"A whole new world" facilitating person-centred care: an action research study

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# TABLE OF CONTENTS

TABLE OF CONTENTS ........................................................................................................... 3
STATEMENT OF AUTHORSHIP ......................................................................................... 7
ACKNOWLEDGEMENTS ........................................................................................................ 7
LIST OF FIGURES ................................................................................................................ 8
LIST OF APPENDICES ......................................................................................................... 10
GLOSSARY ........................................................................................................................... 10
CERTIFICATE OF AUTHORSHIP ......................................................................................... 12
ABSTRACT ............................................................................................................................ 13

## CHAPTER 1: THE BEGINNING ...................................................................................... 15
  1.1 Call to the question ...................................................................................................... 15
  1.2 Background ................................................................................................................ 16
  1.3 Research aim .............................................................................................................. 19
  1.4 Research questions ................................................................................................... 19
  1.5 Methodology ............................................................................................................. 20
  1.6 Practice Development: a collaborative change process ........................................ 20
  1.7 Overview of chapters ............................................................................................... 21
  1.8 Rural and organisational context ............................................................................. 22
  1.9 Précis ........................................................................................................................ 23

## CHAPTER 2: LITERATURE REVIEW .......................................................................... 25
  2.1 Strategies for the literature search ........................................................................... 25
  2.2 Intent and purpose of literature review .................................................................... 25
  2.3 Demography ............................................................................................................. 26
  2.4 Accreditation of aged care facilities and the quality improvement agenda .......... 27
  2.5 Person-centred care ................................................................................................ 28
  2.6 Theoretical underpinnings of person-centred care ................................................ 30
  2.7 The benefits of applying person-centred care ......................................................... 32
  2.8 Developments in the field ....................................................................................... 33
  2.9 Standards for person-centred care ......................................................................... 37
  2.10 Measuring person-centredness to ensure quality of care .................................... 39
  2.11 Challenges and barriers to implementing person-centred care ......................... 40
2.12 The relationship between person-centred care, management and leadership ................................................................. 41
2.13 Précis ........................................................................................................................................................................... 44

CHAPTER 3: METHODOLOGY ..................................................................................................................................... 45
3.1 Selection of the methodology ................................................................................................................................. 45
3.2 Paradigms .................................................................................................................................................................. 46
3.3 Quantitative research ............................................................................................................................................... 48
3.4 Qualitative Research ............................................................................................................................................... 48
3.5 Action Research Origins ........................................................................................................................................ 49
3.6 Action Research ...................................................................................................................................................... 50
3.7 Précis ....................................................................................................................................................................... 53

CHAPTER 4: ACTION RESEARCH-CONCEPTUALISATION OF THE STUDY .......................................................... 55
4.1 Introduction ............................................................................................................................................................. 55
4.2 Ethical and Local Approval .................................................................................................................................. 57
4.3 Overview of the study ............................................................................................................................................. 57
4.4 Participant Recruitment ........................................................................................................................................ 61
4.5 Establishment of the three AR groups .................................................................................................................... 63
4.6 Data generation methods and approaches to analysis ............................................................................................ 70
4.7 Précis ....................................................................................................................................................................... 74

CHAPTER 5: BEGINNING THE PROCESS: ESTABLISHING THE THREE ACTION RESEARCH GROUPS AND IDENTIFYING THE FOCUS OF THEIR ACTIVITY ............................................................................................................................................................. 75
5.1 The Lighthouse ....................................................................................................................................................... 75
5.2 Seaview ...................................................................................................................................................................... 84
5.3 Sandcastles .............................................................................................................................................................. 90
5.4 Précis ....................................................................................................................................................................... 97

CHAPTER 6: THE LIGHTHOUSE ...................................................................................................................................... 99
6.1 Planning – Cycle One – The Welcome Pack ........................................................................................................... 100
6.2 Action– Cycle One – The Welcome Pack .............................................................................................................. 109
6.3 Observation – Cycle One – The Welcome Pack .................................................................................................. 112
6.4 Reflection – Cycle One – The Welcome Pack ..................................................................................................... 127
6.5 Précis – Cycle One – The Welcome Pack .............................................................................................................. 129
6.6 Planning – Cycle Two – The Dining Room ........................................................................................................ 132
6.7 Action – Cycle Two – The Dining Room ............................................................................................................. 141
6.8 Observation – Cycle Two – The Dining Room................................. 144
6.9 Reflection – Cycle Two – The Dining Room................................... 151
6.10 Précis – Cycle Two – The Dining Room........................................ 155
CHAPTER 7: SEAVIEW........................................................................ 159
  7.1 Planning – Cycle One – Devise actions to facilitate inclusion of, and
  information sharing with resident families ....................................... 160
  7.2 Action – Cycle One – Devise actions to facilitate inclusion of, and
  information sharing with resident families ........................................ 164
  7.3 Observation – Cycle One – Devise actions to facilitate inclusion of, and
  information sharing with resident families ........................................ 168
  7.4 Reflection – Cycle One – Devise actions to facilitate inclusion of, and
  information sharing with resident families ....................................... 179
  7.5 Précis – Cycle One – Devise actions to facilitate inclusion of, and
  information sharing with resident families ....................................... 180
  7.6 Planning – Cycle Two – Devise actions to maintain a cohesive team 183
  7.7 Action – Cycle Two – Devise actions to maintain a cohesive team..... 184
  7.8 Observation – Cycle Two – Devise actions to maintain a cohesive team
  ........................................................................................................... 188
  7.9 Reflection – Cycle Two – Devise actions to maintain a cohesive team
  ........................................................................................................... 200
  7.10 Précis – Cycle Two – Devise actions to maintain a cohesive team... 201
CHAPTER 8: SANDCASTLES.................................................................. 205
  8.1 Planning – Cycle One – Increase interaction opportunities between
  residents with minimal or no cognition impairment and caregivers ...... 206
  8.2 Action – Cycle One – Increase interaction opportunities between
  residents with minimal or no cognition impairment and caregivers ...... 209
  8.3 Observation - Cycle One – Increase interaction opportunities between
  residents with minimal or no cognition impairment and caregivers ...... 211
  8.4 Reflection – Cycle One – Increase interaction opportunities between
  residents with minimal or no cognition impairment and caregivers ...... 216
  8.5 Précis – Cycle One – Increase interaction opportunities between
  residents with minimal or no cognition impairment and caregivers ...... 217
  8.6 Planning – Cycle Two – Person-centred care training for new staff ... 219
  8.7 Action – Cycle Two – Person-centred care training for new staff ...... 220
  8.8 Observation – Cycle Two – Person-centred care training for new staff
  ........................................................................................................... 222
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9 Reflection – Cycle Two – Person-centred care training for new staff.</td>
<td>227</td>
</tr>
<tr>
<td>8.10 Précis – Cycle Two – Person-centred care training for new staff</td>
<td>228</td>
</tr>
<tr>
<td>CHAPTER 9: DISCUSSION AND RECOMMENDATIONS</td>
<td>233</td>
</tr>
<tr>
<td>9.1 Background</td>
<td>233</td>
</tr>
<tr>
<td>9.2 Methodology</td>
<td>234</td>
</tr>
<tr>
<td>9.3 Research outcomes</td>
<td>234</td>
</tr>
<tr>
<td>9.4 Recommendations</td>
<td>238</td>
</tr>
<tr>
<td>9.5 Final reflections on this research journey</td>
<td>254</td>
</tr>
<tr>
<td>9.6 Conclusion</td>
<td>255</td>
</tr>
<tr>
<td>TIMETABLE</td>
<td>259</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>262</td>
</tr>
</tbody>
</table>
STATEMENT OF AUTHORSHIP

I, Bronwen Grant Ashcroft, declare that this thesis, submitted in fulfillment of the requirements for the award of Doctor of Philosophy, in the Faculty of Science, Charles Sturt University, is entirely my own work unless otherwise acknowledged. This document has not been submitted for qualification at any other educational institution.

Bronwen Ashcroft

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LIST OF FIGURES

Figure 1.1 The six principles of person-centred care
Figure 2.1 Theorists who influenced the development of person-centred care
Figure 2.2 Elements of leadership and management
Figure 3.1 Comparison of qualitative and quantitative research traditions
Figure 3.2 Typical action research cycle
Figure 4.1 Typical action cycle
Figure 4.2 Cross-section of staff involved in the study
Figure 4.3 Action research, person-centred care and practice development are
inextricably linked
Figure 4.4 Thematic Analysis
Figure 4.5 Showing data sources and how they were converged into codes that
represented all key stakeholder voices
Figure 4.6 Typical thematic map
Figure 5.1 Photos of some of the land around The Lighthouse facility
Figure 5.2 Floor plan of The Lighthouse
Figure 5.3 The breakdown of participants
Figure 5.4 Prioritisation of priorities/goals for The Lighthouse AR group
Figure 5.5 Prioritisation of cycles
Figure 5.6 A collage depicting some of the activities enjoyed at The Seaview facility  
Figure 5.7 Floor plan of Seaview  
Figure 5.8 Break down of participants  
Figure 5.9 Cycle priorities  
Figure 5.10 Prioritisation of cycles  
Figure 5.11 Photos depicting some of the relaxing pastimes at The Sandcastles facility  
Figure 5.12 Floor plan of Sandcastles  
Figure 5.13 Break down of participants  
Figure 5.14 Cycle priorities/goals  
Figure 5.15 Prioritisation of cycles  
Figure 6.1 Photo of a lighthouse  
Figure 6.2 Picture depicting the title page of the Welcome Pack  
Figure 6.3 Photo depicting a family picnic  
Figure 6.4 Photo depicting a family building a life history  
Figure 6.5 Short questionnaires asking expectations of care of both residents and family  
Figure 6.6 Example of the new residents’ information sheet provided to caregivers  
Figure 6.7 Flow chart showing progression to final theme/s for discussion  
Figure 6.8 Example of coding derived from forms completed by new residents and their families  
Figure 6.9 Visual of thematic map derived from action research group data  
Figure 6.10 Visual of thematic map derived from new residents and their families  
Figure 6.11 Wordle tool used to validate text from participants  
Figure 6.12 Wordle tool used to validate findings from new residents and their families  
Figure 6.13 A photo of The Lighthouse dining room  
Figure 6.14 A visual of the priority/goal of the cycle  
Figure 6.15 An example of a personalised placemat  
Figure 6.16 Example of coding manual derived from direct quotes from the action research group  
Figure 6.17 The theme conceptualised following the analysis of numerous codes  
Figure 6.18 Summary of activities undertaken in cycles one and two for The Lighthouse  
Figure 7.1 Photo of the surf  
Figure 7.2 Example of coding derived from forms completed by new residents and their families relating to the questionnaires  
Figure 7.3 Example of coding derived from feedback forms  
Figure 7.4 Data sources and how they were converged to create the codes  
Figure 7.5 The theme conceptualised following the analysis of numerous codes  
Figure 7.6 Wordle tool used to validate text from participants  
Figure 7.7 A suggestions box  
Figure 7.8 Example of coding derived from direct quotes from data collection from the questionnaire  
Figure 7.9 Example of coding derived from direct quotes from data collection from the combined resident and caregiver lunch  
Figure 7.10 The theme conceptualised following the analysis of numerous codes  
Figure 7.11 Wordle tool used to validate text from participants  
Figure 7.12 Summary of activities undertaken in cycles one and two for Seaview  
Figure 8.1 Photo of a beach  
Figure 8.2 Photo of an outdoor area at The Sandcastles facility  
Figure 8.3 Example of one of the invitations for the night out  
Figure 8.4 Example of coding derived from direct quotes from data collection
Figure 8.5 The theme conceptualised following the analysis of numerous codes
Figure 8.6 Example of coding derived from direct quotes from data collection
Figure 8.7 The theme conceptualised following the analysis of numerous codes
Figure 8.8 Wordle tool used to validate text from participants
Figure 8.9 Summary of activities undertaken in cycles one and two for Sandcastles

LIST OF APPENDICES

Appendix 1: Ethics approval
Appendix 2: Information for participants
Appendix 3: Consent
Appendix 4: The first AR group meeting
Appendix 5: AR group discussion questions
Appendix 6: Recommendations and questions to assist in the observation phase
Appendix 7: Reflection questions
Appendix 8: Practice Development Questions
Appendix 9: New resident documents
Appendix 10: Principles of Person Centred Care-Information Sheet
Appendix 11: The Welcome Pack
Appendix 12: Initial AR group meeting running sheet
Appendix 13: Person-centred care feedback-Residents and resident families
Appendix 14: Questionnaire provided to caregivers
Appendix 15: Questionnaire results
Appendix 16: Happiness Questionnaire
Appendix 17: My reflections on dinner

GLOSSARY

Caregivers: Staff whose primary role is to provide essential care to residents. Caregivers are also referred to as assistants in nursing and carers. The role of caregiver in this study extends to people who also assist in kitchen duties, cleaning, administration,
and lifestyle. All people in this study were called caregivers and then their roles were identified. Caregiver as a broad term is meant to reduce power bases arising from qualifications and level within the organisation.

**Director of Care:** Director of care role is one that provides direction to the nursing staff and coordinates health services. A Director of Care typically has many years of experience in the health care field.

**Facility Manager:** The facility Manager provides effective management of an aged care facility, with responsibilities including the maintenance of standards, environmental services, food services and maintenance divisions.

**Holistic care:** Care that considers the physical, emotional, social, spiritual and economic needs of the person.

**Person-centred care:** Care that is centred on the individual and focusses on their strengths, needs and preferences.

**Practice Development:** A continuous process of developing person-centred cultures.

**Reflective discussion:** is the mutual sharing of feelings and thoughts that provides valuable insight into the experiences of staff.

**Register Nurses or Clinical Registered Nurses:** have obtained a three-year Bachelor degree in nursing from a University. Their roles include being responsible for the total care of patients and residents, as well as the management of staff. In residential aged care there are few Registered Nurses and generally on a day shift there may be two Registered Nurses working; however in the afternoons and evenings, there is usually only one Registered Nurse in a facility.

**Residential aged care:** A special purpose facility which provides accommodation and support, including assistance with day-to-day living, and more complex forms of care, to frail aged residents.
CERTIFICATE OF AUTHORSHIP

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis [or dissertation, as appropriate]. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged. I agree that this thesis be accessible for the purpose of study and research in accordance with normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of thesis, subject to confidentiality provisions as approved by the University.

Name: Bronwen Ashcroft

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Date:
ABSTRACT

The impetus for this action research study arose from discussions between the Director of Care (DOC) of an Aged Care Facility (referred to by the pseudonym Beaches Care of the Aged, throughout this document) and myself regarding integration of person-centred care into practice. We agreed that many residential aged care facilities purport to have a person-centred approach to care, including Beaches Care of the Aged; however, the question remains whether it is more an ideal rather than a reality in residential aged care. The aim of the study was to support managers and caregivers at three rurally located residential aged care services implement and sustain a person-centred care approach.

Beaches Care of the Aged first introduced person-centred care in 2007 following discussions at management meetings regarding the need to review the task-centred approach to care used at that time. Initial training and education occurred in mid-2008 and continued for a short time. However, due to the organisation taking over an aged care facility under sanction, the change management and training programs were not fully implemented. The DOC stated she would like to know unequivocally if the managers and staff at Beaches Care of the Aged understood and implemented a person-centred approach to the care they provided. She added that she was interested in the effect management and leadership had in the implementation of person-centred care, stating the importance of well-trained managers specific to the sensitive needs of residential aged care. Following discussions with her, I decided to undertake a PhD study examining person-centred care understanding and the implementation process. The DOC supported my decision and ensured her support of the study and that of the managers.

A review of the literature demonstrated that person-centred care is considered the ideal approach in aged care rather than a task-centred or biomedical approach. However, person-centred care is poorly defined and little understood, and there is a need for further collaboration and engagement of caregivers within organisations to assist integration of the philosophy into practice.

Action research was the methodology of choice for the study as this collaborative change focused research approach is empowering to participants who are both participants and researchers. The study included three aged care facilities: Beaches Care of the Aged; The Lighthouse, Seaview, and Sandcastles. Three action research groups were formed and six action research cycles at each facility were completed.
overall over a six-month timeframe. The study was a negotiated cyclical process; therefore, for the intent of my PhD, my facilitation of the process was limited. Each group consisted of between four and twelve participants, and participation was voluntary. All participants were employees of Beaches Care of the Aged working in one of the three facilities within the organisation. Multiple data generation approaches were adopted which included: observation, photo elicitation, reflective journals, memos, self-assessment, field notes, audio tapes and checklists. Group meetings were digitally recorded and subsequently transcribed to gather information for data analysis. The four elements of action research; planning, action, observation, and reflection, were applied throughout the study. Initially, data from all three sites were kept separate with analysis involving coding, reflection, thematic analysis, analysis of action research group data and interpretation.

The study makes an original and substantive contribution to the nursing body of knowledge and further research with the generation of new knowledge. It is of significant value to residential aged care: aiding understanding and insight into the complexities of implementing a person-centred care approach, improving care standards and practice, as well as the importance of change management.
CHAPTER 1: THE BEGINNING

Person-centred care is often referred to as a philosophy (Caspar, O'Rourke, & Gutman, 2009), which focuses on the person and respects and includes the person’s experiences, values, needs and preferences, in all aspects of care, relationships and environment (Backman, Sjögren, Lindkvist, Lövheim, & Edvardsson, 2016). The term person-centred care is used frequently in aged care policy and practice; however translation of the philosophy into everyday nursing care presents challenges (Arcot et al., 2015; Ross, Tod, & Clarke, 2015), and it is argued that it is more often an ideal in residential aged care rather than a reality.

To establish context for the study, this chapter provides my call to the question. The background to the study includes an overview of the ageing population, an introduction to person-centred care and a description of the rural context in which the study was undertaken. The aim and significance of the research are outlined and the research questions and the methodology are specified.

1.1 Call to the question

From a young age, I was taught to hold the utmost respect for older people. My childhood memories include growing up in a small rural community in New South Wales surrounded by my siblings and older family members; my parents, grandparents, uncles and aunts. I enjoyed listening to their stories, their sharing of wisdom, as well as social outings that involved birthday parties, barbeques, afternoon teas, shopping trips and card games. My maternal Grandmother came to live with my family in 1985 and I recall the enjoyment I got from spending time with her but I also came to realise her increasing frailty. I helped her where I could, and looked out for her safety; however I was aware of her determination to hold on to her independence. These experiences all led me to my dream of becoming a Registered Nurse. I wanted to work with older people and learn what they needed to support them as they aged, in a way that empowered them and protected their dignity, and enabled them to retain maximum autonomy and independence. Following completion of a Diploma of Applied Science Nursing at Charles Sturt University in Wagga Wagga, I worked in mental health services and aged care in private nursing and residential aged care facilities. I began teaching aged care in 2009 and embarked on further studies, completing a Master of Gerontology in 2011 through Charles Sturt University. I decided I wanted to further challenge myself and commenced this PhD in 2012. My commitment to support the individualised care of older people led to the conceptualisation of my PhD study.
1.2 Background

Ageing populations are a global phenomenon that has become prominent in international discourse over the past few decades (Appannah & Biggs, 2015; O’Brien, 2016; Officer et al., 2016). Furthermore, by 2050 the proportion of people in the world aged over 80 years is projected to be four times larger than it was in 1950 due to increased life expectancy and declining fertility (Winterton, Warburton, & Oppenheimer, 2013). Estimations suggest that by the year 2020 the overall number of older people in the world could exceed 1 billion, which translates to 30% of the entire population (Drop, Jędrych, Barańska, Firlej, & Janiszewska, 2016). Additionally, both Australia and New Zealand’s populations are ageing rapidly, both have approximately 15% of their population aged 65 and over (Kowal, Towers, & Byles, 2014), with a large group of post-war Baby Boomers now reaching age 65 (Warburton, Cowan, Savy, & MacPhee, 2015). It is projected that both Australia and New Zealand will experience an 80% increase in the population aged 60-plus years between 2013 and 2050. The increase in the 80 years of age plus population will be 200% or even higher, which will result in 2.8 million Australians and more than 510,000 New Zealanders in this age group by 2050. The speed of ageing in both countries is higher than the average rate of increase in developed countries. The average life expectancy at birth and at age 60 is higher in Australia than New Zealand, with the difference increasing slightly by 2050 (Kowal et al., 2014).

Along with more than half of the world’s governments, those of Australia and New Zealand consider population ageing and its challenges as a major concern and priority. With a wave of Baby Boomers entering retirement in both Australia and New Zealand, efforts are being made to develop strategies and policies focussing on the realities and challenges of this demographic shift, including the design of age-friendly cities, a focus on older adults as key economic consumers, and a revision of pension provision systems and prolonging workforce engagement. Population ageing also has major ramifications for the public health sector, with a shift in health profiles emphasising the rise in age related illness and disease, as well as an expansion of multi-morbidity which threaten the sustainability of current health systems (Keeling, Byles, & Towers, 2014). Moreover, an additional 74,000 beds will be needed in residential aged care across Australia over the next decade, marking a 40% increase in beds from 2012. The challenge for the Australian Government is to establish a regulatory environment that fosters the development of services that achieve, as well as maintain, agreed minimum standards of care and residents outcomes (Baldwin, Chenoweth, Rama, & Liu, 2015). A major goal of government policy is to allow older people to remain in their homes for as long as possible with community support (Walker & Paliadelis, 2016).
While many older people maintain the ability to take care of themselves into older age, others are dependent on formal support from the public sector as well as assistance from their social surroundings (Pálsdóttir, 2012), which is where the provision of quality care or care that is person-centred is emphasised (McCance, Slater, & McCormack, 2009). The promotion of person-centred care and quality improvement remains consistent with the policy directions of health care organisations nationally and internationally (McCormack, Karlsson, Dewing, & Lerdal, 2010). Furthermore, quality of care that is provided to older people residing in residential aged care facilities in Australia is regulated. The quality framework consists of an Accreditation Framework and an Aged Care Complaints Scheme. The Accreditation Framework is underpinned by person-centred care, operationalised through the Australian Aged Care Quality Agency, and reinforced by formal audits as well as visits that are unannounced and appropriate follow-up as required. Facilities that meet a required set of Aged Care Accreditation Standards are eligible to be accredited, therefore can apply for government subsidy for residents. The standards address: (i) management systems, staffing and organisational development; (ii) health and personal care; (iii) resident lifestyle; and (iv) the physical environment and safe systems (Ostaszkiewicz, O'Connell, & Dunning, 2016).

Recent reports from the National Health and Hospital Reform Commission as well as the Productivity Commission, highlighted the significance of challenges facing the Australian health sector, including the ageing of the population, a decline in the availability of informal carers and an increasing demand for better information, access issues particularly for older rural Australians, increasing health costs and increasing consumer expectations, services available and affordability issues. The Australian government responded by stating that a health reform agenda aims to address access as well as equity issues directly having an effect on health outcomes, and articulated their support of the redesign of health services that are increasingly person-centred, sustainable and flexible (J. Davis, Morgans, & Stewart, 2016). Additionally, contemporary reforms of aged care aim to adopt a more humanistic, person-centred model of care. This is in place of the archetypal medical model traditionally accepted by government that assumed older people as highly dependent and financially burdensome (Walker & Paliadelis, 2016).

The six principles of person-centred care as described by McCormack and McCance (2010) below are consistently promoted; however in reality, very few organisations and managers genuinely understand what person-centred care really means and many struggle with the translation of it into everyday practice, and further work is needed to enable residents and caregivers to flourish in a caring and empowering environment incorporating change management (McCormack, Dewing, & McCance, 2011);
(1) Getting to know the resident as a person
Action on getting to know the resident/patient as a person, his or her values, beliefs and aspirations, health and social care needs and preferences.

(2) Sharing of power and responsibility
Enabling the person to make decisions based on informed choices about what options and assistance is available, hence promoting his or her independence and autonomy.

(3) Shared decision making
Shared decision making between the person and healthcare teams, rather than control being exerted over the person, enabling choice.

(4) Flexibility and accessibility
Providing information that is tailored to each person to assist them in making their own decisions based on the best evidence available.

(5) Encouraging autonomy
By supporting the person to assert themselves regarding choice.

(6) Environment
Refers to both the physical and organisational care environment, which has a substantial impact on the operationalisation of person-centred care and has the greatest potential to limit or strengthen the application of person-centred processes.

Figure 1.1 The six principles of person-centred care as described by McCormack and McCance (2010)

Applying person-centred care to consumers of health care is important to Australia’s and New Zealand’s rapidly ageing populations to ensure quality of care for these people. Society needs to prepare for this increasing number of older people, their quality of life, and their prospects for active participation and how they can be supported to achieve this (Pálsdóttir, 2012). Additionally, while a small proportion of older Australians (6%) reside in residential aged care at any given time, there is a high lifetime probability of an older person entering residential aged care, for example, a 70 year old has a 37%
chance of needing high level aged care at some point in the future. The number of older people requiring residential aged care is likely to increase in the future as the population aged, and family and work patterns change (Brownie & Horstmanshof, 2012).

Person-centred care is said to be holistic in its implementation and is described as a humanistic, all-empowering model of care (Edvardsson, Fetherstonhaugh, & Nay, 2010). Many caregivers believe they already provide person-centred care (S. Davis, Byers, & Walsh, 2008), therefore a collaborative change management approach is needed by managers and caregivers within residential aged care organisations to ensure person-centred care implementation. Person-centred care is built on a shared vision and strategy to ensure quality of care, and management support is needed to encourage this quality (Rosengren, 2016). Good management and leadership plays a key role in developing caregiver understanding of resident needs and values, and the acceptance of new innovations to obtain successful change and a positive culture of care (Rokstad, Vatne, Engedal, & Selbæk, 2015) both of which can lead to caregivers embracing person-centred care.

1.3 Research aim

To support managers and caregivers at three rurally located residential aged care services implement and sustain a person-centred care approach.

1.4 Research questions

The Director of Care and I agreed we wanted to guide Beaches Care of the Aged away from a task focussed approach to care, and facilitate person-centred care. We decided that a change management process that empowered caregivers, increased caregiver satisfaction with their work, encouraged collaboration through participation and enabled acquisition of knowledge, and social change was idealistic but worth striving to achieve.

1. What is the understanding of managers and caregivers of a person-centred care approach?

2. What support is required to implement a person-centred care approach?

3. What assistance is necessary to sustain a person-centred care approach?
1.5 Methodology

Action Research is a social process leading to change through collaboration and transformative actions. It is a popular methodology and considered one of the most exciting forms of qualitative research (Taylor & Francis, 2013b). Additionally, Gregory et al. (2011) described the defining characteristics of action research as having a strong emphasis on democratic participation and achieving social change. Moreover, Action Research is a collaborative group process effecting change to achieve specific and agreed goals (Moch, Vandenbark, Pehler, & Stombaugh, 2016). The application of an Action Research methodology was appropriate for this study that aimed to support managers and caregivers at three rurally located residential aged care services implement and sustain a person-centred care approach. Action Research is a collaborative group process effecting change to achieve agreed goals (Moch et al., 2016).

1.6 Practice Development: a collaborative change process

Practice development is well-established in healthcare (McCormack et al., 2009) and is widely known as a continuous process of developing person-centred cultures (Boomer & McCormack, 2010). Practice development enables professional development of individuals and groups through participatory activities, learning and empowerment (Beckett et al., 2013). Practice development as a model of staff development is supported by facilitators who authentically engage with individuals as well as teams to blend personal qualities and creative imagination with practice skills and practice wisdom that realises enhanced individual and team knowledge and practices. McCormack et al (2010) identified the key foci of practice development as:

- increasing effectiveness in person-centred care;
- transforming practice cultures to enable and sustain person-centred ways of working and relating;
- adopting systematic, rigorous and continuous approaches to developing practice; and
- engaging in collaborative, inclusive and participatory facilitation relationships.

McCormack et al (2010) added that facilitating the above foci involves cycles of reflective learning and action to enable caregivers to develop awareness of the need for change by identifying contradictions between what is espoused versus the realities of practice. Practice development focusses on changing practice through reflection. In
developing person-centred nursing (McCormack & McCance, 2010), and for person-centred practice to flourish (Beckett et al., 2013), a sustained commitment to the facilitation of culture change in clinical settings and organisations is required (McCormack & McCance, 2010). Organisational leadership at all levels needs to reflect this (Beckett et al., 2013). The challenge, however, for organisations, is a move from individual, ‘person-centred moments’ to ‘person-centred cultures’, and this cannot happen simply by relying on individual motivation of nurses/carers, rather, the change required needs a sustained commitment and workplace culture change within teams in each organisation (McCormack et al., 2011). A sustainable change in workplace culture, although notoriously difficult, is not impossible (Beckett et al., 2013). Practice development was utilised by the researcher as a framework for developing person-centred cultures at the three participating Beaches Care of the Aged sites.

1.7 Overview of chapters

This thesis consists of nine chapters with each chapter outlined below.

Chapter one provides an overview of the study. Background to person-centred care, the research question and the research methodology, action research, are presented.

Chapter two presents a review of literature examining person-centred care. The theoretical underpinnings of person-centred care are described. Challenges in developing standards and measuring person-centred care are explained, as are developments in the field and challenges to the effective implementation of person-centred care.

Chapter three outlines the methodology used for the study including a brief discussion on qualitative versus quantitative research methodologies. Next, a rationale for adopting the chosen methodology is offered, followed by an overview of practice development. The study aim, design, setting, population, recruitment and ethical considerations, the role of the researcher, potential issues for negotiation and a guide for initial action research groups are outlined.

Chapter four introduces the study setting, ethical considerations and recruitment of participants. The study design is explicated including information sessions held at each facility, as well as allocation of roles and responsibilities. The Nominal Group Technique
is introduced that was adopted by each action research group to guide deliberations and achieve agreed goals.

Chapter five introduces the three action research groups and identifies the focus of their activity, including the priorities.

Chapter six explicates two cycles of action for The Lighthouse action research Group; cycle one “The Welcome Pack” and cycle two “The Dining Room”. Both cycles include the plan, act, observe and reflect components of action research and participants were able to share personal practice experiences aiding reflection. Thematic analysis was used to analyse the data resulting in two themes for cycle one and one theme for cycle two.

Chapter seven describes two completed cycles of action for the Seaview action research Group; cycle one “Devise actions to facilitate inclusion and information sharing for resident families”, and cycle two “Devise actions to maintain a cohesive team”. Again, the plan, act, observe and reflect components of action research were applied to the cycles as was reflective discussion, resulting in two themes following thematic analysis, one theme for each cycle.

Chapter eight outlines two completed cycles of action implemented for the Sandcastles action research Group; “Increase interaction opportunities between residents with minimal or no cognitive impairment and caregivers” and “Person-centred care training for new staff”. The plan, act, observe and reflect components of action research were applied, as was thematic analysis resulting in the conceptualisation of two themes, one for each cycle. This cycle concludes the action research cycles for all three facilities.

Chapter nine concludes the study. The discussion, study recommendations and limitations of the study feature in this chapter.

