of grounded theory is to construct theory from the data itself, solid, rich data are required to elicit thorough, accurate, and complete development of conceptual and analytic issues" (Eaves, 2001, p.656).

While a vast amount of scales and frameworks exist to measure elements of older persons' life in the extended care setting, it was thought more valuable to utilize a flexible approach such as the semi-structured interview to capture the intricate and

subjective nature of human experience in an uninhibited manner. Mackenzie et al. (2004) state that in exploring psychosocial issues among population groups, methods which look beyond outcome scores to the individual experiences are most appropriate. While observational methods were considered, it was thought that the merits of interviews surpassed those of observation. Interviews are conducive to the portrayal, clarification and exploration of issues from the perspective of the participants (Tod, 2006; in Gerish & Lacey, 2006). Therefore, the interview process encompasses many qualities amenable to social science research. Sarantakos (2005) highlights a number of attributes inherent to the interview process, some of which have been adapted to demonstrate the appropriateness of interviews as the method of inquiry for the current study:

- *Flexibility*. Interviews can be modified to aid further exploration of emerging themes as the research progresses and as the circumstances dictate. Furthermore, the flexibility of the interview process allows for participants to articulate their thoughts and subjective experience. Thus, interviews are conducive to the inductive exploration of unanticipated avenues.
- *Ease of administration*. Interviews do not require participants to read and complete long and complex documents as with questionnaires, thus are conducive to all participants due to time constraints on participating staff members and potential sensory deficits among the older participants.
- *Opportunity to observe non-verbal behaviour.* The direct nature of interviews allows for the observation of noteworthy non-verbal cues such as emotion and body language, as it is well-recognised that it is not only what is said, but the way that it is said is significant. Thus, the use of fieldnotes and memos complied during and after interviews which note non-verbal behaviour enrich the narrative data.
- *Completeness.* Unlike questionnaires, the presence of the interviewer facilitates participants through clarifying areas of uncertainty or ambiguity; assisting the interpretation of questions results in greater responses and reduced misinterpretations. (Sarantakos, 2005, p.285-286.)

Thus interviews were chosen for their ability to generate insightful verbal accounts of a complex and subjective phenomenon that is human experience. As summed up by Hammersley and Akinson (1995):

> "The expressive nature of language provides the most important resource for accounts" (p.126).

For the purpose of retrieving data from resident population semi-structured face-to-face interviews were utilized. While the option of focus group discussions was considered, it was thought that the intimate and personal nature of individual interviews was most appropriate to the specialised needs of older persons given the potential for sensory or motor impairments. Faltermaier (1997) maintains that interviews as a method of data collection, promote the exploration of personal meanings, cognitive appraisals, life courses, social and biographical contexts and social relations. Furthermore, this method incorporates reflective listening, story telling and facilitates older people in recounting their care experiences (McCormack, 2008), thus allowing for the further exploration of new and interesting responses (Gerrish & Lacey, 2006). In order to facilitate a fluid interview process a semi-structured interview guide was devised which incorporated a series of open-ended qualitative questions (Appendix, 8a). The flexibility afforded by such an approach encouraged the respondents to articulate their perspectives, thus identifying areas for further discussion, leading to the exploration of unanticipated avenues. Furthermore, an empathic approach reduced the risk of threatening or intimidating interactions (Denzin and Lincoln, 2005); every effort was made to be sensitive to the language and concepts used by the interviewee.

To facilitate access to chosen participants and to minimise disruption of the clinical setting, semi-structured interviews were the chosen method of data collection for the healthcare assistant population. These interviews were lead by a semi-structured interview guide similar to that used in the residents' interviews (Appendix, 8b)

The role of personal characteristics is well recognised as being intrinsic to the outcome of any interview process (Gerrish & Lacey, 2006; Charmaz, 2006). A strong degree of self-awareness is of particular importance when conducting interviews; such

was heightened through the piloting process whereby consideration was given as to how personal characteristics may impact on the interview. Sarantakos (2005) commends the match of the interviewer to the respondents in so far as similarities of social background, gender, race, ethnicity, age and personality aid in facilitating the respondents comfort and ease of participation. Sarantakos (2005) contends that such similarities facilitate the development of an egalitarian relationship; trust, understanding and cooperation producing mutually rewarding interactions. While the grade of staff within the sample varied, it is considered that the researcher's background as a healthcare practitioner allowed respondents to perceive a shared understanding of clinical processes, visible through the respondents' liberal expressions of their personal perspectives and clinical experiences. Due to disparity of age and social worlds it was accepted that the researcher's background was not amenable with that of members of the resident sample however, it was perceived that the researcher's receptive approach, coupled with effective interpersonal skills facilitated a relaxed and comfortable atmosphere, conducive to the collection of rich data.

Focus group interviews were utilized for the process of data collection among the nurse population. As the main co-ordinators of care, nurses' perspectives on the concept of quality of life among older people are of considerable relevance, not only to this study but also for future developments in care of the older person. Kitzinger (1995) suggests that focus group discussions are particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think but also how they think and why they think that way. Idvall and Rooke (1998) emphasize many fortes of focus groups, one of which is the possibility of stimulating spontaneous exchanges of ideas, thoughts and attitudes that may be more easily expressed in a group situation. Focus groups also provide opportunities to build on one another's responses, initiating in-depth thinking that may not occur in individual interviews. According to Curtis and Redmond (2007), focus group theory is founded upon the premise that we are a product of our environment and are heavily influenced by those with whom we interact with. Accordingly, focus group discussions as a method of data collection are fitting considering the epistemological underpinnings of the chosen research approach. Furthermore, the data generated form focus group discussions may contribute to the development of more appropriate content for

subsequent data collection methods (Sims, 1998). Thus, in light of the study's aim, objectives and guiding approach, the principles of focus group discussion are believed to be most applicable to the retrieval of rich data from the nurse population as it was anticipated that the group dynamics would encourage the nurse participants to explore issues of importance within their area of clinical practice.

However, careful consideration to the principles of the specific group dynamics is essential to maximise the outcomes of this approach. Kitzinger (1994) recommends an awareness of how hierarchy within the group may affect the data. For this reason it was thought more appropriate to collect data from the varied sample in a strategic manner, thus similar grades of staff were invited to participate in the focus group discussions. For example, when nurse managers were added to the sample, their perceptions were gathered in a separate focus group discussion. Thus, a concentrated effort was made to ensure a certain degree of homogeneity among participants partaking in the focus groups. Likewise, for the purpose of the entire data collection process, it was considered more appropriate that the three populations were not mixed; as this could comprise the confidence of some participants, leading to the inhibition of certain individuals' perspectives**.**

3.10 Designing the Interview Guides

Due to the inductive nature of the study, pilot semi-structured interview guides and focus group topic guides were devised to reflect the aims and objectives of the study, topics for exploration were elaborated secondary to knowledge gained upon preliminary review of existing literature. It was thought that piloting the guides would serve to develop personal interviewing skills, in addition to gaining insight from experts within the field; that is the staff and residents of extended care facilities, in determining the relevant issues which necessitate exploration to adequately understand this phenomenon. The initial residents' semi-structured interview guide was piloted through individual interviews undertaken with two residents from an extended care facility unrelated to the study site. This process served to ascertain the appropriateness of the interview guide content, emphasising the need for personal awareness and empathic demeanour. Furthermore, additional areas for exploration were highlighted, contributing to the overall development of the interview guide. While key issues for exploration remained relatively constant throughout the data

collection process, further questions were added to explore issues in more depth; facilitating the exploration of emergent concepts. While the interview guide provided some structure to the collection of data, all interviews were conducted in a flexible manner to allow for uninhibited expression from participants, eliciting participants' subjective experience. For instance, the semi-structured interview guide consisted of broad open-ended cue questions on issues found to be related to the exploration of this phenomenon (Appendix, 8a & 8b). Charmaz (2006) commends the use of open-ended, non-judgemental questions as they encourage unanticipated statements and stories to emerge. Furthermore, a suitable semi-structured interview guide is essential to achieving the right balance of direction and flexibility (Gerrish and Lacey, 2006). It was intended that all interviews with residents would reflect the style of a relaxed conversation; using interpersonal skills to redirect and focus the conversation as applicable.

As with the initial semi-structured interview guide, the initial focus group topic guide was piloted during a focus group session consisting of four staff nurses working in an unrelated extended care setting. Again this process served to check the appropriateness of the issues deemed relevant to the exploration of this phenomenon. A list of four agenda items was drawn up as a broad framework to guide the group discussions. This guide encompassed cues pertaining to the environment, social networks, activity and quality of life. The focus group topic guide was further developed following the pilot discussion; the resultant summarised issues deemed relevant for exploration were forwarded to the participants due to take part in the forthcoming discussion (Appendix 9). This step was to facilitate participants' reflection on key issues for the impending discussion, thus facilitating their optimum contribution to the research. In giving premature access to the topic guide, participants were afforded the opportunity to contribute issues pertaining to their experience that may have been otherwise overlooked, thus participants had the opportunity to contribute to the topic guide and the issues deemed worthy of discussion.

The process of the revising and developing both the semi-structured interview guide and the focus group topic guide continued throughout the study. Memos and field notes contributed to the revision of the guides prior to the subsequent interviews and discussion groups. As theoretical sampling progressed, the guides were adapted for

the purpose of retrieving data from the evolving sample population, such as the addition of healthcare assistants and clinical nurse mangers to the sample. Hence, the data retrieved in the preceding interviews guided the ensuing interview.

3.11 Managing the Interviews

Interviews were arranged with residents at a time suitable to participants, usually late morning or early afternoon. Prior to commencement of the interview, the resident's comprehension of the process was assured, informed consent was then obtained in the presence of a nurse witness (Appendix 12). The resident's attention was brought to the use of a small audiotape recorder, which was then discretely placed between the interviewee and researcher so as not to deter the resident. The use of an audio tape recorder was thought necessary to avoid the distraction of extensive note taking during the interview in addition to providing a detailed and accurate account of the interview content. The use of recording interviews is commended as it overcomes the natural limitations of memory; providing a detailed account of the interview; allowing for thorough examination of narratives, thus enhancing overall rigour (Heritage 1984, p.238, in Bryman, 2004).

The interviews ranged from twenty minutes to seventy minutes in length. Throughout all interviews, careful observation of the residents was maintained to ensure that their well-being and comfort was foremost, terminating the interview at any sign of fatigue or distress. Conversely, the majority of the residents appeared to enjoy the interaction of the interview and when asked if they would like to end the interview all expressed their contentment to proceed. The recordings of each interview were listened to immediately after the interview session, which provided opportunity to confirm key aspects of the interview and subsequently identify emerging themes. Thus, field notes were further developed at this point to form memos.

3.12 Managing the Focus Groups

At the point of meeting with each of the study sites' Director of Nursing, permission for the use of a private room to facilitate interviewing was sought. The rationale for such a request was the desire to ensure participants' privacy and comfort needs were foremost, an area free from the interruptions of clinical practice was essential. Approximately one week prior to the focus group discussions, the Director of Nursing

was again contacted to confirm availability of the room and acquiescence for the discussions to proceed. On the morning of the focus group discussion each ward was contacted by telephone to remind staff of the impending discussion and to ascertain the feasibility of the agreed participants' attendance; all of which were pending ward circumstances. Chairs were arranged in a circle manner to promote discussion amongst the group in a natural manner. For the purpose of recording the interview, an audiotape recorder was utilized, its function tested prior to entering the interview room. The audiotape recorder was brought to the attention of the participants and placed on a table in the centre of the circle and set to record. As group dynamics is an inherent aspect of focus group discussion, acknowledging the value of not only what is said but also the way that it is said (Bryman, 2004), a complete account of the discussion was desired. This was achieved through audio-taping the verbal content of the discussion and availing of a colleague's support as an independent observer, which served to alleviate the researcher of the distracting task of note taking and observation of group dynamics throughout the discussion. Thus, audio-tape recording and subsequent verbatim transcriptions of the narrative, in addition to field notes encompassing non-verbal communication and interactions among the group, ensured the complexity of data was captured. Participants were welcomed and made to feel at ease (Appendix 11). It was explained that the researcher would not take part in the discussion but rather act as a facilitator ensuring the relevant issues were discussed. Curtis and Redmond (2007) acknowledge the role of the researcher as facilitator in producing data that is relevant to the phenomenon under exploration. Issues from the topic guide (Appendix 9) were introduced as informally as possible to enable participants to discuss their views and experiences, and to introduce and explore issues that may not have been identified by the researcher.

Prior to commencement of the group interview, written consent was obtained from each participant (Appendix 13). The participants were reminded of the principles of focus group discussion and the importance of group dynamics and natural discussion rather than adhering to an interview processes. Nevertheless, participants were reluctant to voice opinions, waiting for the researcher's cue, tending to let one individual respond while the rest of the group motioned agreement with what was said. It became apparent very early in all four focus group discussions that the group was comprised of varying characters, such as more the domineering members; those

who were comfortable and eager to speak out and those who were more reserved and reluctant to voice an opinion that may contrast with or echo their colleagues expressed opinion. Thus, it was essential to constantly probe for further discussion and invite the quieter members of the group to express their opinions, whether in agreement or contradiction, its value was made explicit. Consequently, every effort was made to invite all members to comment during the discussion. Curtis and Desmond (2007) contend that the intended group dynamics of focus groups can in fact lead to conformity among participants in so far as issues which may have been raised in one-to-one interviews may be withheld. Sim (1998) maintains the more homogeneous the participants the greater the likelihood of genuine group polarization or consensus, thus as homogeneity was explicitly sought, the risk of fictitious conformity was reduced. Furthermore, Lane et al. (2001) contend the possibility of the desire to conform to supposed researchers expectations; whereby participants will tell the researcher what they perceive he or she wants to hear rather than reveal their true perspective. To overcome this limitation participant's confidentiality was assured whilst honest expressions were encouraged; notions of right or wrong statements being deterred.

The focus group discussions were timed to last approximately 60-70 minutes (Appendix 10); due to time constraints and clinical commitments, all interviews were terminated prior to the 70 minutes being exhausted as per advanced agreement with ward managers. The discussion ended with a brief summary of the discussion in order to allow the participants to verify what was said and to determine the researcher's accuracy in comprehending the points made. In all but one focus group this summary lead to further discussion among the participants, predominantly echoing the points made during the main discussion. The recordings of the each group discussion were listened to immediately after the session, the independent observer's notes were assessed and further notes were made upon recognition of important issues regarding both the conduct and content of the discussion. All focus groups were conducted in the same manner, each being comparatively analysed with the latter upon completion. According to Backman & Kyngas (1999) simultaneous collection and analysis of data provides for an emergent theoretical structure which instigates further data collection. Furthermore, Strauss and Corbin (1994) eulogize the data received from participants in sharpening the focus of the exploration and subsequent methods of inquiry.

3.13 Establishing Scientific Rigour

Qualitative approaches to research have long been criticized for their apparent lack of "scientific" rigour and credibility, as unlike the measurement of variables associated with quantitative approaches, qualitative inquiry is alleged to occur within a "value-free framework" (Horsburgh, 2003, p. 308). In defence, many qualitative researchers reject the word rigour, predominantly viewed as a positivist term, and adopt the more qualitative appropriate terms of trustworthiness and authenticity (Lincoln and Guba, 1985). However, in response to the scepticism surrounding the validity of qualitative approaches to research, a dichotomy of standards for assuring validity of findings now exist (Lincoln and Guba, 1985; Beck, 1993; Miles & Huberman, 1994). The original grounded theory methodology referred to the concepts of fit, work, relevance and modifiability as criteria for judgement of quality (Glaser and Strauss, 1967). However, since its inception grounded theory methodology has developed and evolved, an aspect which is visible in its application to this study as features of the original and subsequent version were utilized as applicable to the context of the study. Thus, the need for criteria which determine the validity of findings, extraneous of the approach used, is necessary.

In determining the validity of qualitative work, Whittenmore (2001) attribute the Lincoln and Guba (1985) criteria as "the gold standard" (p.527). Lincoln and Guba's (1985) criteria to determine the trustworthiness of qualitative data encompass credibility, transferability, dependability and confirmability. These, somewhat overlapping criteria, shall be appraised to establish trustworthiness of this research.

3.14 Credibility

According to Polit and Beck (2008) credibility is a significant component in portraying trustworthiness of the adopted approach; explicit and accurate research methods engender confidence in the truth of the data and in the researcher's interpretations of the data. Beck (1993) denotes the term credibility as a method of determining,

> "how vivid and faithful the description of the phenomenon is" (p.264).

As grounded theory is inductively derived from interpretations of the data retrieved, the credibility of the emergent theory may be directly linked to the credibility of the data interpretations. As acknowledged by Strauss and Corbin (1994) theories are interpretations made from given perspectives, thus interpretations may be temporally inhibited and can be pluralistic. However, the inevitable temporality of research is accepted as;

> "phenomena are not conceived of as static but as continually changing in response to evolving conditions"
>
> (Corbin an Strauss, 1990, p.5)

Therefore, the temporality of the data was not considered a limitation to the credibility of findings as the intention of the study is to understand current circumstances in an effort to facilitate future amendments. However, in recognition of the scope for pluralistic interpretations, means of verifying the credibility of the emergent concepts were sought. Goulding (2002) recognises that problems are multifaceted and commonality in judgement is required by means of scrutiny by an additional enquirer or the informants themselves. Respondent validation was initially considered as a means of establishing credibility of the interview interpretations however, as the study evolved it became evident that this approach would not be in the participants' best interests, particularly in the case of the resident respondents. It was thought that a further request of reiterating the lengthy interview contents would be very demanding, for both the staff and the older participants; many having experienced deteriorating health since the interview process. Hence, an alternative method for the purpose of ensuring integrity of the findings was considered.

Subsequently the assistance of an inter-rater was sought. The inter-rater, an advanced nurse practitioner working in a care of the older person setting and an experienced qualitative researcher, benevolently reviewed the interviews extracting predominant themes. The inter-rater's themes and the researcher's themes were then comparatively assessed to determine the level of agreement between the two. The purpose of this peer review was to ascertain whether or not independent interpretations would result in the emergence of comparable themes. Appendix 14 shows a section of the transcript of themes offered by the inter-rater, thus similarities of the themes produced independently of one another are visible. It is argued that this method is supportive of

the positivistic philosophy, which maintains that there is only one accurate interpretation, thus only one reality, and the accuracy of the interpretation is increased as the number of people agreeing increases (Cutcliffe and McKenna, 1999). However, while this method was utilized to enhance the integrity of the findings it does not diminish the qualitative value of the study. Ashworth (1997) maintains that qualitative research is based upon the consensus that there is not one universal truth, but that the social world is multifaceted and an outcome of human interaction, thus a world with "no unequivocal reality" (p. 220). Therefore, the use of an inter-rater does not undermine the subjective nature of the phenomenon but validates the confirmability of the interpretations of the data and the appropriateness of the category labels.

Furthermore, Lincoln and Guba (1985) maintain that the technique of triangulation improves the credibility of findings and interpretations. For the purpose of this study within-method triangulation and data triangulation; whereby data were sought from a variety of populations using a combination of focus group discussions and individual interviews, were utilized to increase the credibility of findings. This approach served to identity patterns of convergence as well as divergence between data sources. Moreover, theoretical saturation which involves staying in the field until no further evidence emerges ensures that verification is continuous throughout the course of the research. For instance, Sim (1998) commends the use of multiple focus group discussions in fortifying the reliability of findings as the use of the comparative method is enhanced. Constant comparison of the data means that data are checked against one another repeatedly and compared and contrasted again and again; checking their representativeness (Cutcliffe and McKenna, 1999, p.378). To ensure reflexivity, meticulous records of each interview were maintained in addition to memos taken during and after the interviews. These served as testimony documents of key thoughts, including decisions to pursue particular lines of inquiry-field notes. Thus any bias is evident.

3.15 Transferability

Researchers have not been well acquainted with, and have had difficulty in accepting the research methodologies of the social sciences in which the generation of hypotheses replaces the testing of hypotheses, where explication is more important than measurement, and where there is emphasis upon understanding rather than

generalisation (Morgan and Drury 2003). While it is accepted that qualitative research does not offer generalizable evidence in the statistical sense (Barbour, 2000), findings may be applicable to a wide range of settings, not just the specific research context. Lincoln & Guba (1985) argued that instead of applying the term generalizability, it is more applicable to discuss the transferability of qualitative findings, while Mason (1996) refers to the concept as theoretical or conceptual generalizability. Regardless of the terms used, Morse (1999) states that if qualitative research is not considered to be generalizable then it is arguably of little use. Beck (1993) draws on Guba and Lincoln's (1981) explanation of another term used to describe transferability; fittingness which;

> "measures how well the propositions fit into a context other than the one from which they are generated." (p.264)

While Lincoln and Guba (1985) consider transferability as an essential determinant of the study's trustworthiness they acknowledge that external validity cannot be specified but rather thick descriptions may be provided so that the relevance of the findings may be independently determined. Furthermore, Barbour (2000) proposes that theoretically generalizable data alludes to explanatory frameworks that may be developed from the data, or processes identified which have applicability beyond the immediate context of the study. Furthermore, Silverman (2006) maintains that if transferability is desired, sufficient information to allow judgment concerning the contextual similarity of the research must be provided. Thick descriptions of the study's context, thoroughly describing the study participants and the research settings have been provided so that the utility of the evidence for others can be assessed in determining the applicability of the evidence derived from this experience to other settings. Furthermore, Goulding (2002) maintains that theory should be supported by extract form interviews which show fit between conceptual abstraction and reality. Through illuminating the perspectives and voices of the participants, the transferability of the theory was ensured in so far as the source of the interpretation was made known. Moreover, in demonstrating the transferability of the research findings, literature relating to each category which emerged is appraised; a method advocated by Chiovitti and Piran (2003).

3.16 Dependability

Beck (1993) draws on Guba and Lincoln (1981) explanation of auditability (dependability), determined as the feasibility of another researcher to follow the audit trail. To ensure the auditability of the methods adopted, all aspects of processes followed and decisions made were made explicit. Thus, dependability is demonstrated through providing an auditable account of the rationale for choice of research methods and subsequent interpretation of data. Silverman (2006) commends the use of patent accounts of the research process in addition to making explicit, the theoretical framework which guides the interpretative process.

3.17 Confirmability

Similar to objectivity, confirmability is the degree to which study results are derived from the characteristics of participants and the study context, not from researcher bias. Authenencity may be demonstrated by quoting significant blocks of raw narrative from the original data (Fade, 2003). The use of rich extensive narratives conveys a vivid picture of the participant's experience thus associates meaning to the data to support the findings of the analysis. Furthermore, authenticity was strengthened through utilising flexible qualitative methods such as semi-structured interviews as a means of data collection, such methods affords participants a certain degree of freedom to speak about issues that are important to them which may have otherwise been overlooked, thus the participant perspective on the phenomenon was sought.

While the audit trail process is commended by Lincoln and Guba (1985) in ascertaining the confirmability of findings, Cutcliffe and Mckenna (2004) argue that such processes do little to enhance the credibility of findings. While the use of an auditor was not requested for the purpose of this study, it was endeavoured to make the rationale and outcomes of each stage of the research process explicit, thus enhancing both its confirmability and auditability. Furthermore, Koch (2004) commends researcher reflexivity in establishing confirmability. For the purpose of this study, consideration of the nature and context of the data retrieved through reflecting on recordings of fieldnotes and subsequent memos was thought to enhance both the confirmability and dependability of the findings. Koch (2004) asserts that reflections may be analysed and dictate subsequent processes. Moreover, Polit and Beck (2008) highlight the need for self-awareness and reflecting on one's behaviour

and how it may influence the data retrieved. The exercise of piloting the initial topic guides served to heighten personal awareness in recognising potentials for bias thus acknowledging the researchers influence to the process and subsequently striving to minimise such influence.

Moreover, in acknowledging the inherent role of interpersonal interaction within the grounded theory approach, Cutcliffe (2000) maintains that the personal values, knowledge and experience of the researcher unavoidably influence the interpretation of reality. Sandelowski (1993) states that two researchers faced with the same qualitative task will produce different accounts due to their individual philosophies and theoretical commitments (in Horsburgh, 2003). Similarly, Guba and Lincoln (1989) maintain that findings are not facts as such, but rather are created via the interaction between the participant, the data and the researcher. Thus, theories are dependent upon the value systems of each party and the context within which they operate (Guba and Lincoln, 1989). Acknowledgement of the role of the researcher as an integral interactant in the research process was made explicit (Strauss and Corbin, 1994). Personal issues pertaining to background, influences and perspectives on research have been made explicit, in addition to providing rationale for each stage of the research process. Thus confirmability was enhanced through transparency of all factors involved in the research process.