1.8 Rural and organisational context

The study was undertaken in a rural New South Wales coastal town with a significant portion of the population aged 65 years and over, and many of the residents of Beaches Care of the Aged came from surrounding farms and small rural towns and villages, and
did not know any other residents personally on arrival. Further to this, there is a paucity of extant literature on rurality and residential aged care, adding to the significance of this study, as little is known about the significant aged care challenges facing rural older people. About a quarter of the population of Australia will be living outside capital cities by the middle of this century (Perkins, 2014), and rural areas are aging more rapidly than urban areas as rural areas are more likely to be populated by older people (Warburton et al., 2015) which resonates with the study. Additionally, facility characteristics, such as staffing levels, can affect the quality of care provided in residential aged care. Rural residential aged care facilities tend to have lower staffing levels, fewer beds, and are less likely to offer specialty services, and these differences can potentially affect quality (Bowblis, Meng, & Hyer, 2013).

A prominent organisation in the town, Beaches Care of the Aged provides for older people with over 600 people in their care at three residential aged care facilities: Lighthouse, Seaview and Sandcastles. This makes it the largest aged care provider in the local area. The organisation claims to provide positive lifestyle choices and purports a person-centred approach to care that is characterised by compassion, commitment, dignity, respect and excellence for older people to enrich and fulfil their lives. Person-centred care features in the organisation’s mission statement and it is expected that caregivers understand and implement the philosophy including the six principles of person-centred care.

1.9 Précis

This introductory chapter highlighted the impetus for undertaking the study. Ageing as a global phenomenon and the implications for Australia were explored providing context for the study. The aims of the study, the research question and the methodology guiding the study, action research, were presented. Person-centred care and practice development were introduced and finally, an overview of the structure of the thesis was provided. The next chapter (Chapter 2) explores the literature on Person Centred Care as a philosophy and as a model of care.
CHAPTER 2: LITERATURE REVIEW

This chapter reviews the extant literature related to person-centred care. The principles that underpin person-centred care are described and the methods promoted for successful implementation of this model of care in practice are considered. The appropriateness of this model of care for residential aged care services is established. Management and leadership as topics were included in this review because person-centred care involves all levels of an organisation, thus establishing person-centred care as the value base is the responsibility of management at a senior level in an organisation. Those responsible for setting care standards and procedures have the main responsibility for organising the individualised approach to care (Røsvik, Kirkevold, Engedal, Brooker, & Kirkevold, 2011).

2.1 Strategies for the literature search

Databases of Primo search, CINAHL Plus with full text, EBSCOhost (health), and EBooks, as well as the Charles Sturt University library and Digital Thesis Australia were searched between 2012-2017 to obtain the necessary and useful information. In searching the literature, it was important to search not only the most current information but also seminal and original works dating back to the origins of person-centred care. Terms searched were: action research, person-centred care, residential aged care, residential aged care staff, residential aged care staffing issues, family involvement in aged care, dining rooms, inclusion, rural health, interaction with older people, interaction opportunities for older people, person-centred care training, older people, person-centred care theorists, person-centred care and dementia, benefits of applying a person-centred care approach, development in person-centred care, implementation of person-centred care, management and leaders in aged care, principles of person-centred care.

2.2 Intent and purpose of literature review

This integrative literature review was undertaken to:

1. Explore the origins of person-centred care,
2. Appreciate the philosophical tenants that underpin this approach to care,
3. Establish a working definition of person-centred care,
4. Understand the methods adopted and implications of implementing person-centred care particularly for residential aged care facilities.
The provision of care for older people in residential aged care is moving away from the traditional biomedical approach, and adopting a more person-centred focus (Buckley, McCormack, & Ryan, 2014). Person-centred care is defined as healthcare providers providing treatment and interventions that are respectful and responsive to the characteristics, needs, preferences and values of individuals. It places the person at the centre of their care, and is described as being supportive of the values, rights, and beliefs of a person, and providing unconditional positive regard, entering their world and assuming there is meaning in all behaviour (Pol-Grevelink, Jukema, & Smits, 2012). The World Health Organization suggests that person-centred care is an essential dimension of healthcare and an important indicator of healthcare quality. However, how person-centred care is implemented differs greatly between countries in response to local cultures, resources as well as consumer expectations of health care (Dewi, Evans, Bradley, & Ullrich, 2014).

2.3 Demography

Globally, population ageing is one of the most pressing social and policy issues faced today. Over the last few decades, the ageing of the world’s population has been recognised as a process of major economic and social significance. The speed at which national populations are ageing is variable. In developed countries including Australia, populations have been on an ageing trajectory for over a century, and population ageing is well advanced. However, in developing regions of the world, ageing is a more recent phenomenon but is occurring rapidly, requiring adaptation at a faster rate (Faulkner, Feist, & Lewis, 2016). This aside, over the next two decades, Australian society will face dramatic increases in the proportion of the population with approximately one in four Australians being 65 years or older by 2056 (Arcot et al., 2015) as the baby boomers move into older age and fertility levels remain low (Faulkner et al., 2016). The average life expectancy in Australia is now 79 years for men and 84 years for women (Kumar et al., 2013). Centenarians, defined as people who have reached 100 years of age or more, represent one of the fastest growing age groups within industrialised nations. In Australia, the number of centenarians increased from 131 in 1971 to 3154 in 2006, with a 235% increase over the past two decades (Richmond, Law, & KayLambkin, 2012). Arai et al. (2012) advise that rather than considering an aging population as a negative social phenomenon, we should foster a society where older people enjoy a healthy, prosperous life through inclusiveness, social interaction, and contribution.

Residential aged care has become a critical issue in developed countries due to an ageing workforce and an overall ageing population. As a direct result, the ageing
process has provided a catalyst for policy, service and practice reform. Prevention focussed health care has been embraced as a strategy to reduce the health burden, particularly relating to older Australians (Kaine & Ravenswood, 2013). The ageing population has contributed to concerns about ensuring a sustainable labour supply to the aged care sector. A key barrier to a sustainable workforce in residential aged care in Australia and New Zealand is the physically and emotionally demanding work, which is generally undervalued and poorly paid (Kaine & Ravenswood, 2013). Additionally, in Australia, qualified and experienced caregivers are needed urgently to provide care and support for residents of long-term residential aged care facilities. Caregivers make up 68% of the workers within residential aged care (Radford, Shacklock, & Bradley, 2015). To this end, an additional 74,000 residential aged care beds will be needed across Australia over the next decade; a 40% increase on the 184,000 beds available in 2012 (Baldwin et al., 2015). Although it is preferable for older people to remain living at home in Australia, between 7% and 10% of people over 65 years will spend some time in a residential facility. In 2007–2008, there were 208,079 people permanently residing in residential aged care facilities in Australia, which is a significant number of older people (Baldwin et al., 2015). To complicate the process, transition into an aged care facility occurs at a time of life when people are vulnerable and when all other options have usually been explored and exhausted.

2.4 Accreditation of aged care facilities and the quality improvement agenda

While many older people maintain the ability to take care of themselves into older age, others are dependent on formal support from the public sector as well as assistance from their social surroundings (Pálsdóttir, 2012), which is where the provision of quality care or care that is person-centred is emphasised (McCance et al., 2009). The promotion of person-centred care and quality improvement remains consistent with the policy directions of health care organisations nationally and internationally (McCormack et al., 2010). Furthermore, quality of care that is provided to older people residing in residential aged care facilities in Australia is regulated. The quality framework consists of an Accreditation Framework and an Aged Care Complaints Scheme. The Accreditation Framework is underpinned by person-centred care, operationalised through the Australian Aged Care Quality Agency, and reinforced by formal audits as well as visits that are unannounced and appropriate follow-up as required. Facilities that meet a required set of Aged Care Accreditation Standards are eligible to be accredited, therefore can apply for government subsidy for residents. The standards address: (i) management systems, staffing and organisational development; (ii) health and personal care; (iii) resident lifestyle; and (iv) the physical environment and safe systems (Ostaszkiewicz et al., 2016).
Recent reports from the National Health and Hospital Reform Commission as well as the Productivity Commission, highlighted the significance of challenges facing the Australian health sector, including the ageing of the population, a decline in the availability of informal carers and an increasing demand for better information, access issues particularly for older rural Australians, increasing health costs and increasing consumer expectations, services available and affordability issues. The Australian government responded by stating that a health reform agenda aims to address access as well as equity issues directly having an effect on health outcomes, and articulated their support of the redesign of health services that are increasingly person-centred, sustainable and flexible (J. Davis et al., 2016). Additionally, contemporary reforms of aged care aim to adopt a more humanistic, person-centred model of care. This is in place of the archetypal medical model traditionally accepted by government that assumed older people as highly dependent and financially burdensome (Walker & Paliadelis, 2016).

2.5 Person-centred care

The term person-centred care is an essential dimension of healthcare and an important indicator of healthcare quality is used frequently in healthcare (Ross et al., 2015), and means much more than just attending to the personal care needs of older people (McKay, McDonald, Lie, & McGowan, 2012). Person-centred care is making sure that residents are acknowledged and recognised as individuals in their own right, or placing that person at the centre of decision making about their personal health (Hardy, 2015). It is often described as an approach to practice established through the formation and fostering of healthful and therapeutic relationships between all care providers, service users and others significant to the person (who is being cared for) in their lives. It is underpinned by values of respect for persons, individual right to self-determination, understanding and mutual respect. It is enabled by cultures of empowerment that foster continuous approaches to practice development (Phelan & McCormack, 2016). Person-centred care is a social model of care, the opposite of task-centred care or the medical model of care (Desrosiers et al., 2014) where the focus is not just about understanding a person, but also about considering their social situation, alongside their medical as well as psychological needs (Hardy, 2015). It is representative of a high quality of nursing care that is also associated with staff satisfaction with work (Edvardsson, Fetherstonhaugh, McCauliffe, Nay, & Chenco, 2011).

The term person-centred care has its origins in the work of Carl Rogers and client-centred psychotherapy. Rogers is known as 'the father' of person-centred care, drawing attention to the need for rebalancing the expert-client relationship to privilege the
client. Although key elements of person-centred care is an essential dimension of healthcare and an important indicator of healthcare quality have been described using an array of terms such as resident-centred care, individualised care, consumer-directed care, patient-centred care and self-directed care, each of the terms shares concepts and definitions that are philosophically congruent with the person-centred philosophy of care (Caspar et al., 2009).

Person-centred care is a multidimensional concept, considered common parlance for practitioners, policy makers, and researchers within aged care (Edvardsson et al., 2010; Edvardsson & Innes, 2010; McCance, McCormack, & Dewing, 2011), where the needs and requirements of an individual must be foregrounded from what the professional thinks is best for that person (Hardy, 2015). It is often seen as establishing the personhood of the person by acknowledging and entering their world (Brooker & Nolan, 2007; Edvardsson, Winblad, & Sandman, 2008), an approach that is very beneficial when working with people with dementia.

The promotion of person-centred care is consistent with national and international policy developments and consistently reflected in approaches to healthcare delivery. With ever increasing numbers of older people in Australia, new models of care reflective of the principles of person-centred care will need to be prioritised by health professionals as they will be supporting an ever growing older population as morbidity rates rise. Person-centred care is a useful model of care that requires staff to develop skills and attitudes to ensure that their practice aligns with person-centred care. (McCormack & McCance, 2010).

Person-centred care is defined as providing care that is respectful of, and responsive to individual preferences, needs, and values, and ensuring what is important to the person, guides all care decisions. Person-centred care is a strong moral prerogative in health care delivery that entails a deep respect for people, and the obligation is for health professionals and decision makers to care for those people on their terms. People are valued, heard, engaged, partners in care, and their preferences are the focus of care delivery, respected (Martin & Félix-Bortolotti, 2014). Person-centred care has a long association with nursing, and is often seen as being synonymous with ageing and aged care services, including dementia care. It is possibly the first approach to advance the concept of individualised care in residential aged care, and is a precursor and foundation upon which numerous models and frameworks have been and will be developed (Caspar et al., 2009).
Although considered an ideal approach to practice (Kirkley et al., 2011; Nay & Garratt, 2009) person-centred care does have its critics, even when correctly implemented. It has been criticised for being too idealistic and thus unworkable on a day-to-day basis (Kirkley et al., 2011), as well as being, ill-defined, too individualised and not inclusive of families (Bergland, Kirkevold, & Edvardsson, 2012; Edvardsson et al., 2010). For some, person-centred care is often seen as yet another management surveillance device (Manley & McCormack, 2008). Additionally, a colleague of Carl Rogers, Wood (2008), expressed his aversion to convert the subtle, implicit reality of the person-centred approach into rule-bound methods which missed the true potential of the person-centred approach and instead lead to ritualised behaviour and pseudo-enlightenment. Moreover, McCance et al. (2011) discussed that person-centred care could be seen as an example of tokenism by those using it, because they use it without any real understanding of what it means or how to use it.

The complexity of the concept of person-centred care (Bergland et al., 2012) contributes to the challenge of fully understanding it and applying it in practice, as well as the lack of a clear definition which is a well-recognised problem, despite wide use of the term person-centred care. The lack of clarity in defining person-centred care could well be a barrier to implementation and an implicated factor in the evaluation of health outcomes (Sharma, Bamford, & Dodman, 2015). Although the basic idea of person-centred care is understood, the ongoing challenge for caregivers and managers is recognising person-centred care in practice. Staff may think they are delivering care that is person-centred, but in reality they often are not (McCance et al., 2011).

2.6 Theoretical underpinnings of person-centred care

While there have been several theorists who have advanced person-centred care, the most influential is Carl Rogers, (see below). Other theorists who have also contributed to the person-centred care movement are summarised in the table that follows.

2.6.1 Carl Rogers (1902-1987)

Carl Rogers was born in Chicago, America. Rogers has been described by Kirschenbaum (2004) as America’s most influential counsellor and psychotherapist and one of the most influential figures in humanistic psychology who coined the term person-centred (Kramer, 1995). The term person-centred was based on an original concept called “the non-directive method” developed by Rogers in 1942. This method asserted that the client has within themselves, the capabilities to understand certain aspects of their lives
and certain things about themselves. It asserts that they have the capacity, as well as
tendency, to reorganise themselves and their relationships in the direction of self-
actualisation and maturity in a way that brings internal comfort (Kirschenbaum, 2004),
and the ability to change (Cheung Chung & Hyland, 2012). Rogers called his therapy
person-centred, to emphasise unconditional positive regard and an empathic
understanding that was central to his therapy. His great contribution rests on his
emphasis on the importance of the therapeutic relationship and empathic responding
(Crisp, 2014).

Rogers was critical of counselling training programmes and textbooks that
misinterpreted his theory as a series of techniques to be mechanically implemented. In
1974, Rogers criticised the way in which person-centred counselling was being taught
as being through reductionist means. "Rogerians" believe that all people possess both
good and evil through their own natural growth and healing from within.

Figure 2.1 below presents Carl Rogers and other theorists who have contributed to the
development and evolution of person-centred care.

<table>
<thead>
<tr>
<th>Theorist</th>
<th>Theoretical underpinnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin Buber (1878-1965)</td>
<td>Rokstad et al (2012) stated that Buber was the person who first described a person centred focus in the 1920's. This approach was aimed at resolving intergroup as well as international conflict.</td>
</tr>
<tr>
<td>Jessie Taft (1882-1960)</td>
<td>Although her work remains largely unknown and unacknowledged, Taft was a major influence on the development of Carl Roger's thinking and of the person-centred approach. Taft emphasised self-acceptance, therapist's non-interference and the importance of therapeutic relationships (Tudor, 2008).</td>
</tr>
<tr>
<td>Otto Rank (1884-1939)</td>
<td>Carl Rogers was familiar with, and heavily influenced by Otto Rank as they worked together for a time. Rank was supportive of Rogers’ person-centred approach (Cheung Chung &amp; Hyland, 2012).</td>
</tr>
<tr>
<td>Carl Rogers (1902-1987)</td>
<td>Carl Rogers coined the term person-centred care. He was a counsellor and psychotherapist who used what he called a person-centred approach on his clients. He has had a pervasive impact on the counselling profession, and entire health profession world-wide (Crisp, 2014).</td>
</tr>
</tbody>
</table>
Kitwood integrated the concept of person-centred care with the philosophy of personhood to define person-centred care for people with dementia through “positive person work” (De Bellis et al., 2009).

Figure 2.1 Theorists who influenced the development of person-centred care

2.7 The benefits of applying person-centred care

The provision of person-centred care according to Edvardsson et al. (2011) is not just an ideal expressed in policy documents for the sake of political correctness; it represents the care that residential aged care staff really want to provide, additionally, high levels of person-centred care are directly associated with higher job satisfaction. Person-centred care can make a positive contribution to the lives of older people in aged care, because it is an individualised rather than a population approach to care (Price, Djulbegovic, Biswas, & Chatterjee, 2015). Furthermore, Masterson (2007) stated that person-centred care is fundamental to the success of improving the health and social care outcomes for older people because it enables them to take an active part in their care (Olsson, Jakobsson Ung, Swedberg, & Ekman, 2013). McCormack et al. (2010) proffered that the inherent good of providing care within a philosophy of person-centred care is irrefutable. The potential benefits of a person-centred approach to care for residents in aged care include: people become less defensive, their self-worth increases, they become more tolerant of others and they are better able to deal with frustration, as well as improved interaction with others, improved relationships with caregivers, positive changes in mood and behaviour, increased feelings of well-being and improved self-determination (Edvardsson et al., 2008). Person-centred care interventions can have positive outcomes for staff; increased confidence and ability to handle agitated behaviour, and decreased emotional exhaustion (Sjögren, Lindkvist, Sandman, Zingmark, & Edvardsson, 2015). However; there is still no consensus regarding the existence of evidence explaining what is needed to provide person-centred care; because models of care based on both staff and organisational characteristics, which can explain the variation in person-centred care, have not yet been presented. However, theory suggests that staff work environments are ultimately connected to person-centred care, and aspects, such as a supportive organisation, supportive leadership and a positive psychosocial environment, have been described as essential facilitators to person-centred care (Sjögren et al., 2015).
2.8 Developments in the field

The use of the term person-centred care has become common parlance in healthcare and social services globally; however it could be argued that the term is used extemporaneously for care that is said to be of high-quality. Moreover, person-centred care in more recent years represents something more meaningful than this, namely, a movement focussing specifically on humanising healthcare by ensuring the patient/client is at the centre of care delivery. In this context, the body of evidence supporting the processes and outcomes associated with person-centred care in healthcare is constantly growing and becoming increasingly diverse (McCormack et al., 2015).

Originally based in the humanistic psychology of Carl Rogers, person-centred care has become a movement of reform in healthcare since the 1990s. Kitwood's early definition of person-centred care as 'a standing or status bestowed upon one human being by others in the context of a relationship', focussed on a key characteristic of person-centred care is that it encompasses relationships that are more meaningful and empowering to the people involved. In more recent years, the term ‘care’ has been broadened to include learning and working relationships, resulting in the concept of person-centred care practice and person-centred care cultures in workplaces. Person-centred care practice and development are underpinned by openness, reciprocity in learning, participation, and engagement (Jacobs, 2015).

One major development in person-centred care has been in research, which has gone from the macro and meso level average health service and collective ‘patient’ to the individual and their journey, at a micro-level. There has been a distinct shift towards increased understanding of an individual’s health trajectory through self-rating health, subjectivism, as well as individual establishment of well-being and goals. Further progress would encompass contribution of therapeutic, intimate and social support relationships to improve older people’s individual health (Martin & Félix-Bortolotti, 2014).

Another development has been that of reflective models of person-centred care such as the VIPS model. Because person-centred care is something that characterises the relation between each nurse and the older person as well as the atmosphere in the facility, the VIPS practice model focuses on the process among the staff. It aims for care staff to become more person-centred, and the building of a shared base of values and knowledge among care staff so that they are able to work together collaboratively
The VIPS model for person-centred care has four constructs, comprising of: ‘valuing the person’, ‘individualised care’, ‘understanding the person’s perspective’, and ‘positive social psychology’ (Wilson, Moss, & Willetts, 2016). This model developed person-centred care because it focussed on care staff by providing a clear set of four constructs delineating the expectations of each of the constructs that care staff can follow to assist them in applying person-centred care.

One of the most significant developments in person-centred care was the development of a person-centred care framework by McCormack and McCance. The framework consists of four steps ((Masterson, 2007; McCormack & McCance, 2010) (1) Prerequisites, which focus on the attributes of the nurse being professionally competent, having interpersonal skills, commitment to the job, having clearness of beliefs and knowing self. (2) Care environment, which focuses on the context in which the care is delivered. (3) Person-centred processes, which focus on the deliverance of care through a range of activities, and (4) Outcomes, the central element of the framework which are the results of efficacious person-centred care nursing and include: overall satisfaction with care; involvement in care; feeling of well-being; and creating a therapeutic environment. McCormack and McCance (2010) noted that the person-centred care framework aids in helping to gain understanding of the dynamics of the components of person-centred care. The development of a therapeutic relationship with service users is integral to the accurate assessment and understanding of resident needs and the implementation of effective, person-centred care (Doherty & Thompson, 2014). A Therapeutic relationship between caregivers and residents is defined as a professional relationship that is established specifically to meet the needs and health outcomes of residents to ensure their safety and that they are supported in their daily lives. It is a relationship where time spent with a resident to maintain the relationship enables caregivers to evaluate, plan and deliver care that is person-centred (Feo, Rasmussen, Wiechula, Conroy, & Kitson, 2017). Rather than curing disease, therapeutic relationships focus on empathy and warmth to help residents feel comfortable and secure. Therefore, to develop a therapeutic relationship with residents, caregivers need to be caring and open, warm and genuine. Therapeutic relationships are fostered by employing listening and questioning techniques as well as providing information, giving support and ensuring care is person-centred (Doherty & Thompson, 2014).

Manley, Hills, and Marriot (2011) support a framework that identifies a number of outcomes that may possibly inform measures or methods that workplaces need to utilise to determine whether or not person-centred care is being delivered. Adversely, the person-centred care framework does not seem to have a feedback loop – i.e., monitoring outcomes is seemingly appropriate; however, what if those outcomes demonstrate that person-centred care is not being implemented Accordingly? There
needs to be a feedback loop that takes it back to step one, two or three, depending on where implementation failed; eg, if a nurse was not fulfilling their role appropriately, you would need to revert back to step one to engage the nurse in further information sharing specific to person-centred care.

### 2.8.1 Person-centred cultures

Major culture change, in even small organisations, can take years to establish (Manley, O’Keefe, Jackson, Pearce, & Smith, 2014); and require a commitment to practice development, service improvement as well as ways of working that embrace continuous feedback, reflection, and ensuring that all voices are heard (McCormack et al., 2015). Transforming culture is definitely challenging and requires sustained effort and commitment from leaders at all levels of the organisation. Change, in and of itself, can be threatening, and can also bring with it uncertainty. Organisational cultures that support innovation and continuous improvement are characterised by shared values, a commitment to continuous learning, team collaboration, and transformational leadership. The impact of the physical environment on culture and patient outcomes has also been identified as an important factor in the development of person-centred care (Beckett et al., 2013). Pope (2012) asserted that nursing culture is fundamental in the improvement of attitudes, because management decides what practice is acceptable, what is not and when change is necessary, and this is important for person-centred care as management plays an important role in the focus and direction of residential aged care facilities. Effective managers ensure that all staff understand and contribute to the vision of an organisation and that they understand the need for organisational change, otherwise staff will believe that current practices are acceptable and change is not needed (Muls et al., 2015). Moreover, Kirkley et al. (2011) stated that many organisations describe their service as being person-centred without making the necessary cultural shift to enable this to happen.

The presence of five attributes that characterise effective workplace cultures can provide feedback that workplaces are travelling in the right direction, and are more likely to deliver on improvements in health outcomes such as one that is deemed person-centred. Transforming culture remains a challenging process, requiring resilient, committed staff, and good systems of high support and high challenge. The process of culture change is unsustainable without a strong commitment to a shared purpose. A practice development project in England in 2011 demonstrated the development of a shared purpose, increasingly reflected in a social movement that has grown up across the organisation and other areas of the local health economy. If shared purpose is the main driver of decision-making and actions, then benefits in terms of cultures that enable everyone to flourish result. The key insights arising from the
journey of culture change in this study were: The importance of developing and implementing shared purpose and value. That explicit attention must be paid to developing effective workplace cultures if person-centred, safe and effective care is to be sustained. An agreement between healthcare providers is a catalyst that enables practice development and knowledge transfer to be aligned with and deliver positive benefits. It is important to empower people with the key skills for enabling others to be effective across organisations. There is a need for organisational strategies such as learning and development, research, innovation and quality to be focused on the shared purpose of the organisation and its staff. Practice development methodology is a powerful way to help organisations define and embed shared purposes around the development of flourishing, person-centred and effective cultures (Manley et al., 2014).

Furthermore, the widespread movement of culture change in residential aged care designed to provide person-centred care has received much attention from the research community, yet in most instances, has ignored the voices of the residents who are at the centre of the care. Interviews with resident living in facilities purporting to provide person-centred care reveal the extent of the participants’ satisfaction with the care received. They challenged the claims of person-centred care by describing the inadequacy of the caring environment, the human indignities, and the loss of the personal autonomy they experienced (Donnelly & MacEntee, 2016).

2.8.2 Key person-centred care studies

Five key themes that were identified by Kirkley et al. (2011) that potentially influence the delivery of person-centred care and have a relationship to aspects of organisational culture are: (1) Understandings of person-centred care (2) Attitudes to service development (3) Service priorities (4) Valuing staff (5) Solution-focused approach. This study reported the views of front-line staff, service managers, commissioners and independent experts on the implementation of person-centred care with no input from residents or their families on what they believe is important for the successful implementation of person-centred care. Even though they may have a diagnosis of dementia, if they are in the first stage of the disease, they are still able to successfully communicate their opinion and if not, they may have family and/or partners who can advocate for them.

One person-centred care study was the Lund trial in Sweden and an Australian replication (Nay & Garratt, 2009). The Lund trial addressed factors preventing staff in residential dementia care facilities from implementing person-centred care and,
concurrently, creating an environment where they are assisted to do so. This trial highlighted the difficulties of providing person-centred care in Australia where resources are stretched and raised questions as to the capacity to deliver person-centred care in many Australian facilities. In conclusion to this trial, it was said that person-centred care will most likely remain evasive in facilities with the exception of the well-resourced and dedicated.

2.8.3 Development of therapeutic relationships

A therapeutic relationship in the context or residential aged care is linked with person-centred care and defined as a relationship in which the resident feels comfortable enough to be open and honest with caregivers. Rather than curing disease, therapeutic relationships focus on showing empathy and warmth to assist residents to feel relaxed and secure, and are facilitated by caregivers being open, caring, warm and genuine. To foster therapeutic relationships, caregivers employ good communication skills as well as the sharing of information to ensure the care provided is person-centred (Doherty & Thompson, 2014). Admission to a residential aged care facility reduces an individual’s ability to maintain an older person’s lifestyle, which can negatively affect the well-being of many elderly people (Bergland et al., 2012). Transition from home to residential aged care rarely goes smoothly for older people, it is a time of great loss and despair for many (Chin & Quine, 2012), and is also said to be a stressful process after leaving the familiarity of a family home (Lewinson, 2015) highlighting the importance of building therapeutic relationships.

2.9 Standards for person-centred care

Manley and McCormack (2008) see person-centred care as a result of an individual’s ability to offer personalised, compassionate and dignified care depending on their characteristics as nurses. Additionally, Manley et al. (2011) proffer that everyone in a team requires skills to be able to implement person-centred care, which will be enhanced if each member of a team is using the same approach. A commonly shared view (Manley & McCormack, 2008; McCormack et al., 2011) is that person-centred care should never be a one-time, special event, rather, continuous development of nursing practice is required with sustained commitment from organisations, managers as well as leaders at each level.

Effective leadership plays a vital role in developing caregiver understanding of resident values, priorities and needs, and embracing new innovations through a change
management process toward person-centred care (Rokstad et al., 2015). Person-centred care expedites the building of strong relationships between leaders and caregivers within an organisation in order to break down the leadership hierarchical structure and create a decentralised view of leadership. This facilitates a supportive environment where decisions can be made in collaboration with caregivers and residents, where the residents are the priority (Corne, du Toit, & van Heerden, 2014). However, there is a paucity of information discussing the relationship between leadership and person-centred care in nursing research, although the person-centred nursing framework highlights the importance of leadership for the implementation of person-centred care (McCormack & McCance, 2006). This framework was derived from theory suggesting that leadership is a prerequisite for the implementation of person-centred care, and that leadership has also been identified as an important element of person-centred care interventions (Backman et al., 2016).

An effective staff training program is said to improve practice faster than any other change that could be made within residential aged care (Levoy, 2011). Furthermore, Kirkley et al. (2011) identified the need for regular staff training, and that person-centred care training should focus more on understanding or comprehension rather than the transfer of knowledge which involves interactions between people. A similar standard of understanding of person-centred care should be expected of all staff within an organisation. Meaningful learning for staff in residential aged care can help with professional and personal development, if appropriate time and space is provided. Staff need support and encouragement to reflect on their personal practice changes by sharing practice experiences and broadening their knowledge on practice (Chia Swee, 2012). Additionally, managers quite often are not always aware of their own need for training in relation to person-centred care, and that central to training for managers is a focus on cultural change. Bolster and Manias (2010) affirmed that although nurses, caregivers and managers might think they are implementing person-centred care, their understanding and practices may not align with the principles that underpin this approach to care.

Manley et al. (2011) cautioned that relationships with residents can be transient requiring caregivers to be skilled, respectful communicators who are vigilant ensuring resident safety at all times. McCormack et al. (2011) contended that the real challenge for all organisations in delivering person-centred care is to move from sporadic, ‘person-centred moments’ to ‘person-centred cultures’. They counselled that simply relying on the individual motivation of nurses and caregivers is not realistic. Adopting person-centred care requires a sustained organisational commitment and workplace culture change. Sustaining changes in workplace culture is a challenge, and personal situations can affect work and attitudes towards work on any given day can carry-
through to impact implementation of person-centred care. Nurses and caregivers can
develop their own interpretation of person-centred care through the sharing of
information and reflecting on their own practice (Bolster & Manias, 2010).

2.10 Measuring person-centredness to ensure quality of care

S. Davis et al. (2008) suggested that although many care workers and professionals
believe they are providing person-centred care, there is limited evidence demonstrating
that it is being measured and monitored in a way that is reflective of the true nature of
person-centred care. Similarly, Edvardsson et al. (2010) add that there are few outcome
studies operationalising person-centred care, and limited use of valid and reliable
assessment scales for the measurement of person-centred care (Edvardsson et al.,
2015).

According to Pope (2012) successful outcomes of person-centred care include patient
satisfaction with care, improved health and involvement of patients in decisions related
to their direct care. Additionally, S. Davis et al. (2008) suggest that the results from
patient and client satisfaction surveys can be very influential in terms of the
determination of service structure, development and financial support. However,
reservations have been raised regarding the validity of both person-centred care and
measurement of satisfaction, as satisfaction surveys do have a role in health care
evaluation. Their utility in the measurement of person-centred care is also limited.

Rokstad et al. (2015) and Edvardsson and Innes (2010) noted that a growing number of
useable tools are available for the measurement of person-centred care in diverse
settings. Twelve tools were reviewed by Edvardsson and Innes and out of those twelve;
eight were developed for the evaluation of residential aged care (Edvardsson & Innes,
2010). An example, one of the tools, the PCQ-S (Person-Centred Climate Questionnaire)
was originally developed in Sweden based on qualitative studies exploring the content
and meaning of psychosocial environments of care as perceived by patients and staff.
The tool can be used reliably and interpretatively both for research and practice
development purposes, and is a tool for nursing management to evaluate the person-
centredness of their environment, to benchmark other organisations, and to identify
staff members at risk of stress, less satisfaction or low support (Edvardsson et al.,
2015).
Edvardsson and Innes (2010) state that by being able to compare, measure and correlate the person-centeredness of environments with other outcome measures of health, there is a definite opportunity to increase understanding of person centred care. However, Edvardsson and Innes (2010) maintain that the lack of wider application of measurement tools since their development means that it is too early to tell how credible they could be. There is definite scope for more testing of available tools to gauge a more accurate measurement of person-centred care, with Nay and Garratt (2009) noting that a large amount of the body of literature on person-centred care, reported clinical experiences, personal opinions, as well as anecdotal evidence. However, they stated that there were very few reliable, valid and clinically useful tools for the measurement of person-centred care. Additionally, Edvardsson and Innes (2010) assert that there is a need for reliable and valid measures, implicating that what is available is not satisfactory.

2.11 Challenges and barriers to implementing person-centred care

Implementing person-centred care in practice is not straightforward because of its ill-defined nature. Furthermore, it could be construed as too idealistic and unworkable on a day-to-day basis. Other suggested barriers to the implementation of person-centred care include: an emphasis on loss and dependency rather than ability and potential; and issues relating to resources and staffing within social care (Kirkley et al., 2011). This section presents further challenges and barriers to implementing person-centred care including: negative attitudes, lack of involvement in decision making, translation of person-centred care into practice, and time constraints, concluding with a summary of the review and justification for further study.

Negative attitudes:

A challenge and barrier to the implementation of person-centred care is ageism; which is a negative attitude towards older people that categorises them rather than recognising them as individuals (Frost, Ranse, & Grealish, 2016). Ageism promotes a powerful social discourse that potentially leads to harm of older people through omission of care due to a lack of skills and knowledge specific to gerontology, as well as through acts that are unintentionally harmful. It is important to address ageism in all undergraduate health curricula (Frost et al., 2016), additionally; organisations and managers need to support maintenance of reformed attitudes and transference of attitudes to all new staff members in order to develop positive person-centred care cultures (Pope, 2012).
Many nurses adopt negative attitudes towards residents that influence how they perceive older people, interact and deliver care (Pope, 2012). Negative attitudes continue to be a barrier to person-centred care implementation as staff can consciously or unconsciously regress to providing the ‘usual’ care or even lack the interest, knowledge, or commitment to change (Moore et al., 2016); Pope (2012) reinforced that some attitudes cannot be changed quickly; cultural change is complex and includes self-discovery, reflection at a personal level and training, as well as the input from management (Pope, 2012).

Lack of involvement in decision making:

Manley and McCormack (2008) expressed concerns about specific limitations described as a definite lack of involvement of older people in the decision-making process regarding their own treatment including how they wish to be cared for, and that a change is needed in the culture of care in workplaces and organisational levels if residents are to receive the dignified, empathetic and personalised care they deserve.

Translation of person-centred care into practice:

Translation of person-centred care into practice is not straightforward due to; the ill-defined nature of person-centred care, it is too idealistic and unworkable on a daily basis. Implementing a person-centred care approach is conflicting with practice reality, which denies diversity and contradicts traditional models of service delivery.

Time constraints

Time constraints including person-centred care training time are often articulated as a reason why nurses and caregivers find themselves unable to provide care that is person-centred, leaving them feeling torn between ‘real’ and ‘ideal’ styles of care (Rushton, 2016). Person-centred care training takes time, and with the fast paced nature of healthcare, person-centred care implementation can be difficult (Moore et al., 2016)

2.12 The relationship between person-centred care, management and leadership

Leadership is defined as an action or ability to influence staff, and guide them to achieve their goals (Rokstad et al., 2015), to inspire individual and organisational excellence, create a shared vision and successfully manage change (Cliff, 2012). In times of
uncertainty people look to leaders, particularly strong and directive leaders, to provide a clear path to follow (Rast, Hogg, & Giessner, 2013). Jones and Bennett (2012) stated that leadership is primarily concerned with human relationships and dynamics and when applied well, can motivate people to perform to exceptional personal levels and achieve great things. Additionally, Josefsson and Hansson (2011) added that nursing leadership is essential for the promotion of evidence-based practice as well as a major factor influencing quality of care. Jeon et al. (2015) support the essential attributes of good leadership for middle managers in aged care of; hands-on accessibility, professional expertise in nurturing respect, recognition, team building, effective communication and flexibility. There are several different management and leadership styles, all fundamental in ensuring subordinates’ acceptance of change, and to motivate them to achieve established goals and high quality care, nevertheless, management styles are a complex concept influenced by individual attributes (Zampieron, Spanio, Bernardi, Milan, & Buja, 2013).

Middle managers have a central leadership role in the development and support of person-centred care practice, and effective leadership engagement in any culture change initiative toward person-centred care is crucial (Cliff, 2012). The relation between management and leadership, and the impact and significance of leadership in relation to person-centred care has rarely been evaluated in nursing research (Backman et al., 2016; Corne et al., 2014). However, there are frameworks that highlight the importance of management and leadership for person-centred care, for example, person-centred nursing framework, and the person-centred framework for long-term care by McCormack and McCance (2006). Those frameworks were devised from person-centred theory and suggest that clinical leadership is a prerequisite for person-centred care (Backman et al., 2016). The role of a manager is seen as a formal role in the context of residential aged care, the manager delegate’s caregiver activity and controls organisational functions. Leadership is about the behaviour of the manager, such as their ability to promote person-centred care innovation and inspiration amongst caregivers, as well as to challenge and guide them by using persuasion in order to achieve specific goals (Backman et al., 2016). It is important for managers to ensure that care for residents is individualised, and to ensure residential aged care facilities are home-like. This requires a focus on resident preferences and quality improvement. Person-centred care training for caregivers is important, as is the inclusion of all staff in decision-making (Shield, Looze, Tyler, Lepore, & Miller, 2014).

Management and leadership although used interchangeably, are two different concepts; however they are intertwined and there is overlap between the roles and functions of leaders and managers in healthcare (Dignam et al., 2012). Managers and particularly middle managers focus on systems, order and control (Dignam et al., 2012). They
communicate information and coordinate activities, as well as implement strategies devised by those above them. They act as change agents and oversee the day-to-day running of facilities (Meissner & Radford, 2015). Middle managers are an essential element of healthcare organisations as they perform a variety of important duties that make significant contributions (Meissner & Radford, 2015). Additionally, Meissner and Radford (2015) stated that in an environment that is constantly changing, the ability to effectively manage change is an essential quality in a middle manager. Managers have a central role in drawing up a clear and consistent professional vision, and being continuously supportive to caregivers, as well as taking an active part in care as role models (Rokstad et al., 2015).

![Table: Elements of leadership and management](Figure 2.2 Elements of leadership and management)

<table>
<thead>
<tr>
<th>Elements of leadership</th>
<th>Overlapping elements of leadership and management</th>
<th>Elements of management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspiration, transformation, direction, trust, empowerment, creativity, innovation and motivation</td>
<td>Communication, decision-making, integrity, role model, negotiation, professional competence and setting standards</td>
<td>Delegation, performance, planning, accountability, finance, teamwork and team building, monitoring and evaluating, formal supervision and control</td>
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</tbody>
</table>

Healthcare is complex, being multifactorial in nature and fast paced (Solman, 2010), and strong leadership is important to ensure the development of the registered nurses professional role in the care of older people (Josefsson & Hansson, 2011). Salmelä, Eriksson, and Fagerström (2013) maintained that leaders are of particular importance during various stages of change because of their strong communication skills as well as their ability to provide vision, among other abilities. Innovative leadership in healthcare is required to keep pace with changes in policy, practice and the promotion of a cohesive workforce able to provide person-centred care to residents (Solman, 2010). Leaders who are able to guide and develop a combination of leadership styles including transformational leadership are capable of vanquishing oppressive traditions and navigate the complex, rapidly changing healthcare environment (Maboko, 2012).
2.13 Précis

Healthcare organisations particularly aged care services are experiencing considerable change largely due to the ageing population (Jones & Bennett, 2012). This chapter identified that the adoption of person-centred care as a preferred model of care will require managers who are visionary, inspiring and committed to developing effective, respectful and collaborative workplace cultures. It also identified that more research is needed to understand the challenges of knowledge transfer into daily practice.

The literature review highlighted the need for more intense preparation for middle management leadership roles in residential aged care. There is also a lack of clear, concise guidelines and key performance indicators to assess management and leadership skills, furthermore, traditional management skills that normally only action on sound organisational work need to be expanded to include leadership skills and competencies (Jeon et al., 2015). Solman (2010) proffered that when working with staff, practice development approaches to leadership enable supportive person-centred values to be present in their development. This chapter has identified gaps and highlighted the need for further work to understand and implement person-centred care, including training needs for all staff associated with residents. A comprehensive review of literature highlighted that person-centred care is considered by many the optimal way to deliver health care (S. Davis et al., 2008); however the literature also highlighted how translation of person-centred care into practice presents challenges, understanding how person-centred care is perceived and implemented in practice by aged care personnel in Australian contexts is not well understood.
CHAPTER 3: METHODOLOGY

Introduction

This chapter provides an overview of the major research paradigms. The rationale for selecting a qualitative research methodology, action research to guide this study is presented. The impetus for undertaking the study and the fit with the chosen methodology are explained. Action research is described and the research question delineated. Finally, the processes associated with undertaking the study, participant recruitment, data generation and analysis within an action research framework are clarified.

3.1 Selection of the methodology

This study was conceptualised following a discussion between the Director of care of Beaches Care of the Aged and myself as facilitator. With the knowledge that the population is ageing rapidly, both the Director of Care and I expressed the significance of, and an avid interest in, improving resident care through translation of person-centred care into sustainable practice. Although person-centred care was included in the organisation’s mission statement, both the Director of Care and I aimed to facilitate change in a manner that resulted in the empowerment of participants, collaboration through participation, acquisition of knowledge, and social change (Taylor & Francis, 2013b), in keeping with the principles of person-centred care.

Because Action Research is distinct from traditional research strategies, having an understanding of the benefits and challenges of this mode of research is a crucial preliminary step in determining the appropriateness of action research for a particular context (O’Leary, 2010). A methodology was required that would incorporate small groups of people to collaborate on a regular basis to discuss real-life issues and concerns that they deemed important to act upon to enable change. It needed to be a methodology that would also enable understanding of person-centred care and the generation of further knowledge. Participants needed to have a desire for change and were required to incorporate critical reflection of their own practice as well as that of the organisation in order to action change. Selection of the most appropriate methodology was achieved following a review of major research traditions and the philosophical assumptions that underpin them. Facilitating practice change was the primary driver for undertaking this research. Thus, a research methodology that engaged and empowered caregivers to review and modify current practice and to
reflect a collaborative understanding of person-centred care that enhanced resident’s connectedness and wellbeing was necessary.

It was important that caregiver experiences were a central focus as they needed to be engaged in, and lead a change process that realised a reconceptualised person-centred care approach (Taylor & Francis, 2013a). For this to occur, it was vital that participant voices were heard through collaborative engagement within a democratic process of change. The major two research traditions, quantitative and qualitative research methodologies, are presented to highlight the decision trail that enabled the facilitator to determine an appropriate methodology to guide this study. Many researchers and indeed research texts classify research approaches as only either quantitative or qualitative. This simplistic classification system ignores philosophical nuances that are highlighted in the paradigms below.

### 3.2 Paradigms

Bunniss and Kelly (2010) proffer that paradigms are sets of beliefs and practices shared by communities of researchers, which regulate inquiry within disciplines. Various paradigms are characterised by ontological, epistemological and methodological differences in their approaches to conceptualising and conducting research, and in their contribution towards disciplinary knowledge construction. (Bunniss & Kelly, 2010) Additionally, there are four major paradigms currently used within research that describe assumptions pertaining to ontology (the nature of reality), epistemology (the nature of knowledge), methodology (the nature of research) and the related research methods for each perspective. The four major paradigms are: (1) Positivism, (2) Post-positivism, (3) Interpretivism, and (4) Critical social theory. Below is a description of each of the four paradigms (Bunniss & Kelly, 2010).

#### 3.2.1 Positivism

Positivism, according to Arghode (2012) is a family of philosophies characterised by a positive evaluation of science and scientific method. Positivism assumes that if there is a problem, there exists a solution. It is helpful in providing a solution to technical problems. Quantitative research aims to measure and is most frequently associated with positivism (McCusker & Gunaydin, 2015), being based in the positivist paradigm or fact as based upon physical evidence (Angers, 2013). The assumptions of positivism are that truth is an independent part of a whole, and that theory should be deductive and a
priori, rational cause and effect is possible. Positivist scientific research aims to be objective and value-free (Henderson, 2011).

### 3.2.2 Post-positivism

Post-positivism shares a common view ontologically with positivism, that social reality is external and objective. Post-positivists challenge the belief of absolute truth and believe in generalisation, but also admit that that knowledge is a result of social conditioning (Ryan, 2015).

### 3.2.3 Interpretivism

Interpretivism is the basis for qualitative research and it is rooted in humanism (Humphrey, 2013). Humphrey (2013) added that research studies in the interpretivist paradigm can use participant observation and that researchers who base their research on the interpretivist paradigm seek explanations and analyse responses in many different ways to uncover their meaning.

### 3.2.4 Critical social theory

Critical social theory draws attention to the underlying principle of oppression and opens up the possibility of learning about oneself from deep within, moving from oppression to liberation (Lapum et al., 2012). Humphrey (2013) stated that critical social theory unveils the deep structures of society which conspire to perpetuate exploitation and oppression in spite of surface measures that are designed to promote equal opportunities. Moreover, critical social theorists distinguish between appearance and reality; what ‘appears to be’ is not reality, for it often does not reflect the tensions, conflicts and contradictions that are eminent in society and appearance is based on illusion and distortion (Sarantakos, 1998). Critical social theory is an engaged theory, meaning that it assumes involvement and activism on the part of the researcher. Researchers do not only study reality, they act upon it (Sarantakos, 1998). Moreover, Action Research is said to have developed out of critical social theory and went beyond it (McNiff & Whitehead, 2012).
3.3 Quantitative research

Quantitative research is a school of thought based on the traditions of natural sciences drawing on a scientific approach of observation (objectification), testing and the verifiability principle as the only claim to knowledge. Quantitative research methodology and its association with positivism operate on strict rules of logic, truth, laws and predictions. Quantitative researchers, as opposed to qualitative researchers, hold the position that “truth” is absolute and that a single reality can be defined by careful measurement. (Williamson, Bellman, & Webster, 2012).

3.4 Qualitative Research

In contrast, qualitative research is associated with subjectivism and is a systematic and methodological approach used to describe people’s life experiences and give meaning to them (Burns & Grove, 2011). Essentially, a qualitative research design attempts to explore the relative nature of knowledge itself which is subjective, unique and context dependent. People and phenomena are subject to change according to circumstances, therefore deeming it inappropriate to make generalisations from a wider cohort of people or things to be studied (Taylor & Francis, 2013b). Additionally, qualitative approaches use insight from participants’ perspectives enabling a researcher to understand the views of the participants (Malagon-Maldonado, 2014). A delineation of the two dominant research traditions are outlined in the table below.

<table>
<thead>
<tr>
<th>The quantitative tradition</th>
<th>The qualitative tradition</th>
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<tbody>
<tr>
<td><strong>Paradigm/assumptions:</strong> positivism, empiricism, objectivism, definitive truth</td>
<td><strong>Paradigm/assumptions:</strong> subjectivism, interpretivism, constructivism, multiple truths</td>
</tr>
<tr>
<td><strong>Methodology:</strong> Scientific method, hypothesis driven, deductive, reliable, valid, reproducible, objective, generalizable, randomised control trials, pre-test post-test, quasi experimental</td>
<td><strong>Methodology:</strong> ethnomethodology, phenomenology, ethnography, action research, inductive, subjective, idiographic, intuitive</td>
</tr>
<tr>
<td><strong>Methods:</strong> large scale, surveys, random control trials</td>
<td><strong>Methods:</strong> small scale, interviewing, observation, document analysis</td>
</tr>
<tr>
<td><strong>Data type:</strong> generally quantitative</td>
<td><strong>Data type:</strong> generally qualitative</td>
</tr>
<tr>
<td><strong>Analysis:</strong> statistics</td>
<td><strong>Data type:</strong> thematic exploration</td>
</tr>
</tbody>
</table>

Figure 3.1 Comparison of qualitative and quantitative research traditions.
Qualitative research is useful when the focus of research is on complex issues such as human behaviour and expressed needs. The goal of qualitative research is to assist in the understanding of social phenomena with the added help of the views and experiences of participants involved in a study (Isaacs, 2014). Due to the uniqueness of qualitative research, which is associated with subjectivism, the research aims were best addressed with the application of a qualitative methodology, rather than a quantitative methodology, which is associated with positivism, as previously explicated (Williamson et al., 2012). To find the multiple realities in the present study, the researcher needed to apply a qualitative approach, underpinned by critical social theory, which needed to be subjective, aligning it with values, feelings and personal perceptions (Burns & Grove, 2011).

3.5 Action Research Origins

Widely used in healthcare, action research has become increasingly popular around the world (McNiff, 2013). Early action research work was pioneered by Kurt Lewin (1890-1947), who is frequently credited for “coining the term” action research (Williamson et al., 2012). Lewin was a Prussian psychologist (who later moved to America) with a special interest in human behaviour who gained his reputation from his unique approach to social issues (Taylor & Francis, 2013b) and had a significant impact on researchers concerned with group dynamics (Infed, 2012). Lewin advised that social scientists should devise and apply techniques that equip groups of people with the ability to change certain aspects of their practice and was responsible for the conceptualisation of action research as a spiral methodology (Williamson et al., 2012).

Other researchers who have made significant contributions to action research include: Kemmis and McTaggart, who published “The Action Research Planner” in 1982, which became a seminal text for action researchers worldwide, and then in 2014, Rhonda Nixon joined them as they published a fully-updated version (Zuber-Skerritt, 2016). Another notable contributor to action research writings, Jean McNiff (2013) proffered that all professionals should be reflective practitioners and need to be able to explicate and articulate their personal theories of practice to demonstrate how they personally hold themselves accountable for their educational influences in learning (McNiff, 2013). Professor William Barry, an American social scientist, was one of the first social scientists to realise the huge potential of action research and the profound effect it could have on educational practice. Barry promoted an approach called “Living Educational Theory” which he described as a transformational and critical approach to the status quo of educational practice. By applying this approach, Barry stated that
teachers would be forced to challenge the status quo by asking the question “how can I improve what it is that I am doing?”("Action Research: The ultimate problem-solving strategy for educators," 2015).

### 3.6 Action Research

Action research is a qualitative research methodology that creates the possibility of change through a collaborative process that raises awareness and supports purposeful action (Taylor & Francis, 2013a). It is known as an artistic endeavour requiring a soulful and imaginative approach to assessing its quality (Houghton, Casey, Shaw, & Murphy, 2013). Action Research is linked with Critical Theory, which asks the question “How can this situation be understood in order to make a change to it?” (McNiff & Whitehead, 2012). The first versions of Action Research in Western cultures have their roots in community development programs (Alston & Bowles, 2003). Elements that characterise Action Research are the emancipatory nature of the research, the active involvement of the participants and its opposition to certain established policies and practices (Sarantakos, 1998). The broader understanding of Action Research in America is ‘the systematic collection of information that is designed to bring about social change (Infed, 2012)’.

Action Research is cyclical in nature and comprises elements of planning, action, observation and reflection (Hegney & Francis, 2015). Action Research is a reflexive process (Taylor, Roberts, Smyth, & Tulloch, 2015) which is defined as a process of a continual internal dialogue with critical self-evaluation in reference to a researcher’s positionality, or where they are positioning the research and in what context, as well as acknowledgement and recognition that this position could affect outcomes (Berger, 2015).

Taylor and Francis (2013) proffered that Action Research consists of a family of research methodologies that have action intent, which is, the research undertaken seeks to find the answer to a question that results in affirmative action. These processes are informed by critical social theory, which was advanced by Habermas who contended that people are oppressed if they do not understand the systems of domination and their associated dependence which are said to be artefacts of western society. Action research is a social process leading to change through collaboration and transformative actions. Action research is a popular methodology and considered one of the most exciting forms of qualitative research (Taylor & Francis, 2013b) which has been adopted by educational and healthcare researchers over time, and is defined as a
methodology utilised by health professionals to collaboratively engage with people (Bigby, Frawley, & Ramcharan, 2014). Additionally, it is a methodology that aims to increase knowledge and address issues of equity where relationships are egalitarian rather than hierarchical, a communicative space where people can enter on equal footing where people come together to discuss a common problem or issue and reach a consensus on action (Bish, Kenny, & Nay, 2013). The key elements of action research as suggested by O’Leary (2010) are that it addresses real-world problems, pursues action and knowledge, and participation.

(1) Addresses real-world problems: action research is said to be grounded in real problems and real-life situations. Generally, it begins with identifying practical problems in a specific real-world context and then attempts to understand those problems to then seek and implement solutions within that context. Action research is quite frequently used in workplaces and rural communities, where the ownership of change is a high priority/goal or where the aim is for improvement of professional practice. It is an effective strategy for use when there is a strong desire to transform both practice and theory (O’Leary, 2010).

(2) Pursues action and knowledge: Action research rejects the two-stage process of ‘knowledge first and change second’ with the suggestion that they are highly integrated. Action researchers believe that enacting change should never be just seen as the end product of knowledge; rather it should be valued as a source of knowledge itself (O’Leary, 2010).

(3) Participation: the very notion of research as the domain of the expert is rejected, with action research calling for participation of, and collaboration between, researchers, practitioners, and any other interested stakeholders. Action research minimises the distinction between the researcher and the researched and places a high value on local knowledge. The premise is that without key stakeholders as part of the research process, outsiders are limited in their ability to build rich and subtle understandings, or implement sustainable change. Contrary to many research methodologies, action research works with, rather than on or for, the researcher, and is regularly viewed as embodying democratic principles (O’Leary, 2010).

O’Leary (2010) described action research as containing two key elements: a focus on action or effecting change and the inclusion and involvement of people, who are fundamental to the issue. The goal is to work with stakeholders in order for new knowledge about a particular situation to be generated (O’Leary, 2010; Williamson et al,
as it is difficult to change a situation without working to understand it more fully (Williamson et al., 2012). The process is emergent and cyclical (O'Leary, 2010; Taylor & Francis, 2013); highly collaborative, democratic and participatory for those people experiencing the situation (O’Leary, 2010; Williamson et al, 2012).

Within action research, there are four basic themes: empowerment of participants, collaboration through participation, acquisition of knowledge, and social change (Ferrance, 2011) which are also congruent with O’Leary’s (2010) key elements of action research. Action research is potentially a powerfully liberating and empowering form of professional enquiry because the participants investigate personal practices making it self-reflective. Additionally, O’Leary (2010) proffered that action research can produce knowledge and change in empowering ways, although the process itself is far from easy.

Figure 3.2 shows a typical action research cycle incorporating suggestions by Taylor and Francis (2013).

A typical action cycle described by Smith et al (2013) is a process whereby research participants engage in activities (focus group activities) including identification of specific problems, planning and development of strategies to address these problems, implementation of actions and, finally, evaluation of the consequences. Reflection is
always a major component of the entire cycle and each phase of the cycle involves a process of shifting between reflection and action.

### 3.6.1 Limitations of Action Research

Taylor and Francis (2013) state that the limitations of action research are that it is context specific, problem focused, and often involves only small numbers of people. Furthermore they argue that the ‘grass roots’ nature of this approach impacts on the generalisability of findings, and that projects are time limited. Timeframes are generally developed from the outset; however recognising and managing for contingencies is always a vital part of the planning process. Additionally action research studies are often hampered by participants withdrawing during the trajectory of a project. Changes to the action research group membership can disrupt progress of a study. Projects can take longer than planned and outcomes may not be achieved that the action research group expected, and also the agendas set by an action research group can change which can impacts on group membership, timelines and require objective resetting.

### 3.7 Précis

This chapter explicated the researcher’s choice of action research as the methodology for the present study including clarification of the key differences between qualitative and quantitative research. The four major paradigms of positivism, post-positivism, interpretivism, and critical social theory were delineated. Action research origins were discussed as were the key elements of action.
CHAPTER 4: ACTION RESEARCH-CONCEPTUALISATION OF THE STUDY

4.1 Introduction

The study setting, ethical considerations, recruitment processes and the methods for data generation and analysis are described in this chapter. The aged care service and the three aged care facilities of this service that were involved in the study are introduced. Additionally, participant recruitment and establishing the action groups at each of the three facilities are presented and the role of the researcher as facilitator for each of the action groups is delineated. This chapter also includes a discussion of practice development as a tool to support the implementation of person centred care at each facility and methods of data generation and data analysis techniques are discussed. Finally, planning developed by each of the action groups to progress their commitment to person-centred care is established.

The decision to undertake a qualitative research study was strengthened by discussion with the Director of Care of Beaches Care of the Aged who, with the facilitator, agreed there was a need to develop a deeper understanding of the meaning of person-centred care along with changes to assist translation into practice. The Director of Care of Beaches Care of the Aged was keen to move the organisation further toward a person-centred care approach and was prepared to set the scene for a change management process. The Director of Care and I agreed that enhancing resident care through consistent and appropriate application of a person-centred approach was necessary. We decided that action research was an appropriate, as we wanted the staff of each of the three residential aged care facilities to be actively involved.

4.1.1 The Study Setting

The study setting was Beaches Care of the Aged, a peaceful garden setting and bird haven on five acres inclusive of three facilities (The Lighthouse, Seaview, and Sandcastles) nestled amongst the gardens within several hundred metres of each other. All three facilities catered for frail older people, couples, and people with varying degrees of cognitive impairment. Resident rooms in all three facilities were private with ensuites, and comfortable communal lounge areas were provided with televisions, ideal for residents and their visitors requiring a social space, that still provided some privacy away from the main areas. Lounge areas were equally as comfortable for residents wanting to sit and read or have a quiet cup of tea or coffee. On entry into each facility...
the pleasant aroma of fresh flowers that are provided weekly, complements the feeling of homeliness for residents and their families.

The workforce for Beaches Care of the Aged consisted of the Director of Care, Managers for each facility, who were also Registered Nurses, Clinical Registered Nurses, and assistants in nursing; kitchen and cleaning staff who are referred to as caregivers in this study. Assistants in nursing represent the majority of the workforce and they were the main providers of essential care for residents. Workforce roles are delineated below;

**Director of Care:** Director of care role is one that provides direction to the nursing staff and coordinates health services. A Director of Care typically has many years of experience in the health care field. Qualifications include a diploma, an associate, or Bachelor’s degree in nursing, and in many cases, post graduate qualifications are required such as a Master's degree.

**Facility Manager:** The facility Manager provides effective management of an aged care facility, ensuring the delivery of quality care, the maintenance of standards, facilitation and promotion of a work environment that is positive, responsibility for administration, nursing and personal care, environmental services, food services and maintenance divisions.

**Register Nurses or Clinical Registered Nurses:** have obtained a three-year Bachelor degree in nursing from a University. They are regulated by a national body, and their roles include; being responsible for the total care of patients and residents, including physical and mental well-being and safety, as well as the management of staff. Registered Nurses are typically employed in health care including hospitals, residential aged care facilities, public administration and safety. In residential aged care, there are few Registered Nurses, and generally on a day shift there may be two Registered Nurses working; however in the afternoons and evenings, there is usually only one Registered Nurse in a facility.

**Caregivers:** (otherwise known as assistants in nursing, or carers, and also includes kitchen staff, cleaners, administration staff, and lifestyle coordinators) have generally obtained a Certificate III qualification from a TAFE College or other training organisation which takes 0-3 months to complete. The role of an assistant in nursing is to support registered nurses, and enrolled nurses in the delivery of general patient care, assisting people to perform essential cares, as well as general assistant kitchen duties.
and cleaning, always under the supervision of a registered nurse. Assistants in nursing are employed in residential aged care, assisted living (at-home care), hospitals; community based long-term care, and other long-term care settings.

Shifts at each facility differed for each role, for example, caregivers provided 24-hour care and their shifts were; 0630-1430, 1430-2230, and 2230-0630. Staffing levels were highest throughout the day, lessened in the evening, and minimised overnight. One Clinical Registered Nurse was provided for each facility with shift times of; 0630-1430, and 1400-2200. A Clinical Registered Nurse was then on-call overnight to provide assistance to caregivers over the phone and to attend a facility of needed.

4.2 Ethical and Local Approval

An application detailing the proposed study was developed and submitted to the Charles Sturt University Human Ethics Committee. Following ethical approval to undertake the study granted by the Committee I contacted Beaches Care of the Aged Issues Committee. I then met with the Director of Care who invited me to attend the forthcoming Beaches Care of the Aged Issues Committee meeting to discuss my study. During attendance at the meeting, I received strong verbal support for the study that was unanimously supported and approved. I was assured by the Director of Care that individual managers would provide support for the study by way of providing work time to enable caregivers to participate in the study, flexibility for caregivers, as well as autonomy with decision making. A presentation was conducted with each facility before recruitment commenced. To address the privacy and confidentiality needs of the study, pseudonyms were used to protect the identity of the organisation as well as staff and residents. Any photographs presented in this thesis were from the facilitator’s personal collection and no identifying images were used.