3.18 Methodological Limitations

A number of limitations of the grounded theory approach were anticipated upon consideration of the research methodology; while the implications of the predicted limitations were expected and thus alleviated, some unanticipated limitations emerged once the methodological framework was put into practice. Glaser and Strauss' (1967) condemnation of the review of existing literature prior to the collection of data was immediately anticipated as a limitation of the grounded theory approach for a novice researcher. Moreover, in relative terms, the notion of ignorance to extant knowledge pertaining to an area of personal and professional interest is unreasonable, for in order to decide to carry out research in a chosen area one must have the capacity to understand the chosen phenomenon to a certain degree. What is more, knowledge in the chosen area is essential for the purpose of attaining funding, ethical approval and determining the research design. In their subsequent writings, Strauss and Corbin

(1990) accept the need to access the literature prior to the collection of data; however they continue to denounce an extensive review of the literature for fear of contaminating the empirical phase. Thus to overcome this limitation, without undermining the chosen approach, a preliminary overview of the existing literature was undertaken. This overview of the literature was thought to be an essential component of the conceptual phase as it served to heighten awareness of existing literature, enhancing ethical considerations, generating questions and inspiring the underlying principles of the study.

In addition, the use of social theories, such as symbolic interactionism, may be perceived as limitation as it is claimed that such approaches tend to reject the idea that actions are somewhat determined by social structures thus fail to acknowledge the influence of those structures (Porter, 1998). However, in the utilisation of the grounded theory approach based on the principles of symbolic interaction, the interplay of social structures was firmly acknowledged. For instance, appreciation of the context of the data; the sets of conditions within which pertinent issues in the data arose, individuals' actions/interactions and how human conduct and behaviour impacts on such issues, assured that influence of social structures was portrayed (Corbin and Strauss, 2008). Hence, this criticism is thought to be unfounded as application of the principles of symbolic interactionism proved to be a merit rather than a limitation of the methodology. However, it cannot be said that others features of the grounded theory approach did not pose limitations.

Upon application of the methodology, the analysis technique of coding transpired to be a methodological limitation as it proved to be very time consuming. As the timeframe for achievement for academic purposes was limited, it was considered a limitation that that the chosen methodology required ample time to generate a significant theory. While the closeness afforded through personally transcribing all the data retrieved was beneficial in familiarising oneself with the data in the initial phase of analysis, a large amount of additional time was needed to further study the large volumes of data for purpose of identifying codes and concepts. In order to appropriately identify key issues it was necessary to read the transcripts and listen to the audiotapes repeatedly.

Furthermore, the process of coding and sorting the data lead to confusion at times. While Strauss and Corbin's (1990) step-by-step systematic approach was thought to be more achievable, Glaser's (1992) more open approach, initially considered, was perceived to be quite overwhelming to a novice researcher as uncertainty was encountered with regard to carrying out some of the recommended procedures, particularly the data analysis methods. Thus, the transparent guidelines offered by Strauss and Corbin (1990) were adopted. Although Strauss and Corbin's (1990) matrix approach guided the data analysis, word by word coding as recommended was not adhered to, as this method fragmented the data to a degree where it lost its meaning and context. Thus, codes were devised based upon interpretation of key points derived from the data and not devised from the words of the actual data.

Additionally, the divergence of the original method of grounded theory created confusion as features from both versions were considered applicable to this study, thus although Straussian approach was predominantly adhered to, some of the features of the original grounded theory method are also evident. However, it is considered that in explicating the divergence of the guiding principles limitations of the methodology may be reduced.

Also, the outcome of the research may be reliant on the theoretical sensitivity of the researcher. As the researcher is the primary data collection instrument, findings are dependent on the researchers personal and professional attributes, thus it acknowledged that there is scope for diverging interpretations depending on readers' personal attributes. However, in order to overcome this limitation all stages of the research process were made explicit in addition to explicating personal issues pertaining to background, influences and perspectives on research. Furthermore, findings include narratives derived from the raw data to bestow readers' insight into the phenomenon as divulged by the sample population.

Although a number of methodological limitations are evident, it is envisaged that through appropriate and timely action, the impact of the anticipated limitations may have been reduced. However, it is accepted that due to a number of external factors not all limitations may be eradicated, thus the importance of explicating such limitations is acknowledged.

3.19 Study Limitations

Personal experience and professional knowledge allowed great understanding and insight into the staff members' perspectives however, this empathetic demeanour was not feasible in the case of the residents due to disparity of generation and socialisation, thus a certain degree of personal bias existed due to predisposition to the perceptions of nurses. However, in identifying such personal bias every effort was made to suppress such preconceptions in order to act in a manner which served the best interests of all members of the heterogeneous sample.

Furthermore, the study's findings may be limited due the restricted timeframe and resources available, nevertheless the empirical findings are considered valuable in generating evidence in the psychosocial dimensions of healthcare for older person's through the instigation of research endeavours and the promotion of proactive interventions.

A further limitation of this study, which may be an alleged limitation of any study, is the participants control over the data in so far as participants can choose the perceptions they wish to explicate whilst retaining the right to withhold other perceptions. Thus, the wholeness of the data retrieved may be questionable. However, from a constructivist perspective it may be said that the interpretation is not only based upon the tangible data but also on the surrounding processes such as the context in which it occurred and the researchers existing insight of the phenomenon, achieved through cumulative interactions within the social world that is; the broader reality of the phenomenon. Although Glaser (2002) discourages the term constructivist grounded theory he acknowledges that constructivist data is a very small part of the data grounded theory utilizes. However abstract, it is accepted that constructivist data is a component of grounded theory data. According to Charmaz (2006) a constructivist approach allows for the exploration and interpretation of implicit statements or actions within the data whereby statements made without elaboration may achieve a higher conceptual order. Thus, in accepting the value of social constructivism, the broader imputed meaning of the data may be appreciated whereby participants facilitate the construction of conceptualisations and subsequent theory.

3.20 Ethical Issues

Potential ethical conflicts exist in regard to how a researcher gains access to a research site and the subsequent effects on the research participants (Orb et al, 2001). Prior to approaching the potential research sites ethical approval was sought and granted by the Health Service Executive Regional Ethics Committee (Appendix 2) and by the Ethics Committee of Waterford Institute of Technology (Appendix 3) Approval for the study and permission to access the research sites was also sought and granted from the hospital managers (Appendix 4a) and the directors of nursing (Appendix 4b). The ethics committee meetings served to highlight any potential aspects of the proposed research perceived to be potentially harmful to the participants. Although the ethical approval was granted without any need for changes to the study design, one committee member did have concerns regarding the length of the interviews for the residents. This concern was acknowledged and a conscious effort was made throughout all interviews to ensure the participants' comfort and well-being was foremost. Furthermore, should any unforeseen incidents have occurred, access to ethical advice from an experienced qualitative researcher was assured through peer relationships.

The articles of the Nuremberg Tribunal and the Declaration of Helsinki (1964) both state that subjects must be told the duration, methods, possible risks, and the purpose or aim of the research. Each participant was provided with information regarding the nature of the study, how the data collected would be used, and at the same time, given assurance that their confidentiality and anonymity would be respected throughout. A brief description of what would be entailed should they chose to participate was also provided (Appendix 5a-5c). All potential participants were also invited to discuss their decision to partake with others, such as an advocate in the form of a relative or staff member. Opportunities were given to ask further questions and receive further information where necessary. It was also stressed that participation was entirely voluntary and withdrawal from the study was viable at any time. To ensure informed consent, in addition to exercising sensitivity to the needs of the older representatives of the population, all resident information was devised using font size 20 to enhance legibility and subsequent comprehension (Appendix 5b, 6b & 12). Also, all older participants were cognitively assessed using the mini mental test score to assure they had the capacity to autonomously participate in the study (Appendix 16). Prior to

signing of consent forms, verification was sought to ensure all potential participants comprehension of both definite and potential entailments of participation; a member of the nursing staff was present at this time to assure residents' human rights were foremost. Denzin and Lincoln (2005) highlight that while the aim of informed consent is presumably to protect respondents, informing them of the possibility of harm in advance and inviting them to withdraw if they so desire is essential. All participants were made aware that in the unlikely event of the disclosure of information that may pose a serious threat to their personal well-being, or indeed to others; the researcher was bound by law to disclose such information to the appropriate authority. According to Cormack (2000) researchers are bound by their professional codes as well as the guidance provided for the conduct of research in general. In Ireland, nurses are bound to their Code of Professional Conduct. This code states that the principles of confidentiality and the provision of information to enable an informed judgment to be made by the participant must be safeguarded when conducting research (An Bord Altranais, 2000).

Orb et al. (2001) maintain that researchers have an obligation to anticipate possible outcome of the interview process; to weigh both benefits and potential harm. Furthermore, Good (2001) highlight the need to be socially sensitive in applying moral principles across various situations in order to demonstrate dignity and respect across heterogeneous samples Thus, in the interests of those residents willing to participate, biographical information was sought from the relevant nurse mangers. This was to sensitise the researcher to any issues of a sensitive nature such as the loss of a spouse, as it was considered that embarking upon such issues may be inappropriate, needlessly causing harm to the participant. Thus, such issues were not introduced by the researcher unless first indicated by the residents.

Once ethical access to the participants was established, the process of data collection commenced. In keeping with the Data Protection Act (2003) all hard data collected were stored in a locked filing cabinet; while all electronic data were stored on password secured software. All data will be stored for a period no less than 3 years, access to which is limited to the researcher and academic supervisor. The single most likely source of harm in social science inquiry is the disclosure of participants' personal information (Reiss, 1979, in Denzin and Lincoln, 2005). Throughout all

phases of the research process the anonymity of both participants and caregivers was safeguarded, as neither may be identified from the study. However, as one of the methods of data collection involved the use of focus group discussions, the anonymity of participants could not be assured due to the group dynamics of this method. Thus all participants were requested to respect the anonymity of their colleagues and not disclose any of the information discussed during the session.

3.21 Data Management

Due to the large volumes of data generated through qualitative methods of research systematic storage of data in a secure manner was essential. All data were stored in accordance with the Data Protection Act (2003) as stated above. While the use of Computer Assisted Qualitative Data Analysis Software (CAQDAS) was considered for its ability to portray rigour and a systematic approach, it was decided to adopt thematic analysis methods based upon the principles of grounded theory analysis, encompassing the constant comparison method, conceptualisations and the role of the researcher in uncovering theory amidst the data. It is widely accepted that analysing data manually provides the opportunity for deeper understanding of the data (Fade, 2003). While commending the use of CAQDAS, Coffey et al. (1996) acknowledge how some packages may entail data analysis strategies that are reductionistic, thus inconsistent with the methodological foundations and theoretical foundations of qualitative research. Furthermore St John and Johnson (2000) express concern regarding the rise in the use of CAQDAS packages as such approaches may lead to focus on quantity rather than meaning, they maintain that CAQDAS packages assist in managing large volumes of data thus create an obligation to obtain large amounts of data leading to insubstantial analysis. Moreover, it is suggested that CAQDAS packages tendency to homogenize qualitative data analysis methods, due to their structured nature and may restrict the evolution of the data, dominating the analysis process rather than assisting it (Barry, 1998; St John and Johnson, 2000). St John and Johnson (2000) acknowledged that;

> "the meaning of words or phrases are derived from context, body language, and inflection…..using technology in qualitative research may strip away the meanings with which inflection and body language imbue words" (p. 396).

Therefore, it may be inferred that the loss of meaning and context associated with the use of CAQDAS may distance the researcher from the data resulting in detached data.

Upon considering the objectives of the study and the context of the phenomena under exploration, the attainment of individuals' unique perspective and meanings was paramount. Thus to take the research beyond its descriptive form it was thought the use of CAQDAS would serve to detach the researcher from the data, whereby potentially key concepts may be overlooked. Furthermore, the process of training in the use of software packages required time and expense which were not viable within the frameworks of this study. Nevertheless, the need to organise and explicate the analysis process was acknowledged thus, to organise data in a manner that was both accessible and comprehendible alternative means were sought.

Initially, a colour coded system, similar to that avowed by Richie and Spencer (2004), was used to manually organise the data. All the transcripts were colour coded to facilitate ease of identification of the data's source. As the transcripts were coded, each code was given a unique colour, the labelled codes were then cut from the transcript and reorganised on large cards representing the appropriate category. Where applicable, colour coded memos were fixed onto the card to preserve the context of the data. Although this system worked well initially, as the study progressed and the volumes of data grew, it became burdensome to organise the large volumes of data in this manner, thus it was considered best practice to manage the data electronically to facilitate ease of access. Word processors were utilized; the split screen function was particularly helpful for sorting and copying data into appropriate files. Categories were arranged by copying and pasting the colour coded labelled narratives and adjoining memos to the relevant file category. Furthermore, hand drawn maps and diagrams proved an invaluable tool for theorising and abstracting meaning from the codes.

All the interview audio-tapes were copied to individual compact discs as a means of "backing up" the audio data, which were then transcribed verbatim into word processor documents; all of which were systematically filed in a locked filling cabinet. The use of compact disc (CD) also assisted in the transcribing as it allowed for ease of listening through the use of a personal CD player.

3.22 Overview of Data Analysis

Grounded theory data analysis techniques have been proposed by Glaser (1978,1992), Strauss & Corbin (1990), Charmaz (2006), and Clarke (2005) however, due to the lack of clarity regarding the linking steps amidst the major phases of coding and analysis, Strauss and Corbin's (1009) more systematic and explicit technique was adopted. Alternative approaches to data analysis were also contemplated. Ritchie and Spencer's (1994) Framework Approach was initially considered as a means of analysing the data, however further research into this approach deemed it incompatible to the methods of this study. According to Pope et al. (2007) the framework approach is most appropriate for applied or policy relevant qualitative research in which objectives are set in advance and determined by the information requirements of the funding body. As the purpose of grounded theory is to inductively derive theory from the emerging data and not à priori conceptions, it was considered more appropriate to adhere to the guidelines stipulated by Strauss and Corbin (1990). It is worth noting however, that Glaser (1992) maintains that Strauss and Corbin's (1990) overemphasis on extracting the significance from the data by means of "coding paradigm" and "axial coding" inhibits the generation of genuine theory but instead, provides descriptive accounts of interpretations, thus a forced rather than emergent theory results. The reformulation of grounded theory by Strauss and Corbin (1990) placed a greater emphasis on the codification of data, believing there was a cause and effect account to explain the inter-relationships between the emerging concepts and categories. This adaptation of the method was criticized by Glaser for "forcing" a conceptualised theory through coding rather than allowing for the "emergence" of inductive theory generated from the data (Glaser, 1992 p.122). Thus, Glaser (1992) questions the reliability of the Straussian approach's resultant theory that is; whether it has emerged from the data or if it is forced upon the data.

Furthermore, Glaser (1978) questions the probability of theoretical sensitivity using the principles outlined in Strauss' adaptation of the method. In the original grounded theory text Glaser and Strauss (1967) referred the concept of theoretical sensitivity; the ability to perceive variables and relationships enhanced by the researchers understanding of the emergent data and extant knowledge. Subsequent to methods outlined in the original approach, Glaser (1978) further developed the concept of "theoretical sensitivity" of the researcher as an acknowledgement of the subjective,

evolving nature of grounded theory development, necessary to identify which data are significant to the chosen phenomenon. Kuziemsky et al. (2007) contend that theoretical sensitivity enhances rigor, by drawing on the literature and personal experience, and by gaining familiarity with the data during coding. It is maintained that while Strauss proposed the use of highly complex and systematic coding techniques, Glaser stresses the importance of interpretive, contextual and emergent theory believing that mechanisms adopted by Strauss reduce theoretical sensitivity and insightful meaning (Glaser, 1992; in Goulding, 2002). However, the theoretical sensitivity of the researcher is acknowledged by Corbin and Strauss (2008) who maintain that through immersion in the data, analysis is based on interpretations of the researcher's understanding of what the participants are trying to convey, thus with time, the researcher gains insight and sensitivity to extract interpretations to a more conceptual level. Furthermore, it is argued by Kelle (2005) that while Glaser aptly identifies some of the weaknesses of Strauss' concepts, he greatly exaggerates the limitations of the Straussian approach. Kelle (2005) also highlights the contradictory nature of the original grounded theory approach which virtues theoretical sensitivity in identifying theoretically relevant phenomena through awareness of the extant literature combined with professional and personal experiences (Glaser, 1978), while at the same time maintains that theoretical concepts should emerge from the data in the absence of preconceived ideas.

Although Strauss and Corbin (1990) have received criticism for the over procedural nature of their method (Glaser, 1978), their work has been commended for providing novice researchers with direction in carrying out grounded theory analysis (Melia, 1996). Kelle (2005) further highlights the need for some form of explicit or implicit theoretical framework to facilitate the identification of categories and the relationship amongst them. It was considered that while Ritchie and Spencer's Framework Analysis (1994) may have restricted the evolution of theory, Strauss and Corbin's (1998) coding paradigm offered a structured approach conducive to the discovery of theory. The following is a summary of the processes involved in the data analysis; it is worth noting however, that while such processes are documented in sequence, in reality they occurred as an iterative process, in accordance with the collection of data from the theoretical sample. This tendency to present data sequentially is acknowledged by Suddaby (2006) who contends that if grounded theory research was

presented as it occurred it would depict an iterative disarray of methods, procedures, and indistinct categories that would be neither efficient nor comprehensible.

3.22.1 Data Analysis Techniques

According to Allan (2003) grounded theory coding is a form of content analysis to find and conceptualise the underlying issues amidst the tangible data**.** The comparison is echoed by Kuziemsky et al. (2007) in so far as data are examined and meaning extracted from the data. However, Kuziemsky et al. (2007) also acknowledge how grounded theory's unique and rigorous analysis procedures add rigor as codes that make a contribution to the theory are expanded through new linkages with other codes, codes that do not make a contribution are simply removed. Thus, upon completion of coding, the data were carefully refined to form a concise and rich theory. The foundations of grounded theory analysis depend upon three systematic coding procedures; open, axial and selective (Glaser and Strauss, 1967; Strauss and Corbin, 1998). However, it must be reiterated that due to the iterative nature of grounded theory, the coding procedures followed a process of weaving back and forth between data and theory (Bryman, 2004). The following processes occurred in unison with the collection of data, some data sets being analysed repeatedly to ensure the significance of the data was captured.

The initial stage of analysis involved familiarisation with the data, achieved through transcription of the interviews, repetitive reading of the interview scripts in addition to listening to the audiotapes and subsequently noting codes and concepts in the margins of the transcripts as they became apparent. While it was anticipated that each interview would be transcribed verbatim proceeding the subsequent interview it was not always feasible to complete this timely task due to restricted timeframes and the desire to comply with the gatekeepers and participants availability. When immediate transcription of the entire interview verbatim was not feasible, the recording was intently listened to whilst devising associated memos. Memos were kept to record the logic behind each stage of the analysis process in addition to reflecting on the emergent data. Strauss and Corbin (1990) acknowledge the positive contribution of the researcher's personal and professional experiences in developing theoretical sensitivity essential to the analysis process. The use of memo's facilitated personal reflection on the evolving research process, assisting interpretation of the data through

assessing its significance thus guiding the direction of the subsequent data collection. The significance of the initial data to the subsequent research processes is commended by Corbin and Strauss, (2008) as the first data set serve as foundations for the subsequent data collection and analysis, hence open coding began as soon as the data were retrieved from the initial focus group discussion.

For the purpose of accurate, transparent data analysis procedures, meticulous records of each interview were maintained in addition to field notes and memos taken during and after the interviews. All audiotapes of the interviews were transcribed verbatim in addition to noting tone of voice, emotional state and body language where relevant; as it is acknowledged that non verbal communication is just as significant as the spoken word (Fade, 2003). The practice of applying codes to depict the corresponding data ensued whereby the transcripts were read very carefully, key words and interpretations were noted and written in the left hand margin of the transcript, these words served as codes (basic–level concepts) (Appendix 15). Codes denote the verbal and non-verbal accounts of the participants as concepts derived from the data (Corbin and Strauss, 2008), thus organise and give meaning to segments of data (Charmaz, 2006). The codes were developed into more accurate phrases to capture the main idea of what was being said, consideration was given to what words, phrases or paragraphs the codes represented and a label was applied to depict the meaning of the data set. Some of the codes were formulated using actual words elicited by the participants themselves, a process known as "in vivo" coding (Corbin and Strauss, 2008).

The above stage of coding is known as open coding, which is the initial coding of the raw data. During the process of open coding;

> "data are broken down into discrete parts, closely examined, and compared for similarities and differences" (Strauss and Corbin, 1998, p.103).

This process generated an extensive list of codes; hence the process of conceptualizing the codes into groups with similar meaning began at this point. The codes were separated, sorted and synthesised to form concepts using axial coding to progress to a higher level of conceptual abstraction (Appendix 17). Similar codes were comparatively analysed to reveal concepts that pertain to a similar phenomenon,

these similar concepts were grouped to form categories which were colour coded and scribed in the right hand margin of the transcript in higher case script to facilitate ease of identification. Hence the process of axial coding involved merging the lower-level concepts to form higher-levels concepts, relating concepts to form categories/themes. Some of the perceived higher-level concepts proved to be categories in their own right, for instance the concept of *Philosophy of Care* advanced to a category, while related lower-level concepts were reorganised within that category. Categories are of a higher more abstract order than codes (Strauss & Corbin, 1990). According to Corbin & Strauss (2008) as the concepts transcend to a broader more explanatory level, they risk losing some of their specificity thus, to ensure the context of the data was not lost the relevant basic-level concepts were maintained in the explanation of the higher-level concepts. Corbin and Strauss (2008) emphasis the importance of concepts in so far as they represent the analyst impressionistic comprehension of what is being conveyed through the verbal and non verbal cues of the participants. According to Blumer (1969) the formation of concepts are central to the analysis phase of the research process as;

> "they are categories for which data are sought and in which data are grouped; they usually become the chief means for establishing relations between data; and they anchor points in interpretation of findings." (p. 26).

Hence, concepts formed the foundation upon which analysis and data collection progressed.

Through constant comparison of the data inclusive of field notes and memos, linkages were made among categories to allow for conceptual order to be placed upon the data through the establishment of analytic categories, accordingly subcategories were identified. Subcategories are defined by Strauss and Corbin (1990) as characteristics or properties of categories along a continuum or dimensional range. All categories were added to reflect the extent of the data rather than reducing the data at this stage (Pope et al., 2007). An electronic file folder was formulated for each identified category within which copies of the sections of narrative and associated memos were filed**.**

To further progress to higher levels of conceptualisation, the use of questioning proved to be an invaluable analytic tool. Corbin and Strauss (2008) maintain that the use of sensitizing and theoretical questions is central to the analysis process to establish what else one needs to know for the purpose of determining the meaning of concepts and to ascertain the existence of relationships among them. In an effort to form a structured aid to the identification of contextual factors, Strauss and Corbin (1990) proposed a Paradigm Model. According to Strauss and Corbin (2008) the paradigm is a set of questions applied to the data to assist the identification of contextual factors and relationships among categories and subcategories. While this model has being criticized for its over "mechanical" approach (Glaser, 1992), it is maintained that that this tool is often over utilized by novice researchers, thus inappropriately dominates rather than directs the analysis (Corbin and Strauss, 2008). In the latest text, Corbin and Strauss (2008) attempt to clarify the use of the paradigm model, they assert that;

> "The analyst is not coding for conditions or consequences per se, but rather uses the tool to obtain an understanding of the circumstances that surround events and therefore enrich the analysis." (p. 90).

In light of Strauss and Corbin's (2008) clarification of the use of the Paradigm Model, the modified version was utilized as an analytic tool to guide the analysis of the data. This entailed considering the conditions, actions/interactions and the consequences of data and the context within which it occurred (Corbin and Strauss, 1998) (Appendix 18). The model allows for a more dynamic view of processes involved in the phenomenon. According to Corbin and Strauss (2008) process in data demonstrates the populations' ability to give meaning to and react to circumstances through sequences of actions/interactions, whilst acknowledging their perceptions to such circumstances. As the analysis procedures progressed through theoretical sampling, the initial research question evolved and became more focused to reflect the participants' perspective on the phenomenon. Interpretations of the staff data set revealed perceived barriers to the provision of psychosocial care while interpretations of the residents and staff data intertwined revealed achievable means of meeting residents' psychosocial needs. This change in focus in discussed in greater detail in the ensuing chapter.