4.3 Overview of the study

Action research as described in Chapter 3 involves cycles of action. Typically, each cycle includes stages of planning, action, observation and reflection (See Figure 4.1).
The study required delineation of the four components of each action research cycle and the activities for each stage as detailed below. This included initial discussions undertaken with each facility where I provided information sessions to the Director of Care, managers, clinical registered nurses and caregivers of each facility prior to seeking commitment and support, as well as clarification of support provided by the facilities, and my role as facilitator. Facilitation to begin the study included:

- Discussions between researcher and Director of Care to establish the need for the study
- Ethical considerations
- Recruitment of participants
- Information sessions
- Establishment of AR groups
- Preparation of research environment
- Establishment of roles and responsibilities
- Initial AR group meetings and establishment of person-centred care definitions for each AR group
- Problem identification
- Application of the Nominal Group Technique
- Prioritisation of goals for each AR group
- AR group reflection
Planning

Planning each action cycle needed to be flexible and involved the following steps:

➢ Developing a plan of action
➢ Reflecting on issues to be actioned from foundation
➢ Reflective journal exercises
➢ Sharing personal practice experiences
➢ Collaboration between participants to become more empowered to overcome organisational and personal restrictions.
➢ Accessing and sharing information to assist action research groups.
➢ Critical reflection
➢ Revising of action plan (for further cycles)

Action

The action for each cycle varied, but generally included:

➢ Discussion with participants regarding risks associated with proposed action/s
➢ Trialling agreed action/s
➢ Collecting and compiling data from each cycle
➢ Process evaluation
➢ Identifying and implementing modifications to action/s

Observation

In order to collect data and results about the effectiveness of each cycle, observation also varied but generally included:

➢ Documenting outcomes of action/s
➢ Analysing outcomes and collating the findings
➢ Discussing findings with action group participants and documenting their feedback
➢ Documenting impact of action/s
➢ Identifying facilitators and barriers that influenced action/s outcomes
➢ other issues

Reflection

Reflection in action research is important to determine how effective the cycle has been and what can be altered to make it more effective. Although reflection varied with each cycle, it usually included:
➢ Consideration of the efficacy of decisions with respect to achieving action group goals and research project aims
➢ Identifying opportunities for process enhancement
➢ Collaborating with action group participants to devise methods to further enhance engagement as a reflective group
➢ Considering the role and outcomes of practice development initiatives identifying the strengths and weaknesses of these and options to improve and sustain practice development
➢ Reviewing implementation of action/s
➢ Deliberating on the outcomes, goals achieved and those not realised
➢ Planning for the next cycle

Overall, this describes the planning, action, observation and reflection which were present in each cycle. How this varied and met the goals of each cycle is explicated in later chapters.

4.3.1 Initial discussions with each facility

Information sessions were scheduled to introduce the study to potential participants and delineate the details of the study. I conducted information sessions at each facility, welcoming potential participants and emphasising the importance of participant contribution and making a commitment to the study, as well as taking ownership of any actions. However, I reiterated to participants that they were free to withdraw from the study at any time without reprisal. Information for participants (Appendix 2) was provided to everyone who attended these information sessions. I guided them through the information, delineating the study; its aims, the potential contribution of the study, and participant rights. I introduced action research and action research groups, the nominal group technique, data generation methods, data analysis and anonymity. Anyone expressing an interest in committing to the study was provided a consent form (Appendix 3) for perusal and signature. All who attended the information sessions agreed to volunteer for the study and provided their signed consent forms. No participants withheld consent to record action group meetings, so all meetings were recorded for accuracy of data collection. I explained that pseudonyms would be allocated to each participant in any published material to protect their privacy.

I reiterated the importance of the role the participants played in the study and reminded them that they were involved in action research and as such were active participants in the cyclical research process. I explained the significance of reflection
throughout the study and the importance of sharing experiences and knowledge. I also explained the value of participant empowerment and taking ownership of their decisions, knowledge and change, aligning with the foundations of action research of increased empowerment, collaboration through participation, acquisition of knowledge, and social change (Ferrance, 2011).

4.3.2 Support provided by the facilities

The Director of Care as well as the managers of each facility provided support for the study from the outset volunteering to participate in the study. They each stated that caregivers would be able to attend regular action research group meetings through flexible rosters. They also allowed the use of their meeting rooms and any equipment, such as projectors and photocopiers, for meetings and group discussions. Financial support was provided to support actions.

4.3.3 Facilitator’s Role

As the researcher, I appreciated the importance of my role in the study not simply to “run” the participant groups, but to ensure participants felt comfortable and respected in an environment where they could share and explore their personal feelings without being judged by the other participants or me as facilitator. As the facilitator, I needed to create an environment that empowered the participants where they could take ownership of their decisions. I strove to create the conditions whereby reflection, critique, collaboration, challenge with support and active learning could be continued as unified components of practice which conjointly brought about changes in the practice culture (McCormack et al., 2010). In creating the conditions mentioned above I noted the suggestions for the effective facilitation of action research as described by Williamson et al. (2012), which included: enabling the participants to show genuine mutual respect to each other; creating a partnership in learning; creating a dynamic goal-oriented process; and practicing critical reflection.

4.4 Participant Recruitment

The study aimed to engage management and caregivers. When considering recruitment to the action research groups, the people included all had to be employees of Beaches Care of the Aged.
Recruitment of staff to the study was achieved by the researcher placing information about the study on notice boards in each of the facilities and the running sheet of information sessions. The information sheet included the intent of the study, participant involvement and the facilitators contact details. Seventeen (n=17) staff volunteered for the study across the three facilities. See Figure 4.2 below for participant details.

There was a cross-section of 17 staff involved in the study, with 11 caregivers (64% of the total number of participants), one was a Clinical Registered Nurse, and three were facility Managers. The number of Clinical Registered Nurses was limited as there was only one clinical Registered Nurse per shift per facility, making it difficult for them to be released to attend action research group meetings. The cross-section of staff is depicted below:

Figure 4.2 Cross-section of staff involved in the study
4.5 Establishment of the three AR groups

Action research groups are formed when a small group of people collaborate to focus on specific research interests (Taylor & Francis, 2013b) to participate in organised conversation (Gaižauskaite, 2012). They explore collective, not individual phenomenon (Kontio et al., 2010) and focus on group interviews and discussions (Taylor & Francis, 2013b). Taylor and Francis (2013b) state that the initial meetings are crucial in setting the tone of action research group work. Therefore it is important to discuss group processes openly as well as gaining a shared understanding of central issues. Participants debate what is important, and how they will work together. The group establish rules for engagement that generally includes commitment to all members being able to speak openly and be heard.

One (n=1) action research group was established for each of the three facilities. The groups each included at least one Manager and/or Registered Nurse, and caregivers. A key characteristic of action research is the socially interactive orientation, it enables and encourages social interaction between participants who share personal and practice experiences (Carolan, Holman, & Ferrari, 2015). The action research groups in this study made decisions and undertook actions as an outcome which is the data collected from action research. These groups come together to discuss an issue/s that is facilitated by the researcher. They may be one of many different sources of data collection or may be the only data generation technique adopted. Action research group meetings also provide a forum for participants to come together, for rapport to be established between participants and ideas to be exchanged, debated and collaborative decisions made. They need to be conducted in environments that promote open, honest, reflexive discussion about personal experiences, attitudes and opinions (Taylor & Francis, 2013b), and real-life problems (O’Leary, 2010). Understanding the need for a suitable place for the action research groups to meet resulted in negotiation with management for space and time release within the workplace for the group meetings was agreed.

4.5.1 Establishment of Roles and Responsibilities

With the formation of the action research groups, roles and responsibilities for both the participants and facilitator were established. It was agreed that the role of the participants was a commitment from them to work collaboratively to undertake changes to practice that closely aligned with person-centred care. It was agreed that my role was to support participation, inclusiveness, reflection, collaborative engagement, and learning, enabling the action research group to achieve their goals. It was my responsibility to provide appropriate resources for participants to achieve their goals.
and assist discussion through reflection. This aligned with the emancipatory nature of action research.

4.5.2 Convening initial Action Research Group Meetings

Notices were placed in staff rooms regarding the times for the initial action research group meetings. This was done partly to enhance visibility of the group and encourage open disclosure and partly because it was the generally the preferred method of communication. As participants had never volunteered for a research study previously, I commenced with a casual but ordered approach to assist understanding and to encourage reflection. For each action research group, I used dot points in the “Welcome to all participants” (Appendix 12) as a prompt for myself to initiate further discussion and ensure that I addressed the main points needing to be covered. This maintained consistency in each action research group meeting. There was general consensus among participants that they could improve their practice and generate awareness and knowledge of person-centred care through action research groups. I sensed a nervous excitement at this point and fielded numerous questions. I approached discussion carefully and thoughtfully, ensuring I did not use complicated jargon.

I reiterated to participants how their participation was valued and placed at the fore of my work, as the majority of participants worked at the frontline of the organisation in very emotionally and physically demanding roles. I discussed the importance of participant voices being heard in this type of study and why dissenting views are so important to participatory action research, as they are crucial in the attainment of new knowledge due to them offering a different approach. A “safe place” was vital for participants to feel confident and share their knowledge and personal practice experiences without being judged. This “safe place” was not just the room in which the action research group meetings were held, but the action research group environment itself. Supporting and encouraging the use of new language in a safe environment is seen as imperative for participants to engage in the process and foster empowerment (Reed & Hocking, 2013).

Conversation flowed throughout the initial action research group meetings as participants were known to one another. Question one of the Action Research Group Discussion Questions (Appendix 5) facilitated good, reflective discussion. However, I noted in my reflective diary that questions two and four were not well received by participants. I thought it was due to the wording of the questions and the complex nature of the questions. In hindsight, they were not conducive to good reflective
discussion. This reinforced to me the necessity to keep my language clear and self-explanatory to facilitate inclusiveness of all participants, otherwise I ran the risk of excluding numerous participants therefore not engaging them which was required to implement action research to its full potential. I discussed this with participants and explained the importance of speaking out if they did not understand something as inclusiveness was vital to the success of the study.

Part of my role in the study was to provide appropriate information resources for the groups. An example of this was provision of the three elements of person-centred care; (1) acceptance (2) congruence and (3) empathy, adopted from Portner (2011), who proffered that without those three elements, the facilitation of person-centred care is impeded. Provision of this information facilitated reflective discussion within action research groups.

Each group was asked to devise their own definition of person-centred care, which facilitated action research group participants offering examples of personal practice experiences. Participants articulated their personal understandings of person-centred care, and then integrated those to devise group definitions. I noted in my reflective diary at the time that the definition for the Sandcastles action research group was the definition provided by the manager. I did not think the manager coerced participants to use her definition, I was more inclined to think the participants did not feel sufficiently confident or empowered to assert their own. I discussed the possibility of revisiting group definitions at a later date to be flexible and responsive, aligning with action research.

The definitions of person-centred care developed by each of the action groups were:

**The Lighthouse action research group** - Caring for the person, and understanding their individual needs, and treating them as an individual not a disease or diagnosis, but rather treating them as a whole and being respectful of their choices. Caregivers need understanding of themselves so they can better understand others.

**Seaview action research group** - Respect, individuality, and dignity, with the resident at the centre of care.
Sandcastles action research group - acceptance of residents, individuality, and choices. To make the residents feel that they are in a homely place, and ensure they are at the centre of care

4.5.3 Techniques and tools adopted to support action research groups

Tools were adopted to assist and support the action research groups to unpack person-centred care and move forward with implementing their respective projects. These tools included: practice development, reflection and the nominal group technique.

4.5.3.1 Practice Development

Practice development is described as an activity that focusses specifically on the development of people and practice rather than processes and systems in order to achieve high-quality person-centred care. It aims to achieve workplace cultures that are person-centred through collaboration, inclusion and participation (Ford, Fitzgerald, & Courtney-Pratt, 2013; Lansdell, 2016; Lavery, 2016). Through participation, learning and engagement (Beckett et al., 2013), practice development enables people to develop professionally. Practice development was integral to this study with the practice philosophy of person-centred care which has been adopted by the organisation. By utilising a practice development framework of participation, inclusion and collaboration, participants were assisted to engage fully in the study, develop leadership skills, and find new ways of working through critical reflection and collaborative engagement. Action research groups of caregivers in each setting were established to facilitate the development of work practices that enabled the sharing of knowledge and ideas to shape work cultures that align with person-centred care. The aim was to achieve an emancipatory change of the culture at Beaches Care of the Aged, not just through raising awareness but through participants being moved to action. To produce a sustainable change, participants needed to take ownership and responsibility for any changes they implemented not only would this align with the principles of practice development but it would develop a culture that was reflexive and able to adapt to the needs of individual residents.

Participants were encouraged to actively and creatively engage with action research, whilst drawing on their knowledge and practice experiences. The use of the practice development framework supported action research to provide groups with a voice and ensure that each person’s views were heard in a supportive and non-threatening environment. Critical reflection was an important feature of practice development and
action research to focus on changing current practice as is described in greater detail below.

As shown in Figure 4.3 action research, person-centred care and practice development are inextricably linked. Action research in this context, engages caregivers in a change process that realises the embedding of person-centred care in their practice thus creating the possibility of change through raised awareness and purposeful action (Taylor & Francis, 2013b). In this study, this was seen through the collaboration between staff in the identification of a problem and the application of appropriate, purposeful action to produce change. Person-centred care places the person at the centre of their care, consistent with the six principles to implement person-centred care which are described in Chapter one. Action research enables the possibility of change to the lives of older people through raising staff awareness in how they are cared for. Purposeful action enables those changes to be effected.

Figure 4.3 Action research, person-centred care and practice development are inextricably linked
Manley et al (2008) described practice development as;

A continuous process of developing person-centred cultures. It is enabled and supported by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformation of individual and team practices. This is sustained by embedding both processes and outcomes in corporate strategy.

Boomer and McCormack (2008) add to this description that practice development is a systematic approach that aims to increase effectiveness of care for the improvement of older people residing in aged care facilities. Assisting people to develop the knowledge and skills that will enable them to transform the culture and context of care therefore has an impact on both practitioners and practice.

I discussed with participants the importance of incorporating a cross-section of staff for the success of the study and how important it was to involve people at every level of the organisation to support improved service delivery. For example, the study included caregivers who attended to the essential physical care needs of residents, as well as the managers of each facility, and the Director of Care. Working together and involving all levels of staff in the organisation enabled increased empowerment, as all participants in the action research groups were involved in the decision-making process of the study. It was important for managers to encourage and include all participants in the decision-making process as they would be directly affected by any decisions made and actions applied.

4.5.3.2 Reflection and Reflective Discussion

Reflection plays a major role in action research and practice development (Nelson, 2012) and in this study included reflexive discussion, the sharing of personal practice experiences and the keeping of reflective diaries by participants and myself as facilitator. Reflection informed participant decision making, and was included to assist; practice development, the sharing of personal practice experiences, increased knowledge, and development of professional relationships, communication skills, and self-awareness. The use of reflection throughout the study including reflective discussion, created opportunities and possibility for changes to be made in the way older people were cared for in a more person-centred environment. It was embedded
into the action research group activities; for example, I encouraged participants to keep a reflective diary to draw on their personal practice experiences, and encouraged reflective discussion to encourage the participants from the action research groups to think and to talk about what they have heard, observed or read. Reflective discussion provides valuable insight into the experiences of staff, and should be used as a continuing process (Dean, 2016). Reflective discussion also enables knowledge to be applied to personal practice and supports professional development. It supports the mutual sharing of feelings as well as thoughts (Middleton & Llewellyn, 2016).

Each group focused on the planning, action, observation and reflection elements of action research action research. They worked independently to address facility specific issues they identified. The action research process described in this study comprised of six cycles of action in total with each action research group completing two cycles. Action research was the chosen methodology for the study, as it aligned with the study aims of; addressing real life problems, pursuing action and knowledge, and encouraging participation as explicated in Chapter three. I sought to empower each action research group to introduce practice change that would improve the overall effectiveness of care for residents and further enhance a person-centred care approach. Further, I placed emphasis on the collaborative engagement of participants, as I aimed to assist participants to work together. I designed the study to be inclusive of all participants as they were fundamental to the study. Another element that characterises action research and one that I adopted for the study was my personal involvement (Taylor & Francis, 2013b). I endeavoured to ensure participants felt I was on their side and a partner in the learning process without me taking control of the study or enforcing my views upon participants. For example, when participants were reflecting and sharing personal experiences, I complemented these experiences with similar reflections of my own personal practice experience, working as a Clinical Registered Nurse at Beaches Care of the Aged. I also attended training sessions and outings organised by each of the action research groups as part of their action cycles.

4.5.3.3 Nominal Group Technique

The nominal group technique is one of the most commonly used formal consensus development methods and provides an orderly procedure for obtaining relevant and reliable qualitative information from a group. The collaborative nature of nominal group technique increases ownership of the ensuing research therefore increasing the likelihood of changing clinical practice and policy (Harvey & Holmes, 2012). I first introduced the nominal group technique briefly to potential participants in the information sessions. The nominal group technique was introduced to support participants in determining problem identification and prioritisation of goals. This
assisted in reaching consensus among participants about planning for variation or changes to routines, procedures and culture change. The following nominal group technique question was provided to each action research group:

"Using critical reflection, can you think of an element of practice you see as a problem or issue that you would like to change that could support person-centred care?"

Following explication of the generic elements of the study, each action research group was enabled to focus on the nominal group technique for problem identification and prioritisation of goals. Once problem identification and prioritisation of goals was established, group discussion moved toward specific problems establishing a convergent path of direction to aid the group plans to change practice.

I aimed to facilitate the nominal group technique in a safe place for the action research group participants, and one that was empowering, supportive, and non-judgemental I needed to be careful not to influence any responses given by participants, as my role was that of support and facilitation only. Participants in each group were provided the nominal group technique question and given time to independently convey their written problems and/or issues; I then invited each participant to share their problems and/or issues with the remainder of the group. Following this sharing of problems and/or issues, group participants then sorted their problems and/or issues into groups, allocating categories. Each participant then independently voted from one to four to rank the categories, with four being the highest priority and one being the lowest priority. The categories with the highest scores overall were agreed by participants to be of the highest priority for each action research group.

4.6 Data generation methods and approaches to analysis

I discussed data generation tools with each action research group and reiterated that each group would need to choose which tools were most suitable to address their goals, as the action research groups drove the study. I asked each action research group for permission to audio-record the meetings. The meeting recordings I explained would supplement meeting notes. I asked participants to keep reflective journals to document their experience, ideas and if required additional resources and support that they might need during the process. Photo elicitation was discussed as a method for stimulating conversation that might be adopted during the study. I indicated that I would write
memos to capture my thoughts on the process and that I would keep field notes that detailed the process and checklists to ensure that what was agreed to in meetings was achieved. I explained that I was undertaking a PhD and that these data generation techniques were necessary as part of my research candidature. I committed to sharing the information I generated with the respective groups and I affirmed that their privacy and confidentiality would be maintained. Further discussion on these clarified any queries or questions for participants.

**Recordings:** were used to record action research group meetings to assist the analysis of data collected from participant discussion in each action research group.

**Observation:** participants agreed to assess events contemporaneously using observation. They were asked to share their observations at action research group meetings held following events.

**Reflective journals:** were used as a way of briefing and debriefing. In addition, they were used to trigger understanding of person-centred care, and used as a reminder to bring up points for further discussion or clarification. The reflective journal entries for the participants in this study appear in boxed sections, are in italics, and headed with “reflective journal entry” followed by the name of the participant (and coloured coded) who added the entry. My journal entries were boxed and shaded grey, headed with “Reflection” only.

**Photo elicitation:** was available as an option to enable participants to use visual images that elicit comments to assist understanding of person-centred care.

**Memos: developed by the researcher** were used as a record for data analysis as they ensured delivery of non-urgent messages and consistent information between participants.

**Field notes: were kept by the researcher** were available as a record of the actions and events for use in further action research group meetings.
Checklists: developed by the researcher were used by participants to ensure that all action research group processes were followed. Checklists also ensured accountability of participants.

Data analysis was completed using thematic analysis informed by Braun and Clarke (2006) approach (see 4.4 below).

<table>
<thead>
<tr>
<th>Steps of data analysis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarise yourself with the data</td>
<td>Immerse in the data and become very familiar with it. If there is verbal data, this is the stage where it is transcribed. In this step, read and reread the data. It is important to actively read through the entire data at least once before coding and searching for meanings and patterns. At this stage notes are taken on initial ideas only.</td>
</tr>
<tr>
<td>2. Generate initial codes</td>
<td>This stage involves the production of initial codes for the data, using highlighters, coloured pens or Post-it notes to take notes on the text being analysed. Systematically code all data in this step. It is important in this stage to code for as many potential codes and themes as possible. After the coding of the data, the same code should be collated together.</td>
</tr>
<tr>
<td>3. Search for themes</td>
<td>This stage is focused on the broader level of themes and involves sorting the different codes into potential themes. Themes are made up of a subset of codes. Some codes may form main themes or sub-themes, whereas other codes may be discarded (or may be kept as outliers). At the end of this stage there will be a collection of themes and sub-themes.</td>
</tr>
<tr>
<td>4. Review themes</td>
<td>This stage involves refinement of the themes. Some themes will collapse into other themes whereas some of the themes may need to be broken down into smaller components.</td>
</tr>
<tr>
<td>5. Define and name themes</td>
<td>This step is to capture the essence of what each theme is about and what aspect of the data each theme captures. Here you will create an overall narrative with all of your data. Analyse each theme and its individual narrative. Identify whether or not any of the themes contain sub-themes. At this point themes (which currently have only working titles) need to be named. Names must be concise, punchy and immediately give the reader a sense of what the theme is about. The end of this phase should be clearly show what the themes are.</td>
</tr>
<tr>
<td>6. Produce report</td>
<td>This stage involves final analysis and write-up of the report. Consider your audience. The report should be concise, coherent, logical, non-repetitive, and provide an interesting account of the story.</td>
</tr>
</tbody>
</table>

Figure 4.4 Thematic Analysis by Braun and Clarke (2006)
Below in Figure 4.5 shows where data sources are placed and how they were converged into codes that represented all key stakeholder voices. Figure 4.6 shows a typical thematic map that will be included in each of the cycles. It shows how the codes at the bottom of the map converge into sub themes and then into the theme at the top.

Figure 4.5 Showing data sources and how they were converged into codes that represented all key stakeholder voices
Figure 4.6 A typical thematic map included in each of the cycles. It shows how the codes at the bottom of the map converge into sub themes and then into the theme at the top.

4.7 Précis

Details of the methods adopted to undertake the study have been described. The participant recruitment process, establishment of three action research groups and the forms of data generation and analysis were outlined. The next chapter details the first cycle of action for The Lighthouse action research group.

5.1 The Lighthouse

Figure 5.1 Photos of some of the land around The Lighthouse facility

The Lighthouse residential aged care facility is situated in a tranquil setting with leafy mountain views. It was a single-story facility catering for 41 permanent low care residents with one additional bed available for respite care. A winding path provides magnificent views and enticed those residents able to do so to meander through the gardens and enjoy morning and evening walks. Residents choose to enjoy outdoor time and unable to walk any distance or unassisted are escorted by wheelchair by one of the caregivers. Most days, one or two residents sit on a garden seat at the front of the facility enjoying the day. The Lighthouse facility does not have perimeter fencing and residents are able to come and go as they please if they are mobile. Many of the residents are older people who have lost a partner and do not want to live alone and/or need assistance with activities of daily living. Figure 5.2 shows the floor plan of the facility. The tea room and lounge as they are shown in the centre of the diagram is now combined into a single dining room, and the separate dining rooms for each wing are used for residents to make a cup of tea or coffee.
5.1.1 The Lighthouse action research group

The two managers of The Lighthouse volunteered to join the action research group as a show of support for the study. Both managers approved the decision to undertake the study and expressed their desire for resident care to be enhanced using a person-
centred care perspective. They also wanted caregivers to be satisfied with their work and felt that supporting them to explore and implement a person-centred care approach they developed would engage the staff. Seven (n=7) people volunteered to be involved: the two managers of The Lighthouse, and five (n=5) caregivers.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holly</td>
<td>Female</td>
<td>Manager 1</td>
</tr>
<tr>
<td>Colby</td>
<td>Female</td>
<td>Manager 2</td>
</tr>
<tr>
<td>Elin</td>
<td>Female</td>
<td>Caregiver: Administration</td>
</tr>
<tr>
<td>Tiana</td>
<td>Female</td>
<td>Care caregiver</td>
</tr>
<tr>
<td>Eke</td>
<td>Female</td>
<td>Care caregiver</td>
</tr>
<tr>
<td>Lucy</td>
<td>Female</td>
<td>Care caregiver</td>
</tr>
<tr>
<td>Eloise</td>
<td>Female</td>
<td>Caregiver: Lifestyle Coordinator</td>
</tr>
</tbody>
</table>

Figure 5.3 Breakdown of the participants

The staff room was the designated room for action research group meetings, as the room was private with comfortable seating and a round table conducive to participation, with acoustics satisfactory for quality recording of action research group meetings. Following recruitment of the participants, the first meeting was held on the 7th August 2013. All seven (n=7) attended the meeting that was held in the staff room. Eke suggested that cycle updates should be discussed at caregiver meetings to keep all caregivers informed, and the remainder of the action research group agreed. This action ensured that the process was inclusive with all staff kept informed throughout the trajectory of the project. Participants discussed and agreed on the scheduling of their fortnightly action research group meetings pending rosters. I reiterated to participants that they determined how the study would proceed.

Participants were encouraged to share personal practice experiences and knowledge in the action research group meetings. The nominal group technique was employed to determine problem identification and prioritisation of goals. The action research group were asked to write an answer to a question about current practice posed by the facilitator. The responses were then collected and discussed at length by participants, who reflected on current practices and aspects of which they thought needed to be changed. They then placed the responses into four separate categories, based on priority/goal. Voting then occurred privately to ensure honest responses without coercion. The most important priority/goal was ranked number 1 and the least
important ranked number 4. Following the ranking of priorities, I created a chart showing results as shown in Figure 5.4 below.

<table>
<thead>
<tr>
<th>Priority/goal 1</th>
<th>Priority/goal 2</th>
<th>Priority/goal 3</th>
<th>Priority/goal 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family involvement</td>
<td>The Dining Room</td>
<td>Improved Communication</td>
<td>Welcome Pack Improvement-Building a Life History</td>
</tr>
<tr>
<td>Families need to be more involved</td>
<td>More flexibility is needed with meals as mealtimes are too rigid, the dining room is a stressful place</td>
<td>We need better communication between managers, caregivers and residents</td>
<td>The “Welcome Packs” do not reflect person-centred care, changes are needed</td>
</tr>
<tr>
<td>Families have so much information regarding the life history of the resident that we can build on</td>
<td>A more homelike setting is needed so that residents can have a meal of their choice</td>
<td>We need a better understanding of individual needs</td>
<td></td>
</tr>
<tr>
<td>Votes 23</td>
<td>Votes 18</td>
<td>Votes 15</td>
<td>Votes 14</td>
</tr>
</tbody>
</table>

Figure 5.4 Prioritisation of priorities/goals for The Lighthouse action research group

The following priorities were discussed at length by the action research group, who agreed that the resident’s daily routines did not align with their perceptions of providing person-centred care, nor did the residential aged care environment reflect individualisation. They agreed their priorities demonstrated their concerns about the institutionalisation of people where their individuality is not highly regarded and their individual wishes not considered. Institutionalisation in this context is the admission of a person into a residential aged care facility where physical care is provided by caregivers and nursing staff (Gawel et al., 2012).

5.1.2 Lighthouse Action Research Group-Priority/goal 1-Family involvement and The Welcome Pack

Following the compilation of the nominal group technique votes and charting of results, participants agreed that family involvement was an important concern of person-centred care. They felt that involving families in discussion and planning care of loved
ones was not strength of current practice. Participants discussed this issue and agreed that their goals for the cycle were;

(1) Families need to be more involved: The group agreed that a stronger focus on the involvement of families was required. They agreed that families should be actively involved in admission and care planning of their family member.

(2) The Welcome Pack-Building a life history: Knowing the resident through building a life history was identified as a method for achieving person centred care. The group argued that creating a life history to be shared with all staff would potentiate stronger relationships between residents and caregivers enabling caregivers to tailor care to suit individual needs. Lucy supported this idea;

‘I think there is so much more we can find out (about the resident) from families as they can tell us things that the resident may have forgotten. Families might be more willing to open up and talk’.

Elin also agreed;

‘What about Cleo, I never realised she had loved gardening so much or had lived in Asia for 10 years. It really bugs me that we only seem to find a lot of these things out when our residents pass away’.

The group felt that once the family's expectations of the facility were attained; person-centred care implementation could be further enhanced. Holly commented;

‘I think we need to encourage the families to discuss their expectations when they place their loved one in care. I mean, surely their input can only help. I have had discussions with family before and they have told me how they expected something different, I don’t know what, but it was like they did not seem to understand what we offer here’.
‘I think the families need to be educated myself. Many of them haven’t got any idea, they make demands without even knowing what we aim to achieve. A woman rang me one day and told me that her mother was to eat in the dining room every day for every meal [new resident]. What about her mother? Did she not count in all of this? She should have the right to do whatever she wants’.

Using reflective discussion, the action research group concurred that there needed to be changes made to the existing ‘Welcome Pack’ (Appendix 11) that was provided to new residents on admission. The group felt that modifying the Welcome Pack would heighten residents, their families, caregivers, and managers’ understandings of person-centred care. Additional forms were to be included in the packs; however no content was to be removed. Further discussion focussed on the importance of encouraging family involvement, and building a life history. Elin conveyed her thoughts on the “Welcome Pack”;

‘The “Welcome Packs” were useful for administrative purposes; however they don’t assist caregivers in facilitation of person-centred care’.

Holly added;

‘What happens is that older people expressing interest in moving into the Lighthouse meet with the Manager, prior to them taking up residence, we give them a full tour of the facility and introduce them to the caregivers on duty at the time. Many of them (prospective residents) come with family and some come alone. We have a meeting which includes them (prospective residents) being given a Beaches Care of the Aged “Welcome Pack”. The packs have been used now for about eight years, but I don’t think they assist much with regard to learning about a resident’s life’.

Participants added that once the forms from the existing ‘Welcome Packs’ were completed by new residents. The completed forms were filed in the administration office. The group complained that this information was not readily available to caregivers. The group believed that the only available information provided to them when new residents arrived was information on essential care needs such as preferred bathing time. The group agreed that when they did have access to the current welcome pack, information was limited. Following a review of the content of the Welcome Packs, the group felt that the information could easily be misconstrued or misinterpreted. They
highlighted that a person with vision impairment or cognitive impairment would struggle to complete the required information without support. They agreed that staff interaction with the new residents was an important aspect of initial orientation to the facility and that assistance from staff to complete the forms would improve the quality of the information requested. The group believed that in general, families had little understanding of the importance of their involvement in the care of their family member and did grasp the implications of person-centred care. Developing an education package/program for families was considered necessary by the group. As Colby explained that;

‘If new residents and their families don’t understand person-centred care from the start, then they are less likely to understand what caregivers are attempting to achieve.’

The group agreed that the focus of care should be more than essential care needs. They stated that care should be tailored to meet the needs of each individual. The group decided to review the contents of the “Welcome Pack”. This resulted in the action research group confirming the “welcome pack” contents did not reflect person-centred care, making additions to the welcome pack was declared the focus by the action research group.

5.1.3 Lighthouse action research group-Priority/goal 2-The Dining Room and Improved Communication

The dining room was discussed as a place where most residents came together. The current dining room was a large single space. Elin recalled a time when there were four separate dining rooms. A decision by management to have a single dining area was made because staff found it difficult to manage four separate spaces. The single dining space room is located in the centre of the facility (Figure 5.2), shown as lounge and tea room) with numerous tables seating four people at each. The new dining space was problematic from the outset as residents became agitated with caregivers and caregivers with residents. Issues included the longer wait times for a meal, the increased noise levels and the inclusion of all residents, including those in varying stages of cognitive impairment who were disruptive. The group believed that there was limited and in some case no interaction between residents at their table. Group members stated that poor behaviours included residents shouted, demanded cups of tea or clicked their fingers as they called out for their meal to be delivered before other tables. They added that many of the caregivers had begun ignoring the residents and
only speaking if necessary. The increasing communication problems and lack of interaction in the resident dining room reflected findings from Levy-Storms, Claver, Gutierrez, and Curry (2011), who argued that adhering to the principles of person-centred care emphasising humanity, empathy, recognition of personal life experiences and relationships and using the social environment as a therapeutic agent, is vital in the implementation of person-centred care. Yasmin described the anxiety that she and her colleagues felt;

‘... We don’t know what we can do, if only they (the residents) would talk more between themselves. Maybe that would ease the tension between residents and caregivers. The residents are constantly yelling out and demanding’.