The process of comparative analysis, originally contrived in the original grounded theory approach (Glaser and Strauss, 1967), was thought to be beneficial to the process of generating theory through internally analysing the emergent data and subsequently externally analysing with the extant literature. Furthermore, information provided by participants was deemed relative to the exploration when constant comparison of the data revealed the repeated presence of narrative pertaining to specific areas of relevance. Hence, interpretations were validated upon comparison with the incoming data (Glaser and Strauss, 1967). Thus, the constant comparison method of data analysis produced an emergent substantive theory (Strauss and Corbin, 1990). In scrutinizing the transcripts after each interview concepts for further exploration were often highlighted and introduced in the subsequent interviews. All interviews were processed in the same way as the preceding interviews and cross referenced to allow for comparison of recurring themes in addition to noting the contrasting or negative cases. The constant comparative method adopted allowed for contradictions or negative cases within the developing theory to be logically explored through the use of memo writing, comparison to other data and inquiry processes in the subsequent interviews. Mays and Pope (2000) highlight the importance of negative case analysis, in doing so they emphasis the need to explore elements within the data that contradict, or seem to contradict, the emerging explanation of the phenomenon under study. Such "deviant case analysis" helps to refine the analysis until it can explain the vast majority of the cases under scrutiny (Mays and Pope, 2000, p.51). Thus, the data were critically appraised in an effort to understand and explain why the data vary. Furthermore, in order to account for variations, questions pertaining to negative cases were introduced in the subsequent interviews in an effort to understand and explicate reasoning for the variations.

Concurrently the literature was referred to, enabling theoretical sensitivity through comparing and contrasting the emerging theory to the extant literature. Goulding (1998) acknowledges the relationship between theoretical influence and empirical work as being in central to the development of theory grounded in the data. Furthermore, Glaser (1978) highlights the importance of extant knowledge in sensitizing the researcher to the conceptual significance of emerging concepts and categories. According to Goulding (2002) knowledge and theory are used as if they were another informant, for without this grounding in existing knowledge, recognition

of patterns would be limited to the obvious and the superficial, thus diminishing opportunities to attain higher conceptualisation. It is such comparisons that ultimately enabled the refinement of concepts and theory. Thus coding, analysis and theorising occurred simultaneously until finally, core categories were identified.

The final stage of data analysis involved selective coding, which built upon the foundation of the previous open and axial coding. Selective coding is;

> "the process of selecting the central or core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development" (Strauss and Corbin, 1990, p.116).

Selective coding involved choosing one category to be the core category and relating all other categories to that category, thus a core category developed around which everything else is draped. According to Strauss and Corbin (1990) the core category is the central theme of the data around which all other categories may be subsumed. However, due to the complexity and the multidimensional nature of the phenomenon under exploration, defining a core category proved difficult at first, several categories, all considered central to the phenomenon, were identified. This led to the development of sub theories regarding psychosocial processes among the staff and residents of extended care settings. Following further analysis and the development of explanatory frameworks; a substantive theory was developed whereby the core categories merged to form a potential framework to facilitate the attainment of biopsychosocial care among older people. Throughout the entire process memos were maintained to document the felt relationships among the data and subsequent categories and themes (Eaves, 2001). However, as the analysis process progressed after data collection had ceased this obstacle was conquered as further insight was achieved; the predominant categories were identified and placed under a relevant category, finally a core category was determined. It is accepted that while the core category may evolve out of the existing categories it may occur that an additional phrase is required under which all other categories may be subsumed. Thus, through reading and rereading the data, reflecting upon the categories and the context from which they emerged an innovative category was deemed the fitting core category. The possibility of "seeing data differently" is acknowledged by Corbin and Strauss (2008)

who maintain that new insights can occur right into the final stages of the study as understanding evolves and aspects of the data which may have been previously overlooked take on meaning following prolonged immersion in the data. Corbin and Strauss (2008) maintain the interrelated processes of forming inductions from the data (concepts) and deductions between the data (relationships between concepts) are central to theorising. Thus, through scrutinizing the raw data, field notes and memos, concepts and subconcepts were linked and developed to construct a theory.

3.23 Summary

This chapter outlined the rationale for the chosen research methodology and subsequent methods. The influence of symbolic interactionism to the formation of the grounded theory approach was highlighted to demonstrate the suitability of the approach to the exploration of the current phenomenon. Subsequently methods pertaining to the collection of data and data analysis were outlined. The final data analysis section entailed a concise portrayal of the analysis procedures employed to provide an auditable account of the processes involved in determining the findings presented in the subsequent chapter. Issues pertaining to ethical considerations, quality initiatives and scientific rigour were also discussed. Furthermore, in collective retrospection, this chapter demonstrates the underpinnings of the conceptual framework based upon the theoretical influences of the methodology and guiding principles achieved through theoretical sensitivity. Appendices 19a and 19b provide a detailed summary of the conceptual and empirical processes of this study.

Chapter 4
Presentation and Discussion of Findings

4.0. Introduction

Using the grounded theory approach outlined in chapter three, this chapter provides an interpretation of the collected data, whilst explicating the development of concepts, supporting processes and subsequent categories in the exploration of the psychosocial needs of older people. It is envisaged that in portraying both the service user and the service providers' perspective, a more holistic understanding of the phenomenon may be achieved. The interview data and field notes were retrieved between the periods of June to September 2007, while the subsequent memos emanate from the entire analysis phase which continued into the final stages of the study until the composition of this report. The following findings are derived from the researcher's interpretations of interactions with the participants; inclusive of interview accounts, memos and fieldnotes. Thus, the role of the researcher in retrieving and subsequently analysing the data is acknowledged. Strauss and Corbin (1998) maintain that,

> "Analysis is the interplay between the researcher and the data." (p. 13).

Hence, the raw data and inquisitive questioning of contexts and processes which were perceived to be significant to both the participants and the research question guided the research process. The process of asking questions such as what, when, where, why, how and determining conditions, actions/interactions and consequences (Strauss & Corbin, 1998) facilitated the formation of categories through actively seeking to collect data that would ascertain the existence of relationships between the assortment of codes and concepts. Thus, the process of asking questions of the data facilitated the conceptualisation of the codes and categories in constructing a substantive theory. It is important to note however, that these concepts emerged from the data itself and were simply processed through the researcher's theoretical sensitivity. Furthermore, the data analysis methods encompassing open, axial and selective coding and the use of questioning is depicted to illustrate the existence of relationships between the established concepts and categories. For this reason, codes and concepts shall be printed in italic format to facilitate transparency. Thus, it is intended that the process

of conceptualising such categories through determining their interrelationships is explicated in this chapter. This chapter demonstrates how the extant literature reviewed facilitated the progression of the emergent theory through appreciating the Irish situation amidst international perspectives of the phenomenon.

The iterative nature of the data collection and data analysis procedures is hereby reiterated for the purpose of affirming the reality of the research process when guided by a grounded theory approach, as it is accepted that this feature of the research process may not be adequately captured due to the necessity of reporting in a clear and comprehensible manner. The need to present data sequentially is acknowledged by Suddaby (2006) who contends that if grounded theory research was presented as it occurred it would depict an iterative disarray of methods, procedures, and indistinct categories that would be neither efficient nor comprehensible. Hence, the norm that has evolved is to present grounded theory in traditional discrete categories; extant theory, data collection, data analysis, findings, discussion and recommendations. Therefore, for the purpose of presenting a clear and accurate theory, findings shall be portrayed in a categorical more so than chronological manner that is; data shall be presented as relevant to the concept being discussed. Furthermore, in some instances the preceding data sets were re-consulted following discovery of additional codes and concepts as data collection procedures progressed. Thus, rather than eliciting a case by case analysis of data sets, findings shall be merged (as occurred with application of the comparative analysis method) to appreciate the relationships between those involved in the phenomenon under exploration and how such relationships and interactions actively construct reality. However, it is endeavored that the presentation of findings shall depict, as near as possible, sequential reflections on the data in order to portray the underlying principles and processes in the formation of the substantive theory.

4.1 Psychosocial Interventions; a Modified Focus

It is important to note that the original proposal for this study involved exploring the relationship between cognitive and social stimulation and the quality of life of older people living in residential care settings. Upon meeting with potential participants the research question was immediately interpreted by them as an exploration of diversional activities such as the ACT Programme, Sonas, reminiscence therapy, and

bingo et cetera. Hence, the participants' perspectives on such activities were explored. However, as the data collection and theoretical sampling progressed it became apparent that while there were a number of valued therapies and activities in place, the availability of such interventions varied among the services, as did the availability of interventions appropriate to the diverse needs of this specialist client group. Thus, the enquiry process and the resultant data evolved to encompass the many processes believed to be both socially and psychologically stimulating, inclusive of factors that were perceived to facilitate and/or inhibit such practices. A number of issues that affect the fulfilment of psychosocial needs were apparent, whether organisational or humanitarian factors, the necessity of considering these influences in order to appreciate the significance of biopsychosocial care and how it may be achieved was acknowledged. Thus, the grounded theory approach allowed for the exploration of the issues perceived as most pertinent to the phenomenon from the perspective of those involved in the social processes under exploration. Therefore, rather than solely explore the relationship between such interventions and quality of life, the contexts and processes pertinent to the issue were explored to encompass caregivers' and residents' attitudes towards interventions in practice, as well personal and organisational factors which influence the psychosocial well-being of residents.

Hence, it was acknowledged that the relevant underlying factors must be appreciated in order to fully understand the complexity of the chosen phenomenon. Therefore, consistent with the grounded theory approach, the data itself guided the direction of the study which resulted in the exploration of the phenomenon through issues perceived to be most pertinent to the sample population. The subsequent modified focus is the product of theoretical sensitivity achieved through immersion in the data and increasing knowledge of phenomenon. Thus, the preceding data sets served to focus the research context in addition to validating or refuting the researcher's instinct regarding the implications of the data, thus determining the subsequent research processes.

4.2 The Reality of Activity in Care; the Inadvertent Psychosocial Benefits

The initial focus group session, attended by members of the nursing staff, yielded much data pertaining to the perceived benefits of the formal activity sessions and diversional therapies provided by the care facility. Such interventions were perceived

to be psychosocially beneficial as they provided opportunities to engage in *meaningful interaction* with others. Caregivers spoke of the residents' enthusiasm towards the activity sessions; with reference to the research site A, the weekly bingo session in particular, was interpreted as a *means of stimulation* in addition to a *source of anticipation* and much enjoyment for residents with varying needs and abilities. Furthermore, the concept of a *source of anticipation* was comparable to concepts derived upon interviewing members of the resident population as the need for *something to look forward to* was evident. The following extract depicts the boredom and negative emotions which ensued when this need was not fulfilled,

> RRA4: I don't know are there any activities much, they do have this patient interactive thing, you know? I don't bother with any of that….you know, you get up in the morning you're looked after, you can't, well you can't say anything about that, that's good, after that you have a dull day…you'd like to have something to be looking forward to doing, you know?
> I: and at the minute what do you look forward to here?
> RRA4: going out for a smoke, that's all, that's a fact, that's all is in it… *Says with despair*
>
> (Resident Interview 4A).

Hence, although activities were available, their outer façade did not appeal to this resident, hence the *heterogeneity of residents need* is apparent, which calls for an *individualised approach to care* that is reflective of residents' individual needs and interests; a concept that shall be discussed in great detail in the ensuing section. Thus, in the absence of meaningful interaction with others afforded through participation in the activity sessions, residents displayed negative emotions which were perceived as being detrimental to their psychosocial well-being. Hence, the need for an individualised approach to care, to nurture and accommodate the heterogeneity of the residents was apparent. Furthermore, the extant literature recognises the detrimental impact of loneliness among older persons as feelings of loneliness, secondary to low-level social engagement have been associated with declines in physical health and psychosocial well-being (Nezlek et al. 2002; Bennett, 2002; Menac, 2003; Gulseren and Aysegul, 2005).

In direct contrast to the above resident's perception of activities, earlier data retrieved upon theoretical sampling of caregivers directly involved in the provision of the activity session, show the perceived benefits of the activity sessions regardless of their

content. The following is an exert which portrays one facilitator's perceptions of the impact of the activity sessions; it is worth noting that although the session is designed to be physically beneficial, the facilitator focuses on the broader, more implicit psychosocial benefits;

> …they have their benefits, they have socially I mean because they're in a group, even though they're sitting in the same sitting room all day, they're actually doing something together, am mentally we'd notice, I'd notice a huge difference from the time we'd go in, it's an hour and a half, so from the time we go into the ward, you know, patients wouldn't be talking to you, or anything like that and then by the time we leave they're telling us stories, ….psychologically it probably gives them a little lift, personally as well you know, their self esteem and that … you make sure to complement people so they feel that they can do something, I kind of feel like in this kind of nursing and in this type of hospital, everybody's doing things for patients all the time and this, they can do something for themselves as in you're focusing on what they can do as opposed to what they can't do
>
> (NRBI1; individual interview).

This extract highlights the social benefits of activity as a means of social interaction with others through participation in meaningful activity. Therefore, the activity sessions were perceived to be a source of meaningful interaction, predominantly attributed to the social context in which they occurred. Consequently, the significance of the social environment, largely dependent on human interactions was apparent. This finding is reflective of seminal work by Glass et al. (1999) who, upon examining the association between social, productive and physical activity and survival among older people, found that social and productive activities with or without fitness benefits lower the risk of mortality. Therefore, Glass et al. (1999) propose that activity may bestow survival through covert psychosocial pathways. It is considered that multifaceted role of communication may create such channels as the construed value of social interaction, afforded through participation in meaningful activity, encompasses the principles of interpersonal communication which appear to be significant determinants of the residents' psychosocial well-being. The meaningful interactions afforded through participation in social activities were perceived to be beneficial to the residents' psychosocial well-being as such interactions facilitated the formation of relationships whilst promoting fulfilment of individuals potential through the enhancement of residents' abilities rather than disabilities, hence the residents' autonomy and independence were nurtured.

Furthermore, the psychological benefit is clearly depicted as enhancing residents' self-esteem through promoting the fulfillment of the individuals' potential achieved through health promoting and health maintenance interventions.

> I think that that's good for them psychologically, you now that kind of way, that they're, you know I can still do that, I'm not just left here in a chair and… (NRBI1; individual interview).

Thus, the role of activities in promoting and maintaining individuals' *autonomy and independence* and *personal identity* in the attainment of optimum psychosocial well-being was apparent amidst the findings. Furthermore, the relationship between autonomy and independence and psychological well-being among older persons is acknowledged in the literature as feelings of helplessness are equated with negative emotions (Baltes and Mayer, 1999), while perceived personal control over aspects of the ageing process have been associated with improved physical and psychological well-being (Rodin, 1986; Lane et al., 2000; Bryant et al., 2001; Lackmann, 2004).

Having been enlightened to the inadvertent psychosocial benefits of activity the researcher referred back to the data retrieved from the initial staff nurse focus group to ascertain the broader, perhaps more implicit psychosocial benefits of activities. Thus, rather than considering the benefit of activity sessions purely based on content, the researcher broadened her focus to explore the broader aspects of interventions that are perceived to enhance residents' psychosocial well-being. The predominant feature perceived to be psychosocially beneficial was the *social interaction* afforded through participation in activity sessions as most sessions encompassed one to one *communication* and/or group dynamics.

> …oh they get to chat and they get to talk and, to be honest with you I think it stimulates their brain as well
>
> (Healthcare Assistant Interview 4A).

Furthermore, the residents themselves noted the social benefits of the activities such as the bingo session. The following narrative is from a male resident who has hemi paraplegia secondary to a spinal injury. He informed the researcher he did not participate in the ACT Programme as he felt he did not need the exercise as he was "able to do that no bother", perceiving the activities to be more suitable to the older

residents in need of health maintenance interventions as "they'd be a bit more stiff", he therefore chose not to participate as he considered that the intervention was not conducive to his needs.

> I don't do the activities some do, but I do take part every Friday, she has game of bingo for us and I enjoys that, the craic, 'tis great craic, great little craic you know? Last Friday I think I won four little prizes they said, ah they were all saying "ah you're cheating" *(laughing)*, but I enjoy that game of bingo, it passes away an hour and a half every Friday you know like? So that's nice, all the lads play that now, most of them that are able to use, you know, maybe the hands
>
> (Resident Interview A6).

Thus, this resident chose to participate in this activity for the social interaction and the "banter" with the fellow residents, hence it became a social activity and a source of *meaningful interaction* with others. Note also how the resident boasts of his achievement in winning and the positive interactions which ensued. It is evident that the *feel good factor* observed by caregivers was in fact experienced by the residents. Thus, activities which promoted self-esteem, social interaction and the fulfillment of the individuals' potential through acknowledgement of their *autonomy and independence* were noteworthy.

The perceived benefits of the activity sessions upon psychosocial well-being were further explored in a focus group discussion with clinical nurse mangers, they also perceived the group activity session such as the bingo to be a *medium of social interaction* as well as *source of anticipation*

> CNMA3: highlight of the week, highlight of the week!
> CNMA4: you know they build rapports as well, if you have a common interest, I think you know even outside of bingo then, they're going to be chatting as well you know
> CNMA3: the boys against the girls and that
> CNMA4: it's all about stimulation
> CNMA1: it is, very simulating, it improves them immensely,
> CNMA4: immensely yea
> CNMA1: they really look forward to it; I think it keeps them in touch with…normal activities at home
>
> (Clinical Nurse Manager Focus Group A).

Following analysis procedures with the initial interview data, it was evident that activity sessions were valued predominately for their social benefits, which in effect had psychological benefits. Thus, the concept of *the value of social interaction* was developed as the research progressed and will be discussed in greater detail in the subsequent sections.

4.2.1 Acknowledging Heterogeneity; the Need for Individualised Care

While the benefits of the activity sessions were undeniable, they were not universal as the apparent heterogeneity of the older people within the extended care settings intensified as the data collection progressed. Hence, the capacity to meet the diverse needs of residents within the service means was further explored in the subsequent interviews with residents and caregivers. The following extract further depicts the inappropriateness of the interventions available in practice in light of the diverse needs and capabilities of older people.

> RRB3: ah sure there's not much activities do you know….. They come, they'd have a sort of a– once or twice a week they come here, ah 'tis alright 'tis kind of childish amusement for adults you know? ...hopping a ball and this sort of thing you know *facial expression depicts disinterest*
> I: right okay. So do you do the Activities?
> RRB3: ah sure you go what ever you're asked to
> I: you go along with it?
> RRB3: ah I do.
> I: But do you enjoy them?
> RRB3: ah sure it pass the time, it pass the time *says without conviction*
> I: They don't really appeal to you?
> RRB3: ah sure it's childish you know, you're hopping a ball from one to another, you know! At 90 years of age! Good Heavens! *Laughs*
>
> (Resident interview 3B).

Evidently, this gentleman felt that the activity sessions were inappropriate for his age, functional ability, cognitive capacity and personal interests. The notion that the activities were unsuitable was echoed by caregivers from both care settings in so far as the activities did not reflect the needs of their clients and thus were unbefitting. Caregivers expressed their insight into the suitability of the activity sessions in practice as they questioned the suitability of standard activity sessions for a client base of varying needs and abilities. The following exert is taken from the transcript of an

interview with a caregiver who relays her experience of residents reactions to some of the activity programmes.

> …depending on the individual again am "are we children?", "what do they think we are?...I suppose given their state or whatever… "what do they think we are? Do they think that we're children? Throwing balls at each other"
>
> (Healthcare Assistant Interview 3A).

The Sonas Programme was particularly viewed as being degrading due to its perceived inappropriate content and means of stimulation;

> The Sonas I never liked, I thought it was very condescending, you know "Hello everyone" *(puts on infant voice, boring tone)*, that something you do to school children
>
> (Healthcare Assistant Interview 4A).

> …the diversional therapy (Sonas), can be good … but when I have somebody going up saying "twinkle, twinkle little star" *(flashing hands at either side of face to show actions)* "itzy bitzy spider" I just think it's very, very degrading, personally! … my nephew who's two, dances to that, not a 97 year old woman! I just don't agree with it
>
> (CNMA2; Clinical Nurse Manager Focus Group A).

Analysing these processes from a symbolic interactionist perspective led to the interpretation that encouraging individuals to participate in inappropriate, somewhat degrading activities may inhibit rather than promote psychosocial well-being through damaging self-esteem and *failing to nurture individuals' potential* whereby the individual may revert to society's perception of them in spite of their true entity. (Appendix 18). This interpretation is reflective of Mead's (1962) postulation of social nature and origin of the self whereby one defines one-self through social roles and expectations of society. Mead (1962) posited the notion of self emerges through an appreciation of how others see us. Scrutton (1990) espouses Mead's theory as he suggests that conveyance of society's perceived limitations of older people reduces their expectation of themselves thus restricts their potential. In providing care and interventions that are incongruent to residents' needs or abilities it is inferred that individuals may interpret such acts as a reflection of how others view them, thus assume that social role; inhibiting one's potential and damaging personal identity. Therefore, it is perceived that the residents may conceptualise their notion of self

based upon their interactions with others and how they act towards them. Accordingly, the need to appropriately assess, plan and implement individualised care that is reflective of each individual's holistic needs is fundamentally apparent.

Furthermore, it was admitted that participatory activities such as bingo and quizzes were sources of stimulation for "the more independent people" thus the researcher was intrigued to ascertain how the complex needs of a heterogeneous group were adequately met. While music therapy in the form of bands and singing was perceived to meet the diverse needs of the residents, particularly those with cognitive and sensory impairment who may not be able to participate in the activities such as bingo and in some cases the ACT Programme, it was apparent from contextual and narrative data that a disparity of services existed. One nurse manger participating in a focus group discussion expressed her anger at the lack of suitable interventions for residents with advanced dementia, she highlighted that the majority of the organised interventions were aimed at residents with higher cognitive and functional capacities;

> ..it's lovely; the bingo, but I don't see any bingo on my ward! *(Bitter tone noted)* It's lovely the ah, the ah, say it for me; throwing balls with the patients but if you threw balls to any of mine, it'd probably hit them because they can't react! *(Awkward laugh)*
>
> (CNMA2; Clinical Nurse Manager Focus Group A).

The above narrative depicts the apparent lack of *person-centred/individualised care* in so far as the majority of formal activities are perceived to be catered towards the needs of residents who can interact and actively participate. This is in direct contrast with the large volumes of literature which call for more individualised, person-centred approaches to care (McCormack, 2004; McCormack and McCance, 2006; McCormack et al., 2008). The findings infer that the limitations of standardised practices are reflective of the marginalisation of older people whereby older persons' individual needs are failed to be acknowledged. However, it is contended that the effectiveness of *the person-centred approach to care* is dependent upon the *therapeutic relationship* and the accuracy of the assessment process (Meyer and Sturdy, 2004; Nolan et al., 2004; McCormack, 2004) all of which are dependent upon the effectiveness of interactions among multidisciplinary team, the residents and their significant others.

However, as data collection advanced, alternative means of stimulation perceived as *appropriate interventions for heterogeneous needs* were acknowledged by caregivers. For instance, due to its far-reaching communicative abilities, music therapy was perceived to be quite beneficial as a positive intervention for residents with varying functional ability. Upon inquiring how caregivers felt residents with limited cognitive ability were stimulated, interactive communication through music was perceived to be most appropriate;

> Looking at it, music seems to be the, music seems to be the strongest thing you know…you will get people who aren't able to string two words together in a conversation and they'll sing the verse of a song for you
>
> (NRBI1; individual interview).

Music was recognized as an invaluable means of communication as its universally comprehensible language stimulated senses and evoked reaction in residents who may not respond to other sensory stimuli.

> I have some of them, no matter, you know no matter how bad they are, they're sitting up and there is that communication with them and once they hear the music, they're reaping up you know!
>
> (CNMA2; Clinical nurse Manager Focus Group A).

Furthermore, in spite of earlier rejections of the Sonas Programme, some caregivers from site A commended its use in meeting the psychosocial needs of this specialist client group whilst actively stimulating cognitive function. The Sonas Programme was perceived to be cognitively stimulating, socially rewarding and psychologically beneficial as it founded upon the principles of fundamental human interaction and sensory stimuli.

> The Sonas Programme is very good you know what I mean, it has all the old songs and even the rhythm of the songs…it's all about you know, good communication; eye contact…it is a good way for getting patients to be interactive because if you have a singer, they'll be dying to sing you know what I mean and they would sing a song
>
> (CNMA4: Clinical Nurse Manager Focus Group A).