Group members agreed there were several problems in the dining room; residents were seen by the group as demanding and calling out for service, there was tension between residents and dining room caregivers, there was a perceived lack of interaction between residents, and dining room caregivers and residents, there was a perceived lack of autonomy and choice for residents, and finally, a perceived labelling of residents, for example; “they are all whingers” (by dining room caregivers). The situation was made worse because there were minimal caregivers rostered on at mealtimes. Elin captured her dismay in a notation in her reflective diary:

‘Breakfast is the worst mealtime of the day, including weekends as there are limited caregivers on duty. This situation is making residents and caregivers unhappy. The caregivers are stressed before mealtimes even begin. Everyone is talking about it at the moment’.

The group felt that the behaviours outlined previously occurred because many of the residents had minimal interaction with one another during mealtimes. They agreed they would like to do something to change the situation in the dining room regarding the lack of resident autonomy. They discussed how they thought it was important for residents to be able to choose their own breakfast cereal, condiments and beverages as this was only a small point but added to resident autonomy and person-centred care. At the time of the study, residents did not choose their cereal daily. If they ate cornflakes, cornflakes were delivered to their table every breakfast, as was jam or honey for toast etc. Participants spoke to kitchen caregivers who stated that all residents had to do was ask and they could have something different, although they agreed it was never going to be the same as choosing for themselves. They considered that the number of residents at
each table was not conducive to a pleasant dining experience. It was felt that more residents could be at each table to try and aid conversation. Elin offered;

‘Mealtimes appear to be a very unpleasant time for residents and caregivers, with both feeling unhappy about the entire situation.’

While Holly commented;

‘Everything is wrong. I think there are not enough residents seated at each table for good conversation.’

For Yasmin the situation had become distressing. She stated;

‘I cannot cope with what is happening in the dining room much longer if things don’t change. Not only are the residents stressed, the caregivers are as well. I thought it would work well having one large dining room but I am not sure it has’.

A comment by Elin focussed the group’s discussion and guided their deliberations;

‘I don’t think things will change unless we can do something to improve communication between residents and caregivers.’

The Nominal Group Technique was adopted to explore and identify a process to address the issues of concern. This approach was applauded by Yasmin who asserted;

‘I realise I can make a difference. I can see the decisions we have made already as a group for our action cycles and it is so amazing how we came to those decisions. I feel much more confident’.
Collaboration, sharing knowledge and reflexive discussion was a feature of the action research group meetings. They decided to combine priorities one and four; “The Welcome Pack” and “training” for one cycle of action, and the following two priorities “The Dining Room” and “More Interaction” for second cycle of action.

Prioritisation of cycles as shown below in Figure 5.5

<table>
<thead>
<tr>
<th>Priority/goal</th>
<th>Action Research Cycle #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraging family involvement and building a life history</td>
<td>1-The Welcome Pack</td>
</tr>
<tr>
<td>Create a positive mealtime experience</td>
<td>2-The Dining Room</td>
</tr>
</tbody>
</table>

Figure 5.5 Prioritisation of cycles

5.2 Seaview

Figure 5.6 A collage depicting some of the activities enjoyed at The Seaview facility

Seaview is a small, personal facility catering for 21 residents. This facility provides residential care for frail older people needing support. A lifestyle coordinator provides daily activities and entertainment for residents such as bus trips to the local shopping centres, lunch engagements and tai chi classes. There are no perimeter fences as this facility caters for aged persons who are still able to go for evening walks or go out with family and friends independently. The diagram below (Figure 5.7), floor plan of Seaview shows the small, homelike size of the facility.
5.2.1 The Seaview Action Research Group

The managers of this facility supported the study by enabling the action research group participants to attend meetings during work hours. This group included five participants (shown below in Figure 5.8) all referred to as caregivers in the study, and their specific role is shown in as a broad term meant to reduce power bases arising from qualification and level within the organisation.
<table>
<thead>
<tr>
<th><strong>Pseudonym</strong></th>
<th><strong>Gender</strong></th>
<th><strong>Role</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Holly</td>
<td>Female</td>
<td>Caregiver: manager</td>
</tr>
<tr>
<td>Colby</td>
<td>Female</td>
<td>Caregiver: manager</td>
</tr>
<tr>
<td>Suma</td>
<td>Female</td>
<td>Caregiver: administration</td>
</tr>
<tr>
<td>Havanna</td>
<td>Female</td>
<td>Caregiver: kitchen assistant</td>
</tr>
<tr>
<td>Ron</td>
<td>Male</td>
<td>Caregiver: lifestyle Coordinator and Person-Centred Care Champion</td>
</tr>
</tbody>
</table>

Figure 5.8 Break down of participants

The Seaview action research group meetings were held in a small room situated close to the office as this was the only appropriate place to have small group meetings with a door that closed the room off from the rest of the facility, and table and chairs to seat six people. The group planned to hold fortnightly meetings pending caregiver rosters and personal commitments.

The first meeting of the group involved delineating priorities and goals that they wanted to achieve. As with the Lighthouse action research group, the nominal group technique was utilised. were then collected and discussed at length by participants, who placed them into four separate priorities; however participants decided that the last two priorities could be merged into two as the group agreed there was overwhelming support for: the inclusion of, and information sharing with resident families; and maintaining good relationships between caregivers and residents. In collaboration with the group, I charted the results as can be seen below in Figure 5.9, Participants decided to undertake two action research cycles.
<table>
<thead>
<tr>
<th>Priority/Goal 1</th>
<th>Priority/Goal 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion of, and information sharing with resident families</td>
<td>Maintaining good relationships between caregivers and residents</td>
</tr>
<tr>
<td>Whatever the residents want to do should be their choice not that of their family</td>
<td>We (caregivers) need to work together more to maintain the good relationship we all have with caregivers and residents</td>
</tr>
<tr>
<td>A resident might come to you and tell you they want to do sky diving and the family say that they forbid their Mother to do that, when in actual fact, it is Mum's decision</td>
<td>We have a good Manager here. The caregivers are mostly happy.</td>
</tr>
<tr>
<td>The families don't listen to what the residents want</td>
<td>It would be good if we could spend more time with the residents</td>
</tr>
<tr>
<td>Votes 30</td>
<td>Votes 18</td>
</tr>
</tbody>
</table>

Figure 5.9 Cycle priorities

### 5.2.2 Seaview action research group-Priority 1- Inclusion of, and information sharing with resident families

The group acknowledged that traditionally, management and staff at Beaches Care of the Aged encouraged family involvement in resident care. This included decisions relating to the care of residents and social activities. The level of involvement of many of the families differed, as some residents came from rural and remote properties and seldom saw their families; other residents had no family. Group members reported problems with several of the resident families, who did not appear to understand or listen to what residents wanted and, at times, even ignored resident's decisions. Ron, who was involved in family meetings with residents and their families, reflected that these meetings were convened to discuss any issues the residents or their families may have with care and care decisions. Ron reported that often the family insisted their relative be offered opportunities they believed were important; however whenever a resident was offered the opportunity requested by the family, they declined. Holly affirmed that;

‘Families need to have a better understanding of what the residents want and that whatever the residents choose to do, and how, should be their choice.’
Colby also supported autonomy for older people;

‘... Prior to entering a residential aged care facility, I would think that the majority of older people would live in their own homes with the freedom to exercise their autonomy and maintain a sense of control over their lives. Why should it be any different when they come in here?’

To assist the group, I provided them with the journal articles below that I felt would clarify concerns and provide insight into the behaviours of the families and the residents. I felt it was important that the group understood that although many facilities promote the attainment of an active and meaningful life, many older people perceive their institutionalisation as the beginning of their loss of autonomy and independence (Brownie & Horstmanshof, 2012). The group agreed that many residents did not realise that their autonomy and independence were diminishing. I drew group’s attention to Welford, Murphy, Rodgers, and Frauenlob (2012), who proffered that although older people living in long term care represent a unique group of people largely because care is provided in their place of residence, it is apparent that their level of autonomy is eroded in the very place they call home. They added that autonomy needs to be completely understood before person-centred care can be realised and subsequently an increased quality of life experienced. As such, it would appear that it is not just the caregivers who need to understand and implement individual autonomy. In residential aged care and in this situation specifically, it needs to be a combined effort from both caregivers and resident’s families.

5.2.3 Seaview action research group-Priority 2-Maintaining good relationships between caregivers and residents

The group agreed that teamwork and caregiver satisfaction was an important element in achieving person-centred care. They added that if caregivers were not happy, there would be a negative effect working with residents. The group felt that they had a happy, positive and cohesive team. The challenge they acknowledged was sustaining a positive workplace culture in a dynamic environment. Changes to the staffing profile as an outcome of staff retiring and resignations were highlighted as a potential threat. The senior leadership of the facility was applauded. Ron remarked;

‘I think caregivers need to be happy in order to implement person-centred care, but we can add to that by maybe spending more time with the residents...we don’t spend any time with the residents having fun together. I just think this would help’.
The group described the culture as close-knit and cohesive and the manager they felt was approachable, fair and responsive. I provided participants with journal articles to raise their awareness about good leadership and the impact on a workplace culture and to encourage the group to replicate these attributes. Chi, Chung, and Tsai (2011) stated that leader positive moods have significant effects on team member affective states, attitudes, and behaviours. This gives rise to the question of whether leader positive moods impact performance on teams. Moreover, they add that it is possible that leaders in positive moods can influence team processes or performance through explicit dual processes, such as transformational leadership behaviours, and implicit (emotional contagion) processes. Within the group affect and leadership literature, studies have indicated that leaders with higher positive moods can lead their teams to better performance.

The group agreed the Manager engaged in behaviour that encouraged subordinates to respect and admire her. She was never afraid, they agreed, to get in and work with them, and was quite often seen taking a resident to the toilet or cleaning something off the floor following a spill. The group applauded the Manager’s willingness to engage in care of the residents, share her ideas with the caregivers and ask their opinions. She was seen to encourage caregivers to encourage creative thinking and solve problems in new ways by asking what they thought about things, and was known to ask caregivers if they had ideas or suggestions to discuss them with her. The Manager was seen by caregivers to be attentive. She was, as far as the participants were concerned, flexible and considerate toward caregiver needs.

The group identified problems and prioritised goals that enabled them to move to the planning, action, observation and reflection components of action research. Figure 5.10 Prioritisation of Goals reflects the groups planning. The action research cycles were named “Devise actions to facilitate inclusion of, and information sharing with resident families” and “Devise actions to maintain a cohesive team”.

<table>
<thead>
<tr>
<th>Priority/goal</th>
<th>Action Research Cycle #</th>
</tr>
</thead>
<tbody>
<tr>
<td>The inclusion of, and information sharing with resident families</td>
<td>1- Devise actions to facilitate inclusion of, and information sharing with resident families</td>
</tr>
<tr>
<td>Maintaining good relationships between caregivers and residents</td>
<td>2- Devise actions to maintain a cohesive team</td>
</tr>
</tbody>
</table>

Figure 5.10 Prioritisation of cycles
5.3 Sandcastles

Sandcastles is a residential aged care facility within the grounds of The Lighthouse, Seaview and a village that specifically caters for frail, older people including those in varying stages of cognitive impairment. Couples are catered for with several larger rooms available where two beds can fit parallel. There are 55 residents; 53 permanent and two receiving respite care. Set in spacious grounds, there is a winding path inviting pleasant walks through the beautiful extensive leafy gardens and waist high garden beds to provide for comfortable gardening. There is an array of native trees and shrubs inviting birds to them, whilst residents enjoy the caged facility birds also within the grounds. The grounds are enclosed by high, attractive fencing with a coded gate for the safety and security of residents.

Every bedroom in the facility has an en-suite as well as built-in wardrobe. Several residents have a companion cat or dog that they keep in their rooms, and assistance is provided by caregivers to maintain care of the animals. Activities are provided to residents each day, including morning and afternoon tea, bingo, visiting choirs, school children visiting, pet therapy and bus trips to various destinations. Lifestyle coordinators organise activities, as well as crafts, outings, trips away and any other special events. Each afternoon, residents are invited to happy hour in the main lounge, with caregivers providing drinks. There is an on-site hairdresser available to style and colour hair, and a massage therapist frequents the facility as well as a physiotherapist. Residents enjoy the outdoors with the use of a fully covered deck including a barbeque run by volunteers. Trips and events are facilitated by volunteers who give their time to assist. Sandcastles facility has a good reputation for quality care and support of residents.
Sandcastles are proud of their low caregiver turnover. At the time this study was undertaken a number of staff were retiring. There were 54 caregivers including six registered nurses in total to provide 24hr/7 days a week care for residents. Caregivers stated they are often under pressure to attend to physical care needs of residents with high care needs such as showering, toileting, nutrition etc, and care needing to be prioritised.

Figure 5.12 shows the floor plan of Sandcastles. It provides a map of the physical environment in which the caregivers worked and the residents lived. It also shows the lounges provided in every wing as well as the main lounge area, facilitating the opportunity for interaction.

Figure 5.12 Floor plan of Sandcastles
### 5.3.1 The Sandcastles Action Research Group

Nine female and two male staff volunteered for the study from Sandcastles. See below (Figure 5.13) for the break down of participants who volunteered for the study.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janice</td>
<td>Female</td>
<td>Caregiver: manager</td>
</tr>
<tr>
<td>Pauline</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Sharron</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Sue-Ellen</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Joan</td>
<td>Female</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Stewart</td>
<td>Male</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Prue</td>
<td>Female</td>
<td>Director of Care</td>
</tr>
<tr>
<td>Reg</td>
<td>Male</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Adira</td>
<td>Female</td>
<td>Caregiver: clinical registered nurse</td>
</tr>
<tr>
<td>Penny</td>
<td>Female</td>
<td>Caregiver: lifestyle coordinator</td>
</tr>
<tr>
<td>Channel</td>
<td>Female</td>
<td>Caregiver: administration</td>
</tr>
</tbody>
</table>

Figure 5.13 Break down of participants

The group meetings were held in the facility staff room, a large room with large table and chairs to comfortably seat fifteen people. The room was comfortable, easily accessible, featured adequate lighting and ample space to ensure participant eye contact. Participants discussed regularity of group meetings and it was decided that they would be held each fortnight pending rosters and the workload on the day for approximately one hour. At the time of the study there were major building works being undertaken at the facility, and participants decided to have several meetings outside on a picnic table as the noise of power tools made it difficult for the group to concentrate and be heard. Meetings were informal with casual but purposeful conversation. Initially the majority of group members attended each meeting. As Christmas approached attendance reduced due to workplace and family commitments.
Figure 5.14 details the delineated priority/goals achieved using the nominal group technique described earlier.

<table>
<thead>
<tr>
<th>Priority/goal 1</th>
<th>Priority/goal 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase interaction opportunities between residents with mild or no cognitive impairment and caregivers</td>
<td>PCC training for new caregivers</td>
</tr>
<tr>
<td>I feel that we almost neglect the residents without cognitive impairment</td>
<td>New caregivers need to understand PCC and be able to demonstrate ways to apply it to their personal practice</td>
</tr>
<tr>
<td>We have minimal time to socially interact with residents who don’t have dementia</td>
<td></td>
</tr>
<tr>
<td>Votes 33</td>
<td>Votes 13</td>
</tr>
</tbody>
</table>

Figure 5.14 Cycle priorities/goals

The priority goals initially included

1. interaction opportunities for residents with mild or no cognitive impairment,
2. Person-centred care training for new caregiver

5.3.2 Sandcastles Action Research Group - Priority 1 - Increase interaction opportunities between residents with mild or no cognitive impairment and caregivers

The group acknowledged that the dining room was the focal point of Sandcastles. They described it as a large comfortable space with a homely touch of flowers and a variety of decorative items on the walls. There were windows on either side of the room with a passage through to one of the resident wings. There were twenty tables with seating for four people at each table, and efforts were made to decorate the dining room for personal, sporting and social events, and it was not uncommon to see streamers and balloons on the roof and walls for various celebrations. While it appeared a comfortable
space, caregivers felt that the level of interaction between themselves and the residents was minimal.

Mealtimes for residents were as follows:

- Breakfast 7am,
- Lunch 12pm
- Dinner 5pm.

To ensure residents with advanced dementia (approximately six at the time of conducting this study) were well nourished, and to avoid situations resulting from disruptive behaviours, residents with advanced dementia were assisted to eat half an hour earlier than the majority so that they were usually finishing their meals as the other residents arrived. The majority of residents consisted of: residents with mild or no cognitive impairment as well as residents with dementia.

The group believed that residents with mild or no cognitive impairment were largely ignored by caregivers who prioritised residents requiring assistance with feeding. The group lamented not being able to spend time with the residents who were self-caring to get to know them as individuals. They felt they needed to prioritise the care needs of residents, and in doing so, tended to leave the residents with little or no cognitive impairment to attend to their own care and social needs. Sharon reflected on this:

‘... the residents without dementia have, in the past, requested changes to the dining room because they were frustrated with the situation at each mealtime as they attempted to assist the residents with dementia to eat their meals and it was affecting their mealtime. Discussions with the manager at the time led to the agreement that light screening in the way of palms could be placed between residents with mild or no cognitive impairment and the remaining residents. Unfortunately, this never came to fruition. Not sure why?’
The group felt they were not meeting the needs of this group of residents. Adira commented on this;

'They (residents without cognitive impairment) don’t receive the same attention from us that the residents with dementia receive. I mean, those residents (with minimal or no cognitive impairment) can make their own way to the dining room and eat their meal without needing assistance from us'.

The group were concerned residents with minimal or no cognitive impairment were at risk of becoming socially isolated as an outcome of this situation. Reg inspired the group stating;

‘... Remember the residents without cognitive impairment asked in the past if they could have a meal or do something different away from the residents with dementia?'

Sue-Ellen responded stating;

'It is only fair that all residents should have an equal amount of time with us [caregivers]. They should have the opportunity for more social interaction and stimulation, and we need to address the situation. We have approximately nine residents here [at Sandcastles] who do not have dementia or cognitive impairment and several more with mild cognitive impairment. We should do something special for them away from the residents with dementia such as having a meal or something'.

It was agreed that the group would advance planning for a special event for this group of residents that would provide opportunity for socialising between residents and with staff.
5.3.3 Sandcastles Action Research Group - Priority 2 - person-centred care training for new caregivers

The group discussed their second priority/goal to be investigated in cycle two. They felt that many of the new caregivers beginning employment at Sandcastles seemed “lost” when they began caring for the residents. The group agreed it was important for all new caregivers to understand person-centred care so they were able to apply it to their personal practice. Adira offered:

‘If they (new caregivers) all start with an understanding of person-centred care and show they can implement it then surely it must be worth sharing our knowledge with them to help both them and the residents’.

The group felt that current practice by the organisation to employ new caregivers, and provide them with minimal training in person-centred care was not sufficient to maintain a person-centred care approach. They discussed how they wanted to make a change to this current practice so new caregivers understood and were able to demonstrate how they implemented person-centred care into their daily practice.

Participants discussed their priorities below (Figure 5.15) for each of the cycles; cycle one: Increase interaction opportunities for residents with mild or no cognitive impairment, and cycle 2: Person-centred care training for new caregivers.

<table>
<thead>
<tr>
<th>Priority/goal</th>
<th>Action Research Cycle #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore ways to increase social interaction for residents not requiring high levels of essential care</td>
<td>1- Increase social interaction opportunities for residents with mild or no cognitive impairment</td>
</tr>
<tr>
<td>Ensure new caregivers develop an understanding of person-centred care and can demonstrate how they implement it</td>
<td>2- Person-centred care training for new caregivers</td>
</tr>
</tbody>
</table>

Figure 5.15 Prioritisation of cycles

With emancipation being one of the major elements of action research, I was pleased the majority of participants were caregivers, as these people undertook the essential daily cares for residents. Using reflective practice, participants were able to establish
problem identification and prioritise goals. This in turn, assisted organisational learning and created conditions conducive to change, aligning with the major underpinnings of action research. It was clear that strategies were needed to address the problems identified by each group, and the nominal group technique enabled planning for interventions explicated in the following chapters specific to each facility.

5.4 Précis

This chapter introduced the three facilities in the study and included the study setting, ethical considerations, recruitment and participants. The study design was explicated and included information sessions held at each facility, as well as establishment of roles and responsibilities. Group meetings were described and included action research group discussions on problem identification. The nominal group technique was introduced and applied to each action research group, with priority/goal identification established. Each group established a clear plan for their cycles enabling progression to planning, action, observation and reflection stages, as described in the following chapters.
CHAPTER 6: THE Lighthouse

Figure 6.1 Photo of a lighthouse

ACTION RESEARCH CYCLE ONE - THE WELCOME PACK, AND CYCLE TWO-THE DINING ROOM

Introduction

This chapter explicates two cycles of action for the Lighthouse action research group. As discussed in Chapter 5, (Cycle one) the group agreed the existing “Welcome Pack” required modification to reflect a person-centred care approach. They prioritised goals of: Encouraging family involvement through sharing expectations of care for family members relocating to residential aged care facilities, as well as sharing family experiences and, building a life history for all residents and their family that is inclusive of sharing their expectations of care, personal experiences and preferences to enable caregivers to deliver person-centred care.
For cycle two, the group identified that there were issues with the resident dining room that included: residents demanding and calling out for service, tension between residents and caregivers, lack of interaction between residents, caregivers and residents, lack of autonomy and choice for residents, and labelling of residents in the dining room. The group prioritised the goals of: creating a positive mealtime experience, and improved communication. The prioritisation of goals enabled participants to move forward to the essential elements of action research, being planning, action, observation, and reflection. This chapter describes cycles one and two for the group, demonstrating how those essential elements were implemented.

6.1 Planning – Cycle One – The Welcome Pack

![BEACHES CARE OF THE AGED WELCOME PACK](image)

Figure 6.2 Picture depicting the title page of the Welcome Pack

In the planning phase, the group discussed their overall plan and agreed on data collection tools to be used in this cycle. The group also determined their individual roles in the study. They agreed to volunteer for different roles when the need was established, for example, someone needed to devise documents for the action research group and Colby volunteered for the role to be undertaken in collaboration with the other participants. Colby offered;
'We have our action research group, our audio, reflective journals, and observation. Elin will be doing the observing for us. I think that is all we need'.

Meetings were held in the craft room, there were initially six group participants, and one expressed their motivation and enthusiasm. Yasmin conveyed her enthusiasm;

‘This is a whole new experience for me, being involved in research. I am hopeful we can make some changes to current practice that will benefit the residents as they are the reason we are here. I am happy to be a part of this’.

Eloise agreed and added;

‘I feel quite valued now as an employee being invited to join this research, it’s very exciting for me’.

Group discussion focussed on the problems and priorities of this cycle and the changes they wanted to make to current practice; encouraging family involvement, and building a life history. Encouraging family involvement entailed; sharing expectations of care for the family member, and sharing family experiences. The group also decided that they would address each goal cycle by cycle in a systematic fashion, considering changes in direction as necessary depending upon feedback received.

**Reflection**

I encouraged the action research group to critically review current practice to assist them to plan and implement the changes they had identified as necessary.

The group worked collaboratively to develop additional documents for the “Welcome pack”, as well as resident information forms to assist caregivers in their implementation of person-centred care. To assist the above, the group were encouraged to reflect upon their practice to determine what they say they do in comparison with what is actually done. This reflection would enable them to identify any gaps they can see in their own practice or that of organisational policies.
Reflection

Personal assumptions and preconceived notions were noted in my reflective journal. I referred to these notations throughout the study, as I reviewed data. This process heightened my awareness of my beliefs and foreknowledge allowing me to gain a greater understanding of what was happening.

6.1.1 Encouraging Family Involvement – Goal One-Cycle One – The Welcome Pack

The group identified: encouraging family involvement, through sharing family expectations of care and sharing family experiences, as the first goal to be addressed in this cycle of action. The planning component of the cycle demonstrates how the action research group prepared the actions to facilitate the encouragement of family involvement. The group discussed the important rural aspects of the study; they agreed this was a rural town with many residents coming from out of town or remote properties some distance away. Additionally, many of the resident’s families lived such a distance from them that they seldom saw them, and other residents saw their families when they made their weekly trip to town from their properties for supplies.

The group acknowledged the importance of encouraging family involvement during the transition from home to facility. They agreed that this was an important component in meeting the individual needs of each resident so that families know from the outset they are welcome and that they can assist in the care of their loved ones in many ways other than attending to their personal care needs, even if they are unable to get to the facility on a regular basis. The group agreed that by encouraging family involvement for each resident would assist the transition for residents, and the facilitation of individualised care for each resident, resulting in a small though positive change toward person-centred care.

The group agreed that to encourage families to become actively involved in care, rather than just feeling like visitors in the facility, would better reflect a participatory and interactive approach to care. They decided that a revised “Welcome Pack”, which had a person-centred care focus, would enhance the gathering of information regarding the resident, as well as inclusion of families’ expectations. I provided the group with a paper by Buron (2010) who proffered person-centred care interventions often incorporate family and their expectations into care delivery. This paper generated fresh ideas into the group and stimulated discussion. Colby shared her thoughts regarding the “Welcome pack”;
‘I have always thought the existing “Welcome Packs” were lacking, I mean, they seem to be just a heap of documents for new residents to fill out and now that I think about it, they don’t really help caregivers in any way. I think they could be utilised much better. These changes will be great’.

The group felt that additional documents included in the “Welcome Pack” with a person-centred care focus would be appropriate, and Elin volunteered for the role of assisting new residents and their families with the documents as she was already providing new residents with the existing “Welcome Packs”. Elin offered her thoughts;

‘I thought I was the obvious one to facilitate the new documents as I always give them [new residents] the existing “Welcome Packs”. I can now sit the new residents and their families and go through the documents together and hopefully engage them in conversation to encourage them to be forthcoming with more information about their lives’.

The group discussed and agreed that the “Welcome Packs” should not be provided to new residents to take home and complete, as was the existing policy. Completing the form at the facility with a staff member to assist and provide an opportunity for new residents and their families to ask questions was considered to be consistent with a person-centred care approach.
Elin accepted the role of engaging families of new residents in a conversation to generate biographical information that would assist staff. Information sought from these proposed conversations included the new resident and their family member birthdays, and reflections on important family social events, fun times, and holidays. The group believed that this strategy would improve the transition of the new resident to the facility and assist the family reconcile with this decision. Reflecting on this, Holly offered her thoughts;

‘It would be great if the families could share their stories with us. It would help us immensely to better understand each person. I don’t think the families realise how much that could help’.

And Yasmin agreed;

‘I think the families have so much to share, I mean, they have so many memories that they can share, so many fun times and things that have happened over the years. I would be encouraging families [to share these] as much as we can’.
Sharing family expectations of care and sharing family experiences were the focus of planning in order to meet the goals of encouraging family involvement and building a life history. The group agreed that encouraging new residents to share their personal experiences and preferences, and their expectations of care, would enable the staff to better meet needs and personalise care.

6.1.2 Building a life history– Cycle One – The Welcome Pack

The group identified building a life history as the second goal for this cycle as they agreed that the building of a resident’s life history can contribute to person-centred care through knowledge of the resident’s previous life in the community. The photo above shows an example of how different events and activities assist in building a life history for families. Life history can include the use of life review activities such as: the dictation of family recipes, the construction of a reflection book, and the re-enactment of past social roles to acknowledge an older person’s life story, identity, and selfhood. Through such activities and conversations, residents feel recognised, understood, and validated (Bhar et al., 2015). The group aimed to make changes to current practice that would include families in the admission process to assist them to build life histories for each new resident, which they agreed would be conducive to the implementation of
person-centred care. I demonstrated my commitment to the group as a partner in the learning process, by providing several journal articles pertinent to person-centred care to further assist planning and encourage reflective discussion and decision-making. The group perused an article by Riedl, Mantovan, and Them (2013), who proffered that older people’s experience of transitioning into residential aged care is unique to each person and a critical point in their lives. Yasmin commented after reviewing this article;

‘As far as I am concerned, the “Welcome Packs” should include information not only about the life people are coming into here, but also the life they lived before they moved in here. I mean, it must be so scary for older people to move into an aged care facility, I know I would be nervous, leaving my home’.

The group agreed with Colby who argued that;

‘Better informed caregivers can tailor care to meet individual resident’s needs’.

The group critically reflected on existing documents in the “Welcome Packs”, noting that requesting information regarding an older person’s preferences did not generate the depth of information they felt was required to build a life history and hence facilitate person-centred care as highlighted by Colby;

‘Looking through these “Welcome Packs”, there really is not enough there to encourage people to discuss their life, it’s like, we need to get people talking. Just writing stuff down is never going to be as good as talking to someone’.

Yasmin agreed, stating;

‘I think we [the entire group] agree that to build a life history for the new residents, it needs to be interactive, otherwise it just won’t work.'
Colby reflected on the discussion and added;

‘Well if we can get people to interact, I think it’s a win-win situation for everyone here, I mean, it’s better for the residents because they will be happier because people [caregivers] know more about them. It’s better for the families because they get to feel more involved in everything, and it’s better for the caregivers because they will understand the residents better and what they need, isn’t that what person-centred care is all about?’

Reflective journal entry – Colby

I think we all [action research group] agree that an important element of building a life history is a willingness by new residents to share information regarding family events, gatherings, get-togethers and important moments, via biographical conversation. To share that information with someone [caregiver] from the facility is important as it will all contribute to person-centred care, but equally important, is the attentiveness of the person [caregiver] they share the information with so that they can compile a resident information sheet for the caregivers.

The group decided to create three documents, two short questionnaires as (see below in Figure 6.5): expectations of care from new residents, the families of new residents, and a person-centred care information sheet delineating the principles of person-centred care for both new residents and their families (Appendix 10).

Expectations of Care – Resident

What are your expectations when coming into care?

What is your understanding of person-centred care?

What are your needs? Please list below.
Expectations of Care – Family

What are your expectations for your family member when coming into care?
What is your understanding of person-centred care?
What outcome would you like to see for your loved one?

Figure 6.5 Short questionnaires asking expectations of care of both residents and family.

It was agreed that Colby would receive the information from new residents and their families, and type the resident information forms to be placed in the staff room for easy access by caregivers. The group acknowledged that Elin’s role was substantive. She had accepted responsibility for providing a “Welcome Pack” to new residents and their families and assisting them complete the information requested. Elin acknowledged her role;

‘I am excited about it. I am really looking forward to doing this and can already think of two new residents to trial [the forms].’

The group decided that crafting a life history for new residents would demonstrate their awareness of, and commitment to person-centred care. They believed that this action would also facilitate the establishment of relationships of staff with new residents and their families.

Reflection

The action research group are learning strategies to work together and they are learning the importance of their social relationships as they work through the planning.