Thus, music was commended by caregivers for its contribution to quality of life among residents with varying needs and abilities. This finding is comparable to existing evidence derived from a controlled study which found music therapy to be

effective in caring for persons with dementia by reducing the incidence and severity of challenging behaviour whilst increasing social participation (Koger, Chapin and Brotons, 1999). However, the benefits of music are not restricted to those with cognitive impairment as there is evidence to suggest it has far-reaching benefits to the enhancement of older persons' quality of life by contributing to positive self-esteem, promoting feelings of autonomy and independence and reducing psychological distress (Hays and Minichiello, 2005).

The concept of meeting residents' diverse needs was further explored in the subsequent focus group session with staff nurses in the research site B; participants included one staff nurse who was actively involved in the provision of organised activity following professional development training in the ACT Programme. Immediately a *disparity of resources* was recognized, as with site A this care facility utilized the ACT Programme as a therapeutic intervention, however this was the predominant source of stimulation, with music sessions limited to festive occasions such as Christmas celebrations. Furthermore, in direct contrast to site A, outings and bingo sessions were abandoned due to the restricted functional ability of the majority of long stay residents;

> …we had to give up on bingo because you'd need somebody with every patient and we just couldn't
>
> (CNMB2; Clinical Nurse Manager Focus Group B).

As a result, the diversional activities available were primarily in the form of the chair based exercises of the ACT Programme. What is more, upon analysis of the initial data derived form the staff focus groups of site A, the researcher questioned the level of psychosocial interventions for those residents with varying levels of cognitive and functional ability. It was interpreted from the data that as functional ability declined so too did the availability of suitable interventions to meet residents' needs that is; as residents needs became more complex, rather than modifying interventions to suit individuals' needs they were simply abandoned with no alternate intervention in place. Furthermore, it was apparent from the data that the psychosocial needs of such residents were often more difficult to accurately assess and subsequently meet, hence the codes; *appropriate interventions for heterogeneous needs* and the *challenges of complex needs*, were applied to the relevant data.

Upon first noting the lack of formal sensory stimulation in site B the researcher questioned the level of stimulation afforded to those with impaired cognitive and/or functional ability. However, in considering the data collectively the researcher began to broader her focus. In hindsight it is now considered that theoretical sensitivity allowed the researcher to conceptualise the data to a higher level at this point. Therefore, in considering the broader aspects of the value of interactions, the conditions and consequences of the interactions were considered; heightening the researcher's sensitivity to the significance of the social context within which actions occur, rather than the action itself. The following memo provides insight into the researchers' reflections;

> The Sonas Programme based on the principles of non-verbal communication was perceived to be extremely beneficial by caregivers in site A having utilized and/or witnessed this intervention in practice, particularly in meeting the cognitive and psychosocial needs of those with cognitive and/or functional impairment through effective sensory stimuli. However, the use of such interventions was not apparent in site B. Should there be concern as to how residents with impaired functional and cognitive ability are stimulated for the purpose of assuring their optimum psychosocial well-being through health promotion and health maintenance initiatives? The repeated references to activities involving interaction and interpersonal communication are insightful. Just because this setting does not formally utilize the Sonas Programme does not mean residents are not achieving the same benefits through purposeful yet informal interventions such as singing and talking to/with the resident. The predominant means of activity; the ACT Programme is intended to be physically beneficial; however it is evident that both staff and residents perceive wider benefits of this Programme secondary to it's group dynamics which facilitate meaningful interaction.

(Theoretical memo entry 10-07-07; reflection on data retrieved from staff nurses and CNMs A&B).

Consequently, the researchers initial interpretation of the data entailed the formation of a concept pertaining to research site B's formal focus on physical activity; *task orientated care*, which was thought to be reflective of the facilities focus on physical care; "physical care seems to be what's priority", (NRB3; staff nurse focus group B) a concept which shall be explored in greater detail later in this chapter. What is more, the initially perceived fundamental value of social interaction now appeared to be growing as a multifaceted means of meeting residents psychosocial needs; a concept that shall be discussed in detail in the subsequent section.

These data show the profound impact appropriate intervention can have on the older person's psychosocial well-being. While at the same time, demonstrate how standardised practice can result in inadequate care that is not conducive to individuals' needs; hence *routinized rather than individualised care*; a concept that shall be further explored at a later stage of this chapter. Furthermore, it is evident that a consistent means of assessing and subsequently fulfilling residents' fundamental psychosocial needs is required, whereby the implementation of appropriate interventions, conducive to residents' individual needs, would follow. Thus, the need for a more *person-centred, individualised approach to care* is apparent in order to provide care that is conducive the heterogeneity of residents' needs.

4.3 The Value of Social Interaction

Upon acknowledging the broader implications of the activity sessions, caregivers articulated *the value of social interaction* as a diverse, effective means of meeting the psychosocial needs among residents of varying profiles. However, as data collection progressed the multifaceted *value of social interaction* truly became apparent. The premise that social interaction was valuable to residents' well-being, irrelevant of the individuals' functional or cognitive ability, was consolidated in the subsequent data; some caregivers believing that social interaction was the most appropriate and most beneficial intervention for residents' psychosocial needs. This is a significant finding given the large volume of literature which avows social interaction as one of the main determinants of quality of life (Bowling et al., 2002) and psychological well-being among older people (Nezlek et al., 2002; Bennett, 2002; Menac, 2003; Wilson et al., 2007).

The identification of *the value of social interaction* was combined with two concepts that had emerged from a very early stage of data collection; *caregivers as a source of stimulation* and *therapeutic relationships*. While these concepts were evident from data derived from both research sites, the significance of these interactions became evident upon analysing data from site B (where diversional activities were limited). The meaningful interactions between caregivers and residents were invaluable means of stimulation due to their consistency, flexibility and attainability. Thus the concept; *appropriate interventions for heterogeneous needs* also merged as social interaction

was perceived to be beneficial to the residents irrelevant of their profile. It was portrayed by caregivers that the residents were not able for extensive activity involving physical participation, yet communicating with residents was seen as being a particularly valuable means of fulfilling their psychosocial needs;

> …they don't want to be doing things all day, they, most of our patients, I think we have 3 out of 20 that are under the age of 80, and if they were at home they'd be probably snoozing in the afternoon or you know whatever…you know they don't have to be kept stimulated all day, physically! …what they want is just somebody to sit and talk to them, not to be doing ball games and whatever cause they're, they're too old!
>
> (NRB3; Staff Nurse Focus Group B).

Furthermore, caregivers commended the use of effective interaction as valuable means of meeting the needs of those residents who cannot interact, yet benefit from interaction within their social environment. The notion of *caregivers as a source of meaningful* interaction is supported by Mcgilton (2002) who maintains that the interactions of caregivers form the primary means of stimulating interaction and fundamental social support within the extended care setting. The significant *value of social interaction* to the resident's psychosocial well-being is supported in the literature; a clear association between participation in meaningful social activity, social supports, well-being and quality of life amongst older persons is evident (Browne at al., 1994; Farquhar, 1995; Albrecht and Devieger, 1999; Bowling et al., 2003; OCS Consulting, 2004; Murphy et al., 2007).

The perceptions of caregivers as to what residents desired to meet their psychosocial needs were echoed in the interviews with residents. Throughout one interview a female resident frequently reiterated her desire for "company". Social supports were incredibly important to this resident as she expressed her pleasure in participating in any form of social activity for the reward of meaningful interactions with others;

> …ah anything that's on, give me company, I'd go, you know?
>
> (Resident Interview A1).

Thus, the desire for social interaction may be directly linked to psychological well-being achieved through meaningful interaction with others and feelings of safety and security.

Furthermore, throughout all of the resident interviews, it was consistently noted how the residents took pleasure in reminiscing on and sharing important chapters from their lives such as the death of a spouse, personal achievements, and memories of their past home life such as their parents, children or daily activities. Although some may be perceived as painful memories, the residents showed an eagerness to speak of significant periods in their lives as it enhanced, thus maintained their *personal identity* and *continuity of self*. The following extract is taken from an interview with a female resident who throughout the interview, consistently spoke of her current circumstances in a sequential manner to past experiences. Here she depicts the circumstances leading to her move back to Ireland and the subsequent transition to extended care having lived in London for a significant period of her life, she expresses contentment with her current situation due to the meaning attributed to the preceding experiences;

> I was over in London… and I had everything going, but he (husband) got sick and he used to say "if you bring me home, I'll get better in the fresh air". ..so I packed up and brought him home. A week he lived in *local hospital,* a week, least I say I gave him his wish, I gave him his wish.
>
> (Resident Interview A1).

Other residents reverted back to happier times; one male resident who now has hemi paraplegia secondary to a spinal injury, spoke of his love of sport and its significant role throughout his life;

> …oh god I played for twenty years, hurling and football…I played a few football games in me day, for *local city team*, I not gona say they all were but I played there, I wore the *local city team* jersey, you know and I was proud of that, played the few matches and we won an auld league, yeah that was 1960 or '61 …played with *local club* for nearly twenty years
>
> (Resident Interview A6).

Hence, it is considered meaningful social interaction provided opportunities to reflect and reminisce on significant life events.

Furthermore, processes conducive to residents' *continuity of self* were interpreted as being valuable for their psychologically stimulating and therapeutic effects. For instance, following frequent interactions with residents a therapeutic relationship was

formed whereby the residents' characteristics and personal needs were ascertained, in part through acknowledging their life history and past behaviours combined with acknowledgement of their present circumstances. Furthermore, in knowing individuals characters, certain skills and behaviours may be acted upon to promote cognitive functioning, *continuity of self* and subsequently promote psychological well-being. Hence, the need to promote care which facilitates the *positive adaptation* of individuals' needs, abilities and interests was apparent. Some caregivers facilitated selective optimisation with compensation (Baltes and Baltes, 1990; Baltes and Smith, 2002). In doing so the residents' potential was drawn upon to actively counteract inevitable losses associated with ageing by selectively optimising available resources that is; focusing on what can do as opposed to what one can't. A prime example is given whereby caregivers facilitate continuity of self and selective optimisation with compensation through adapting past roles to current circumstances;

> CNMB4: … there's a lady now and I give her a little bucket in the morning while I'm doing the medication and she goes around and she cleans all the tables, the window ledges and, it's a little activity for her
> CNMB3: like being at home cleaning
>
> (Clinical Nurse Manager Focus Group).

The need to maintain one's personal identity through *positive adaptation* and *continuity of self* was acknowledged by caregivers, it was considered that continuity of such behaviours was intrinsic to the individuals' quality of life in the extended care facility.

Therefore, caregivers highlighted the need to communicate with the residents in order to ascertain their needs; in some instances this interaction in itself was perceived to be psychosocially beneficial. Thus, the formation of the *therapeutic relationship* was an essential component in the assessment and fulfilment of psychosocial needs as the *therapeutic relationship* forms the foundations upon which caregivers attain their understanding of individuals' needs and how they may be fulfilled. Comparative analysis of the data as it transpired, in addition to collectively analysing the total data set, confirmed fundamental human interaction and *communication* as the most lucrative means of assessing and subsequently fulfilling the heterogeneous psychosocial needs of older people residing in extended care. In *communicating* with residents a *therapeutic relationship* is formed whereby the caregiver may

progressively devise a plan of care that is reflective of the individuals unique needs based on knowledge of previous life experiences, thus *continuity of self* and *positive adaptation* is facilitated.

> Although all participating staff highlight the importance of activity sessions such as music therapy and bingo it is acknowledged that such means of stimulation are intermittent, thus the need to explore how psychosocial needs are met on an everyday basis is apparent. The issue of social support is queried through asking the group to discuss relationships within the residential setting. It is evident that while some relationships are formed amongst residents, many residents do not interact with each other. The role of staff in facilitating social interaction is acknowledged. Furthermore, the role of the therapeutic relationship is emphasised as the significance of relationship between staff and residents is highlighted as a consistent means of promoting positive psychosocial well-being.
>
> (Theoretical memo entry 19-06-07; staff nurse focus group A).

However, the need to advocate on behalf of those residents unable to voice their own needs was apparent;

> CNMB1: most of our patients can't tell us…I'd say 20 out of 28 of our patients can't speak coherently
> CNMB2: you wouldn't know what they'd want
> CNMB3: …probably if they got more interaction they would be better, do you know
>
> (Clinical Nurse Manager Focus Group B).

Hence, the *value of social interaction* was again highlighted, on this occasion in the form of purposeful *communication* with relatives of individuals in order to ascertain residents characters and past experiences to effectively meet their boarder psychosocial needs;

> …like they have their own characters, but unless the family tell us their characters, we don't know from these people…. if you don't know the patients and you don't know the backgrounds you're lost, they will be neglected because you don't know anything about them … so that's why family involvement is core, cause if they don't give us the information about the person we don't know… it's what they like, where do they go, where did they go to school? Am you know, we might ask something like "were they into music?" "What kind of music did they like?"
>
> (Healthcare Assistant Interview A4).

Therefore, findings support the notion that the effectiveness of *the person-centred approach to care* is dependent upon the *therapeutic relationship* and the accuracy of the assessment process (Meyer and Sturdy, 2004; Nolan et al., 2004; McCormack 2004) all of which are dependent upon the effectiveness of interactions among the multidisciplinary team, the residents and their significant others. Conversely, the person-centred approach to care has received criticism for it's over emphasis on individualism and its failed acknowledgement of individuals' interdependent social relationships (Nolan et al., 2004). However, in the context of this study it is inferred that a person-centred approach to care is dependent upon the interactions of stakeholders and recognition of the individual in the social context as the interplay of processes involved in the attainment of psychosocial well-being is acknowledged (Landers and McCarthy, 2006). Nolan et al. (2004) commend the value of interactions between such stakeholders as they form the medium for exchanging the knowledge and insight required for accurate assessments and subsequent interventions that are reflective of individuals' holistic needs. A negotiated plan of care which takes into account the needs of the individual and the professional knowledge of the nurse are seen as central to the operationalisation of person-centred care (Landers and McCarthy, 2006), Similarly, it is construed from the data that the quality of the assessment process; determined by the quality of the interactions and the conveyance of information, is dependent of the quality of the therapeutic relationship among the caregiver, resident and their family. However, findings also highlight a significant barrier to the fulfillment of residents psychosocial needs due to inadequate knowledge of the resident, thus *the role of family* was highlighted as an invaluable means of information as well as partners in the care of their loved one.

In summary, the *role of family* in communicating their knowledge of the individual for the purpose of establishing residents' individual needs was perceived as crucial to the provision of person-centred, holistic care. For the purpose of meeting residents psychosocial needs regardless of family involvement, the significance of the *therapeutic relationship* and *advocating for residents needs* became apparent**.** Consequently, the multifaceted role of social interaction as an invaluable means of determining and meeting the psychosocial needs of the heterogeneous client group was evident. Furthermore, such interactions were found to be essential in determining residents current psychosocial needs based upon knowledge of past life experiences in

so far as *continuity of self* promoted *positive adaptation* and psychological well-being. Moreover, social interaction, which served both as a foundation and a by product of the therapeutic relationship, lead to the formation of support structures for residents and a means of assessment for caregivers. Thus, the infinite value of social interaction is evident, it's consistency guaranteed due to the close and frequent interaction between residents and caregivers; it's flexibility also, as the way in which caregivers interact may be modified to suit the residents' individual needs and characters. Therefore, social interaction is considered to be an attainable intervention in the endeavor for psychosocial well-being among residents of extended care facilities. However, it is dependent upon a number of factors such as caregiver characteristics; a concept that shall be discussed in detail in the subsequent part of the ensuing section.

4.4 Determinants of Residents' Psychosocial Well-being

4.4.1 Residents' Internal Locus of Control

Both the personal characteristic of caregivers and residents were interpreted as being influential to psychosocial well-being of residents. The significance of the residents' personal outlook and ability to adapt and accept age related changes was evident upon the collection of data from the resident population. One female resident expressed particular discontent with the circumstances surrounding her placement in the extended care facility which in turn, it is interpreted, determined her psychosocial well-being. The resident appeared to be unhappy with the subsequent occurrences, always reverting back to her initial placement and the negative emotions which she associated with it thus, blaming the transition to extended care as the cause of her functional decline.

> RRB1: You see when I coming and the lads were asking me for respite for fourteen days… but then when I came in there was no reason for keeping me in here but they kept me two years instead of it. I still…I feel kind of hurt about it…I'd say to the nurses that I'd be happy to walk around with the walking aid, then they give me no chance you know, like they'd have said we'll make you practice
> I: and do you ever get a chance to practice?
> RRB1: never, then the last couple of weeks they're kind of saying if you want to stand up you better hold the walking aid, you better hold the walking aid or you'll have to get into this, I don't know what they call it, the hoist
>
> (Resident Interview 1B).

The discontent expressed by the resident concerned the researcher, thus following the interview additional information regarding the resident and her circumstances was sought from a member of nursing staff. The following is a memo devised upon reflecting on the interview and the subsequent interaction with the staff nurse;

> Contentment was apparent when reflecting upon past life events; family, work, independent living, however negativity surrounded her depictions of life in the extended care facility. When asked regarding her present circumstances she persistently reverts back to past experiences, perhaps avoiding the reality of her present circumstances? She also expresses a lot of regret and discontent with things that happened. While the resident blames her placement in the extended care facility for her functional decline, it is noted that she previously admitted that she was unable to mobilise when admitted for respite, however opportunities for rehabilitation are queried. Note also that there are no physio services available to those in extended care. Although attempts were made by caregivers to promote and maintain her functional ability, the residents' ability to stand using a Zimmer frame was poor; staff nurse alleged "she can hardly weigh bear". The psychological implications of deteriorating functional ability are acknowledged, as is the need for health maintenance initiatives for extended care residents as available to rehabilitation patients. In spite of this, it perceived that this resident has a negative attribution to the extended care facility and the loss of her independence, which may affect her ability to adapt to life in extended care.
>
> (Theoretical memo entry 16-08-07; resident interview 1B).

Thus, in the subsequent interviews the researcher sought to explore the concept of *outlook among residents* to determine its influence on their psychosocial well-being. In the ensuing interviews, one resident's overwhelming sense of contentment in her present circumstances was noteworthy. Upon closer appraisal of the data it became evident that the resident based her appraisal of current circumstances on her how she adapted and accepted significant life events, she frequently stated that she had "no regrets or no remorse" and thus expressed contentment with every aspect of her life;

> I looked after my parents and my husband until they drew their last breath, and I have no remorse in that way in life. Having seen the three of them off to heaven, my parents and my husband. I can live with myself because I have no remorse and no regrets and that means a lot
>
> (Resident Interview 2B).

When asked about pastimes and how she enjoyed spending time in the past, she elucidated that her loved ones were her life however, she was not in mourning as she reiterated;

> I have no remorse you see that means a lot, or no regrets. That means a lot
>
> (Resident Interview 2B).

Furthermore, this resident's positive *internal locus of control* is apparent in her response to her perceived quality of life;

> I: So you think that you have a good quality of life?
> RRB2: oh I have yeah
> I: Do you think it has improved since you've come here?
> RRB2: no I improved it!
> I: You improved it?
> RRB2: *nods with unmistakable conviction*
>
> (Resident Interview 2B).

Furthermore, the significant role of the residents' *internal locus of control* in determining their psychosocial well-being was fortified in the succeeding interviews. For instance, the following narrative portrays how this resident coped with feelings of boredom and loneliness by taking charge of his feelings through actively seeking to adopt behaviours that promoted positive emotions;

> RRB4: …there's no cause to be bored, because there is no need to be bored because it's up to yourself to do whatever you can you know. It's up to yourself to make the best of it.
> I: so you think it's what you make it yourself?
> RRB4: I do, it's what you make of it yourself. It's your own lonely, if you don't want to talk to somebody you don't have to, but I like to have a chat with somebody you know, the auld day can be long when you're doing nothing, you know. I find it alright now when I'm able to go around.
>
> (Resident Interview B4).

Findings suggest that the residents' internal locus of control plays a significant role in determining how the individual will adapt to changing circumstances associated with the ageing process. O'Neill (2002) supports the notion that threats to psychosocial well-being are largely dependent upon how individuals adapt to changing circumstances associated with the ageing process. It is inferred from the data that those with a perceived optimistic locus of control over life events, positively adapt to changing circumstances thereby alleviating the impact of such events on their psychosocial well-being.

In addition, the residents' positive outlook was found to be associated with personal *faith and spirituality*. All residents interviewed referred to their faith at some point during the interview process. The following depicts a female resident's outlook which she adopted in order to help her to cope with significant loses in her life such as loss of her spouse, loss of her home and loss of her ability to mobilise following a leg amputation.

> I think when God, God ah- he don't harm you I don't believe that but when something happens in your life and you need him, if he, if he's going to take that way from you he'll give you something instead, I really believe that, he'll give you something instead; he won't leave you idle all the time, you won't be vacant
>
> (Resident Interview A3).

Hence, it is interpreted that the residents' outlook and internal locus of control greatly contributed to their psychological well-being (Appendix 18b). It is apparent from the data presented that those with a positive internal locus of control perceived significant life events as just that; an incidence amidst the life journey which they must cope with, while at the same time adapt and accept one's current situation in a positive and fervent manner. It is considered that such an outlook facilitated the individual to adapt to the changes associated with ageing whilst retaining their personal identity through acknowledging the role of their past in the construction of their current situation. Hence, practices which foster a positive internal locus of control are warranted.

4.4.2 Caregivers' Characteristics

Alas, it is accepted that regardless of one's internal locus of control, social supports are crucial in the attainment of optimum psychosocial well-being. As highlighted above, caregivers play a significant role in facilitating psychosocial wellbeing through *meaningful interactions*, accurate assessments and *advocating for residents' needs*. However, it is construed that the personal characteristics of caregivers somewhat determine the effectiveness of such actions and their subsequent outcomes. In one of the focus group sessions attended by clinical nurse managers with a combined experience of 38 years within older person services, the influence of staffing characteristics was truly acknowledged. It is considered that caregivers must have certain characteristics, such as *inert sense of thoughtfulness*, which allows them go beyond their formal duties in order to ensure that individuals' biopsychosocial needs

are fulfilled, the following narrative data, which portrays caregivers perceived role as an extended family, consolidates this concept;

> CNMA3: if they've been to matches they'll bring in a programmes for their hurling matches and you...You do it!
> CNMA4: yea you just automatically do it; you don't even think about it,
> CNMA2: and I mean if you're, if you're not like that yourself, you wouldn't work here, in this environment
> CNMA2; you have to have that, that just that extra bit of
> CNMA4: caring
>
> (Clinical Nurse Managers Focus Group A).

Furthermore, the need to go *beyond formal duties* and to *personalise care* was acknowledged by another caregiver who expressed her willingness to do whatever it took to make the residents happy;

> …if they want me to stand on me head and I could I would, cause their old people and after all they're someone's mother and I look at them, I lost my mother when I was very young, they're all kind of nannies to me
>
> (Healthcare Assistant Interview B1).

However, this tendency was very much dependent on the personal attributes of caregivers and their level of interest in the well-being of the residents;

> …well its give and take, some people will go all out and then there's others that don't have the interest you know…you can't change staffs' natures and that's it
>
> (Healthcare Assistant Interview A5).

Thus, it is accepted that the uptake of such roles is dependent upon caregivers' characteristics and their willingness to *advocate for residents' needs* based upon an *inert sense of thoughtfulness* and a willingness to act *beyond formal duties* to *personalise care* so that residents' broader needs are met. Such actions may be what Kantian ethics refer to as *imperfect duties*; duties of compassion, concern, benevolence, respect and care (Sullivan, 1990; in McCormack 2003). It is inferred that the willingness to perform such duties are dependant on caregivers' willingness to go beyond the remit of *perfect duties*; based on strict guidelines and rules, to consider the residents needs as well as the professional polices and protocols which guide formal practice. These findings are reflective of *the multifaceted role of caregivers*

secondary to the need to encompass a multitude of duties to adequately provide for the complex needs of older persons; many of their needs falling beyond caregivers' professional role boundaries. For instance, the provision of care for residents' physical needs was perceived to be caregivers' remit, while residents' broader psychosocial needs were acknowledged depending on the caregiver's insight and willingness to act beyond their formal role in the interests of the residents' well-being and quality of life.

One caregiver perceived the role of personal characteristics of staff in determining residents outcomes was so profound that she believed the health service was not attracting the right caliber of staff, thus she emphasizes how personal characteristics of caregivers impact on resident outcomes;

> …you have people that are coming in to the service nowadays and they couldn't care less if the patients heads were hanging off, they've no interest and unfortunately we seem to be attracting more staff like that now than we did…they seem to be more in it because it's a good paying job and it's pensionable, than I actually enjoy the job or I like the patient, and you'd know the one's that are not interested cause they never interact with the patients, they just don't seem to… it's almost like it's just a job, I'm here for the money and that's all I'm going to do and that's bad, because you're losing that much interaction now as well … you're now getting the people that just don't want to spend the time
>
> (Healthcare Assistant Interview A4).

Hence, the characteristics of caregivers are perceived to be significant to level of interaction afforded to residents, thus may be directly linked to their psychosocial outcomes as the above data clearly explicates social interaction as a means of therapy and assessment.

Furthermore, caregivers' *knowledge and education* was found to impact on their ability to adequately fulfill residents' psychosocial needs. During one of the focus group sessions attended by clinical nurse mangers with exceptional clinical expertise coupled with additional academic and clinical qualifications, one participant voiced her perceived knowledge deficits which she believed affected her ability to accurately meet the resident complex and specialist needs;

> ..I oft… sometimes I query, you know, what do we know as General Nurses about looking after these patients, how educated are we? …I just query sometimes with am, with how good, how well are we educated….as therapists
> (CNMA2; Clinical Nurse Manger Focus Group A).

The continuing practice and professional development required to meet the specialist needs of this heterogeneous group is acknowledged in the literature (Joy et al., 2000; Nolan and Nolan, 1999). However, it is contended that older person nursing does not have a defined focus secondary to the poor availability of theories relevant to gerontology as it is considered that most of the common models and theories of nursing provide little or no guidance as to how to positively facilitate older people within healthcare services (Wadensten and Carlsson, 2003). It is inferred that this lack of focus and in some cases specialist education, led caregivers to comply with the dominant philosophy of care without considering its principles or implications on the residents. Hence, the individual characteristics of caregivers are perceived as being significant determinants of residents' psychosocial well-being. Not only that, caregivers were significantly influenced by their colleagues behaviours as the apparent philosophy of care based upon the predominant routine of care and the organisation dramatically dominated practice.

Furthermore, one caregiver demonstrated how lack of understanding, secondary to education deficits, can lead to misinterpretation of residents' broader needs. The following narrative demonstrates the residents' inability to effectively communicate their psychosocial needs, thus lack of understanding by the caregiver may entail that the residents' behaviour cannot be comprehended on a higher level, thus the caregiver fails to adequately advocate for the residents needs and instead provides care that is psychologically detrimental as it promotes dependency among the resident. The following narrative elucidates the rationale for this interpretation;

> …sometimes I'm just in; I'm gone into that mode, yeah. I'm gone into "I'm a carer" mode, and I have to look after everybody and no, we do, I mean people do only come into long term care and that's it! Now you get up at 8 o' clock, we'll sit, we'll feed ya, we'll wash ya we'll save ya, we'll put your trousers on, we'll bring you to the toilet, we'll do… you know where you can literally, they can do it all themselves!?...but then that's lack of education in staff as well, your just after coming on the ward and automatically go and help so and so where everybody else is not helping them and, but then patients will use people as well *(little snigger)*, when they see a new face they'll abuse it,

> people do that as well, they'll just turn into zombie's who can't do anything when they see a new face, cause they know if they ask me I won't do it, cause I know them
> I: but why do you think that is? Do you think they want the attention?
> HCAA2: maybe attention seeking/ company, there's a lot of different things you can say yeah…company? Somebody being around, somebody pottering over them? Somebody they can talk to?
>
> (Healthcare Assistant Interview A2).

The above narrative demonstrates how residents' psychosocial needs may be neglected due to the overemphasis on physical needs and the *task orientated routine* and *philosophy of care*. Thus, it is considered that if the residents' physical needs are fulfilled or if they are independent in their activities of daily living, it is perceived that they do not require any other intervention from caregivers. However, analysis of the above narrative led the researcher to consider that in attempting to acquire the unnecessary assistance of caregivers, residents may be covertly attempting to fulfill their own psychosocial needs through the pursuit of meaningful interaction with others.

Furthermore, the above narrative depicts how caregiver's actions may impact on the resident's perception of self whereby dependency is promoted owing to a routinized *philosophy of care*; subsequently individuals' needs and abilities are neither considered nor nurtured. From a symbolic interactionism perspective it is considered that in failing to neither acknowledge nor promote the residents abilities, both their potential and existent capabilities are hindered upon conforming to their conception of how others see them based on their interpretation of the interaction; in the above case notions of dependency were conveyed therefore such a persona was accepted by the resident. This interpretation is reflective of Blumer's (1969) premise of symbolic interactionism whereby;

> "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows"…these meanings are handled and modified through, an interpretative process used by the person in dealing with the things he encounters" (Blumer, 1969, p.2).

Therefore, it is considered such *routinized rather than individualised care* is detrimental to the residents' biopsychosocial well-being as it fosters marginalisation and stereotyping, thus limiting individuals' potential and destroying their personal

identity. Hence, it recognized that knowledge deficits, in addition to the dominant *philosophy of care*, may impact on the fulfillment of residents psychosocial needs.

Additionally, caregivers highlighted the need for a multidisciplinary approach acknowledging that certain aspects of the residents needs were beyond the caregivers role boundaries, thus required the expertise of a specialist practitioner;

> ….it's not good enough, and also the psychological side of going to extended care, I mean there's nobody addresses that, we have no social worker, no counsellor, like to be told one day, like to be up and to be an active lady one day and to have a CVA and become inactive and then in a wheelchair, you're wheelchair bound, nobody looks at the psychological side of that, there's nobody here looking at the psych side, and then to go from the failed rehab to extended care to know that this is it, this is where I'm going to be now for the rest of my life, as long as that is
>
> (Healthcare Assistant Interview A4).

While conversing with residents was seen to be psychologically beneficial in addressing emotional and psychological needs, the caregivers' skills in facilitating psychological well-being amidst acute or chronic psychological issues was limited. Hence, in acknowledging the limited scope of any one discipline *the merits of a multidisciplinary approach* in achieving care that is reflective of residents' needs is apparent. The practice of sharing knowledge between disciplines is commended within the literature (Arnetz and Hasson, 2007) as it is accepted that formally educating all staff members with specialist knowledge is not always feasible (McCormack et al, 2008).

4.4.3 The Philosophy of Care

The philosophy of care was also perceived to determine the acknowledgement and subsequent fulfillment of residents psychosocial needs. This concept was markedly clear from the start of data collection as caregivers spoke of their inability to fulfill psychosocial needs due to their low priority amidst their daily tasks;

> …physical, physical care seems to be what's priority, and the emotional and psychological and rest is neglected a little bit
>
> (NRB3; Staff Nurse Focus Group B).

> … I find too like a lot of it is task orientated and I think like the activities, the 12 activities of daily living, and the working and playing one and expressing

> sexuality and all that kind of stuff is kind of hidden, so we don't do anything with it, it's kind of eating and drinking and washing and dressing and all that is all done but it's kind of left to last, the working and playing one
>
> (NRB1; Staff Nurse Focus Group B).

The following memo depicts the researcher's initial thoughts pertaining to the data retrieved from one of the staff nurse focus group discussions;

> The caregivers spoke of the task-orientated nature of care in a manner which suggested their disapproval of it, at the same time it was evident that caregivers conformed to such practices as they were the norm. Therefore the philosophy of care overshadowed individual caregiver's intuitions. Hence physical needs were prioritised and the acknowledged theoretical components of holistic nursing care were perceived to be irrelevant in practice.
>
> (Theoretical memo entry 26-06-07; staff nurse focus group B).

Heavy workloads in addition to insufficient staffing levels are frequently cited as contributing to high stress levels and the inability to adequately meet individuals' needs (Stanton and Rutherford, 2004). The caregivers' time appeared to be dictated by *the task orientated philosophy of care*. It is suggested in the data that due to the overwhelming workloads, physical care was prioritised as it required all of the caregivers available time, hence the broader determinants of health and well-being such as residents psychosocial needs were not catered for due to limiting factors beyond caregivers control, thus the concepts of *resource rather than needs based care* and *routinized rather than individualised care* emerged. These concepts are reflective of findings by McCabe (2004) who found nurses' actions were dictated by a need to fulfill tasks rather than patients' needs.

The following narratives provide an example of the rationale for such emergence of concepts;

> NRB1: it's very task orientated, you know it's all kind of, you know you do the drugs then you put them back to bed, then it's dinner time and then everything is kind of, you kind of have to get on
> NRB3: so when you do get a quiet time you go off and do your notes cause
> NRB2: that's right yeah and then you go out again and you do your drugs,
> NRB1: yeah whatever like,
> NRB2: teas or back to bed, you know our day
> NRB3: is task orientated
> NRB2: all our work is centred around isn't it, 8 hours in the day
>
> (Staff Nurse Focus Group B).

Hence, the need to prioritize one's time in order to maximize opportunities to fulfill residents' holistic needs is apparent. The following narrative, derived from a focus group discussion, portrays caregiver's perception of time constraints and the need to optimize time spent with residents to provide optimal outcomes. While the necessity to optimize the time spent with the residents was acknowledged, the caregiver highlights how some colleagues do not optimize this time due to personal attributes and the domineering *philosophy of care;* thus how time is managed is dependent upon staffing characteristics and the perceived priorities of care;

> …even just to sit down a lot of them are just lonely they want the chat, unfortunately nine times out of ten you don't get the time to sit down to chat to them, but it's up to every individual to make the time
>
> (Healthcare Assistant A5).

Yet again, the influence of caregivers' characteristics is apparent and thus is perceived to be a significant co-determinant to the fulfillment of residents' psychosocial needs. Furthermore, it was acknowledged that workloads were continually expanding due to the rising complexity of resident needs secondary to changing profiles associated with increased longevity; nevertheless the availability of resources remained static. Thus, it was evident that human resources were overstretched; hence for many caregivers the perceived *time constraints* limited their ability to effectively facilitate psychosocial well-being;

> ….we don't have the same amount of time as we did have to talk to the patients anymore ….we used to have a lot more time, like we could sit on the end of the bed and we could have a chat with them, that time seems to be gone, it's going, it's not gone yet, it's going, so the level of care wouldn't be as good as it was in that sense, that we're not looking after their mental health, as much as we did
>
> (Healthcare Assistant Interview A4).

This caregiver was extremely frustrated with how limited resources restricted her ability to provide adequate care that was reflective of residents' holistic needs. The following narrative depicts how this caregiver perceived the negative effect of resource constraints on resident outcomes and staff morale.

> we're letting the patients down *(genuine emotion in voice and facial expression),* we're- like it's patient centred care-my backside, do you know what I mean it's not anymore, it's budget centred care, it's what's there and what's available, but why can't they have all they need, they worked all their

> lives, they pay their taxes, we'd have nothing if it wasn't for them, why are we letting them down, and the elderly seem to be forgotten about a lot of the time
>
> (Healthcare Assistant Interview 4A).

Furthermore, *managements' influence* on providing for residents complete biopsychosocial needs was apparent, although caregivers clearly depicted the perceived significance of interacting with residents both during and outside of their formal duties, it was perceived that interacting with resident outside of formal duties was "dosing";

> I believe this intensely, that if we could-were allowed, to sit down, say herself is up sitting down talking to **** ***** or who ever, that you shouldn't feel guilty and you shouldn't have to jump up and look as if you're busy when someone comes in … it's this old fashioned thing you must look busy, you must, it must, unless you're doing something physically, a task thing, you're not working and I think that's very wrong
>
> (NRB3; Staff Nurse Focus Group B).

However, it is important to note that this perception regarding managements' negative influence on the philosophy of care was only apparent in the data retrieved from one of the study sites; the other study sites philosophy of care was perceived to predominantly permeate from the caregivers "routine". Thus, while *managements' influence* was perceived to be significant, it was considered that caregivers' attitudes and behaviours were most significant as it is the caregivers who provide direct care; their action perceived to be dictated by their personal characteristics and education as opposed to theory or polices. Hence, it is considered that the philosophy of care, determined by the availability of resources in addition to the personal characteristics of caregivers, dictated the provision of care and subsequent client outcomes.

4.5 Synthesis of Categories

It is considered that the above findings highlight the significance of interactions within the extended care setting; *the multifaceted value of interaction* was perceived to be significant to residents' psychosocial well-being on a number of levels. Foremost, residents valued social activity based upon fundamental social interaction with others. It is interpreted that such interactions facilitated the formation of relationships whilst promoting fulfilment of individuals potential through the enhancement of residents' abilities rather than disabilities, hence the residents'

autonomy and independence were nurtured. Furthermore, *meaningful interaction* with others was a determinant of psychological well-being as it provided cognitive stimulation for residents with varying profiles whilst reducing the incident of loneliness; a factor found to contribute to the onset of poor psychological health among older persons (Nezlek et al. 2002; Bennett, 2002; Menac, 2003; Gulseren and Aysegul, 2005). Additionally, interactions formed the foundation of the *therapeutic relationship*, which in effect determined the quality of the information received from the resident and their family as positive nurse client relations were shown to positively enhance residents' quality of life through the fulfilment of psychosocial needs based on knowledge of the residents and their past life. The very process of communicating with the individual in order to ascertain their needs was in itself therapeutic.

Similarly, interactions between caregivers were shown to determine the *philosophy of care* as dominant routines were communicated through the attitudes and actions of caregivers. Hence, if the general ethos of care was predominantly *task oriented* with physical needs prioritised caregivers tended to conform, despite underlying professional knowledge and personal intuition. In the same way, when the caregivers displayed willingness to *advocate for residents' needs* based upon an *inert sense of thoughtfulness* and a willingness to act *beyond formal duties* to *personalise care*, the tendency to look beyond physical care was more widespread. Hence, it is interpreted that caregivers followed example of their colleagues rather than educational influences. While social interaction was perceived to be the most influential means of meeting residents' psychosocial needs, it was not always achieved dependent on the caregiver's knowledge of the residents, the level of family involvement, caregiver's characteristics and the guiding philosophy of care.

4.6 Development of Core Category and Subsequent Theory

The formation of theory occurs when the data are refined, conceptualised and reassembled in new ways. According to Morse (1994)

> "a theory provides the best comprehensive, coherent and simplest model for linking diverse and unrelated fact in a useful and pragmatic way. It is a way of revealing the obvious, the implicit, the unrecognized and the unknown" (p25).

Relationships between codes were explored and hierarchical structures within subcodes were identified. Furthermore, the formation of concepts helped to merge the disconnected data created during the process of open coding. Thus, the interrelated nature of the concepts and categories was apparent upon determining concepts and categories amidst the coding procedures (Appendix 17). Hence, the above concepts and categories in addition to the codes, sub codes and context in which they occurred lead to the development of the following substantive theory.

Upon reflecting on the data, inclusive of memos and fieldnotes the perceived complexity of determining and subsequently meeting residents' needs beyond their apparent physical entity was evident. However, as theoretical sampling and data collection progressed, the innate knowledge of caregivers was apparent. Although often underestimated by the caregivers themselves, the accounts of their experiences in care highlighted consistent, attainable, flexible and cost-effective methods of assessing and subsequently fulfilling individual residents' needs. It is noteworthy that all methods pertained to the principles of effective interpersonal communication through fundamental social interaction. Furthermore, it was evident that many of the interventions designed to promote and maintain functional ability and physical health, inadvertently promoted psychosocial well-being. Hence, the seemingly complex task of meeting residents' needs simplified with the progression of data collection and the researchers ensuing theoretical sensitivity.

Furthermore, the importance of psychosocial well-being among residents of extended care facilities is highlighted by the service-users themselves as the data demonstrates how effective coping skills, positive adaptation and an optimistic internal locus of control can promote psychosocial well-being by reducing the impact of negative life events and optimising present circumstances. Equally, the data show how a negative outlook and perceived loss of control may damage psychosocial well-being through the development a negative attribution to life occurrences. However, it is considered that the limitations of caregivers' role warrant the skills of the multidisciplinary team and/or specialist training to facilitate positive cognitive processes among residents to promote optimum psychosocial well-being. The principles of interventions such as Cognitive Behavioural Therapy; a psychotherapy based on cognitions, assumptions,

beliefs, and behaviours, with the aim of influencing negative emotions that relate to inaccurate appraisal of events may be merited.

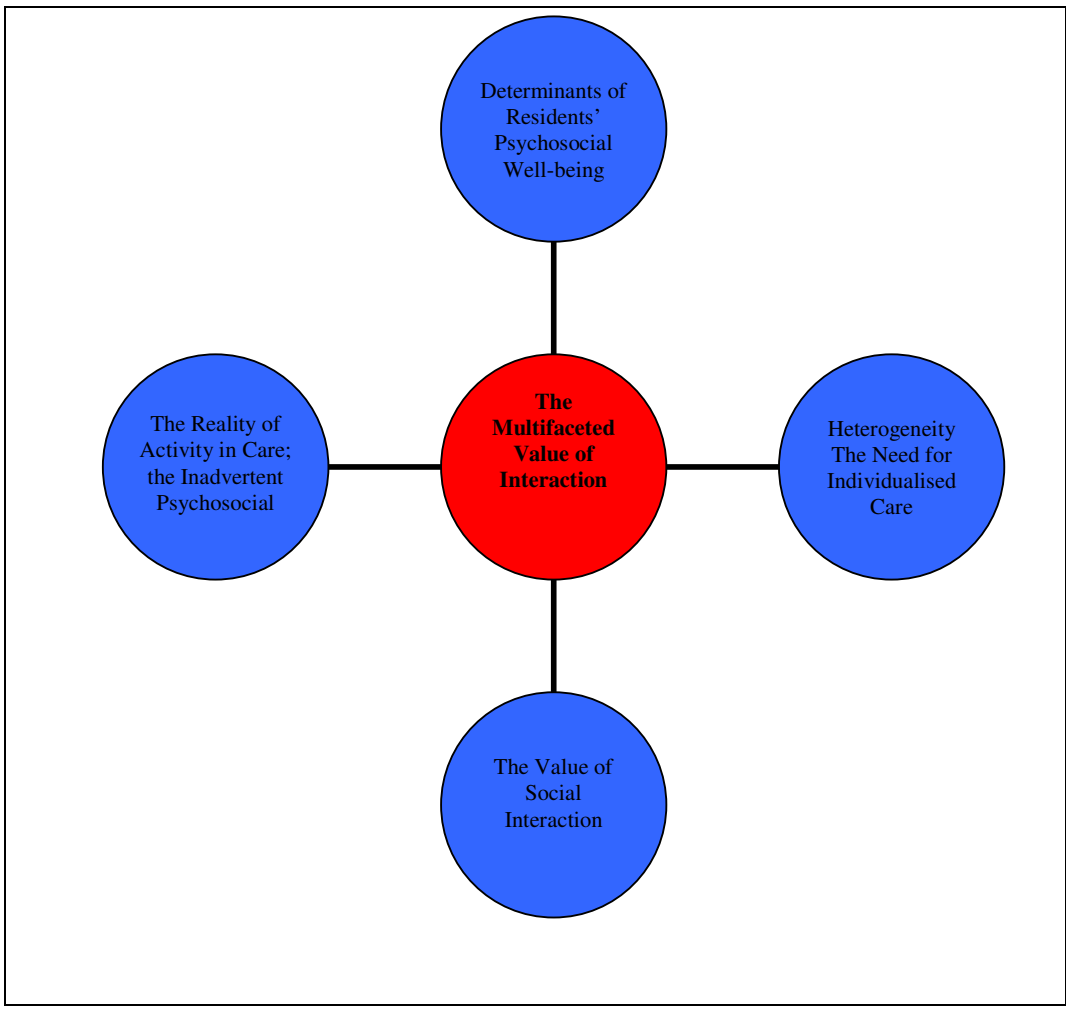
Furthermore, the heterogeneity of the older person in receipt of extended care gives sufficient justification for the formulation of a plan of care that is reflective of individuals needs as opposed to that reflective of routines and resources. While it is established that the psychosocial needs of residents vary depending on personal characteristics, their psychosocial health may also be linked to the fulfillment of perceived needs and priorities, many of which may be determined by past social roles and social processes. Hence, the recognition of the socialisation of older person is significant. Moreover, the fulfillment of such needs is overtly dependent upon the availability of resources and the perceived role boundaries of caregivers. Not only do the priorities and personal characteristics of caregivers contribute to resident outcomes, but so too do the organisational characteristics of the facility within which they work inclusive of management influence, resources constraints and the general philosophy of care. Furthermore, the significant role of management in communicating with caregivers, supporting evidence based practice and professional development leading to a philosophy of care that is reflective of the biopsychosocial needs of older person in receipt of extended care is audible.

While the interrelated nature of the concepts and categories was evident during the simultaneous processes of data collection and analysis (Appendix 17), it was not until theoretical saturation was achieved that the significant link that would bind all the categories together emerged. It was considered that interaction, based on the principles of interpersonal communication played an intricate role in all the categories presented above. For this reason the phrase; *the multifaceted value of interaction*, derived from the interrelated connotations of the existing categories, was applied to from the core category to which all others subsumed. The data suggests how meaningful interactions, based on interpersonal communication, are intrinsic to resident's psychosocial well-being; as a therapeutic intervention and as a means of promoting continuity of self, positive adaptation and positive personal identity. Furthermore, interactions form the basis of the therapeutic relationship with the resident and family thus, supports an individualised plan of care through accurate assessment facilitated by interpersonal communication which ascertains the residents

more implicit needs; those beyond their apparent physical entity, yet essential to one's optimum well-being. Finally, interactions among caregivers form the basis of learning and effective multidisciplinary cohesion through the sharing of knowledge in the endeavour to achieve a philosophy of care that is conducive to residents needs while also reflective of evidence based practice.

Furthermore, interaction not only underlies the research categories, it also underlies the endeavour for optimum quality of life as it is evident from the literature that the interaction between the bio, psycho and social components of well-being must be addressed in order to facilitate optimum quality of life (Bowling et al., 2002). Thus, upon consideration of the findings in conjunction with the extant literature, *the multifaceted value of interaction* in the endeavour for psychosocial well-being was perceived noteworthy. Hence, it is considered that the *multifaceted value of interaction* forms an appropriate core category as the intricate role of interactions is apparent throughout the data set, thus forms the central theme of the data around which all other categories may be subsumed. It is considered that with the application of a core category, the interrelated nature of the original categories is further enhanced. Figure 4.0 demonstrates the interconnection among the categories.

Figure 4.0 Categories Pertaining to the Core Category



4.7 Summary

In demonstrating the underlying concepts and categories of the substantive theory, this chapter has described the research processes which underpinned the formation of a substantive theory. It clearly demonstrates how the initial focus of the study adapted according to the data, that is; to reflect the reality of the phenomenon as perceived by those who experience it. Hence, the retrieved data shaped the direction of the study and subsequent findings, thus the applicability of the findings to the reality of the phenomenon in practice is enhanced. Adopting a grounded theory approach, using both constant comparison and theoretical sampling, guided by the underlying principles of the approach that is; symbolic interactionism, led to an accurate

representation of the current situation in practice whereby the innate social processes, in addition to the actual data retrieved, facilitated the emergence of a substantive theory.

Chapter 5
Conclusion and Recommendations

5.0. Introduction

Drawing on the relevant extant literature and the data derived from the current study, this final chapter represents an overview of the key findings in relation to the objectives of the study. The implications of the study to policy, practice, education and research in the psychosocial dimensions of healthcare among older persons are also considered. Furthermore, this chapter shall discuss the generated theory in relation to the existing body of knowledge. Limitations of the findings are explored while recommendations with regard to policy, practice and research initiatives are made.

5.1. Overview of Findings in Relation to the Study Rationale

In an era where longevity is celebrated and seen as one of mankind's greatest achievements, society fails to appropriately acknowledge those who actually achieve it (MacGregor, 2003). Bhattacharya et al. (2004) proposes that prolonged life expectancy as a result of recent medical innovations, unduly prolongs life that is void of quality. This attitude is based on the premise that by increasing life expectancy, older people will experience greater years of ill-health and disability associated with reduced quality of life (Polder et al., 2002; Mac Gregor, 2003; Baltes & Smith, 2002). While advances in technology and standards of living have led to an increase in quantity of life, greater emphasis now must placed on assuring quality of the years added to life (NCAOP\DOHC, 1998).