The group believed the information forms would assist greatly in building relationships with each resident as they would help understand each resident. They agreed that the forms should be brightly presented to catch the attention of caregivers and placed in a prominent position in the office so they would not go unnoticed. Holly and Colby agreed
to notify caregivers that the information forms would be available and to offer encouragement to review the forms regularly. To ensure caregivers heard a consistent message regarding the information generated from the information was to be provided to staff at each day’s shift handover. Preceding implementation of the new documents, Elin sought permission via an email from the Director of Care of Beaches Care of the Aged to trial the forms. Permission to implement this action was provided on the basis of a six-month trial. A review of the process was to be undertaken following the end of the trial period to determine if it was worth implementing the documents into the “Welcome Packs” on a permanent basis.

6.2 Action– Cycle One – The Welcome Pack

Group numbers reduced to four by the time the action component of the cycle commenced. The four remaining participants were; Holly, Colby, Elin, and Yasmin. Managers Holly and Colby remained in the action research group and continued to show their support through attendance at all action research group meetings and flexibility to enable changes. Participants who were unable to continue involvement found it difficult to get to the meetings as the meetings did not always coincide with their work.

The group identified three new residents at The Lighthouse for trialling of the additional documents (see Figure 6.5 for questionnaires, and Appendix 10 for information sheet). They discussed the risks associated with introducing the modified “Welcome Packs”, and Holly shared her thoughts on this;

‘Worst case would be that we as a group would be left feeling dissatisfied if there was no positive change made toward being more person-centred. We take pride in our work and if the action was not successful, it would leave us [action research group] feeling disappointed. I believe the action would only be unsuccessful if it was not transferred into practice, so together we need to put in our best effort to make it work’.

The group felt that the potential benefits outweighed the possible risks.
Reflection

It is good to see reflection and critical thinking from all levels including the managers, it encourages collaboration.

Elin arranged three separate meetings with three new residents and their families to discuss and complete the additional forms as planned. The meetings were held in an office at The Lighthouse where there was minimal interruption and opportunity for maximum interaction between Elin, the new residents and their families.

A summary of the planning and actions by the group:

- Identification of the new residents and trialling of the modified welcome pack that included the additional 3 documents for 6 months
- discussed the risks involved
- arranged the meetings with the new residents and their families to discuss and complete the additional forms
- arranged a suitable venue for the meetings

6.2.1 Encouraging Family Involvement – Goal One - Cycle One – The Welcome Pack

The group concurred that Elin was an active caregiver who readily engaged in activities at the facility and prided herself in being a socially interactive person. During each meeting with the new residents and their families, Elin discussed how she engaged them in conversation, inviting them to share personal family experiences with her in a comfortable environment. She asked the questions and invited new residents and their families to add any additional information. If anyone had difficulty writing, Elin was able to write for them.

Elin reported to the group that it was disappointing to note the new residents were reserved, and it was the families who answered most questions. New residents, she stated, appeared slightly overwhelmed. One new resident found it difficult to write her responses and stated she was grateful that Elin was available to write for her. Elin was happy to talk about her feelings;
“I love to talk and people just open up to me. The families shared experiences with me which was lovely. They told me stories about birthday parties and family get-togethers. I heard about trips overseas and funny habits. One family member even told me that her Mother went sky diving at the age of 80. I couldn’t believe it” (Elin)

Elin collected the responses to the questions asking expectations of care of the new residents and their families. She reported that families were delighted to be included in this process.

6.2.2 Building a Life History – Goal Two- Cycle One – The Welcome Pack

Following the meetings with the new residents and their families, Elin met with the group to debrief about the meetings with new residents and their families and present the information generated from the two short questionnaires (see Figure 6.5). A short summary of each of the new resident’s daily routines was developed and provided to caregivers. Figure 6.6 is an example of the new resident’s information provided to caregivers to assist them to deliver person-centred care:

Susan\(^1\) likes to be woken at 7am and then have her shower and breakfast. She does not like coffee and only eats wholemeal bread. She is a private person and keeps to herself. She prefers to sit alone at the meal table. She enjoys doing jigsaw puzzles after lunch and then has an afternoon nap at about 2pm. She likes to keep busy in the garden and goes outside every day at 3pm to tend to her garden. She gets upset if her routine is interrupted. Sometimes the only thing that will settle her if she gets upset is to listen to classical music.

Figure 6.6 An example of the new residents’ information sheet provided to caregivers

Reflection

It was a lot of pressure placed on one participant in this cycle; however, Elin seemed really happy to do it and stated she enjoyed the challenge. It is nice to see the participants feeling empowered.

\(^1\) Pseudonyms were used throughout the document to protect resident’s identities as well as those of study participants.
Below is a summary of the planning and actions the group undertook;

- engage new residents and their families during the meetings
- typed the information forms re each new resident
- placed the information forms in the office
- Appropriate placing of forms in office, deciding upon a prominent position.
- notified caregivers at the next meeting about the resident information forms

6.3 Observation – Cycle One – The Welcome Pack

The findings of the cycle are documented below including the themes generated from the questionnaires for the cycle. Included in the observation is the action research group interpretation of the findings, the effects of the action, both intended and unintended, the circumstances of, and constraints on action, how circumstances changed planned action, and any other issues for discussion.

The groups reflections on the actions undertaken to generate meaningful information about new residents through changes to the “Welcome Packs”. The group wanted to encourage family involvement, increase caregivers knowledge of new residents so that they could deliver care that better aligned with a person-centred care approach.

6.3.1 Data Analysis – Cycle One – The Welcome Pack

The data collected by the action research group from the results of the questions asked of new residents and their families was analysed by the group with assistance from me as facilitator. A thematic analysis process following the step-by-step method proposed by Braun and Clarke (2006) was utilised. I transcribed the group’s deliberations on behalf of the group, and engaged in reading the data collected from the groups deliberations on the information provided by the new residents and their families. Synthesising of the information occurred using a thematic approach to delineate the key points/themes that would then be used to construct the thematic map. Patterns in the data were chosen in collaboration with the group and categorised by similarities, for example; “To have family contact most important”, and “To visit my husband on a regular basis”, and frequencies, for example; certain words were used frequently such as change and safety. I coded interesting features of the data, and invited the group to peruse the resident and resident family expectations of care to assist analysis. They were happy to be included and stated they felt empowered by being asked their opinions. We collated codes into two themes, gathering all the data relevant to each theme. Elin offered her thoughts on being involved in the data analysis;
It made us all feel really important to be asked [to assist in analysing the data from new residents and their families], felt like we were a part of something.

Elin offered;

‘The changes we made to the “Welcome Pack” really were a good strategy that we devised as a group. I can see how small changes like this can lead to us being more person-centred in our work’...and

‘I was really glad that the Director of Care was on board for this otherwise it would not have even got off the ground’. Colby responded:

‘I agree, it is hard to make changes if the hierarchy are not on board’

The group discussed how the innovation was not carried through when Elin retired. They only got to trial the changes on several new residents and their families.

Eke expressed her disappointment;

‘Very disappointing [innovation not continued], it seems that we only just got started. I thought we had already made progress [toward being person-centred] and then it all stopped.’

Tiana also conveyed her disappointment;

‘Why didn’t someone help us so that they [changes] could have continued?’

The group discussed their understanding of a person-centred care approach, and Eloise shared with the group;
‘I must say, I think this is all harder than it seemed. I mean, there is so much to do toward making changes that are person-centred. I did enjoy it but it didn’t really help us because the forms were filed away anyway and we couldn’t see them’.

Holly did not agree with Eloise;

‘Well I think the idea [of the additional forms to be included in the “Welcome Packs”] was really good and I did see a difference. I think the families seemed happy to be included and I think we have all learnt more about person-centred care, we now know how important it is for both residents and caregivers to understand the person which comes from building a life history and sharing stories with them and their family’.

Lucy agreed with Holly;

‘I know I can see a difference in myself since we made the changes because we [Lucy and new resident] were talking and I was able to talk to her about gardening straight away because I had read the form, and I found out she loved gardening. Made me feel really good and she [new resident] had a smile on her face. I think that is what person-centred care is about’.

Elin changed the subject and commented on being part of the group;

‘It made us all feel really important to be asked to be part of this study, felt like we were a part of something really special. The beauty of it has been that we all learnt something about person-centred care’.

There seemed to be mixed feelings from the group about the success of the cycle as evidenced by the group reflections above.
Figure 6.7 Flow chart showing progression to final theme/s for discussion

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident safety and security</td>
<td>Residents and their families described physical and emotional safety was an important factor</td>
<td>For her [Mother] to feel safe and secure at all times. To be treated with respect. To feel safe and secure. Being in a safe environment.</td>
</tr>
<tr>
<td>For residents to be respected and treated as individuals</td>
<td>Residents and their families identified respect and dignity as being important in care</td>
<td>To be treated as an individual with dignity and respect. I want my family member to be treated with respect and understanding. “For all aspects of the resident’s lives to be discussed and valued.</td>
</tr>
</tbody>
</table>

Figure 6.8 Example of coding manual derived from forms completed by new residents and their families

**Thematic Maps**

Direct quotes and paragraphs were examined for meaning which led to a code being developed and eventually, theme development (see Figure 6.9). In collaboration with participants, I searched for themes using a cutting and pasting technique of codes into categories and checking these against the direct quotes and the data for validity. I
examined and re-examined the codes and contrasted them against the literature to identify themes that emerged that accurately depicted the codes. Each theme encapsulated something important, meaningful and significant about the data in relation to person-centred care. Themes were derived directly from the data collection pertaining to new residents, their families, and participants. Data relevant to each potential theme was re-examined, then either kept or discarded. Two thematic maps were conceptualised with the themes defined, then named, all the while checking and re-checking the data set. Codes were checked against the transcripts and separate themes of; “Support caregivers to create a home for residents” (Figure 6.9), and “Support residents to maintain their self-worth” (Figure 6.10) were conceptualised. The first thematic map was a reflection of data from the action research group, and the second thematic map was a reflection of data from new residents and their families. Participants stated both themes reflected the direct responses provided by themselves, new residents and resident families.

Figure 6.9 Visual of the thematic map derived from action research group data demonstrating how five codes (at the bottom) merged into two sub-themes, with the theme at the top.
When discussing the themes, I encouraged participants to remain reflective, responsive, and open-minded. It was important to remain focused on the aim of the study which was to support managers and caregivers at three rurally located residential aged care services implement and sustain a person-centred care approach, as well as the goals of the cycle; (1) Encouraging family involvement through sharing expectations of care for their family member, and sharing family experiences (2) Building life history; involving new residents sharing their expectations of care, as well as new residents and family sharing personal experiences and preferences. As the facilitator I supported inclusiveness and collaborative engagement with the participants during this process.

**Theme 1 – Support Caregivers to Create a Home for Residents**

The group identified the theme; “Support caregivers to create a home for residents”. This theme highlighted the importance placed on having a home, being at home, and having a family, as well as the importance of creating a homelike setting for residents. The theme encapsulates the sub themes; “New residents miss their homes” and “Support caregivers with targeted education”. New residents conveyed how much they loved their homes and how the thought of leaving it caused them distress. Elin offered her thoughts on this;

“She (new resident) said she loves her home, and loves being home. She said she feels safe and protected from the world and can do whatever she wants in her home. She stated she can be herself”.

**Sub theme – New residents miss their homes**

The group discussed how a home is so much more than people ever realise until such time that they have to leave. They discussed the concept of home and the different words they used to describe a home were; “comfort”, “peaceful”, “castle”, “retreat” “sanctuary”, “love”. The action research group discussed that if they were to emulate “home” for the residents, they would need support from management to achieve this.

The group noted that new residents were stressed by leaving their homes and moving into residential aged care. The thought of leaving what was familiar to them, including
their local community, which may have been a small rural one, was overwhelming and could lead to such identifiable indicators as being withdrawn, stress and feelings of loneliness.

**Sub theme – Support caregivers with targeted education**

The group discussed how they felt it was necessary for caregivers to be supported with targeted education regarding person-centred care to enable them to adequately implement changes to practice. This included how they develop relationships with residents and address all resident care needs. The group also noted that any education should be conducted in collaboration with the caregivers by management.

The sub-theme “support caregivers with targeted education” encompassed developing good relationships with residents, changes needed in collaboration with caregivers, and the need to consider all aspects of resident care needs. Together they highlighted the need to share information with caregivers in a bottom up approach. It is about management working in collaboration with caregivers to implement sustainable change. Elin offered;

*I think our relationships with the residents mean a lot to them as well as us. They (the residents) probably feel a bit isolated and we can fill that gap for them and make them feel more at home*. 

The group agreed changes were needed in collaboration with caregivers and to achieve this, critical reasoning was necessary to transform practice. Elin supported this viewpoint;

*‘Caregivers tend to be too task actioned ... We need a change of attitudes’.*

The group deemed it important to consider all aspects of resident care needs. They discussed that although essential care needs were important, equally so were the psychological and social needs of residents. Yasmin stated she felt pressure to deliver quality care for the residents;
‘We need to develop good relationships with the residents; we have to be respectful of their choices, and try to accommodate what they want, it can be really hard sometimes to get it all right’.

Theme 2 – Support residents to maintain their self-worth

Figure 6.10 Visual of thematic map derived from new residents and their families demonstrating how four codes merged into two sub-themes “A sense of belonging”, and “Family concerns for residents”, with the theme “Support residents to maintain their self-worth” at the top.

Following analysis of numerous codes, the sub-theme “A sense of belonging” was conceptualised. From the sub-theme, the theme; “Support residents to maintain their self-worth” was conceptualised. The codes supporting the sub-theme and theme were;
for residents to be accepted, respected and treated as individuals, retain independence, resident safety and security, and retain contact with family and friends.

**Sub theme – A sense of belonging**

Reflective discussion was used by the group to determine what a sense of belonging meant to them. Key words that arose from those reflections were; loved accepted, content and happiness. A sense of belonging was the sub-theme identified by the group. Examples of quotes supporting the code were; “For her (Mother) to feel comfortable and happy in her surroundings as possible”, “Quite contented knowing I am in the right place”, “For Mum to be cared for”. Life in residential aged care has been described as inactive, lonely and most of the time lacking social activities, further described as a place where residents own care was described as “meetings”. A sense of belonging and capability are important for the meaning of life in residential aged care (Anderberg & Berglund, 2010). The group agreed that for residents and their families, a sense of belonging was important to both residents and their families. Elin shared with the group what a sense of belonging meant to her;

‘A sense of belonging is for me, feeling accepted, comfortable, loved, happy, and contented, as far as I’m concerned, it is a basic need for people and it does not matter what age they are, everyone needs to feel they belong and are accepted in their life’

Elin also shared with the group how a new resident commented that she wanted a friendly and participative atmosphere in the facility, which the group discussed and agreed, aligned with a sense of belonging. Colby offered her thoughts;

‘If you ask me what participation is, I say for me, it is joining in activities with family and friends, participating in something like a walking group or just being involved in something that makes you feel like you belong’

Group discussion noted that from the quotes regarding a sense of belonging, it was equally important for new resident families as it was new residents, to know that their loved one felt they belonged. They also discussed that within a sense of belonging were the four codes discussed below.
The group agreed that an important factor in belonging was to be accepted, respected, and treated as an individual. New residents at the Lighthouse indicated they want to be respected and treated as individuals. The group agreed with an article by Portner (2011). Portner (2011) proffered that people in residential aged care want to treated as individuals, taken seriously and not reduced to their insufficiencies and deficiencies. They don’t want to be ‘activated’ or animated to do things they are not interested in. They want to be engaged in the things that are important to them. They don’t necessarily want to be entertained in ‘seniors programmes’ or to participate in special exercises for the elderly. Portner (2011) continues, stating she wants to decide for herself if she gets up or stays in bed a while longer, which clothes she wants to wear, if she feels like watching television or listening to music, when to have a shower, wash her hair and cut her nails, adding that she realises she may need a little help with these things. The agreed this resonated with what the residents wanted and highlighted the importance of treating people as individuals.

The group discussed a relationship between retaining independence and retaining contact with family and friends. The new residents at the Lighthouse stated contact with family and friends as most important to them, and the group discussed how retaining that contact also affords a person more independence. The group referred to articles by Riedl et al. (2013), and Tse, Leung, and Ho (2012), who stated that residents still want to feel a part of society outside residential aged care and they wish to remain in contact with family members and friends, therefore maintaining the social contacts they had prior to entering full nursing care.

The group agreed that the maintenance of contact by staff with the resident’s family and friends was a demonstration of the respect they have for the older people living in residential aged care, for them to make an effort to have positive contact with the resident’s family and friends when they visited. Family and social contacts are viewed differently by residents after entering residential aged care than they were prior to that. The group noted an article by Tse et al. (2012), suggested that living in residential aged care is a difficult experience for many people. It represents an alteration of living environment, leading to reduced socialisation with family and community, a decrease in physical activity and an increased perception of loneliness. Riedl et al. (2013) added to this, offering that many new residents feel a change in social status, the impact on independence, the feeling of having no place to call home, the change in social contacts, and the reduction of habitual activities. Many residents express feelings of unhappiness, loneliness, depression and a sense of failure when they have to stay in residential aged care (Tse et al., 2012). Reflective discussion of the articles by Riedl et al. (2013) and Tse et al. (2012) amongst the group, supported the view that older people have a strong
desire to retain contact with family and friends outside residential aged care and for this to occur, they need to retain a degree of independence.

As an added reflective technique, the group decided to use Wordle software as a means of exhausting all possibilities to see if anything significant had been overlooked. Two Wordles were constructed; (1) from data derived from participants during action research group meetings (Figure 6.11), and (2) from data derived from a short questionnaire that utilised an open-ended question format (Figure 6.12). Using the Wordle software as an adjunct tool validated the findings. It provided rapid output and was a visually rich and fast way of visualising general patterns in the data. It is important to note that Wordle was used only in its capacity as a validation tool and it was noted that it only counts the frequency of words used, making it misleading as it neglects the semantics of the words and sentences. The first Wordle contained text derived from audio notes, and the questions posed to participants in chapter four, establishment of the study. It was more relevant to present the Wordles here because they complemented the data analysis as an adjunct way of validating the findings.

Figure 6.11 Wordle tool used to validate the text from participants.
Following formation of the thematic map pertaining to data from new residents and their families, the Wordle tool was used to provide rapid output and as a visually rich way of displaying general patterns in the data. The action research group agreed the Wordle reflected everything they had discussed.

**Sub theme – Family concerns for residents**

The group identified that family concerns for residents included that their family members needed to retain as much independence as possible while in care and also that the safety and security of their family members was paramount. Several of the direct quotes from new residents and their families were; “Residents should be able to live as close to their home environment as possible”, “That Mum can be as independent as possible”, and “Attend Mass every Sunday”. The group identified with a manuscript by Portner (2011). Portner (2011) proffered that instead of realising that a person is no longer capable of doing something and doing it for them, it is much better to offer that person specific support that helps them reconcile this incapacity and, to a certain degree, act independently. The participants debated that sometimes in residential aged care facilities, older people are served a meal, even though they do not touch it, to then have it taken away with a comment from care caregivers “You didn’t eat your meal.”
again”. The fact is ignored that, depending on their condition, some older people are still able to take single steps, but cannot combine them anymore. They might need some guidance and prompting such as “Now you need to pick up the spoon”. It is the duty of the caregivers to find out what support is needed as they are the ones who have the majority of the contact with residents. It is important that caregivers can discriminate between someone who has little appetite, and someone who has an appetite but is no longer able to manage the process, and therefore needs support. This awareness is often lacking in contact with people and unnecessarily increases the helplessness of many older people who will not get the appropriate support they need to act independently (Portner, 2011). Elin shared some of the feedback from new residents and their families and her own view on independence;

“They (new residents and their families) shared with me; that retaining independence was vital. They indicated in their responses that they wanted to continue, or wanted their family member to continue with many of the activities they did prior to admittance to the Lighthouse, which is fair enough. I mean, I would want to still be able to do as much as I could’.

Elin also added how much she has learnt from this experience;

“This has been a real learning experience for me’.

The group discussed their raised awareness of how important retaining independence is to older people particularly in residential aged care. Elin shared de-identified information and themes from her discussions with the new residents and their families, which assisted acquisition of knowledge for the action research group.

Several of the direct quotes from new residents and their families expressed clearly that safety and security were of paramount importance, with many simply and explicitly stating almost the identical thing: “For Mum to feel safe”, “For her (Mother) to feel safe and secure at all times”, “To feel safe and secure”, “Being in a safe environment”. The action research group discussed how new residents and their families shared their safety concerns. In order to feel safe, residents aspire to recreate a home-like environment (Anderberg & Berglund, 2010). The group felt that facilitating communication between caregivers and managers is important, and participants stated they felt that their current managers fostered an environment in which caregivers felt comfortable to identify and report safety issues.
Reflection
It is definitely up to the managers to ensure the caregivers feel comfortable to report safety issues, but I think it is also a collaborative effort. Caregivers appear willing to take responsibility for safety issues and managers appear willing to empower them.

The actions undertaken in this cycle included trialling agreed changes to the “Welcome Pack” as well as engaging new residents and their families in biographical conversations. Findings were discussed with the group for interpretation and documentation of the effects of the action, both intended and unintended, the circumstances of, and constraints on action, and how circumstances and constraints changed planned action, and addressed any other issues that had arisen during the action.

Reflection
It is important for me to promote ownership of actions for the participants.

The group realised they were not taking responsibility to inform new residents and their families about person-centred care. Additionally, they reflected that many of the residents had cognition issues and therefore “informing” them about a new approach to care would be inappropriate. It was agreed that caregivers had a responsibility to understand and embody person-centred care in their practice, be able to describe person-centred care to others and demonstrate how to implement it.

6.3.2 Encouraging Family Involvement

Elin stated she was pleased there was family involvement in the arranged meetings about sharing family experiences and expectations of care. The families appeared willing to engage in discussion regarding their expectations of care for their family member. These families were also agreed to contribute to a biographical conversation with their family member and they were informed that this would enable the facility to get to know their loved one. Elin conveyed that the new residents were reserved and the families spoke for them most of the time. The group discussed that this was disappointing as they wanted new residents to feel comfortable to ask questions and
interact with them freely. The group felt that if new residents did not feel they could be open with the caregivers, then their capacity as caregivers to implement person-centred care could be compromised. Although Elin had indicated that the families appeared willing to be encouraged to be involved with their resident family members, encouraging family involvement could not just be a one-off event, it had to be integral to usual practice. The group believed that the encouragement of family to be involved with their resident family members had progressed person-centred care. They also acknowledged that engagement of families must be a priority for the facility. The recommendation from the group was that this topic be reviewed regularly by managers as an agenda item in staff meetings. A review of the process was to be undertaken following the end of the trial period to determine if it was worth implementing the documents on a permanent basis.

6.3.3 Building a Life History

Elin reported she was pleased with the success of the initiative to build a life history for each new resident. She stated that during the meetings, she had encouraged interaction and the families were forthcoming with biographical conversation and preferences regarding their family member. They conveyed information regarding family birthdays, trips, weddings, and special events, allowing Elin to take notes for resident information forms. Additionally, she offered that, although it was useful to interact with families, she would have liked the new residents to contribute more to the conversation. She expressed concern that the families dominated the conversations. The group discussed the possibility of also having an additional conversation with new residents to confirm and add additional information to that collected during the initial meeting with family and new resident.

This action cycle realised a “quick win”, that according to Sabic and Zaimovic (2012), is a quick tangible result. The benefit of this achievement to the group was that they identified an issue and implemented a change that they believed enhanced person-centred care, increasing their confidence in implementing person-centred care. Holly and Colby as managers stated they were happy with the documents and were certain they were making a positive difference, and had provided an awareness of person-centred care new residents and their families. The group noted; however that quite often, the new resident information forms were not provided for caregivers to peruse. The also noted that Elin retired shortly after the study finished and her position became available to anyone already involved in administration from one of the three facilities able to step in for a day, making it difficult to have consistency.
6.4 Reflection – Cycle One – The Welcome Pack

Through the collaborative efforts of the group, outcomes achieved from cycle one were; a greater awareness and understanding of new resident needs and their expectations for care within a residential aged care facility, inclusion of families from outset, collaboration and team building activities for caregivers as they worked through the cycle, and empowerment of the group who made the decision to further investigate the problem and act on it with support from management. On receipt of the questionnaire responses, from new residents, several of the answers were difficult to decipher due to shaky, handwritten notes. This presented a challenge for participants as it took time and effort to work out what the residents were attempting to articulate. Although several words and sentences were indecipherable, the overall meaning of what was being conveyed was captured by participants. The implications for the study from this cycle were: families’ input is an important factor in implementing person-centred care, they can share information, and their involvement is vital for the continuation of a person’s life when they are admitted to a facility and; families like to be consulted regarding the ongoing care of their family member, for example, several family members stated to Elin that they were grateful they were included in the pre-admission meeting and stated it was nice to be asked their opinion regarding the care of their family member.

New residents also benefit from initial discussions with facility staff. Through sharing personal experiences that enable staff to build life history information for all new residents, person-centred care can be achieved - provided it is shared with caregivers. It is important for caregivers to understand from the outset the importance of person-centred care and how to implement it for residents, as this also assists and enables those people to continue with a life as close to what they led in their own home prior to transitioning into residential aged care.

The group worked well together through collaboration to identify issues and make changes to practice. This demonstrated their empowerment, as they were able to identify strategies they considered would contribute toward person-centred care. The group considered the importance of encouraging resident families in sharing information about their loved one in care and without that involvement, crucial biographical information regarding new residents could be omitted thus adversely impacting on the outcome, for example, a new resident could have cognitive impairment and not be in a position to divulge much personal information. Conversely, a family member could provide caregivers with information about their partner or parent such as; they may have always loved the outdoors and gardening, or watching old movies. This information could have a significant impact on the experience of residential aged
care for this person and the implementation of person-centred care. Therefore, it was important for caregivers to understand the value in including families in the process.

Due to the nature of the study, it was necessary to consider the possibility that participants from the group had perceived exclusivity. When considering who benefitted from the current situation, and who was disadvantaged by the situation, there were distinct benefits and disadvantages arising from power differences. A few group participants and caregivers benefitted from the current situation as they held the knowledge and power regarding the new residents. This gave those group members an unfair advantage over the remainder of caregivers (non-action research group members) who were only provided the essential care information regarding the new residents. Caregiver’s privy to this information would then be able to advise others to assist the resident when they experienced episodes of agitation. Both new residents and remaining caregivers were disadvantaged by the current situation due to a select few caregivers holding the power and knowledge regarding new residents. An example of this from Colby:

‘Deidre was admitted to [the Lighthouse] twelve months ago following a diagnosis of dementia. She became very frustrated within days, and became depressed. When the family were contacted, we found out that Deidre had previously loved her garden and spent most of her days in it. She never enjoyed the company of other people. Once caregivers were made aware of this they were able to provide Deidre with pots and seedlings and a raised garden bed to increase her happiness. To further person-centred care in that situation involved a collaborative effort.’

The above was deemed an important issue relating to team dynamics and power relationships. The way it was managed was critical to the group members and caregivers in general, feeling empowered to ask questions and take actions. This cycle, from the viewpoint of participants was about changing the thinking of residents and their families rather than actioning what they as participants were doing that could be done better. For sustainable change to occur the group needed to look inward and begin to take some responsibility for what was happening and they agreed that needed to be more critically reflective of their own practice.

It was deemed advantageous by the group to introduce the new documents to the “Welcome Packs” and following the six-month trial, they were able to leave the forms in the packs indefinitely as informal feedback suggested they were conducive to person-centred care implementation. Participants stated the new documents further advanced
person-centred care from the outset. However, when I checked some months later, the forms were not readily available to caregivers. When I asked caregivers where they were the reply came that the administrative officer had retired. The group stated they heard that some caregivers were not reading the forms and eventually, they were not printed at all, suggestive of either a lack of motivation on the part of the caregivers to implement change to practice, or lack of communication in communicating the innovation. The group agreed that with Elin retiring, it changed everything. Elin was the one, they stated, who was the driver of the forms and the one who happily sat with new residents and their families and encouraged the sharing of family experiences etc. They said they thought that the new administrative officer was not keen to continue with the forms and facilitation of conversation as she decided it was “not her project”.

**Reflection**

In hindsight, the action research group should have considered that it is so important for any changes to have the buy-in of all staff and importantly, management, so that if one staff member retires, the innovation continues through effective succession planning.

The definition of person-centred care, devised by participants at the initial meeting, was re-visited; resident autonomy, building mutual trust, and respect for resident privacy and confidentiality. The action research group stated they would alter their original definition to include family involvement. They stated they had increased knowledge regarding the importance of including family after completing the cycle. For the short time the additional documents were used in the “Welcome Packs”, the action research group agreed that they did assist the building of a life history for new residents, as well as inclusion of families through the sharing of personal experiences and expectations of care. Following cycle one there had been an incremental change to practice as the action research group stated they felt more empowered to ask questions as well as make decisions for themselves.

**6.5 Précis – Cycle One – The Welcome Pack**

In cycle one, the Lighthouse action research group detailed how they facilitated the actioning of their shared goals; encouraging family involvement and building a life history by making changes not only to the “Welcome Pack” but the way in which the “Welcome Pack” was delivered to new residents and their families. In keeping with action research, the cycle was underpinned with reflection and participation by the team. Progress was made in the form of changes to practice and demonstrated by
participants volunteering for various roles in the cycle, empowering them to make changes to practice, which was in keeping with the goals of the study; increased understanding and implementation of person-centred care.

The actions of cycle one informed this cycle by producing early success for the action research group, increasing their empowerment and knowledge. The group became more aware of the importance of including families in care, and building a life history for residents. The group had learnt to collaborate and reflect as a group also building their ability and confidence to work as a team toward shared goals. Despite three participants resigning from the group, the remaining four were positive and determined to make changes to the resident dining room.

The group considered the aims of the study as well as the cycle, and agreed they had firstly made progress toward the aims of the study by demonstrating an understanding of person-centred care, and they made changes to current practice, albeit small. They agreed they had engaged families; however only the families of new residents were engaged, they had engaged caregivers by providing resident information forms; however when the key information collection person (Elin) retired, the forms ceased being given to caregivers. Secondly, the group achieved the goals of the cycle of; Encouraging family involvement through sharing expectations of care for family members relocating to residential aged care facilities, and sharing family experiences, and; Building a life history for all residents and their family inclusive of sharing their expectations of care, personal experiences and preferences to enable caregivers to deliver person-centred care. Cycle one was deemed effective overall, including the challenges presented to the group (Elin retiring), which forced the group to consider sustainability when implementing innovations. The group discussed the achievements resulting from the cycle;

- The group had a greater awareness of their situation in order to take action
- Increased awareness of the importance of involving residents in care
- Collaborative learning through the actions of the action research group activities
- The group focussed on changes they could make to current practice
- The group critically reflected on current practice then planned and actioned changes
- Increased empowerment in being allowed to make decisions

The group discussed what could have been done differently in the future;
• To involve more than one key person in an action to ensure sustainability
• More emphasis on teamwork to action change
• The engagement and involvement of all caregivers in the decision-making process when proposing to make changes

To conclude cycle one, the group discussed the second cycle of action, with goals and priorities determined in chapter four regarding the dining room. Unfortunately, time had passed and group numbers had dwindled since inception and determining priorities; however though smaller numbers remained, the group agreed they would forge ahead as they were committed and keen to make changes to the dining room. They agreed they could build on the learning and challenges they faced in cycle one.