Unfortunately, extended care settings are too often perceived as places of purgatory; where older people live passive lives without any autonomy or independence (O'Connor and Walsh, 1986; Age & Opportunity, 2003). Such negative images of ageing are exacerbated by the continued emphasis on the expenditure associated with an ageing population, which according to O'Shea (2007) will only to serve to marginalise older people. While the literature highlights a multitude of implications of population ageing for consideration, it is the economic impact of ageing that captures the greatest attention, so much so that economic concerns appear to be the main

driving force in the movement to improve our healthcare systems (Anderson & Burckhardt, 1999). Hence, it is considered that polices and procedures which not only serve the best interests of individuals, but also the best interests of government finances, receive the most consideration. For this reason, the economic merits of promoting optimum quality of life through initiatives designed to promote and maintain optimal health and well-being were considered as an element of the rationale for this study. However, it is acknowledged that a complex mix of physiological, psychological and social processes is involved in the onset and experience of disability, which may be modifiable through interventions designed to improve holistic health and quality of life (Nezlek et al., 2002; Herman et al., 2005). Therefore, it is envisaged that such interventions may not only achieve optimum quality of life for the older person living in extended care, but will also reduce the expenditure associated with the onset of disability. The reality of psychosocial well-being as strong determinant of holistic well-being and quality of life is apparent in the findings, as are the perceived determinants which affect the psychosocial well-being of older persons in extended care. Thus, it is anticipated that the study findings will enhance the significance of the psychosocial determinants of well-being and quality of life among older persons in extended care settings; hence contribute to the development of best practice policy and guidelines in the psychosocial dimensions of healthcare for older people.

5.2. Overview of Findings in the Context of the Study Objectives

The aim of this study was to explore the psychosocial needs of older people in extended care settings in Ireland, from the perspective of both residents and caregivers. This was achieved by addressing issues considered noteworthy upon preliminary review of the extant literature and those perceived to be pertinent to the sample population upon retrieval of the raw data. Hence, theoretical sampling and a flexible research design allowed for the exploration of concepts perceived as being significant to the sample population, and were thereby conducive to the attainment of rich data reflective of the reality of the phenomenon. The interpreted data commends the significance of psychosocial determinants to optimum quality of life yet, suggests a number of determinants which affect the attainment of such holistic well-being. This finding is analogous with the existing body of evidence with commends a holistic approach to ageing through acknowledging biopsychosocial processes (Faltermaier,

1997; Harwood et al., 1998; Albrecht and Devlieger, 1999; Bowling et al., 2002; Thompson, 2007). However, this body of knowledge fails to offer tangible evidence of the implementation of such approaches in practice. Moreover, the findings portray current practices are based on traditional tasks rather than residents holistic needs, the occurrence of which is exemplified in the literature (Choowattanapakorn et al., 2004; McCabe, 2004).

Both residents and caregivers perceptions of the experiences relating to psychosocial being within the extended care setting were identified throughout the data collection procedures, illustrations of which are evident in the narratives depicted in the preceding chapter. The extant literature in association with insight of this phenomenon afforded through residents and caregivers accounts, clearly underpin the generated theory concerning psychosocial care in practice.

The following depicts the main conclusions that may be drawn from the research findings:

- Social interaction is both and underestimated and underutilized means to assessing and meeting the psychosocial needs of residents in extended care settings;
- The importance of a standardised assessment tool to determine residents' needs and ensure the subsequent implementation of care that is conducive to individuals' unique holistic needs is apparent;
- Lack of knowledge proved to be a significant barrier to fulfilling residents' psychosocial needs, thus the importance of the sharing of knowledge among members of the multidisciplinary team, in addition to promoting resident and family involvement in devising an appropriate plan of individualised care is core;
- In acknowledging the value of the multidisciplinary team, the use of cognitive therapies which promote and maintain optimum psychological well-being through facilitating positive adaptation to the ageing process is warranted.
- The occurrence of *resource rather than needs based care* was apparent throughout the findings, as is evident in the literature, as older person services have long been considered an underdeveloped resource (Nolan, 1997; Ford

and McCormack, 2000). The need to reduce marginalisation of older persons and to appeal for services that adequately fulfil residents' basic human rights is apparent. Until such provisions are in place, the formulation of policies and protocols that optimise available resources may be warranted.

5.3 Considering the Implications of the Study

The inference of the research findings have many implications for healthcare services, nursing practice and education, policy and research; all of which shall be discussed independently.

5.3.1 Implications for Health Services

The implications of demographic transformations call for a revised approach to caring for older persons, facilitating optimal health and well-being. Indeed, it is considered that the findings of this study raise the profile of older persons' holistic needs while proposing attainable means of intervention, conducive to the psychosocial needs of older people. It is suggested that the findings of this research may contribute to the contention for more a proactive rather than reactive healthcare service. In failing to provide proactive care which promotes and maintains quality of life and well-being, healthcare services unduly limit older persons' role in society. Furthermore, the tendency to accept rather than to challenge current practices has resulted in a temporally static service that has not progressed with the evolving needs of our ageing population. Such passiveness may inadvertently relay on the attitudes of older persons thus limit their potential. While there have been a number of practice developments in older person services, changes are often reflective of national and local policy without evaluating the impact on the service users (McCormack et al., 2008). There is a need therefore to develop linkages among a variety of developmental processes to ensure that the experience of older people is held central to improvement strategies (McCormack et al., 2008). It is considered that in attaining the perceptions of older persons themselves, the current situation in practice may be adequately assessed whereby accurate and timely practice developments may be initiated and subsequently evaluated. It is thought that in reforming services to proactively meet the needs of older people not only will optimum quality of life and well-being be achieved, but also a more efficient service will evolve that may effectively cope with the notoriously reported implications of population ageing. The findings of this study may

contribute to such practice developments as the current situation in the psychosocial dimension of healthcare for older people is exposed, as are underestimated resources. It is anticipated that the findings of this study will facilitate health services to adapt current practices in order to optimise the interactions between service users and service providers, resulting in improved client outcomes.

5.3.2 Implications for Nursing Knowledge and Theory Development

While the literature commends a biopsychosocial approach to care, it is evident from the findings that a biomedical approach continues to permeate practice. It is particularly perturbing that such a deficient approach should dominate a discipline in which broader determinants of health and well-being significantly influence client outcomes (Herman et al., 2005). Analogous to the findings of this study, the literature concedes that the broader determinants of health are often neglected due nurses' preoccupation with physiological health (Andersen & Burckhardt, 1999; Choowattanapakorn et al., 2004). While it is evident that many of the caregivers acknowledged effective means of meeting residents needs beyond their physical entity, all of which were predominantly based upon the principles of social interaction, there appeared to be a number of perceived barriers to facilitating these needs. However, it is accepted that both the practice environment and the caregivers' characteristics were directly related to the significance of these perceived barriers; a clear association existing between the dominant philosophy of care and the attitudes and behaviours of caregivers. Considering that one of the study sites participants perceived theses barriers to be more effectual, it was concluded that the local philosophy of care was the most influential determinant of residents' psychosocial well-being. Hence, the general ethos of care, above theoretical insight, was seen to be a resounding factor in the facilitation of residents' psychosocial needs. This is a worrying finding for practice development as it inferred that evidence based practice is a mere theory that is unattainable in reality. Furthermore, it is contended that older person nursing does not have a defined focus secondary to the poor availability of theories relevant to gerontology as it is considered that most of the common models and theories of nursing provide little or no guidance as to how to positively facilitate older people within the healthcare services (Wadensten and Carlsson, 2003). It is inferred that this lack of focus, and in some cases specialist education, led caregivers

to comply with the dominant philosophy of care without considering its principles or implications on the residents.

Fairhurst & Huby (1998) consider strategies to encourage practice based on clinical evidence, they contend that regardless of procedures to incorporate research into practice such efforts are likely to be futile. Fairhurst & Huby (1998) recommend strategies which centre on developing informal consensus; in the absence of a tradition of using evidence, the strongest tendency may be to do what everybody else does. This strategy is particularly significant in facilitating junior staff members and student nurses to ensure that learned behaviour is reflective of best practice rather than routine practice. Furthermore, the practice of sharing knowledge among caregivers is thought invaluable. McCormack et al. (2008) acknowledge that many policy developments in healthcare practice are not transcending into clinical practice and subsequently recommend a more integrated approach to care with greater clinical governance. It is considered that because the majority of caregivers were of a senior calibre, some away from the educational setting for a prolonged period, they may not be receptive to changing practices and methods. The practice of students relaying their theoretical insight may be an effective means of communicating practice developments. It is considered that the promotion of such practices would unleash the theoretical insight among caregivers, thus facilitate the operationalisation of intuition into practice.

Hence, the need to reform caregivers' attitudes through interactively raising awareness of the significance of the psychosocial determinants of well-being and quality of life among older persons in extended care may be a cost-effective means of promoting quality of life and optimal health outcomes. It is considered that the findings of this study may enhance caregivers' awareness to such aspects of care to facilitate optimal quality of life and well-being among their residents. Furthermore, the findings suggest means of fulfilling residents psychosocial needs which are already in caregivers possession, thus it is anticipated that this research will encourage caregivers to act upon these resources; maximizing their interpersonal skills. The need for supportive management influence in association with collaboration among caregivers of all grades may facilitate the shift to a philosophy of care that is both in keeping with local polices and foremost; the residents' needs. A modified approach to

care of older person practices is supported in the acknowledgement of the continuing educational needs of nurses to meet the specialist needs of this heterogeneous group (Joy et al., 2000; Nolan and Nolan, 1999). Furthermore, it proposed that the development of integrated programme of policy, development, research and education may enable more appropriate and responsive care (Ford and McCormack, 2000). As the findings of this research provide insight into the services users' and service providers' perspective, it is contested that the recommendations are practice rather than theory driven. Therefore, it is anticipated that the findings will meaningfully contribute to practice developments in the psychosocial dimensions of healthcare for older people through a collaborated multidisciplinary approach which will transform and develop practice that is reflective of the dynamic needs of our ageing population.

5.3.3 Implications for Policy and Education

Findings show the predominant focus of care was on residents' physical needs; however it is acknowledged that mere fulfilment of physical needs is inadequate to guarantee optimal quality of life among older people in extended care facilities. Although government polices and initiatives support and campaign for the broader determinants of health to be catered for in the extended care setting (DOHC, 2001; Age and Opportunity, 2001; Irish Government, 2007) it is evident that such polices are not transcending into practice. It is contended that in acknowledging the significance of the broader determinants of well-being and quality of life in old age, governments polices which argue for a more proactive service should adequately facilitate the materialisation of such recommendations. The above literature suggests that current health care systems are not conducive to the ongoing health needs of older persons as emphasis appears to be on cure rather than rehabilitation and optimisation.

The theory of selective optimisation with compensation (Baltes and Baltes, 1990; Baltes and Smith, 2002) offers a practical yet fulfilling approach to facilitate effective ageing. It is based on the premise that the successful ageing may be facilitated by individuals' ability to offset inevitable losses by selectively optimising available internal and external resources, thus compensating for these loses by focusing on what one can do rather than what one can't. This theory echoes concepts portrayed in Atchley's continuity theory, which depicts life as a continuous process in which one adapts to ones current life stage based on innate personal characteristics and the

surrounding social world (Atchley, 1989). Thus government polices must actively seek to support initiatives that are conducive to individualising care in order to promote optimal biopsychosocial well-being through the successful adaptation to ageing among older persons. Through the formulation of policies which reflect evidence based practice it is endeavoured that minimum standards may be stipulated whereby both educational institutions and healthcare facilities must endeavour to maintain high standards of care through ensuring caregivers are equipped to provide evidence based practice that is conducive to older persons' holistic needs. It is considered that formal interactions with service providers and indeed service users would facilitate the implementation and subsequent governance of such initiatives.

5.3.4 Implications for Research

The implications of this study's findings relate to both methodological and theoretical issues. The use of a methodological approach that is founded upon symbolic interactionism proved invaluable to the study of this phenomenon as it's underlying principles were analogous to the social process under exploration. Developed by sociologists, this approach proved favourable to understanding the broader sociological aspects of nursing and life in extended care settings and thus may be utilized in related fields of research.

Consistent with the principle of person-centredness this research took the approach of consulting with older people themselves in order to develop an understanding of their psychosocial needs and how they may be fulfilled. Such an approach is conducive to ensuring appropriate and responsive service delivery. Furthermore, Fudge et al. (2000) commend the involvement of older persons in research as they found such experiences to be of a positive nature for older people as a result of increased knowledge, awareness and confidence, meeting others in similar situations and empowering older people.

While involving older people in research is important for the purpose of ascertaining their perspectives, it is considered that the findings of this study may progress further research, perhaps by means of action research, whereby the issues identified by key stakeholders such as the caregivers, the residents and perhaps the family, would form the basis for the reformation of practice. Such efforts would then be evaluated to

ascertain the impact on the residents' well-being and quality of life. For instance, the findings highlighted how lack of knowledge and accurate assessment of residents' needs contributed to psychosocial determinants of health not being fulfilled. It would be interesting to formulate a practical assessment process involving the resident and the family in which a specific domain addresses the issue of psychosocial needs. Practices to promote positive self identity, continuity of self and meaningful interactions with others would comprise some of the many important objectives of this assessment. The complexity of caregivers' role also warrants deeper exploration in order to facilitate the effectiveness of practice developments. Therefore, it is considered that while this research provides a deeper understanding of residents' psychosocial needs and how they may be achieved, further research is desirable to facilitate sufficient practice reform.

5.4 Recommendations

Throughout this research process, a number of issues have been found which pertain to the phenomenon of the psychosocial needs of older people in extended care. Pertinent issues include the acknowledgement of the heterogeneity of older persons, the need for accurate assessment and the role of personal characteristics. Upon consideration of the implications of the study findings on healthcare for older people, certain recommendations have been made with regard to policy, practice and research initiatives;

- Healthcare service providers and policymakers must ascertain current situations in practice to effectively formulate policies and initiatives which address both the needs of older persons and the capacity of services so that proposed government initiatives may be realistically attainable in practice; in doing so current practices must be reviewed and areas for reform addressed to ensure that resources are appropriately targeted at the existing needs of older people.
- Healthcare services for older people must become more collaborated so that effective practice developments may be nationally implemented, hence resource allocation must be reviewed to ensure all services have minimum level of resources according to their service provision.

- All extended care residents should have access to health maintenance therapies to help them maintain their baseline function for as long as possible.
- All residents should be reviewed by psychologist at the time of admission and thereafter to facilitate with the transition to extended care services and to ensure optimum psychological well-being.
- All caregivers should attend mandatory practical educational sessions to clarify the dimensions of their role in practice and subsequently provide practical and evidence based information as to how caregivers may fulfil this role in practice. Sessions should also refer to the issues of ageism, collaboration and the philosophy of care.
- Clinical governance initiatives must be implemented to assure recommended practice developments are effective and appropriate for residents, leading to positive outcomes. Specifically, assessment procedures must be evaluated to assure accurate assessments and subsequent interventions are achieved in practice.

5.5 Limitations of the Study

There are a number of limitations within this study which warrant consideration.

- The qualitative nature of this study, together with limitations of resources implicates that the above recommendations are made without having the opportunity to gauge their effect in practice; however it is considered that further research into this area may facilitate the implementation of some of the above recommendations.
- The qualitative methods utilized for this study may limit the applicability of the findings to all practice settings, however explication of research process may increase the transferability of findings to similar sites or phenomena.
- Time constraints and the necessity to accommodate study participants denoted that some interviews took place in succession, thus limited time was available to analyse the data prior to the subsequent interview, however memos were utilized to expand the data collection tool accordingly.
- It is viable that the professionals who attended focus group discussion may have responded according to their professional code, stipulated polices or

theoretical knowledge rather than conveying true perceptions as the presence of peers may have influenced their response

- Premature closure due to specific timeframe for completion could imply that the narrative data was under-analysed thereby, limiting a higher level of analysis and interpretation.

5.6 Conclusion

The rationale for this study emanates from the continued concern regarding the quality of life afforded to older persons in receipt of extended care services. While there is large body of knowledge on this phenomenon there is a dearth of research findings from an Irish perspective. This study explores the interaction between the service user and service providers' perspective of psychosocial needs and enhances comprehension of the reality of the situation in practice; illuminating the internal consistencies and inconsistencies of caregivers and residents' views. The findings from this study may be transferable to the extent to which they help in understanding beliefs and practices within residential settings. In deriving explanations which are theoretically generalizable, qualitative research can also draw, where appropriate, on pre-existing bodies of theory-most commonly those deriving from the social sciences (Barbour, 2000). Whilst qualitative research may illuminate the processes and phenomena under exploration without recourse to sociological theory, the application of theoretical perspectives can allow hypothesis to be extended and thereby provide "added value".

The intricate relationship between social networks and psychological health is well recognised in the literature, a clear association between participation in meaningful social activity, social supports, well-being and quality of life amongst older persons is evident (Browne at al., 1994; Farquhar, 1995; Albrecht and Devieger, 1999; Bowling et al., 2003; OCS Consulting, 2004; Murphy et al., 2007). Furthermore, the continued adherence to biomedical rather than biopsychosocial approaches in practice is supported within the literature (Bowling and Dieppe, 2002). While it is accepted that psychosocial approaches are assuming increasing prominence as a means of achieving maintenance, promotion of health and secondary prevention through fostering healthy behaviours and adherence to them, reducing disability, promoting function and enhancing well-being and quality of life (Thompson, 2007), it is contended that such

approaches remain mere frameworks for practice, but in reality are not implemented in practice.

It is apparent that while effective interventions exist to promote psychosocial well-being among residents of extended care settings, such interventions are somewhat sporadic and vary across settings. Furthermore, the multiplicity of interventions is limited, with many residents' needs not being adequately fulfilled, which negatively impacts on the residents' holistic well-being. The desire to be involved in meaningful interaction with others was a significant finding; it highlights the need to promote opportunities for social interaction among residents and caregivers, failure to do so serves to materialise the conception of extended care settings as environments where older people live passive lives that are void of quality (O'Connor and Walsh, 1986; Barba et al., 2002; Age and Opportunity, 2003). Furthermore, failing to facilitate participation in meaningful activity may serve to exacerbate individuals' conditions as such practices have been shown to promote and maintain optimum quality of life, psychosocial well-being and functional ability (Glass et al., 1999; Seeman, 2001, Stessman et al., 2002; Acree et al., 2006; Christensen et al., 2006; Farley et al., 2006).

It is also interpreted from the findings that the philosophy of care, determined by the care settings' management system and the dominant caregivers' work ethics significantly influences the quality of care. It is accepted that despite education based on the most up-to-date evidence, caregivers' attitudes and behaviours dominate the philosophy of care thus influence junior caregivers' perceptions and subsequent practice (Thomas, 1992; Ahmed and Kitson, 1993; Robinson and Hill, 1995; Ryan, 2003). Hence, it is interpreted from the findings that the interactions between caregivers greatly influences the philosophy of care as it is considered knowledge sharing encompassed the enforcement of routines rather than evidence based practice. It is accepted that caregivers cannot tend to all of the residents complex needs, thus the role of knowledge sharing and a collaborated approach to care is acknowledged.

Findings show that while polices and initiatives related to care of the older person are based on a holistic model, everyday practice appears to be consistent with the biomedical model. Findings portrayed the overwhelming task orientated nature of care to the extent that caregivers shift was dominated by tasks related to residents' physical

needs, while it was perceived time constraints did not always allow for quality interactions with residents. Furthermore, it is apparent that practices centred on age old routines often defined by physical tasks, as opposed to practices defined by residents' holistic needs. Moreover, the findings also highlight the caregivers' tendency to conform to the philosophy of care even when it went against their own professional intuition.

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Appendix 1: Summary of Key Literature Reviewed

Paper	Purpose	Sample	Data Collections	Data Analysis	Key Findings
Bowling et al. (2002) Quantitative Correlational National Survey	To define the constituents and indicators of quality of life	Probability cohort sample of 1003 older persons living in their own home in Britain	Omnibus Interview Surveys using The Quality of Life Survey Questionnaire	Frequency distributions, chi-square, correlation analyses and self-evaluation of quality of life rating	Predictors of self-rate quality of life; social comparisons and expectations, personality and psychological characteristics, health, functional status and social capital.
Nezlek et al. (2002) Quantitative Correlational Study	To investigate the psychological well-being among older people in relation to their daily social interactions	Purposive Cohort sample of 131 healthy older persons living in the community in the USA	Life Satisfaction Index A, the Satisfaction with Life Scale, UCLA Loneliness Scale and the Emotional and Social Loneliness Scale and the Rochester Interaction Record	Hierarchical linear modelling; a random coefficient modelling technique	Positive and frequent social interactions can enhance psychological well-being including life satisfaction and loneliness
Wilson et al. (2007) Quantitative longitudinal clinicopathologic study	To test the hypothesis that loneliness is associated with increased risk of Alzheimer disease (AD).	Simple random cohort sample of 823 older persons free of dementia at enrolment were recruited from continuing care facilities in Chicago, USA	A modified version of the de Jong-Gierveld Loneliness Scale, open ended questions, Center for Epidemiological Studies–Depression scale and the Mini-Mental State Examination and various episodic memory testing tools. Post mortem of the brain to assess pathology and cerebral infarctions.	Generalized estimating equation models , linear regression models Model assumptions were then examined graphically and analytically	Risk of Alzheimer's Disease was more than doubled in lonely persons. Loneliness was associated with lower level of cognition at baseline and with more rapid cognitive decline during follow-up.
Bergland and Kirkevold (2007) Qualitative descriptive exploratory study	To describe nursing home residents' perceptions of the significance of peer relationships to thriving.	Purposive sample of 26 residents of two nursing homes in Norway	Field observation and interviews	Thematic analysis methods	The caregivers' role as facilitators in the development of meaningful interactions was essential
Glass et al. (1999) Prospective correlational methodological triangulation study	To examine any association between social, productive and physical activity and survival among older people.	Random cohort sample of 2761 older persons living in their own homes in Connecticut, USA	Face to face interviews, annual telephone follow up interviews	Proportional hazard models; Kaplan-Meir life tables and time models specifying the duration of survival	Social and productive activities with or without fitness benefits lower the risk of mortality, thus activity may bestow survival through psychosocial pathways

Paper	Purpose	Sample	Data Collections	Data Analysis	Key Findings
Lachman, (2006) Review	Review of the literature on adaptive beliefs and behaviours, and perceived control over age-related decline occurrences	Search strategy and inclusion exclusion criteria not detailed	Not applicable	Not applicable	Adults with a low sense of control over aging-related declines may be vulnerable to memory problems and physical disabilities in later life, partly as they are not likely to use compensatory strategies or adopt health promoting behaviours.
Stabell et al. (2004) Systemic observational triangulation study	To describe the pattern of social interaction between nursing home residents and nursing staff	Purposive sample of 6 residents From nursing home in Oslo, Norway	120 systemic observations using structured observational scheme by Baltes (1996)	Frequency distributions	Residents were rarely socially active. Behaviour known to support social engagement while stimulating independence was inconsistent among nursing staff. Opportunities to enhance social activity in the form of informal conversation were not utilized.
Bowling & Grundy (1997) Quantitative Longitudinal cross-sectional study	To investigate changes in functional ability and associations of these changes to physical health, psychiatric morbidity, life satisfaction, service use and social circumstances	Stratified random cohort sample 630 people aged 85+ at baseline from London and Essex, Britain	Structured interview survey, scales of functional ability, psychiatric morbidity, life satisfaction and social support, and items measuring number and type of health symptoms and services were used.	SPSS-10 Univariate and bivariate statistics, x^2tests, Pearson's product moment correlation, Spearman's Rank correlation and Wilcoxon tests	Decreasing levels of physical functioning were correlated with poor mental health. Decline in health and functional ability was the strongest predictor of depression, exacerbation of depression and low life-satisfaction. Low priority was given to secondary prevention or rehabilitation
Choowattanapakorn et al. (2004) Qualitative grounded theory guided study	To explore how gerontological nursing practice is experienced and described by patients, family and nurses	Theoretical sample patients aged 60 and over (n=7) family members (n=5) and nurses (n=11) All associated with a public hospital in Thailand	In-depth interviews	Constant Comparison method	Although nursing rhetoric supports holistic care, in reality, practice is dominated by a biomedical approach.