6.2: ACTION RESEARCH CYCLE TWO-THE LIGHTHOUSE-THE DINING ROOM

Figure 6.13 A photo of The Lighthouse dining room

For cycle two, the Lighthouse action research group addressed problems in the resident dining room relating to communication, interactions and choices. The prioritised goals were to: create a positive mealtime experience; and improve communication.
Figure 6.14 A visual of the goal of cycle 2, showing how it was to be achieved and linking it to person-centred care.

**Reflection**

They [participants] are more confident this cycle. They are using their increased knowledge and empowerment right from the start and seem more focussed.

### 6.6 Planning – Cycle Two – The Dining Room

In recognition of the need for the action research group to address the problems identified in chapter four to create a positive mealtime experience, they agreed to utilise the skills they had learned in cycle one. They appeared more comfortable within the group environment, and had increased knowledge and empowerment as was evidenced by them asking more questions and sharing personal practice experiences. They agreed they wanted to use the same data collection tools as cycle one; the action research group, audio and reflective journals. The priority/goal of the cycle was to create a positive mealtime experience by addressing each problem identified in chapter four, residents were perceived as demanding and calling out for service, there was tension between residents and dining room caregivers,
residents and dining room caregivers, there was a perceived lack of interaction between residents, and dining room caregivers and residents, there was a perceived lack of autonomy and choice for residents, and a perceived labelling of residents by dining room caregivers, for example; “they are all whingers”. Holly shared her thoughts;

‘The problems in the dining room are huge, but hopefully we can work through them to alleviate the issues. I don’t know how much longer I can put up with this; it has really got to me’.

I undertook preliminary observational work at the Lighthouse to be a partner in the learning process, which I shared with the action research group. The observational work occurred in the resident dining room on commencement of the cycle to observe usual mealtime proceedings on three occasions to assist in providing insight into the current cycle. Participants planned to address the identified problems with appropriate strategies. Several examples of ideas discussed amongst the action research group as below;

“Maybe we could have fewer tables with six people on each instead of four” (Elin)

“Maybe we could have a continental breakfast” (Elin)

“Maybe we could introduce a breakfast trolley with a choice of tea or coffee and different cereals for people” (Colby)

“Do you think people might like to serve themselves?” (Yasmin)

The group devised four strategies to address each problem; new seating arrangements, separate mealtimes, personalised placemats, and a breakfast trolley. They agreed for the strategies to be implemented together, and certain strategies would address multiple problems.
6.6.1 New Seating Arrangements

Elin had suggested during action research group discussions that new seating arrangements could facilitate interaction between residents. The action research group agreed that the dynamics of a couple of the tables were conducive to interaction, whilst most were not. Mostly the residents sat and ate their meals without any interaction with the other residents on their tables. They discussed the reason the dynamics of a couple of the tables worked was because the residents who sat at those tables had common interests. They further discussed if the residents were placed at tables where they shared common interests, and then interaction would proceed. Holly suggested the current configuration of tables was the reason for this lack of interaction;

‘Maybe the configuration could work better if there were fewer tables and more people on each one to encourage interaction’.

When the group discussed the table configuration, they discussed that instead of smaller tables seating four people, there would be fewer, larger tables seating six. They agreed this strategy would be conducive to encouraging interaction between residents, as there would be more people to converse with, and a more cohesive group seated at each table, for example; sitting residents together who enjoyed gardening, music or sport. The group discussed that the residents had always sat at the same table and same seat every day for each meal. They referred to an article by Thomas, O’Connell, and Gaskin (2013) that reported regularly sitting at the same tables every day gives older people the opportunity to develop friendships with others (Thomas et al., 2013). This article contradicted what was currently happening with the residents as many of them did not appear to have formed good friendships despite them sitting at the same table each meal. Adding to this, there were tensions between some residents at the time of the study, with some reporting difficulties when attempting to socialise with residents who had dementia. Thomas et al. (2013) also discussed the placement of residents with dementia on the same tables, leading the action research group to decide that residents with cognitive impairment would sit together closer to the kitchen so that caregivers could monitor them more closely. The group decided on fewer tables seating six people (apart from the tables to be left as they were, being the tables which were already meeting the resident’s needs) and Holly was happy to organise the changes over the next week. Elin and Yasmin volunteered to work with lifestyle caregivers to identify those residents with common interests.
Reflection

The action research group are quite passionate about this and I can tell the whole situation has caused great angst. They seem very motivated to make these changes.

6.6.2 Separate Mealtimes

The group decided to introduce two separate mealtimes which would address several problems, including residents demanding and calling out for service and tension between residents and dining caregivers. Preliminary observations showed residents demanding their tea, coffee etc, and calling out for service.

“Where is my cup of tea, I have been waiting, and you are talking to the other girl [caregivers]. Am I invisible or something? (Resident, from observation)”

The group agreed that the agitation and tension between residents and caregivers was escalating and they needed to make changes. Colby suggested two separate mealtimes for breakfast and the evening meal to better suit the residents and reduce agitation and tension between residents and caregivers. Elin shared with the group her thoughts;

“The residents click their fingers to gain attention from the caregivers serving meals. If the caregivers don’t respond immediately, the residents get angry. This behaviour [from the residents] is distressing both the residents and the caregivers’.

Elin continued;

‘Why can’t they just be more patient, there is no need for this, what happened when they used to go to restaurants, did they behave like this if their meal did not come out first?’
Dining caregivers stated they felt tension between themselves and the residents prior to mealtimes, increasing existing tensions. Several residents called out continually demanding service and clicked their fingers to gain caregivers’ attention. The suggestion of two separate mealtimes was welcomed by Holly who stated:

’What a great idea. I think that would be perfect. We could have them 15 minutes apart. I cannot see any negatives with that, much less pressure on everyone’.

The group agreed that introducing two separate meal times could serve to alleviate tension between residents and caregivers. They further agreed that caregivers would be able to concentrate more on fewer people at breakfast and dinner making the mealtime experience more enjoyable for the residents. The group agreed to trial Colby’s suggestion of two separate mealtimes for one month to see if it was worth implementing on a permanent basis. They decided to invite half the residents in fifteen minutes before the usual mealtimes for breakfast, and dinner. They decided that it was not necessary to include the lunchtime meal in this as many of the residents were out throughout the day. The group discussed which residents should be invited to the first sitting and decided that any residents with cognition issues should be first as well as residents who became anxious. The group decided to notify caregivers via notices on the caregiver’s notice boards in the main office and caregiver’s dining room, as well as the kitchen. They decided it would be appropriate to deliver invitations to the residents regarding their altered meal times, explicating the date the changes would be implemented.

6.6.3 Personalised Placemats

The group planned to introduce personalised placemats to facilitate interaction between residents, and discussed an article by Brownie and Horstmannshof (2012) which stated that person-centred care has always been defined as ‘valuing people as individuals’. They also discussed ideas that could address the lack of interaction. Yasmin volunteered an idea she had heard about;

’We could use personalised placemats for each resident. You get the residents to choose a favourite photo and then you print it out on A4 paper and laminate it. You then write their name down the bottom in thick black marker. The residents will love it I’m sure and it should help heaps with conversation as the residents love to tell their story’.
Reflection

It is important for caregivers to recognise the inherent power they hold as part of their role as caregiver and to ensure to seek the residents’ opinions on any changes before simply implementing them.

The residents had stated previously they felt caregivers were not attentive enough when they spoke to the residents, as indicated during observation. Colby offered;

‘The residents expect instant acknowledgement of their requests, which is not necessarily possible at the time’.

Labelling was identified by the group as a potential explanation as to why certain caregivers did not speak to residents unless asked a question. The group discussed that neither the caregivers nor the residents appeared to realise that communication is so much more than an exchange of information, as they perused an article by Waring (2012). Waring (2012) stated that communication is the means by which people express their thoughts, feelings, hopes and aspirations. It could be a glance, a touch of the hand or a smile which connects human beings, banishing loneliness and a sense of isolation. Interaction between caregivers and residents can be very rewarding, therefore making it important for staff and residents to reflect on how they communicate with each other.

Reflection

It is important for caregivers to acknowledge the difficulty that residents may have in communicating and take greater responsibility for this by taking the lead and displaying good communication skills with each other and with residents.

To assist in alleviating the perceived labelling that was occurring, the group discussed and agreed that caregivers needed to respect the residents as individuals, and the inclusion of the personalised placemats could assist in valuing residents as individuals who have lived a full life, rather than perceiving them as simply homogenous ‘elderly people’. Discussion amongst the group welcomed the idea of personalised placemats
for each resident (See Figure 6.15 below), stating they would be perfect to encourage interaction. An example of the placemat design is seen below.

Figure 6.15 Personalised Placemats

Holly was hopeful;

‘I am hopeful that the introduction of the placemats will help interaction between residents and caregivers. I think they [the placemats] will be good for the caregivers to realise that the residents have had a full life and were people functioning in the community before this’
Yasmin volunteered to collect resident photos and laminate them, and Elin offered to write the residents names on the placemats. Holly and Colby stated that they would inform all the caregivers and residents regarding the changes via notices.

### 6.6.4 Breakfast Trolley

The idea of introducing a continental breakfast was discussed amongst the action research group. Elin stated;

> ‘It [continental breakfast] would enable the residents to not only choose their own breakfast but also the opportunity for them to be able to serve their own breakfast when they were ready’.

The group reflected on personal journeys they had taken where they stayed in accommodation and had enjoyed a continental breakfast in the mornings. Elin offered;

> ‘It is always a treat to stay somewhere and have a continental breakfast’.

Holly was thinking ahead;

> ‘Tables could be placed alongside one of the walls of the dining room with table cloths, a choice of juices, breads, cereals and condiments for residents’.

The group concurred the idea of a continental breakfast could be raised at the next resident and caregiver’s meetings which were planned in the coming days, to gauge interest, disinterest or potential problems. The residents were asked at the meeting if they would like to have a continental breakfast; however most of them did not like the idea, stating they would rather be served breakfast at their tables as per current practice. When asked why, many of the residents stated they would find it too difficult with their walkers to go and get their food and drinks, and negotiate their way back to their tables, then sit down and place the food and drinks on the table. The caregivers resisted the idea for the same reasons. The group changed their plan to address the lack of autonomy and choice for residents. Colby offered her thoughts on this;
‘Well, the next best thing could be a breakfast trolley, it would enable the residents to choose for themselves what they wanted to eat, for example, choices of cereals and condiments, as well as tea or coffee and they wouldn’t have to move. The caregivers could park the trolley at each table and serve the residents whatever they wanted. It would not only help with choices but would also help lessen the tension’.

Yasmin was taken with the idea;

‘Well I think it will be great, a hit. It will give the residents more choice to have what they want for breakfast. Might even make people a bit happier’.

The group agreed a breakfast trolley would be more beneficial than a continental breakfast, as the residents would not have to leave their seats. They also felt it was an option that could increase resident autonomy by offering choices. They decided to trial the trolley simultaneously with the other changes. The trolley would be wheeled around the tables by the caregivers, and residents offered a choice of tea, coffee and different cereals for people to choose from, with warm porridge included in the cooler weather. Holly said she would organise for a trolley to be purchased in readiness, and also notify caregivers and residents of the changes.

The group were of the opinion that the introduction of the breakfast trolley would address their problems in the dining room; residents reportedly demanding and calling out for service, tension between caregivers and residents, lack of interaction between residents, and caregivers and residents, and a lack of autonomy and choice for residents. Elin noted;

‘Minimal caregivers are rostered for mealtimes, and breakfast is the worst mealtime of the day, followed by dinner. Weekends are also challenging as there are limited caregivers on duty. The caregivers are anxious before mealtimes even begin’.
Colby offered her thoughts on the problems;

> ‘At the moment, the caregivers are literally running to make the residents happy, they [the residents] just don’t seem to understand there is only so much a person can do’

The group discussed how disappointing the mealtime experience was for the caregivers and the residents due to the tension between residents and caregivers, and that the overall mealtime experience was not pleasant for the residents. An article provided to the group for further learning and awareness by Thomas et al. (2013), described food in nursing homes as relevant to quality of care at several different levels, with the importance going well beyond the satisfaction of nutritional requirements and hunger satiation. Critical aspects of the mealtime experience discussed by Thomas et al. (2013) that the group identified with, where the familiarity of the environment, the mealtime schedule, the education of caregivers, personal interactions between caregivers and residents at mealtimes, the attitudes of the caregivers towards mealtimes, interactions amongst residents at mealtimes and the freedom and autonomy of residents to be able to choose what, where and with whom to eat. The group compared this with the mealtime experience at the Lighthouse and agreed that the aspects discussed by Thomas et al. (2013) aligned with the problems identified by the action research group.

### 6.7 Action – Cycle Two – The Dining Room

Four participants remained in the group, Holly, Colby, Elin and Yasmin, and each volunteered for a role in the cycle. The actioning of four strategies to address the problems; new seating arrangements, separate mealtimes, personalised placemats, and the breakfast trolley, were implemented together as the action research group discussed it would work better for everyone if the changes were made together. They thought it would be more beneficial and have more of an impact. In readiness, Holly and Colby notified caregivers of all changes via notices on caregiver noticeboards in the main office and caregiver dining room, as well as the kitchen. Residents were notified of the changes via notices delivered to each resident.
6.7.1 New Seating Arrangements

Holly had larger tables from another facility moved to the Lighthouse and had the smaller redundant ones removed. Elin and Yasmin met with lifestyle caregivers to establish residents with common interests. The lifestyle caregivers were valuable because they spent time with the residents on outings and trips as well as shopping and relaxation events. Between the lifestyle caregivers and Elin and Yasmin, they were able to establish groups of residents with common interests who, for example; loved animals, movies, gardening, sport, and travelling. Elin offered;

‘It is amazing, I had no idea Joan [pseudonym, resident] loved travelling, she has been to every part of the world. I found out so much about the residents doing this’.

The residents were guided to their tables and seats with the personalised placemats. They were familiar with the other residents at their tables but possibly did not know them well. Several of the residents from the previous arrangements were sitting at the new tables. There was chatter amongst the residents immediately as they compared the new tables and who was sitting where. They were also distracted by their placemats.

Reflection

While the group tried to link residents with common interests in mind, it would have been better if they had not it taken upon themselves to decide who residents would sit with, as this could be seen to limit residents’ autonomy.

6.7.2 Separate Mealtimes

Elin organised invitations and delivered them to each resident stating the changes to the meal times, the date the changes would take effect, and which time slot each resident would be dining. The two separate meal times were introduced for breakfast and dinner. The first breakfast was at 0745, and the second breakfast was at 0800. The first dinner was 1645, and the second was 1700. Colby gave an update;
‘It is working alright so far [one week], some [residents] are coming to the wrong timeslot but that’s ok’.

Reflection

The residents were not consulted regarding the changes to meal times, which again, could be seen to limit autonomy. For residents to maintain autonomy, it is important for caregivers to collaborate with residents regarding any new idea they have for improving residents’ lives, no matter how good the intentions of the caregivers or how well received they think the idea may be.

6.7.3 Personalised Placemats

Yasmin organised to see all the residents and asked them to choose a special photo that could be used for their personalised placemat, and the residents were forthcoming with photos. Yasmin was so pleased; she shared with the group;

‘They had lots of different photos, it was amazing, one lady even chose her wedding photo and I didn’t even recognise her. There were photos of families, partners, weddings, babies, animals as well as river scenes. You don’t realise that they have done so much in their lives’.

Yasmin used the iPad to copy the resident’s photos so they could keep their originals. They were then enlarged to A4 size and laminated. Elin wrote the resident names on the bottom of the placemats with large print black marker, and the placemats were provided at each resident’s table setting in conjunction with the other changes.

6.7.4 Breakfast Trolley

Holly organised for the purchase of the breakfast trolley and it was placed in the kitchen ready for use. Caregivers were notified of the commencement date and details of what would be available on the trolley. It was introduced to the residents in conjunction with
the other changes, and the residents were able to choose each morning what they wanted from the trolley, containing condiments, juices and cereals.

6.8 Observation – Cycle Two – The Dining Room

In this, the observation section, I am reporting on behalf of the group’s progress of developing and implementing person-centred care. The group’s findings from the data; audio recordings, observations, and reflective journals are documented below and includes the analysis of the data, as well as the groups interpretation of the findings, and the theme that was conceptualised from the cycle.

6.8.1 Data Analysis

I analysed the dining room findings data in collaboration with the Lighthouse action research group. I engaged in reading the data collected from audio recordings, reflective journals and observational notes, to familiarise myself with it and to examine the relationships within it. While doing so, I noted the data that aligned with the cycle priorities and which indicated change. Meanwhile, the action research group reviewed the actions of the cycle and their effectiveness via reflective discussion.

Each line of the coding manual included the code, a description of the code, and an example taken from direct quotes in the data. I consulted with the action research group discussing the findings as I went, and their critical and reflective approach was appreciated. An example of the coding manual is provided in Figure 6.16 below, and was derived from direct quotes taken from the action research group.
<table>
<thead>
<tr>
<th>Code number</th>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Caregivers cannot see the benefit of changes</td>
<td>Some caregivers are choosing to focus on the benefit of maintaining current practices rather than the benefits of change</td>
<td>The caregivers take everything that is said as a criticism when we are trying to put changes in place. A couple of the caregivers just cannot see how the changes are going to work.</td>
</tr>
<tr>
<td>2</td>
<td>Residents are anxious about the changes that negatively impact upon their ability to move about freely</td>
<td>Some residents are resisting the changes in the dining room, specifically relating to walkers and the impact these can have on mobility and ambulation.</td>
<td>One resident said she was not happy because she feels the walkers are blocking her. Residents were concerned about how they were going to manage their walkers.</td>
</tr>
</tbody>
</table>

Figure 6.16 Example of coding manual derived from direct quotes from the action research group

Words were grouped together, not just because they were alike but because they had a theme of resistance in common for example, Holly offered;

“They [the caregivers] are not passionate about making this work.’

Thematic Map

Quotes from the group and paragraphs were examined for meaning which led to codes being developed that led to theme development (see Figure 6.17). In collaboration with participants, I searched for themes and placed them into categories, and then checked
these against direct quotes and data for validity. This process continued until I was certain I had exhausted every possibility. I examined and re-examined the codes, contrasting them against the literature to identify emerging themes that accurately depicted the codes. Data relevant to each potential theme was re-examined, then either kept or discarded. A thematic map was conceptualised with a theme defined, then named, whilst checking and re-checking the data. Codes were checked against transcripts and the theme; “Support is needed for sustainable change” was conceptualised. The action research group stated that the theme aligned with the direct quotes provided by themselves and residents.

Figure 6.17 The theme conceptualised following analysis of numerous codes
The codes supporting the theme showed two distinct categories, one that showed vulnerability to change and the other, acceptance of change. Quotes supporting the codes included where Holly gave an example of a caregiver being vulnerable to change:

‘I said, leave the cereal in the packets and let the residents choose. Some of the caregivers are having problems with that. A couple of them just cannot see how these changes are going to work’.

And Colby offered an example of a caregiver being accepting of change:

‘A caregiver has adapted to the changes who used to be inflexible’.

**Reflection**

Both residents and caregivers showed some resistance to change. While caregivers often could not understand the purpose for the changes, residents often could not see the positive benefits for the changes.

**Reflection**

The action research group did not foresee the problems that resulted from the changes as they had not expected the resistance that came from the residents and caregivers.

### 6.8.2 New Seating Arrangements

Some residents were argumentative with other residents when the new seating arrangements were introduced. The overall consensus of the new seating arrangements was a negative one, with comments being relayed back to the group. Yasmin shared with the group;
‘The residents are all complaining; they just want things to go back to how they were’.

The group decided that more changes needed to be made to the table configuration to get the personality mix right. A table of six residents were arguing and approached Holly who stated they were all grown adults and had the choice of moving to a table of their own if they chose. Holly stated the residents needed to make the decision to move themselves. By dinner, two had moved, and by breakfast the next morning, three had moved, the arguing then ceased amongst that table; however she commented that the mix of personalities needed to be changed again because of the residents moving tables and upsetting the dynamics again.

**Reflection**

It is important to treat residents individually and allow them to make their own decisions; using a paternalistic approach to the seating arrangements may have inflamed the situation further.

The group noted that, many residents were not happy in the beginning with the seating in the dining room, and they were also not comfortable with changes of this order being made without collaboration.

**6.8.3 Separate Mealtimes**

Initially, the separate mealtimes appeared to be working well; however caregivers soon found that many of the residents from the second timeslot began coming in to dine in the first timeslot. Several weeks later, the caregivers reported residents had been coming earlier and earlier and they were at a point where they were all arriving for the earlier timeslot, which, caregivers stated, had made matters even worse. Caregivers became distressed with this occurrence and the residents were not happy, as they complained that it was taking too long to get their breakfast and they just wanted everything back the way it was. Yasmin shared her thoughts;

‘They all want their breakfast early, they’re not happy with the changes’.
And Holly, still feeling distressed;

‘Everyone is complaining, the caregivers are not happy and residents just want things back the way they were’.

**Reflection**

It can sometimes be difficult for people to be expected change their routine if they can see no benefit in it for themselves.

The situation had regressed to the point where most residents were arriving for the same meal time as in the past and the caregivers were voicing their dissatisfaction with the situation.

### 6.8.4 Personalised Placemats

The personalised placemats were introduced with the other changes and were very popular amongst both residents and caregivers. The group noticed that the residents appeared to have Duchenne smiles on their faces when they talked about the stories behind their photos. Quotes from residents supporting this included:

“*This is me on my wedding day....*”

And;

“*Isn’t he beautiful [dog]...he loved my husband and used to follow him everywhere! Do you have a dog?*”

**Reflection**

Numerous residents have a story to tell about their lives and they derive pleasure in sharing those stories with others.
The group agreed that the placemat idea was a small but successful change for both residents and caregivers because it enabled residents to share something of themselves, while also enabling caregivers to learn more about the residents, making the facility more conducive to person-centred care.

6.8.5 Breakfast Trolley

Several caregivers were using the breakfast trolley; however other caregivers used it once or twice and would not use it again. One caregiver refused to even use the breakfast trolley at all. This caregiver stated she could not see any advantage in using the trolley and complained that it slowed her down. Quotes supporting this include:

‘I heard one of the kitchen caregivers saying to another that the changes are stupid and costing more time’ (Yasmin)

And;

‘I don’t see the point in the breakfast trolley at all. Why offer the residents different tea, coffee and cereal when they are still choosing the same things they always had?’ (caregiver)

And;

‘I don’t have time to take the trolley around; I still have to run back to the kitchen to get porridge and toast’ (caregiver)

Reflection

While the action research group thought they were providing residents with a person-centred approach by offering a wide choice of options for breakfast, this was unsuccessful due to the lack of buy in from many caregivers.

Many of the residents stated that they were happier when their cereal was already on the table when they arrived in the dining room. The trolley was either not being used at all by caregivers, or they were finding it difficult to organise their time to incorporate it into their routine. Adding to this, residents stated they preferred things the way they were when they were provided with their tea, coffee, and cereal.
6.9 Reflection – Cycle Two – The Dining Room

The reflections on observations are documented below with discussion on some of the points noted from the observations as to why there were different responses to changes.

6.9.1 New Seating Arrangements

The new seating arrangements were implemented to facilitate interaction between residents by seating residents together with similar interests. This strategy was largely unsuccessful as relationships between residents were not strong. The residents were unhappy with the changes, and voiced their disapproval to the caregivers.

The group had not realised that possibly, the disapproval of the changes by the residents could have been because they wanted the autonomy to choose to sit with whomever they wanted, on any given day. They also rejected Management enforcing a mealtime slot on them. Conversely, the success with the placemats demonstrated how the residents wanted to be treated as individuals, with a life story to tell. It is important for caregivers to get to know the residents, finding out their likes and dislikes, and what is important to them. To also find out what they as caregivers can do for the residents by providing support, as well as finding out their life story (Abley & Thompson, 2013).

Having a mixed table where residents with varying degrees of cognition issues sat with people without cognition issues, resulted in conversations between the two. This meant that those who had been largely ignored or spoken to by other residents in a negative tone, prior to the changes and when at separate tables, were now engaging in friendly conversations. Following the changes, the group noticed these residents appeared more relaxed at meal times and communicated more between each other than had previously occurred.

Following discussions with the group, they acknowledged that numerous residents were possibly not accepting of the new seating arrangements because of their vulnerability to change, and reflected that possibly they just did not understand why the changes were being implemented. The residents were told about the changes to the seating but it was never explained to them why and their opinion was never sought. This was something the group only realised in hindsight. It was noted in observation by
the group that one of the residents commented they just wanted things to go back to how they were. These residents had already had so much upheaval and loss in their lives; losing people they love, losing their independence, losing their homes, ill health, etc, the thought of any more upheaval and change could be too much to cope with.

6.9.2 Separate Mealtimes

The group discussed their decision to introduce separate mealtimes for breakfast and dinner. The change was introduced to address the demanding and calling out for service by residents and the tension between residents and caregivers. The group made the decision to have the two separate mealtimes for breakfast and dinner, and begin the first one fifteen minutes prior to the usual times of 0800 for breakfast and 1700 for dinner. Caregivers found the first few trials went well as they were able to concentrate on fewer residents at each timeslot therefore providing better service. However, residents who allocated to the second timeslot presented to the dining room for the first timeslot, causing confusion amongst dining room staff and residents, exacerbating the situation. The group did not anticipate that this would happen and discussed the need for contingency plans when making changes.

Reflection

It is imperative for caregivers and Managers to recognise, and not abuse, the inherent power imbalance that exists due to their role as staff. Furthermore, they must recognise that this does not always mean that residents will do as they are asked as residents may choose to assert their autonomy when they can.

Tension between residents and caregivers did not improve with the changes to the meal times. The group discussed why they thought the residents were arriving earlier, and they decided that there were possibly two reasons;

1. the residents thought they were missing out on something if they did not arrive earlier, maybe they thought there would be less food and they would have to eat the leftovers, and
2. the residents may have been asserting their right to have their meals when it suited them.

Retrospectively, the group agreed it would be reasonable to assume the residents felt that at their age, no one should impose rules and regulations on them by telling them
which mealtime they had to attend, and that this was possibly an assertion of autonomy by the residents. With consideration to the aforementioned, the group discussed how they could have done things differently. They spoke of the need to discuss suggested changes with residents prior to implementing them, rather than just assume that residents would accept changes because they were thought to be in the residents’ best interests.

6.9.3 Personalised Placemats

The placemats were implemented along with the other changes and the residents were delighted with them. Caregivers noted that the residents were talking about them constantly to other residents and caregivers. They were found to increase interaction between the residents and caregivers. One only had to look at the residents faces when they were showing someone their placemat to see the smiles. This was a genuine, Duchenne smile and not just the polite one people use for a social script. These people were asked questions by other residents and caregivers about their lives rather than just being asked if they wanted milk or sugar. The group agreed that introducing the personalised placemats showed the residents as individuals, who have lived full lives and have a story to tell, not just “older people living in a facility who become “non-people”. The group reflected that this strategy was successful because the residents were consulted about the photos they wished to use and because it was something that resulted in residents feeling empowered, autonomous and valued as individuals.

6.9.4 Breakfast Trolley

The breakfast trolley was introduced to address; residents demanding and calling out for service, tension between caregivers and residents, lack of interaction between residents, and caregivers and residents, and lack of autonomy and choice for residents. On reflection, the group discussed that the caregivers voiced dissatisfaction about the introduction of the trolley from the outset. Caregivers complained that residents still chose the same tea or cereal, for example, that they would have had if it was given to them without offering choice. The caregivers stated that if the residents wanted something different, all they had to do was ask. Residents also voiced dissatisfaction from the outset. They complained to caregivers that they were waiting longer to get their breakfast and that they were happier before the changes. The group agreed that the residents possibly enjoyed being waited on and it made them feel special that the caregivers remembered what they liked and had it ready for them.
The caregivers rejected the trolley and one caregiver refused to use it. This rejection was indicative of resistance to change. The caregivers did not understand the significance of the breakfast trolley, and the group agreed it was not a good idea to introduce the breakfast trolley without educating the caregivers first as to why it was so important for the residents to have choice. They agreed that time management education would also have benefited the caregivers as many of them struggled to have porridge, for example, cooked and ready on the trolley for serving when breakfast was ready. The group also agreed it was not a good idea to introduce the breakfast trolley without explaining to the residents, the perceived benefits to them.

Reflection

Having a group limited to just four people, two of who were managers, meant that a cross section of caregivers’ opinions were not included in the changes. This created a power imbalance between caregivers and managers and possibly limited the autonomy of both the caregivers and the residents. No wonder some of the caregivers rejected the change when their opinions were not sought.

Retrospectively, the group needed to realise how residents feel when they are not consulted and asked for their opinions prior to changes being implemented to their lives, in their homes. However, this does not appear to have been the case.

The group identified with an article by Brownie and Horstmanshof (2012), who discussed that residents need to feel confident that they still have some personal identity and self-esteem. In addition, they also need to be able to express themselves and voice their views and opinions and to feel as though their opinions will be heard, understood and valued. The group agreed that possibly, the residents called out for service for the reasons stated in the article. The residents were also resistive to the introduction of the breakfast trolley, which was again, indicative of their vulnerability to change. The residents must have wondered why the changes were occurring without any explanation. The only time the residents were asked their opinions was when the action research group thought they might like a continental breakfast.
Reflection

One of the issues I was very conscious of when guiding the group was to not impose my thoughts and opinions on them, in an effort to not skew any outcomes or impose my perceived power as a researcher and facilitator over the group. This cycle showed very clearly what can go wrong, which I think is just as important as knowing what works.

The group discussed the decisions that were made, and stated they were not unhappy with their decision to make changes to the dining room; however they were disappointed by the results, expecting to see positive outcomes from the changes made, not realising or understanding that they should not have imposed the changes upon the residents. They agreed that the overall mealtime experience was still not a positive one as the problems remained in the dining room.

Due to the negative response from caregivers and residents, Holly and Colby decided to halt the changes and revert back to how the dining room had functioned previously, with the exception of the personalised placemats that were successful. Unfortunately, the changes did not have the intended effect of creating a positive mealtime experience; instead they exacerbated an already stressful situation. The new seating arrangements did not work as many residents did not get along. Data supported the view that the breakfast trolley didn’t work as both caregivers and residents resisted the changes. The separate mealtimes had not worked as the residents ended up going to the earlier breakfast and dinner.