Paper	Purpose	Sample	Data Collections	Data Analysis	Key Findings
McCabe (2004) Qualitative Heideggarian/Gadamarian Hermeneutic phenomenological study	To explore and produce statements relating to patients' experiences of how nurses communicate.	Purposeful sample of patients (n=8) in a general teaching hospital	Unstructured interviews	Reflective process and thematic analysis	Health care organizations do not value the importance of using a patient-centred approach when communicating with patients to ensure the delivery of quality patient care. A task-centred approach to patient care continues to dominate.
Worden et al. (2006) Quantitative correlational study	To examine accuracy of assessment procedures for older people to avoid misplacement in nursing homes and ensure that rehabilitation takes place where possible.	126 care homes in North West England	Postal questionnaires were sent to care home managers along with a request to provide copies of their blank assessment and care plan documentation.	Content analysis Domains of assessment were derived from the Minimum Data Set/Resident Assessment Instrument (MDS/RAI) SPSS	Important key domains were infrequently mentioned on the assessment forms including mental health and preventive health domains. Findings suggests that the well-being and quality of life of some residents may be poorly addressed
McCormack et al. (2008) Qualitative descriptive case study	To explore the impact of health and social care organizational structures on older persons experiences of whole systems:	Disproportionate stratified sampling patients aged 65 years and over (n=50), from a healthcare setting in UK relatives (n=10) GPs (n=8) Community nurse manager, 1 Primary Care Trust (PCT) Manager (n=1). Delegates who represented, service users (n=60)	Conversational interviewing style with patients, mapping patient journeys, Focus group with general practitioners and primary care managers and delegate conference	Thematic analysis. QSR NVIVO	Effective communication is crucial to providing for older persons' individual needs. Older people felt disempowered by the system of care delivery which they felt did not include them in decision making, providing routinized care rather than individualized care.
Bowling and Dieppe (2005) Systematic literature review	To review existing models of the constituents of successful ageing from the social, psychological, and medical sciences.	Sources: PubMed, PsycINFO and SocioFile 170 papers presenting reviews or overviews of the topic, data from cross sectional, longitudinal surveys and qualitative studies	A systematic literature review	Not explicated	Biomedical models emphasised absence of disease and good physical and mental functioning as successful ageing, while psychosocial models emphasised life satisfaction, social functioning and participation, or psychological resources.

Paper	Purpose	Sample	Data Collections	Data Analysis	Key Findings
Arnetz and Hasson (2007) Quantitative prospective, non-randomized controlled Intervention study	To evaluate the possible effects of an educational ‘‘toolbox’’ intervention on nursing staff ratings of their competence, psychosocial work environment and overall work satisfaction.	Nursing staff in two municipal elderly care organizations in western Sweden. Exact number not specified	Nursing staff ratings of their competence and work were measured pre and post-intervention by questionnaire. Quality-Work-Competence (QWC) questionnaire, Likert-type response scale,	Chi square statistics Kolmogorov–Smirnov test. One-way analysis of variance (ANOVA) and Multivariate ANOVA	Nursing staff ratings of their competence and psychosocial environment, including overall work satisfaction, improved significantly with the intervention. Work-related exhaustion and work stress both decreased
Murphy et al. (2007) Methodological triangulation study	To explore the quality of life of older people living in extended care in Ireland	Stratified random sample of staff (n=48) and residents (n=101) from 327 extended care facilities in Ireland	Quantitative survey and qualitative interviews s	Constant Comparative Method (Strauss and Corbin, 1990), SPSS *v*12, *F*-tests, cross tabulations, Pearson’s chi-squared, the Mann-Whitney test and the Kruskal-Wallis test	Findings highlight the influence of management and organizational structures within extended care settings the on quality of life of residents. Services must be conducive to quality of life as well as quality of care.
O’Shea (2006) Position Paper Commissioned by the Older & Bolder Campaign	To demonstrate the current situation in Ireland and make recommendations for a new strategy for older people	Not applicable	Not applicable	Not applicable	An argument for a new National Strategy for Older People is made to promote a positive ageing experience for all individuals. Also emphasizes the need for partnerships achieved through inter-generational solidarity.
Barrett (2006) Position paper, review of literature	To make a case for the examination of late life frailty as a dynamic social phenomenon	Not Applicable	Not Applicable	Not Applicable	Highlights the role of society in the incidence of frailty, the need to clarify social characteristics which may affect the production and distribution of frailty.
Albrecht and Devlieger (1999) Qualitative Study	To develop an explanation of the disability paradox; quality of life against all odds	Stratified random sample of 153 individuals with disabilities living in the community, sheltered accommodation and their own homes	Semi-structured interviews	Thematic analysis	Quality of life is dependent upon finding a balance between body, mind and spirit in the self and on establishing harmony between one’s social context and the eternal environment.

Appendix 2

Confirmation of Ethical Approval from the Health Service Executive

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Waterford Regional Hospital,
Dunmore Road,
Waterford,
Ireland.

Telephone 051 848000
Fax 051 848572

Ms. Laura Cantwell
School of Health Sciences
Department of Nursing
W.I.T. Cork Road
Waterford

HEALTH SERVICE EXECUTIVE SOUTH EASTERN AREA
REGIONAL RESEARCH ETHICS COMMITTEE

STUDY TITLE "Cognitive and social stimulation for older adults: effect on quality of life"

PROTOCOL NUMBER: N/A

AMENDMENT N/A

NAME AND ADDRESS OF SPONSOR N/A

NAME AND ADDRESS OF PRINCIPAL INVESTIGATOR: Ms. Laura Cantwell
School of Health Sciences, Department of Nursing, W.I.T. Cork Road
Waterford

The committee has reviewed the above study

1. (√)Protocol
2. (N/A)Amendment
3. (√)Patient Information Leaflet
4. (√)Patient Consent Form
5. (√)Recruitment Literature
6. (N/A)Indemnity letter
7. (N/A)Investigator brochure
8. (√)Investigator's CV
9. (N/A)Investigators MDU/Insurance
10. (N/A)Sponsor insurance
11. (N/A)Funding for the study

This study has now been…APPROVED

- (√) Approved
- ( ) Conditionally approved pending :
- ( ) Approval denied

Comments:
Please send copy of completed study to the Research Ethics Office

Date of review: 26th March 2007

Signed

Pp: Chairperson: Dr. Paula Lane, Vice Chairperson Ms. Una O'Brien
Health Service Executive South Eastern Area

Appendix 3

Confirmation of Ethical Approval from Waterford Institute of Technology

Waterford Institute *of* Technology WIT

Institiúid Teicneolaíochta Phort Láirge
Waterford, Ireland
TEL: +353-51-302000
WEB: www.wit.ie
EMAIL: enquiries@wit.ie

10th May, 2007.

Ms. Laura Cantwell,
Postgraduate Student,
Department of Nursing,
WIT.

Dear Laura,

Thank you for bringing your project *'Cognitive and social stimulation for older adults: impact on quality of life'* to the attention of WIT Research Ethics Committee. I am pleased to inform you that we are very satisfied that you have considered all the ethical implications of your research and we will convey to Academic Council that the project has our approval.

We wish you well in the work ahead.

Yours sincerely,

Venie Martin

Dr. Venie Martin,
Chairperson,
Research Ethics Committee.

cc: Dr. Paula Lane

Appendix 4A

Access Request; Letter of Approval to the General Manager

Laura Cantwell,
Personal Address
Phone Number,
E-mail Address,
Date.

Name,
Manager,
Hospital Address.

Dear _____,

I am currently undertaking an MSc research study in association with Waterford Institute of Technology. The aim of the study is to explore the relationship between cognitive and social stimulation and quality of life among older adults in extended care settings. It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents. Findings of the study may be published and used in future studies.

All data obtained from the study will be protected under the Data Protection Act (2003). Anonymity of both the participants and the hospital will be safeguarded as neither will be identified in the study.

Data will be collected by means of face-to-face interviews with residents and staff of the hospital's extended care units who meet the inclusion criteria of the study. I am hoping to conduct these interviews in surroundings that are conducive to the comfort and privacy of the participants. I would be extremely grateful if a suitable room within the hospital could be made available for this purpose.

Ethical approval for the study has been granted by the Regional Research Ethics Committee and is currently being sought by the Ethics Committee of Waterford Institute of Technology. In support of my request for permission please find enclosed a copy of the research proposal to facilitate your informed decision. I will contact you within the next few days to arrange a meeting to discuss this request further.

Thanking you in anticipation,

Yours sincerely,

_____

Laura Cantwell
Postgraduate Student,
Department of Nursing,
Waterford Institute of Technology

Appendix 4B

Access Request; Letter of Approval to the Director of Nursing.

Laura Cantwell,
Personal Address,
Phone Number,
E-mail Address,
Date.

Name,
Director of Nursing,
Hospital Address.

Dear _____,

I am currently undertaking an MSc research study in association with Waterford Institute of Technology. The aim of the study is to explore the relationship between cognitive and social stimulation and quality of life among older adults in extended care settings. It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents. Findings of the study may be published and used in future studies.

All data obtained from the study will be protected under the Data Protection Act (2003). Anonymity of both the participants and the hospital will be safeguarded as neither will be identified in the study.

Data will be collected by means of face-to-face semi-structured interviews with residents and staff of the hospital's extended care units who meet the inclusion criteria of the study. I am hoping to conduct these interviews in surroundings conducive to the comfort and privacy of the participants. I would be extremely grateful if a suitable room within the hospital could be made available for this purpose.

Ethical approval for the study is currently being sought from the Ethics Committee of Waterford Institute of Technology and by the Regional Research Ethics Committee. In support of my request for permission please find enclosed a copy of the research proposal to facilitate your informed decision. I will contact you within the next few days to arrange a meeting to discuss this request further.

Thanking you in anticipation,
Yours sincerely,

_____
Laura Cantwell
MSc. Student.
Waterford Institute of Technology

Appendix 4C

Access Request; Letter of Approval to Clinical Nurse Managers

Laura Cantwell,
Personal Address,
Home Number,
E-mail Address,
Date.

Name,
Clinical Nurse Manager,
Hospital Address.

Dear _____,

I am currently undertaking an MSc research study in association with Waterford Institute of Technology. The aim of the study is to explore the relationship between cognitive and social stimulation and quality of life among older adults in extended care settings. It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents. Findings of the study may be published and used in future studies.

Prior permission for the study has been granted by Ms ****** * ****. Ethical approval has been granted by the Regional Research Ethics Committee and is currently being sought from the Ethics Committee of Waterford Institute of Technology. I would appreciate access to nursing and care staff and residents in your unit and would be extremely grateful for your help on enlisting those who are willing and eligible to participate in this study. I have enclosed a copy of the inclusion and exclusion criteria to assist you with this task. I propose to gather data by means semi–structured face-to-face interviews and focus groups; this method will assist in the accurate portrayal of participant's views and experiences.

All data obtained from the study will be protected under the Data Protection Act (2003). Anonymity of both the participants and the hospital will be safeguarded, as neither will be identified in the study. Individual informed consent will be sought from each participant. I can assure you that disruption to your unit and staff will be kept to a minimum. I will contact you within the next few days to arrange a meeting to discuss this request further.

Thanking you in anticipation,
Yours sincerely,

_____
Laura Cantwell
MSc. Student,
Waterford Institute of Technology

Appendix 5A

Nurses' Information Leaflet

Name of Researcher
Laura Cantwell, MSc Student, Department of Nursing, School of Health Sciences, Waterford Institute of Technology.

Title of Study
Cognitive and social stimulation for older adults: relationship on quality of life.

Introduction
You are being asked to take part in a research study. Before you decide, it is essential that you understand why the research is being done and what it will involve. Please take the time to read the following carefully, you may discuss it with others if you wish. If you have any queries please do not hesitate to contact me and I will be happy to answer your questions and provide further information.

What is the purpose of this study?
The main objective of this research is to explore the relationship between stimulating activities (such as music sessions and reminiscence therapy) and the quality of life of older adults in extended care settings. The findings of this study may have implications for policymakers and healthcare professionals such as nurses in their approach to care. It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents.

What is involved?
If you decide to take part you will first be asked to sign a consent form and return it to Laura Cantwell, the lead researcher. Your participation in this study will be voluntary therefore you are free to withdraw at any time. A decision to withdraw at any time, or a decision not to take part, will not affect your position in any way. Those aged 65 and over, and living in the residence for a period of 6 months or more are eligible to take part in this study. Care staff members working in extended care units for a period of 6 months or more are also eligible.

It is proposed that information regarding your views and experiences will be gathered through focus groups. Focus groups are a form of group interview where participants as asked to discuss a chosen topic under the guidance of a researcher/moderator. A topic guide will be provided and other issues relevant to the study may be discussed. The focus group will last approximately 60-90 minutes. Discussions will be audio tape-recorded to ensure your views and experiences are accurately portrayed in the study findings. An assistant will take notes during the session to ensure the accuracy and objectivity of my reporting. Following analysis the tapes and transcripts will be securely stored for a period no less than 5 years. You will be given the opportunity to receive a summary of the results on completion of the study.

Although there are no known risks anticipated as a result of taking part in this study, participants may feel uncomfortable sharing information whilst being audio taped.

The focus groups will be conducted in an informal yet professional manner and every effort will be made to ensure your comfort needs are met. Any information gathered will be coded and kept strictly confidential so that you cannot be recognised from it. All documents and computerized information will be securely stored, accessed only by the researchers.

In the unlikely event of the disclosure of information that may pose a serious threat to the well-being of participants or others, the researcher is bound by law to disclose such information to the appropriate authority.

A direct benefit to participants taking part in this study cannot be assured however; findings from this study may lead to improvements in practice and contribute to improving the quality of life of older people.

Once again, your participation in this study will be voluntary therefore you may quit at any time. If you decide not to participate, or if you withdraw from the study, you will not be penalised in any way.

Although it is unlikely, the researcher may stop your participation in the study at any time without your consent.

The Regional Health Executive and Waterford Institute of Technology Ethics Committees have approved this research along with the hospital's Director of Nursing. An extremely experienced and qualified researcher will also oversee this research. The results may be published in a health care journal and findings may be used in future studies.

If you would like any further information about this study and what is involved please contact Laura Cantwell on telephone *** *******. The researcher will be in contact within the next week once you have expressed interest in partaking in the study. You will then be asked to read and sign an informed consent form. Thank you for your time and co-operation.

Appendix 5B

Residents' Information Leaflet

Name of Researcher

Laura Cantwell, MSc Student, Department of Nursing, School of Health Sciences, Waterford Institute of Technology.

Title of Study

Cognitive and social stimulation for older adults: relationship on quality of life**.**

Introduction

You are being asked to take part in a research study. Before you decide, it is essential that you understand why the research is being done and what it will involve. Please take the time to read the following carefully, you may discuss it with others if you wish. If you have any queries please do not hesitate to contact me and I will be happy to answer your questions and provide further information.

What is the purpose of this study?

The main objective of this research is to explore the relationship between stimulating activities (such as music sessions and reminiscence therapy) and the quality of life of older adults in extended care settings. The findings of this study may have implications for policymakers and healthcare

professionals such as nurses in their approach to care. It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents.

What is involved?

If you decide to take part you will first be asked to sign a consent form and return it to Laura Cantwell, the lead researcher. Your participation in this study will be voluntary therefore you are free to withdraw at any time. A decision to withdraw at any time, or a decision not to take part, will not affect your position in any way. Those aged 65 and over, and living in the residence for a period of 6 months or more are eligible to take part in this study. Care staff members working in extended care units for a period of 6 months or more are also eligible.

It is proposed that information regarding your views and experiences will be gathered through interviews; opportunities for you to articulate your views or recommendations will be encouraged. Interviews will last no longer than 60 minutes approximately. All interviews will be audio tape-recorded to ensure your views and experiences are accurately portrayed in the study findings. Following investigation the tapes will be securely

stored for a period not less than 3 years. You will be given the opportunity to receive a summary of the results on completion of the study.

Although there are no known risks anticipated as a result of taking part in this study, participants may feel uncomfortable sharing information whilst being audio taped. The interviews will be conducted in an informal yet professional manner and every effort will be made to ensure your comfort needs are met. Any information gathered will be coded and kept strictly confidential so that you cannot be recognised from it. All documents and computerized information will be securely stored, accessed only by the researchers.

In the unlikely event of the disclosure of information that may pose a serious threat to the well-being of participants or others, the researcher is bound by law to disclose such information to the appropriate authority.

A direct benefit to participants taking part in this study cannot be assured however; findings from this study may lead to improvements in practice and contribute to improving the quality of life of older people.

Once again, your participation in this study will be voluntary therefore you may quit at any time. If

you decide not to participate, or if you withdraw from the study, you will not be penalised in any way.

Although it is unlikely, the researcher may stop your participation in the study at any time without your consent.

The Regional Health Executive and Waterford Institute of Technology Ethics Committees have approved this research along with the hospital's Director of Nursing. An extremely experienced and qualified researcher will also oversee this research. The results may be published in a health care journal and findings may be used in future studies.

If you would like any further information about this study and what is involved please contact Laura Cantwell on telephone *** *******. The researcher will be in contact within the next week once you have expressed interest in partaking in the study. You will then be asked to read and sign an informed consent form**.** Thank you for your time and co-operation.

Appendix 5C

Healthcare Assistants' Information Leaflet

Name of Researcher
Laura Cantwell, MSc Student, Department of Nursing, School of Health Sciences, Waterford Institute of Technology.

Title of Study
Cognitive and social stimulation among older adults: relationship on quality of life.

Introduction
You are being asked to take part in a research study. Before you decide, it is essential that you understand why the research is being done and what it will involve. Please take the time to read the following carefully, you may discuss it with others if you wish. If you have any queries please do not hesitate to contact me and I will be happy to answer your questions and provide further information.

What is the purpose of this study?
The main objective of this research is to explore the relationship between stimulating activities (such as music sessions and reminiscence therapy) and the quality of life of older adults in extended care settings. The findings of this study may have implications for policymakers and healthcare professionals such as nurses in their approach to care. It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents.

What is involved?
If you decide to take part you will first be asked to sign a consent form and return it to Laura Cantwell, the lead researcher. Your participation in this study will be voluntary therefore you are free to withdraw at any time. A decision to withdraw at any time, or a decision not to take part, will not affect your position in any way. Those aged 65 and over, and living in the residence for a period of 6 months or more are eligible to take part in this study. Care staff members working in extended care units for a period of 6 months are also eligible.

It is proposed that information regarding your views and experiences will be gathered through interviews; opportunities for you to articulate your views or recommendations will be encouraged. Interviews will last no longer than 60 minutes approximately. All interviews will be audio tape-recorded to ensure your views and experiences are accurately portrayed in the study findings. Following investigation the tapes will be securely stored for a period not less than 5 years. You will be given the opportunity to receive a summary of the results on completion of the study.

Although there are no known risks anticipated as a result of taking part in this study, participants may feel uncomfortable sharing information whilst being audio taped. The interviews will be conducted in an informal yet professional manner and every effort will be made to ensure your comfort needs are met. Any information gathered will be coded and kept strictly confidential so that you cannot be recognised from it.

All documents and computerized information will be securely stored, accessed only by the researchers.

In the unlikely event of the disclosure of information that may pose a serious threat to the well-being of participants or others, the researcher is bound by law to disclose such information to the appropriate authority.

A direct benefit to participants taking part in this study cannot be assured however; findings from this study may lead to improvements in practice and contribute to improving the quality of life of older people.

Once again, your participation in this study will be voluntary therefore you may quit at any time. If you decide not to participate, or if you withdraw from the study, you will not be penalised in any way.

Although it is unlikely, the researcher may stop your participation in the study at any time without your consent.

The Regional Health Executive and Waterford Institute of Technology Ethics Committees will approve this research along with the hospital's Director of Nursing. An extremely experienced and qualified researcher will also oversee this research. The results may be published in a health care journal and findings may be used in future studies.

If you would like any further information about this study and what is involved please contact Laura Cantwell on telephone *** *******. The researcher will be in contact within the next week once you have expressed interest in partaking in the study. You will then be asked to read and sign an informed consent form. Thank you for your time and co-operation.

Appendix 6A

Letter of Invitation to Potential Participants from the Staff Population

Laura Cantwell,
Personal Address,
Phone Number,
E-mail Address,
Date.

Dear Participant,

I am currently undertaking a research study in association with Waterford Institute of Technology as part of the requirements for a Research Masters. The aim of the study is to explore the relationship of cognitive and social stimulation on the quality of life of older adults in extended care settings.

It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents. Findings of the study may be published and used in future studies. All information collected will be securely stored with limited access to only the research team. Your confidentiality will be respected as neither you nor the hospital will be identified in the study. Participation in this study is entirely voluntary.

Please find attached an information leaflet regarding the proposed study. Prior permission has been sought from the Director of Nursing. Ethical approval for the study has been granted by the Ethics Committee of Waterford Institute of Technology and by the Regional Research Ethics Committee.

If you are interested in taking part in the study please complete the attached acceptance form and place it in the envelope labelled “acceptance forms-research study” located at the nurses’ station on the ward. If you have any further queries about this study and please do not hesitate to contact me on the above phone number.

Thanking you in anticipation,
Yours sincerely,

_____

Laura Cantwell
MSc. Student.
Waterford Institute of Technology

Appendix 6B

Letter of Invitation to Potential Participants from the Resident Population

Laura Cantwell,
Personal Address,
Phone Number,
E-mail Address,
Date.

To whom it may concern,

I am currently undertaking a research study in association with Waterford Institute of Technology as part of the requirements for a Research Masters. The aim of the study is to explore the impact of cognitive and social stimulation on the quality of life of older adults in extended care settings.

It is anticipated that this research will generate valuable information which may contribute to improving practice guidelines in the interests of those currently in receipt of extended care and for future residents. Findings of the study may be published and used in future studies. All information collected will be securely stored, with access limited to the research team. Your confidentiality will be respected as neither you nor the hospital will be identified in the study. Participation in this study is entirely voluntary.

Please find attached an information leaflet regarding the proposed study. Prior permission has been sought from the Director of Nursing. Ethical approval for the study has been granted by the Regional Research Ethics Committee Ethics and by the Ethics Committee of Waterford Institute of Technology.

If you are interested in taking part in this study please complete the attached acceptance form attached and place it in the large envelope labelled "Acceptance forms-research study" located at the nurses' station. If you have any further queries about this study and please do not hesitate to contact me on the above phone number.

Thanking you in anticipation,
Yours sincerely,

_____

Laura Cantwell
MSc. Student.
Waterford Institute of Technology

Appendix 7

Eligibility Criteria

For the purpose of meeting the studies objectives the following criteria will apply:

- Residents must be aged 65 and over
- Residents must be in a state in reasonable mental health in order to understand the full implications of involvement in the study and to provide legitimate informed consent. This will be assessed using the abbreviated mental test score.
- Residents must be in receipt of extended care for a period of 6 months or more.
- Staff must be working in the extended care units for a period of 6 months or more.
- Staff must have some involvement in the activities provided (participant or observer).
- Healthcare assistants must process the appropriate FETAC level 5 qualifications.
- Both men and women are required for equality of sampling.

Exclusion criteria include:

- Those with cognitive impairment to the degree that it would render them unable to provide valid consent to participate.
- Those in receipt of respite care, rehabilitation or any form of intermittent care

I would greatly appreciate access to a list of staff nurses', health care assistants and residents who may be eligible to participate. This will facilitate the process of random sampling i.e. names will be randomly selected from this list and invited to participate by means of letter and information leaflet.

I would also appreciate some demographic information about the residents such as age, educational level, marital status, occupational grouping and place of dwelling prior to residing in ** ******** Hospital. This information will be required once the resident has expressed a desire to partake.

All information obtained will securely stored in accordance with the Data Protection Act 2003, with limited access to the research team only. In addition, all information gathered will be coded and kept strictly confidential so that neither the participants nor the hospital can be identified.

Thank you most sincerely for your time.

Appendix 8A

Semi-structured Guide for Resident Interviews

Domain	*Cue Questions/Prompts*
Environment	Do you like living here? If so, what aspects of life here do you most enjoy? Is there anything you don't like? How happy or unhappy were you with the decision to come here? Outlook*, acceptance, ability to adapt* Do you feel this is your home? Homely environment? Security?* Feel safe?* Sense of belonging?* Space for personal belongings? Photos etc. Relationships with others within the facility?
Continuity of self	Do you feel the facilities here to help you continue to live your life as when you lived in your own home? Can you think of something from your past that was important to you, can you access that here? Do you miss anything from your home? Are you near your home here? Did you live with anyone? (Companionship) Did you have much opportunity to see people when lived at home? Do you see more or less people now that you live here?* Opportunities for social activity?* Did you have any hobbies in the past? What did you do to pass the time when you were at home? Can you compare your life at home to your life here now? Social life, hobbies etc. Links to past life* Maintaining one's identity*, continuity of self, space for personal effects (environment)* Links to community/past life*
Connectedness to family/ Community	Do you get outdoors as much as you want? Do you ever go out on trips/visits? Where? How often? If yes, who takes you? Family, staff, friend, volunteers? Do you keep in contact with your family and friends? (Continuity of supportive relationships*) Accessibility of communication with family* How do you keep in touch? (Visit, telephone, written correspondence). Explore continuity of relationships with friends,

	family neighbours* Do you feel part of the local community outside of the unit? Do you ever feel isolated here? Do you feel you are up to date with local news (and maybe political issues)? How do you feel about visitors or members of the local community joining in the activities here? (School children, pets etc.) Do you have many visitors? (Examples) Do you see them often? Do you have visitors from anyone else e.g. neighbours, voluntary groups? Do you have much opportunity for privacy or quiet time if you so wish?
Social Activity*	Do you enjoy the company of other people Do you have the opportunity to meet and chat with other people living here? (Mealtimes, group sessions) Did you know any of the other patients before moving here? Have you made friends here? Think of a supportive relationship that you have? Who's this with? (i.e. nurse, friend, relative, carer etc.)
Therapeutic/supportive Relationships*	Have you mage any friends since moving here? Companions* Type of relationships formed?* Social interaction with whom? Would you talk with the staff, fellow residents?* Explore continuity of relationships with friends, family neighbours
Activities	Do you look forward to the activity days? Do you get involved in the activities provided? How do you enjoy the activities you have been taking part in here? If so, which do you most enjoy? Do you like (solitary) activity alone as well as group activities? Preference? Feelings toward either? Examples? If preference is group activity-Why?* Daily past times? (Reading, TV, videos, music, exercise, old movies/songs) Has your life here changed since being involved in activities? Confidence in your abilities? How do you feel on the days there are no activities? Boredom? Contentment? Are there any additional activities you would like to be available to you here? How did you spend your time when you were at home? Opportunities for continuity of self*
Cognitive well-being	Do you feel you have the opportunities to learn new

	thing here or to build on existing skills? If so what? Have you taken up any new hobbies since moving here? Or is there anything that you are particularly interested in and would like to learn more about or be more in touch with? Do you ever feel bored/sad here? Any unmet needs? Outlook & coping-Fears, anxieties, hopes? Sense of control-autonomy & independence (continuity of self)
Psychological well being	Do you ever feel bored or sad here? Coping* If so, any suggestions of how to relieve that boredom? Why might you feel sad? Religion? (Reminiscence, support systems) Outlook & coping-Fears, anxieties, hopes? Sense of control-autonomy & independence (continuity of self)
Health, functional ability	How do you perceive your overall health and ability to carry out daily tasks? Independence/ dependence/ autonomy Current level of independence compared to prior to moving here?
Autonomy/ Involvement in panning of care	Do you feel you have a say in the planning of your care?* Can choice in how you spend the day?* Are your wishes facilitated?* Do you feel you are dependent on the staff here? How do you feel about being cared for? Are you happy for people to do things for you? Would you like to/ do you feel you could do more for yourself? Are you involved in the planning of activities? If yes, how is your opinion reflected in the activity schedule? If no, would you like it to be? Do you know if there is a residents' committee here?
Quality of Life	How you perceive your overall quality of Subjective, explore outlook in determining quality of life* Is there anything that could be done to improve your overall quality of life? How has your quality of life changed since moving

	here? Has it deteriorated or improved in any way? Any recommendations to improve your mental health and social well-being?
General	Are there any further comments you wish to make about the quality of your life with regards to; How you pass the time, involvement in decision-making, sense of personal control* Overall level satisfaction with current circumstances* Opportunities to engage with other people

*Additional cues for exploration following comparative analysis and the progression of the data collection phase

Appendix 8B

Semi-structured Guide for Healthcare Assistant Interviews

Domain	*Cue Questions/Prompts*
Environment/ Facilities/ Social environment	Are communal facilities available for residents such as; television, newspapers (large font) video/DVD, library/ book lending, games, music, musical instruments, public telephone, family/visiting room? Do you think residents have access to things they might value as important to their psychological and social well being? Opportunities to continue past interests?* Continuity of self, maintaining personal identity* Do you think the environment conducive to residents' needs? Are there outdoor/garden facilities here? If so, can residents access the garden? Is there any links to the outside community? Do you think there is a community within the community within the hospital? Social relations among residents? Social relations among staff and residents?*
Connectedness to family/ community/social networks	Do you think residents have opportunities to engage with other people living here? If so, do you think they enjoy this interaction? Do staff engage with residents?* Do you see any relationships formed among residents? Do they interact with each other?* Factors contributing to or inhibiting such interaction?* Can you think of any supportive relationships that residents may be a part of? In your opinion, who is think type of relationship formed with? Do you think residents have opportunities to engage with the local community outside of the unit? How do you feel about visitors or members of the local community joining in the activities here? How are visiting hours organised? How do you think the involvement of visitors, or members of the local community in activities effects the residents?
Activities	What kinds of activities are available to residents living here? How often are these provided? Is this facility involved in any programmes or activities? (Such as Sonas, ACT, Art, Dance, Bingo,

	Gardening, Complementary Therapies, visits from school children?) Do you feel the residents look forward to the activity days? Do you think residents enjoy the activities available here? If so, please identify the relevant activity/activities? Do you feel activities are a topic of conversation among residents and between residents and staff? How do you think activities benefit the residents? Group activities/solitary activities? If so, how? If you feel activities are of no benefit, please explain? Do you think the available activities meet the residents' needs?* Are residents' views reflected in the activities schedule? Do you see any difference in the residents since becoming involved in new or extended activities? How do you perceive the residents on days there are no set activities? Do you think activities impact on residents' mental health and/or social well-being? If so, how? Can you suggest any other activities not yet available here that might appeal to the residents? In your opinion, whose responsibility is it to carry out activities with residents and facilitate a stimulating environment What do you feel stimulates the residents on the days there are no activities* Sources of meaningful activity for the residents to promote their psychosocial well-being?*
Health, functional Ability, Person-centredness*	How do you perceive the overall health and Functional ability of residents impacts on involvement in meaningful activity? Do you think residents varying needs are catered for? How?*
Psychological well-being Mental health	Do you ever observe any indications that residents are bored? Besides planned/organised activities what keeps residents cognitively, physically and socially stimulated/active? Do you think spirituality or religion is important to residents? Do you thing spiritual needs are met?* In your opinion, do the residents have any unmet needs? Are there opportunities to learn new things or to build

	on existing skills? Explore variety and diversity within the facility*
Continuity of self	In your opinion, are there opportunities for residents to continue to take part in hobbies or pastimes that they enjoyed before living in extended care? Is there opportunity for residents to continue personal routine?* Choice for residents in how they spend their time?* Opportunity for personal effects, maintenance of personal identity* How are personal needs/interests determined?*
Autonomy? Involvement in planning of care **Philosophy of care**	What is the general ethos of care i.e. do Residents' exercise choice in their activities of daily living? Perceived needs of residents?* How needs are determined?* Routine of care, staffing, flexibility for residents to be involved in decision making?* Is personal autonomy and independence encouraged?* Are residents involved in the planning of activities? Are their views reflected in the activity schedule? Opportunities to maintain hobbies/pastimes from life before living in extended care? Is there a residents' committee in your facility
Quality of life	Do you feel that social activity or involvement in meaningful impact on the overall quality of life of the residents? If so, how? If not, why? Do you think stimulating activities and social interactions impact on residents' quality of life? Is so how? can you identify any further issues that you believe to be important to residents psychosocial well-being and quality of life
General	Opportunities for further comments

*Additional cues for exploration following comparative analysis and the progression of the data collection phase

Appendix 9

Topic Guide for Focus Group Discussions

- **Hospital environment and surrounding community**
  - Facilities
  - Impact of the environment on well being
  - Impact of the environment on social relationships
  - Links to the community

- **Social Networks**
  - Companionship
  - Opportunities to engage with other people
  - Community within the hospital
  - Link to family and friends
  - Visitors
  - Perceived impact of social relationships on the quality of life of residents
  - Supportive relationships

- **Activities**
  - Available activities
  - Response to activities
  - Willingness to participate
  - Planning of activities
  - Opportunities to maintain hobbies/pastimes from life before living in extended care
  - Besides organised activities what keeps residents cognitively, physically and socially stimulated/active?
  - Responsibility to facilitate activity/stimulation

- **Quality of life**
  - Relationship between cognitive and social stimulation and quality of life
  - Suggestions for ways to maintain or improve quality of life.

Suggestions of further relevant topics for discussion are welcomed.
If you have any queries regarding this study please do not hesitate to contact me;
Laura Cantwell
Personal e-mail
*** *******

Appendix 10

Focus Group Discussion Schedule

Focus Group
Date
Time allocated: 70 minutes max

Welcome

- General introduction
- Establish rapport
- Participant introduction
- Ensure all participants have read and fully understand the information sheet
- Ensure informed consent has been obtained
- Give brief outline of study, including;
    - Methodology
    - Structure of data collection
    - Potential implication of findings
    - Ethical considerations
- Remind group that participation is voluntary and individuals are free to withdraw at any time
- Emphasise the nature of focus groups and intrinsic nature of confidentiality
- Inform the group of the role of facilitator
- Inform that the interview is being recording and ensure equipment is working
- Begin recording and give first question/probe to start the discussion
- Summarise the key points of the discussion and provide opportunity for confirmation and feedback
- Give information regarding gaining access to the transcripts
- Thank all for attending
- Refreshments

Appendix 11

Focus Group Welcome Talk

Thank you most sincerely for taking the time to attend this focus group session today. As you are aware, I am undertaking this research in association with Waterford Institute of Technology as part of the requirements for a Research Masters.

The purpose of this session is to gain an insight into nurses' perceptions of the impact of stimulating activities on the quality of life of older people in extended care settings. As you work with older people, interacting with them on a regular basis, your attitudes and perceptions towards this concept are vital in identifying and subsequently meeting the needs of older people. There are no right or wrong answers, I invite you to speak freely, this is a discussion, not a question and answers session. I understand speaking out in a group situation may be somewhat daunting, but please do not worry what others think, each individual opinion is valued and very much appreciated. I remind you that you are free to withdraw from the discussion at any time.

For the purpose of this session I will adopt the role of the facilitator, guiding the session, but not participating in it. My colleague will make notes during the session to ensure accuracy and objectivity of my reporting, she will not take part in the discussion.

The discussion will be audio taped, this is once again to ensure accuracy and also, to aid analysis. In accordance with the Data Protection Act (2003) the tapes and transcripts will be securely stored for a period of 5 years and then destroyed. All data will be dealt with in a professional manner, with confidentiality being foremost. Any data, which makes reference to a specific individual or place, will be coded so that it is not identifiable from the study. You will be given the opportunity to review and the transcripts of your participation in the discussion; this will also be an opportunity to verify any aspects of the discussion. I trust you received the topic guide outlining areas for discussion; having reflected on these issues I encourage you to speak open and honestly about your views and experiences. I also invite you to discuss any issues not outlined, that you feel are relevant to the concept being studied. Throughout the discussion I will jot down the key points mentioned, which I will summarise at the end of the discussion. Thank you.

Any questions?

Appendix12

Resident Informed Consent Form

Title of Study

Cognitive and social stimulation for older adults: relationship on quality of life

Name of Researcher

Laura Cantwell, MSc Student, Department of Nursing, School of Health Sciences, Waterford Institute of Technology.

Thank you for agreeing to participate in this study, the purpose of which is to explore the relationship between stimulating activities (such as music sessions and reminiscence therapy) and the quality of life of older adults in extended care settings. It is intended that information regarding your views and experiences will be gathered. The researcher will conduct interviews to gather information regarding your views and experiences. Each interview will last no longer than 60 minutes approximately; opportunities for you to articulate your views or recommendations will be encouraged. All interviews will be audio tape-recorded to ensure accuracy. Any information gathered will be securely stored, coded and kept strictly confidential so that you cannot be recognised from it. Following analysis the tapes will be securely stored for a period not less than 3 years. The research findings will be made available to participants, upon

request. You will be given the opportunity to receive a summary of the results on completion of the study.

In the unlikely event of the disclosure of information that may pose a serious threat to the well-being of participants or others, the researcher is bound by law to disclose such information to the appropriate authority.

This research will be approved by the relevant ethics committees and overseen by an experienced and qualified researcher. There are no known risks anticipated as a result of partaking in this study. The results may be published in a health care journal and findings may be used in future studies.

Participation in this study is voluntary and you are free to withdraw your consent at any stage in the course of the study.

This is to certify that I freely and voluntarily agree to participate in the above study. I have been given the opportunity to ask questions and all questions have been answered to my satisfaction. I hold a copy of this agreement.

_____	_____
Name of Participant	Name of Witness
_____	_____
Signature	Signature
_____	_____
Date	Date

Appendix 13

Staff Informed Consent Form

Title of Study
Cognitive and social stimulation for older adults: relationship on quality of life

Name of Researcher
Laura Cantwell, MSc Student, Department of Nursing, School of Health Sciences, Waterford Institute of Technology.

Thank you for agreeing to participate in this study, the purpose of which is to explore the relationship between stimulating activities (such as music sessions and reminiscence therapy) and the quality of life of older adults in extended care settings. It is intended that information regarding your views and experiences will be gathered. The researcher will conduct interviews to gather information regarding your views and experiences. Each interview will last no longer than 60 minutes approximately; opportunities for you to articulate your views or recommendations will be encouraged. All interviews will be audio tape-recorded to ensure accuracy. Any information gathered will be securely stored, coded and kept strictly confidential so that you cannot be recognised from it. Following analysis the tapes will be securely stored for a period not less than 3 years. The research findings will be made available to participants, upon request. You will be given the opportunity to receive a summary of the results on completion of the study.

In the unlikely event of the disclosure of information that may pose a serious threat to the well-being of participants or others, the researcher is bound by law to disclose such information to the appropriate authority.

This research will be approved by the relevant ethics committees and overseen by an experienced and qualified researcher. There are no known risks anticipated as a result of partaking in this study. The results may be published in a health care journal and findings may be used in future studies.

Participation in this study is voluntary and you are free to withdraw your consent at any stage in the course of the study.

This is to certify that I freely and voluntarily agree to participate in the above study. I have been given the opportunity to ask questions and all questions have been answered to my satisfaction. I hold a copy of this agreement.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Witness	Signature	Date

Appendix 14

Sample of Transcript as Coded by Inter-rater

Influence of management

NRB3: well again, I'll just say I think you know for a nurse to sit down with two or three patients and have a discussion about whatever; family, their worries, you know their childhood, whatever is a good thing, but it's not encouraged by management. Management feel we are dosing!

I: right

NRB1: yeah

Task Orientated

NRB3: and you know, why, have you nothing to be doing, physically sort of, task you know, we should get way from this task orientated way of nursing, this is

Patients Home

their home and you know, they don't want to be doing thing all day, they, most of our patients, I think we have 3 out of 20 that are under the age of 80, and if they were at home they'd be probably snoozing in the afternoon or you know whatever

NRB2: yea they tire easily you know they tire

NRB3: you know they don't have to be kept stimulated all day, physically!

I: and do you all agree with that

Task Orientated

NRB1: yeah, I think so, like I find too like a lot of it is task orientated and I think like the activities, the 12 activities of daily living, and the working and playing one and expressing sexuality and all that kind of stuff is kind of hidden, so we don't do anything with it, it's kind of eating and drinking and washing and dressing and all that is all done but it's kind of left to last, the working and playing one

Task Orientated
Physical Care Predominates

Emotional/Psychological care neglected

NRB3: physical, physical care seems to be what's priority, and the emotional and psychological and rest is neglected a little bit

I: and why do you think that is?

NRB3: it's just old fashioned way of thinking, it'd general nursing attitude I worked in psychiatry for years

Appendix 15

Example of Open Coding Applied to a Focus Group Transcript

Value of Interpersonal communication Acknowledging residents' psychological needs Lack of management support Philosophy of care/ Task orientated nature of care Desire to change Hospital V Home Determining residents' needs	NRB3: … I think you know for a nurse to sit down with two or three patients and have a discussion about whatever; family, their worries, you know their childhood, whatever is a good thing, but it's not encouraged by management. Management feel we are dosing! NRB1: yeah NRB3: and you know, why, have you nothing to be doing, physically sort of, task you know, we should get way from this task orientated way of nursing, this is their home and you know, they don't want to be doing thing all day, they, most of our patients, I think we have 3 out of 20 that are under the age of 80, and if they were at home they'd be probably snoozing in the afternoon or you know whatever NRB2: yea they tire easily you know they tire NRB3: you know they don't have to be kept stimulated all day, physically! I: and do you all agree with that? NRB1: yeah, I think so, like I find too like a lot of it is task orientated and I think like the activities, the 12 activities of daily living, and the working and playing one and expressing sexuality and all that kind of stuff is kind of hidden, so we don't do anything with it, it's kind of eating and drinking and washing and dressing and all that is all done but it's kind of left to last, the working and playing one NRB3: physical, physical care seems to be what's priority, and the emotional and psychological and rest is neglected a little bit I: and why do you think that is? NRB3: it's just old fashioned way of thinking, its general nursing attitude
Determining residents' needs	
Task orientated nature of care Theory/Practice gap Holistic needs not being met	
Physical care is primary goal Holistic needs not being met	
Philosophy of Care Staff characteristics philosophy of care & priorities	

Appendix 16

Abbreviated mental test score (AMTS)

Question	***Score***
What is your age?	
What is the time to the nearest hour?	
Give the patient an address, and ask him or her to repeat it at the end of the test	
What is the year?	
What is the name of the hospital or number of the residence where the patient is situated?	
Can the patient recognize two persons (the doctor, nurse, home help, etc.)?	
What is your date of birth?	
In which year was the Easter Rising (adjust this for a world event the patient would have known during childhood)?	
What is the name of the present monarch (head of state, etc.)?	
Count backwards from 20 down to 1.	

(Hodkinson, 1972)

Appendix 17: Evolution of Concepts and Categories through Coding Procedures

Open Codes	Axial codes-concepts	Selective codes-categories
Staff as a source of stimulation, facilitating meaningful social interaction, "need something to look forward to", "it's a dull day", motivates residents, social benefits, relief of boredom, group dynamics, medium for conversation	means of stimulation, source of anticipation, autonomy and independence, meaningful interaction, feel good factor, the value of social interaction, psychosocial benefits	**The Reality of Activity in Care; the Inadvertent Psychosocial Benefits**
Need for social support, desire for meaningful interaction, interpersonal communication, "knowing your patient", diversity of needs, assuming needs, loneliness, need for consistent interventions, therapeutic relationship, impact of the social environment, interventions conducive to needs	supportive relationships, therapeutic relationship, role of family, caregivers as a source of stimulation, appropriate interventions for heterogeneous needs, personal identity and continuity of self, the value of reminiscing, positive adaptation, ascertaining needs, advocating for residents needs	**The Value of Social Interaction**
Acknowledging varying resident profiles, functional ability determines level of interaction, need for autonomy and choice, unable to voice needs, unfilled needs, determining needs, advocating for residents needs, beyond physical needs, power of non-verbal communication, value of interventions when matched to patient interests, activities degrading	Standardised rather than individualised care, appropriate interventions for heterogeneous needs, disparity of resources, degrading interventions, the socialisation of older people, promoting poor self-esteem, endorsing stereotypes, limiting individuals' potential, person-centred individualized care, challenges of complex needs, focus on physical needs, task orientated care, failing to nurture individuals' potential	**Acknowledging Heterogeneity; the Need for Individualised Care**
Routine dominates, time constraints, the merits of a multidisciplinary approach influence of management,	outlook among residents, continuity of self, positive adaptation, personal identity, internal locus of control, faith and spirituality, personal intuition, beyond formal duties, task orientated care, resource rather than needs based care, routinized rather than individualised care, knowledge and education, socialisation of older people, hospital versus home, practice developments; barriers to integration into practice	**Determinants of Residents' Psychosocial Well-being;** **-Residents' Internal Locus of Control** **-Caregivers' Characteristics** **-Philosophy of Care**

Appendix 18A

Application of the Paradigm Model (Corbin and Strauss, 2008)

Conditions	Standardised activity sessions incapable of meeting the heterogeneous needs of residents with varying levels of functional and cognitive ability. Example; individual participating in activity below one's personal capacity
↓	
Action/Interactions	Inappropriate intervention endorses stereotypes as the individual interprets of level of the intervention as a reflection of one's personal capabilities, thus adapts to conform to an enforced social role whereby reduced cognitive and functional ability is expected.
↓	
Consequences	Lack of proactive interventions means that the individuals' potential is neither nourished nor fulfilled to the extent that the activity has a negative effect on one's self-esteem and personal identity.

Appendix 18B

Application of the Paradigm Model (Corbin and Strauss, 2008)

Conditions	Individual is presented with a significant life event which alters the subsequent chapters of their life Example; loss of spouse
↓	
Action/Interactions	A positive outlook coupled with faith allow the individual to deal with loss through positively adapting to and dealing with the implications of the loss while at the same time reflecting on positive life events inclusive of the positive aspects of one's present circumstances
↓	
Consequences	Negative connotations on the individual's psychological well-being are significantly alleviated.

Appendix 18C

Application of the Paradigm Model (Corbin and Strauss, 2008)

Conditions	The transition to extended care may result in significant loses, threatened personal identify thus, poor psychosocial well-being.
↓	
Action/Interactions	Verbal and non-verbal communication is utilized to stimulate psychological well-being and promte optimum quality of life
↓	
Consequences	Therapeutic relationship is formed through frequent social interactions and the sharing of knowledge where reasonable. The meaningful social interaction promotes positive psychosocial well-being while at the same time, permits accurate assessment of the resident thus facilities the construction of an individualised plan of care that is conducive to individuals' holistic needs

Appendix 19a: Summary of Grounded Theory Iterative Approach-Conceptual Phase

Stage	Action	Procedural Outcomes	Learning Outcomes
Consideration of Methodology*	-Review of possible methodological approaches in isolation and in triangulation -Review of subsequent research methods -Advice from experienced researchers sought -Considered in relation to chosen phenomenon upon preliminary review of literature	-Appropriate methodology decided in light of results of preliminary review and communication with experienced researchers -Methodological fit achieved	-Appreciation of the ontology an epistemology of research methods heightened.
Preliminary literature review*	Concepts pertaining to rationale for research explored	Initial scope of research ascertained	-Insight into the phenomenon attained -Knowledge deficits acknowledged and built upon
Ethical approval sought	Case presentation to appropriate ethic's boards	Ethical approval granted	-Heightened awareness of the potential vulnerability of sample
Pilot phase	Data collection methods piloted with relevant pilot	-Scope of interviews identified -Sample frame revised	-Self critique facilitated improvement of interview skills -Development of organisational and interpersonal communication skills

*Occurred simultaneously and recursively

Appendix 19b: Summary of Grounded Theory Iterative Approach- Empirical Phase

Stage	Action	Procedural Outcome	Learning Outcome
Selection of Study Site	Access negotiated to extended care settings	-Access granted -Rapour established with "gatekeepers"	-Insight into the operation of services for older people achieved -Negotiation skills enhanced
Sampling	-initial purposive sampling -theoretical sampling -Iterative process	-Appropriate sample relevant to the phenomenon under exploration achieved. - Saturation of main concepts and categories.	-The value of multidisciplinary team acknowledged -Multifaceted nature of services for older people highlighted
Data collection*	-Initial interview guides devised based on preliminary review of literature and pilot interviews -Guides expanded and developed as study progressed. -Data analysed as retrieved thus data analysis and collection occur as simultaneous processes	-Scope of interviews determined by data -Sample frame revised -Data collection adjusted as phenomenon dictated. -Emerging concepts were explored in subsequent interviews, allowing for exploration of unanticipated avenues	-Communication skills enhanced -Reflective skills developed -Appreciation of the reality of work and life in extended care facilities achieved -Disparities among theory, policy and practice acknowledged
Data Analysis*	-Audio interviews transcribed -Concepts labelled, colour coded -Word processor notation sheet devised for each emergent concept. -similar concepts added to notation sheet in chronological order -New concepts added to subsequent interview guide. -Open coding -Axial coding	-Data processed -Iterative process allowed emergent themes to be further explored -Theory inductively derived from the data. -Labels formed concepts, concepts grouped to form categories -Conceptual relationship between categories developed to build sub categories -Categories integrated to form propositions	-Development of analytical skills -Development of management and organisational skills -Deeper insight achieved to acknowledge interrelationship among concepts which create a multifaceted phenomenon
Literature Comparison Phase	Comparison of emergent theory with extant literature	-Allows for of revelation of conflicting or consistent evidence. -Improves validity establishing the value of findings in current existing body of knowledge	-Development of critical appraisal skills -Appreciation of national and international literature -Appreciation of the Irish situation in relation to European and international counterparts