6.10 Précis – Cycle Two – The Dining Room

Chapter six detailed two cycles of action undertaken at the Lighthouse. Cycle one described the actions that contributed toward changes to the “Welcome Pack” of additional forms and encouragement of family. Cycle two described issues surrounding “The Dining Room” and the priorities of the cycle. The group were empowered to volunteer for roles in the cycles, and they worked collaboratively using a reflective approach to their work to achieve the cycle goals. Incremental changes were made in each cycle and themes were conceptualised for final discussion.
At the completion of cycle two the expected outcomes were not achieved and left the group feeling deflated. I facilitated a group discussion to reflect on the process, highlighting decisions that may have influenced the outcomes. The group agreed that:

- any decision making requires a cross section of staff to be involved so that there is not a power imbalance between managers and caregivers;
- managers and caregivers need to recognise the inherent power that they hold and ensure the engagement and inclusion of all people, namely residents, caregivers, and resident families, because it is an important consideration in any change management process at this facility.

**Reflection**

The participants of this action research group held a privileged position in that they were aware of the reasoning behind the changes that were being made. There was a role for the action research group in communicating those changes more broadly to ensure collaboration with all caregivers and residents. Not wishing to impose my opinions on the action research group resulted in this not having been the case, indicating that a stronger and more assertive role from the researcher/facilitator is necessary.

This cycle demonstrated how changes can be ineffective if all people involved in the changes are not included in the decision making surrounding the changes.

Below (Figure 6.18) shows a summary of the activities undertaken for both cycles.

<table>
<thead>
<tr>
<th>CYCLE 1- The Welcome Pack</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Themes:</strong></td>
</tr>
<tr>
<td>1. Support caregivers to create a home for residents</td>
</tr>
<tr>
<td>2. Support residents to maintain self-worth</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
</tr>
<tr>
<td>Encouraging family involvement</td>
</tr>
<tr>
<td>Building a life history</td>
</tr>
<tr>
<td><strong>Actions</strong></td>
</tr>
<tr>
<td>Sharing expectations of care for their family member</td>
</tr>
<tr>
<td>Sharing family experiences</td>
</tr>
<tr>
<td>New residents sharing expectations of care</td>
</tr>
<tr>
<td>New residents and their families sharing personal experiences and preferences</td>
</tr>
</tbody>
</table>
### CYCLE 2 - The Dining Room

**Theme:** Support is needed for sustainable change

<table>
<thead>
<tr>
<th>Goals</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating a positive mealtime experience</td>
<td>New seating arrangements</td>
</tr>
<tr>
<td>Encouraging autonomy and choice</td>
<td>Separate mealtimes</td>
</tr>
<tr>
<td>Encouraging interaction during mealtime</td>
<td>Personalised Placemats</td>
</tr>
<tr>
<td>Relieving tensions between residents and caregivers</td>
<td>Breakfast Trolley</td>
</tr>
<tr>
<td>Respecting residents as individuals</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6.18 Summary of activities undertaken in cycles one and two for The Lighthouse

Findings from cycle two demonstrated the importance of engagement and inclusion of all people when change within the organisation is proposed. The following chapter six details two completed cycles of action for the Seaview Action Research Group; cycle one “Devise actions to facilitate inclusion of, and information sharing with resident families”, and cycle two “Devise actions to maintain a cohesive team”.

157
CHAPTER 7: SEAVIEW

Figure 7.1 Photo of the surf

ACTION RESEARCH CYCLE ONE- DEVISE ACTIONS TO FACILITATE INCLUSION OF, AND INFORMATION SHARING WITH RESIDENT FAMILIES, AND CYCLE TWO- DEVISE ACTIONS TO MAINTAIN A COHESIVE TEAM

Introduction

This chapter is an amalgam of all activities that occurred in the two cycles of action for the Seaview action research group: (1) Devise actions to facilitate inclusion of, and information sharing with resident families, and (2) Devise actions to maintain a cohesive team, as discussed in Chapter 5. These two cycles of action occurred separately as the trajectory for cycle one lead to a focus on caregivers and teamwork. The priorities/goals for the two cycles for Seaview were: they occurred as a continuous process over six months from August 2013 to January 2014. There were 12 action research group meetings in total for the two cycles.

The Seaview action research group

Five participants initially volunteered for the study (Figure 5.8), and those participants remained for the duration of the study. The Lighthouse and Seaview facilities were managed by the same management team at the time and the managers volunteered to participate in both action research groups for The Lighthouse and Seaview as a show of support for the study.
Reflection

There is bound to be an impact on the team dynamics (not sure if it will negatively or positively impact) having the management team from both The Lighthouse and Seaview as participants in the study.

7.1 Planning – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

Following the identification of problems and prioritised goals as described in chapter five, planning for the action involved reflective discussion amongst the group to determine how they were going to fulfil the cycle goal of; Devise actions to facilitate inclusion of, and information sharing with resident families. The group acknowledged Seaview as a small, personal care facility, the number of residents requiring support from caregivers was 21. The group agreed they felt Seaview functioned as an ideal person-centred care facility. Colby offered;

‘As far as I am concerned, we are already doing person-centred care; we have a pretty good understanding of it here’.

The group believed they took a person-centred care approach to their work; however they felt that many of the resident families did not understand person-centred care. They felt that information sharing would assist resident families to gain a better understanding of person-centred care. Ron offered;

‘Quite often, the resident families want for their family member something different to what the residents want, and it is very frustrating for the residents as well as us [caregivers]. We want the families to be aware that it is the resident’s choice if they want to go shopping, bushwalking, or stay in bed until 10am for example, not that of their family’.
The group also discussed what they believed was the importance of family involvement in the lives of residents, as well as the importance of their inclusion in the care of their loved one, and they perused articles specifically relating to family involvement to assist reflective discussion and planning for this cycle. I provided several papers that proved useful. One of the papers by Irving (2015) discussed how inclusion of family and their involvement in the lives of residents is considered an important part of the provision of care that is individualised for older people residing in residential aged care. The action research group concluded that family members can share vital information about a resident’s life as they often express an interest in maintaining their relationships and continuing to be included in the resident’s life by seeking to oversee their care, and to be informed about any changes and to have an involvement in care that is not limited to practical task assistance or initial care planning. Family inclusion and involvement facilitates increased interaction between caregivers and family, provides increased opportunity for meaningful communication, and improves satisfaction with care. Colby reflected on this;

‘It is a pity more of the families did not come in and take the residents out for a drive or a meal. The residents would love that’.

Holly argued;

‘I just don’t think family members are as involved as they could be or should be, some are, but most are not. This situation could be improved’.

The group identified with an article provided by Thomas et al. (2013), who proffered that family members can facilitate contact and socially interactive opportunities for residents through being available to spend time with them, and drive them to social outings, celebrations and visits to other family and friends who may not otherwise be able to visit themselves due to distance or health issues (Thomas et al, 2013). The group discussed how many residents saw their families on a regular basis and agreed that not many of them did. Discussion led them to realise that many of the resident families from Seaview did not live close by, with several living on rural properties and interstate. They realised why many families were unable to visit on a regular basis. Colby commented on this;
I had not even thought about this [distance], I have often commented, and complained that the residents don’t see enough of their families but I realise now the distance can really affect that [visits].

The group agreed that distance and isolation is a reality for many people living in rural communities in Australia where the distance to drive to visit friends and family in residential aged care is quite often prohibitive. The group identified that maintaining close family contact especially is an important form of social interaction for older people in residential aged care; however, they agreed that unfortunately the distance to visit can determine the amount of face to face contact. Ron reflected on the above discussion;

'I didn’t realise the time and distance it takes to drive for many people, I was not thinking, and this is a real problem for many people. I don’t think many people consider how difficult things can be for rural Australians'.

The group also acknowledged that although many of the resident families did live a distance away, there were several who lived locally. The group worked out that approximately 40% of the residents at Seaview at the time of the study had families living locally or within 50 kilometres of Seaview. They agreed that the families who did live locally might appreciate the sharing of information to assist in their understanding of person-centred care as a way of facilitating their inclusion and involvement. The group discussed appropriate action to achieve inclusion and involvement. Ron offered;

'We could run an information session for the families? We could have it here [Seaview] and invite the residents and their families along and incorporate with afternoon tea, that way then we would also be including them and encouraging their involvement'.

The group welcomed the idea of information sharing combined with an afternoon tea, They agreed that such an event would be more conducive to person-centred care, and Ron discussed the volunteering of roles for the cycle;

'We will need guest speakers, invitations, food, setting up the dining room. Who wants to volunteer for which job? I will volunteer myself to organise the date and time, and to oversee the whole thing'.
The group agreed that Ron was confident, enthusiastic and a motivator. They stated how they welcomed his leadership ability and positive attitude. They also agreed that he was clearly a person-centred care champion, and asked if he would be happy to accept the position of person-centred care champion for the duration of the study, which he gratefully accepted.

The group unanimously agreed that Holly should be the main speaker for the afternoon tea and information session, which she accepted. They also agreed they would like the Director of Care to be invited to speak so she could reinforce the importance of person-centred care for older people and its significance within the organisation. Suma volunteered to organise the invitations, and Havanna and Colby volunteered to organise the food and set up the dining room. The group discussed that an hour and a half was an appropriate length of time for the afternoon tea. The group discussed the data collection tools they would use in the cycles and decided on; the group, audio, reflective journals, observation, and memos. Group meetings were held in the caregiver’s lunch room.

I reminded the group that they needed to have some way of gauging the effectiveness of the afternoon tea and they decided to provide feedback forms for both residents and families. Ron made a suggestion that the feedback forms could ask the residents and their families; their understanding of person-centred care, how they believe we could achieve it, what is important to them, and if they think we need to improve in any way. He asked the group if they agreed the feedback forms should be given to the residents and their families as they arrive for the afternoon tea and asked if they could fill them in and hand them back afterwards which they agreed to. Suma volunteered to print the forms.

**Reflection**

What a motivated group! They have made such a good start and seem determined to achieve their goals. They obviously feel empowered enough to volunteer for different roles as needed.
7.2 Action – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

Ron organised the afternoon tea on a Tuesday afternoon, mid-year 2013 at 2pm. Suma prepared invitations and sent them to the Director of Care, residents and their families. The Director of Care accepted an invitation to be a guest speaker, and eight family members replied indicating they would attend. Havanna and Colby purchased food in readiness, and prepared the dining room on the day. Twenty out of twenty-one residents attended (one resident was unwell), as did the eight family members. Feedback forms were provided to residents and their families to complete and return following the information session. Holly welcomed everyone to the afternoon tea and spoke about person-centred care. The information session which was presented was based on Beaches Care of the Aged training manuals delivered to caregivers during the past 12 months. Holly spoke for approximately fifteen minutes and included in her talk information about Maslow’s Hierarchy of Needs, and the implications for aged care. The Director of Care discussed person-centred care within the context of the organisation and aged care, while the group offered afternoon tea to the residents and their families. Feedback forms were collected by the group for interpretation and discussion. Twenty-four forms were returned with four outstanding. Nine forms were returned but not completed, leaving 15 in total returned and completed. The afternoon tea concluded with Holly thanking everyone for coming and offering for anyone to contact the action research group if they had any further questions regarding person-centred care.

Following the afternoon tea, the group read through the questionnaires to reveal something they perceived as devastating. The feedback overwhelmingly pointed to the caregivers not listening to residents or needing to listening to residents more.

Reflection

They [action research group] seem devastated, and as they are reading the feedback over and over, they are actually taking offense to some of the comments. They did not think for one moment that they were in the wrong and had exercised their inherent power over the residents and their families by setting about “educating” them, without realising it. They had not realised that they were being perceived as not listening to the residents or their families.

The group decided to take stock, regroup and rethink how they could overcome this challenge, how they could address the feedback.
Colby offered;

‘I have never had anyone tell me we don’t listen to the residents. Obviously we have become complacent’.

The group agreed that working together to make the required changes that ensured they actively listened to the residents was acknowledged as the way forward. To move forward, Ron offered;

‘We need to start again. Revise the plan if we can to reflect the feedback from the residents and their families’.

The group acknowledged that Seaview is a small facility with a devoted team of caregivers who pride themselves on the care they provide. They agreed that revising the plan was the most appropriate option, and reviewed their actions:

- Actions were undertaken to organise afternoon tea.
- Invitations to the afternoon tea were prepared and delivered.
- A guest speaker was organised.
- Food was purchased.
- The dining room was prepared.
- Feedback forms were provided to residents and their families.
- An information session was prepared.
- Feedback forms were collected.
- Feedback forms were read
- Group decided to pause and review their plan due to the feedback

7.2.1 Revised Plan– Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

To support the group at their low point, I provided resources that included numerous research articles to stimulate discussion and reflection, one of the articles’, by Enuku and Evawoma-Enuku (2015) discussed the importance of reflection and use of reflective skills in nursing, and another article by Edwards (2014) discussed the central role of reflection in practice and the impact it has on effective practice. Additionally, another article by Devenny and Duffy (2014) highlighted the importance of reflective practice.
stating that when reflection is used as a tool for revisiting experiences, staff can learn from this and can it to understand often complex problems of professional practice.

The group used their reflective skills to identify with an article by Anderberg and Berglund (2010) that stated poor communication and a lackadasical approach to care, can lead to an older person feeling abandoned, and that the ultimate aim for older people is to be listened to and understood on their own terms. The group discussed and reflected on their practice experiences and unanimously agreed with the article, stating that they can now understand how older people can feel abandoned through poor communication which was obvious from the feedback they received. The group also perused an article by Thomas et al. (2013), stating that communication with other residents, family, friends, and caregivers was the most important activity older people performed, and yet they reported there were often insufficient opportunities for this communication to occur. This inspired Colby;

'It makes you think doesn't it, I mean, we just assume we are communicating effectively with the residents when obviously we are not. I mean, obviously, we are not listening'.

**Reflection**

I think the group are feeling deflated and disappointed at this point. I also think they made the mistake of thinking they were already "doing" person-centred care. I am pleased they are willing to take responsibility now and move forward. This is big learning curve for them.

The group discussed that the revised action plan should include an information session for caregivers regarding effective communication, with an emphasis on listening, to reflect the feedback from residents and their families. Holly volunteered to organise a speaker, who was the Beaches Care of the Aged educator. The educator provided training to all staff from Beaches Care of the Aged intermittently. The educator accepted the invitation, stating she would be available in mid-November, 2013 for one hour. Holly also organised a social worker to speak about listening, and the importance of respect for each other. The social worker agreed to talk for half an hour. Ron volunteered to print notices for caregivers regarding the information session and place them on the notice boards. Suma volunteered to organise feedback forms for caregivers to fill in following the presentation.
Reflective journal entry - Suma

We [action research group] know each other well and I think there is a lot of trust between us. This study has proved that we can work well together to achieve our goals.

The group reviewed the plan and actions:

- Resourced provided by the facilitator were read and discussed.
- A revised action research plan was discussed, including an information session for caregivers.
- Guest speakers were organised.
- Notices were caregivers were placed on the noticeboards.
- Feedback forms were organised.

7.2.2 Revised Action – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

Thirteen caregivers attended the 90-minute education session that included presentations from an educator and a social worker. The educator presented information on verbal and non-verbal communication and active listening. Person-centred care and the relationship to effective communication were also discussed. The social worker's presentation focussed on listening and respect, included definitions and explicated the importance of listening and respect in aged care.

Attendees at this event were asked to provide feedback through a questionnaire (Appendix 13) following the presentation. Of the 13 questionnaires provided to caregivers, 85% (n=11) were mostly completed (Appendix 14); however not all caregivers completed every question.

Havanna stated she heard one of the caregivers conveying:

‘Why didn’t someone tell us about all this stuff [communication] years ago, it would have made our jobs easier’.
Reflection

I can sense a great feeling of relief amongst the group. I think they felt so disappointed in themselves following their initial action that they were determined this revised action would work. They have really come together and shown their strength as a team. Although their initial plan was inherently flawed, they were able to learn from it and began to critically reflect on themselves and how they delivered person-centred care.

7.3 Observation – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

The findings of cycle one-Devise actions to facilitate inclusion of and information sharing with residents, are documented below including data analysis, group reflections of the cycle, and the theme that were conceptualised from the data findings’.

7.3.1 Data Analysis – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

The data collected was analysed using thematic analysis method proposed by Braun and Clarke (2006) in order to report the actions of the group to implement person-centred care. I transcribed all data collected from; feedback forms from questionnaires, audio recordings, reflective journals which were provided to me voluntarily by participants to use for the data, reflections, and observational notes to become familiar with it, and transcribe ideas, and engage reading. I grouped sentences together, not just because they were alike but because they had common meaning for example, “I would like to have more of this kind of training”, and “I wish I had learnt this a long time ago”. To generate the initial codes from the data, transcribed data was examined and coding numbers placed down the sides to assist in the search for codes. Interesting words or phrases were identified and categorised by; similarities, for example; “I did not realise we don’t listen to everything that is being said”, and “I learnt to listen more”, and frequencies, for example; certain words were used frequently such as “training” and “education”. Codes were validated with the group throughout the analysis. Similarities and frequencies were used to categorise the data because they allowed for a quick comparison of the words used. Data analysis was iterative; I read the data set at least twice to gain a thorough understanding and familiarity. Below is the data relating specifically to the feedback from the information session and afternoon tea for residents and their families.
Twenty-one residents (n=21), and eight resident family (n=8) members attended the information session and afternoon tea. 54% of feedback forms from the questionnaires were received, 71% of those received showed limited understanding of person-centred care, suggesting that the average person on the street has limited or no understanding of the term which is widely used in healthcare; however despite the fact that residents and their families showed they had limited understanding of person-centred care, the responses overwhelmingly suggested that involvement for residents, and social support and connectedness were an important consideration for both residents and their families. 33% supported listening and communicating as a way of achieving person-centred care, which is consistent with their responses to the questionnaire. 25% considered being listened to as being important to them. Again, this is consistent with the feedback stating that the caregivers need to learn to listen more to residents. 37% considered happiness and friendship important, and 50% of residents and their families were happy with the care being received. Although the percentages do not indicate overwhelming support for the caregivers to listen more, the caregivers discussed how the term ‘listen’ and feedback indicating that communication skills were important featured throughout the questionnaire responses. Colby reinforced this;

‘The word “listening” keeps coming up here, is everyone noticing that? Apparently we don’t listen enough’.

Suma agreed, adding;

‘The message from residents is that they want someone to listen to them when they speak’.

The group reflected on the responses to the questionnaires. Havanna expressed her dismay;

‘I am upset by the comments, no doubting that. I honestly thought we were almost experts at person-centred care’.

‘How could we have missed this? Something so important, I just don’t understand.’
Colby added;

‘But the residents appear happy most of the time, and we rarely receive any complaints at all. It just doesn’t make any sense’.

Havanna offered;

‘This whole thing has certainly made me realise that we [caregivers] need to be responsible for applying person-centred care not the residents and their families, even though the feedback told us that the residents and their families had limited understanding of person-centred care. It is our job to understand it and to do whatever we can to provide it in the care of our residents’. Suma added;

‘The responsibility is ours. The residents and families have let us know what is important to them and it is up to us to make sure we learn everything we can to implement person-centred care’.

Colby found it hard to move forward;

‘I have to say I was so insulted when we found out we didn’t listen to the residents. I really thought we had person-centred care “down pat”, it really knocked me for a while. I just want to do everything I can to be able to implement person-centred care’.

Ron agreed that;

‘We made a mistake thinking that others [resident families] had to learn or we had to educate them, when it was us who needed to learn to take responsibility for our actions’.
Havanna felt inspired to say;

‘I realise how important listening and communicating is, and it is obviously important to the residents and their families. When you think about it, it would make the implementation of person-centred care impossible if you didn’t listen and communicate with residents. Makes you think more about person-centred care and really, how many different ways you could implement it’.

Ron pondered the results of the feedback;

‘I think we have done really well overall, 50% were happy with the care which is great. We made a mistake but how good were we to realise that and then move on together. That alone proves how resourceful we are and gives me confidence in our ability to be more person-centred with the care we provide’.

And he added;

‘Also, it makes me realise that if we are going to understand person-centred care and apply it then we need to be more proactive in our approach, we need to be open to criticism and learning’.

Havanna finished the discussion with;

‘We do need help though, we can’t be expected to do it all on our own. I think there are really high expectations on us. It makes me nervous that 50% of residents and families are happy with the care we provide as it puts more pressure on us to either keep that percentage or improve on it’.

Figure 7.2 below is an example of the coding manual derived from direct quotes relating to feedback from questionnaires provided to residents and their families highlighting; how the group felt there were perceived high expectations of caregivers to provide person-centred care from the organisation, residents and their families, and residents and families asking caregivers to listen more to the residents.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>High expectations of caregivers to meet the</td>
<td>There were high expectations of caregivers from the organisation, residents and their</td>
<td>Caregivers need to look at their perception of caring for another person</td>
</tr>
<tr>
<td>needs of residents</td>
<td>families</td>
<td>It is really important that caregivers are aware that it is a person they are caring for and to find out from that person what is important to them and why and then help them with their needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregivers need to listen to resident needs</td>
<td>The residents and their families asked for caregivers to listen more to the residents</td>
<td>Just listen to my complaints</td>
</tr>
<tr>
<td>and preferences</td>
<td></td>
<td>Being available to talk to residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For someone to listen to my requests</td>
</tr>
</tbody>
</table>

![Figure 7.2 Example of coding manual derived from direct quotes from residents and their families](image)

The following is data relating specifically to the training session for caregivers regarding listening and communication. Thirteen caregivers attended the listening and communication training, and 85% (n=11) returned the questionnaires (Appendix 14). The first question: **What did you like the most about the training?** 34% said they liked the listening and communication component of the training the most, the other replies for that question were; 17% liked the honesty, 17% liked everything about the training, 17% liked how it was about the residents and staff, and 17% said they liked the interaction. The second question: **What did you learn?** 90% said they learned how to listen and communicate better, while 10% said they did not learn anything new. The third question: **What could be added to this training?** 72% said they would like more of this type of training.

The results of the questionnaire (Appendix 15) highlighted how much caregivers value and support training that assists the implementation of person-centred care, with the majority (90%) stating that they learned how to listen and communicate better, and 72% stated they would like to receive more of this type of training in the future. The results emphasise that caregivers considered listening and communication a necessary
skill, and support the notion that if they learn how to listen and communicate effectively, their communication will improve with residents as well as families, enabling inclusion of resident families, and supporting information sharing which were the original goals of the cycle. The results also highlight how important management support is to implement a person-centred care approach which was evidenced by the group deciding to hold a training session; however in order to do so, they needed the support of management facilitate organising such an event. The results were also suggestive of ongoing and regular training contributing to the sustainability of the intervention. The group reflected on the feedback from the training session. Suma commented on the results of the training session;

‘I feel a lot of pressure coming from not only families but the organisation itself, it’s like we are expected to know what person-centred care is and how to implement it when we really have not had a lot of specific training’. Holly added;

‘I do agree, more training would be beneficial for everyone, and the results showed how much they [caregivers] valued that specific type of training’. Havanna pondered;

‘Yes but we need a lot of support too. I don’t always understand what is said in training, it needs to be something that everyone can understand and also help us to achieve what is said in the training’. In addition to this, Colby offered;

‘I guess we all realise now that listening and communication skills play an important part in the implementation of person-centred care, because if we are not listening to the residents, how can we tailor their care, and support them as individuals?’.

(Figure 7.3) is an example of the coding manual derived from direct quotes relating to feedback from the listening and communication training session for caregivers highlighting that caregivers realise the importance of ongoing communication training to develop effective communication skills that can be applied to heighten the effectiveness of a person-centred care approach.
Caregivers support ongoing training to improve their communication skills

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers support ongoing training to improve their communication skills</td>
<td>Caregivers realise that effective communication skills are an important element in the implementation of person-centred care, and they support ongoing training to achieve it</td>
<td>I wish I had learnt this [communication skills] a long time ago. The training taught me to be a better listener. I would like to have more of this kind of training.</td>
</tr>
</tbody>
</table>

Figure 7.3 Example of coding manual derived from direct quotes relating to feedback from the listening and communication training session for caregivers.

### 7.3.2 Thematic Map – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

In consultation with participants, I searched for themes in the data derived from feedback from residents and their families, as well as feedback from the caregiver communication training, and data collected from audio recording, action group member’s reflective journals, and my observation notes. Using a cut and paste technique of coding followed by categorising codes and checking against the data for validity. I examined and re-examined the codes and contrasted them against the literature to categorise the codes. I reviewed the codes and placed them into potential themes. A preliminary thematic map was constructed that showed conceptualisation of themes and other interesting parts of text that had the potential to develop into themes as the process continued. Figure 7.4 below shows data sources and how they were then converged to create codes.
Data relevant to each sub-theme and theme was re-examined, then either kept or discarded. A thematic map was constructed with the theme defined, then named, all the while checking and re-checking the data. The codes were checked against the data and the theme; “Equip caregivers with the skills and knowledge to facilitate self-fulfilment for residents” was conceptualised. The theme encapsulated something important, meaningful and significant about the data in relation to person-centred care. The thematic map was a reflection of data from; Feedback from afternoon tea and information session questionnaires for residents and their families, feedback from listening and communication training session questionnaires for caregivers, group audio recordings, reflective journals, and observation.

Figure 7.4 Schema that shows data sources and then how they were converged to create the codes
Figure 7.5 A visual of the thematic map derived from group data demonstrating how four codes (at the bottom), merged into two sub-themes, with the theme at the top.

7.3.3 Review Theme: Equip caregivers with the skills and knowledge to ensure self-fulfilment of residents—Cycle One—Devise actions to facilitate inclusion of, and information sharing with resident families

Review of the theme reflecting the codes and sub-themes supporting the theme showed that for self-fulfilment of residents which includes their psychosocial, biological, and
psychological needs, caregivers need to be able to assist residents to fulfil these needs. In order for caregivers to be able to fulfil these needs, they need to be equipped with the skills to enable them to do so. The self-fulfilment of residents aligns with Abraham Maslow’s hierarchy of needs. The hierarchy, displayed as a pyramid, suggests that people are motivated to fulfil basic needs before moving on to other needs. Needs at the bottom of the pyramid are the basic requirements of food, water, sleep and warmth. Once these needs have been met, people move on to the next level of needs, which are for safety and security. As they progress up the pyramid, needs become increasingly psychological and social, including the need for love, friendship and intimacy. Each level has specific needs, which require them to be fulfilled before the next level can be reached. This process continues until the highest level of self-actualisation is achieved (Bayoumi, 2012). Conversely, Tse et al. (2012) argue that Maslow’s hierarchy of needs can be difficult to achieve for older people living in residential aged care. Additionally, they proffered that in order to achieve a higher level of needs in the Maslow hierarchy, and to make the facility a better place for older peoples, an holistic approach to care is required. Holistic care is described as behaviour that recognises a person as a whole, and acknowledges the interdependence between the biological, social, psychological, and spiritual aspects of that person (Zamanzadeh, Jasemi, Valizadeh, Keogh, & Taleghani, 2015) which aligns it directly with person-centred care, as person-centred care is described as delivering interventions or treatments that are respectful of and responsive to the characteristics, needs, preferences and values of the person or individual (Dewi et al., 2014).

The theme was conceptualised from the codes; “caregivers need to listen to resident needs and preferences”, “caregivers support ongoing training to improve their communication skills”, “involvement and social support is important for residents”, “families are satisfied with the care the residents are receiving”, and “high expectations of caregivers to meet the needs of residents”. Analysis suggests the importance of older people being able to reach self-fulfilment, and recognises the need for support and enablement to do so through facilitation by caregivers who have the appropriate skills and knowledge to assist older people to achieve it.

As an added reflective technique, Wordle software was used (Figure 7.6) as a means of exhausting all possibilities to see if anything of significance had been overlooked. Using the Wordle software as an adjunct tool validated the findings; it provided rapid output and was a visually rich and fast way of visualising general patterns in the data. It is important to note that Wordle was used only in its capacity as a validation tool and it was noted that it only counts the frequency of words used making it misleading as it neglects the semantics of the words and sentences. It was more relevant to present the
Wordles here because they complemented the data analysis as an adjunct way of validating the findings.

Figure 7.6 Wordle tool used to validate text from data collection derived from residents and their families.

Sub theme – Caregiver’s attentiveness can facilitate social involvement for residents

Data analysis highlighted the importance of caregivers developing the appropriate knowledge and communication skills to be able to listen to resident needs and preferences. By doing so, they can discover ways to involve residents through social support opportunities.

Sub theme – Caregivers work hard to satisfy resident care needs

Data analysis highlighted that the majority of families were satisfied with the care the residents were receiving and that caregivers worked hard to achieve and maintain this high level of care. Additionally, data suggested there was perceived high organisational expectations of caregivers to implement person-centred care.
7.4 Reflection – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

Because this study was a group process, everyone should be engaged in part of it, my reflections on the cycle were shared with the group. They identified the challenges that confronted them during the cycle, due to them possibly becoming complacent, thinking they were already facilitating person-centred care for the residents, and they were very comfortable in their position riding on the good reputation Seaview had always had. The main challenge they experienced was their surprise and disbelief to discover they were not listening to the residents, on receipt of feedback. They worked well as a group demonstrating they were able to take responsibility for their actions by revising their action plan and addressing the issue of not listening to residents that had been brought to their attention through critical reflection. They expressed their relief when the revised plan and action was a success, as they stated they initially felt deflated and disappointed that they thought they would not meet the goals of the cycle. They realised team cohesiveness does not happen by coincidence, they reflected how they know each other well and trust each other, and have managers they trust and know they can confide in. They expressed their interest in undertaking a second cycle which had already been prioritised in chapter four, to focus on maintaining cohesive teams.

Reflective practice is used increasingly to enhance team functioning (Nancarrow, Smith, Ariss, & Enderby, 2015), and is central to professional practice (Asselin, Schwartz-Barcott, & Osterman, 2013), and it is important for caregivers to develop reflective practice to improve their practice and ultimately enhance resident care (Devenny & Duffy, 2014). There is a need to create a supportive environment for caregivers if they are to feel they are assisted to explore their practice to make changes and alter the culture in which they work. Creating a space where people feel able to focus and reflect on changes without threat of loss of self-identity or integrity is essential to organisational learning. Additionally, the concept of supportive environments connects changeable workplaces to the health, resilience and well-being of individuals and teams. Without the trust and respect found in supportive environments, individuals will minimise the risk to self by avoiding ‘to act’, unless they are certain of the outcome (Brown & McCormack, 2016).

I supported inclusiveness and collaborative engagement within the group during the cycle, for example, I encouraged the action research group from the outset to volunteer for different roles within the cycle and to discuss how they would work together to bring the plan to fruition. I also encouraged all participants to speak and invited everyone’s opinion. From the experiences of this cycle, the group learnt to work
together better as a team to achieve the goals of the cycle through developing the skill of critical reflection.

There was a direct and positive impact on the team dynamics at Seaview with the inclusion of the management team involved in the study as participants. The management team were equal participants for the duration of the study; however they held the final say as managers on whether or not the activities of the cycle could go ahead. Due to their support of the study, they willingly discussed and agreed to the activities and were in the unique position to be able to convey during group discussions any limits, financial or otherwise the organisation would place on their activities.

This cycle was a unique experience and learning curve for the group and they stated they grew from it as a team, and as individuals as they became reflective practitioners who were able to identify challenges and work through them. The outcomes of this cycle included a group of people who were empowered to think critically and more intuitively, and through this process they developed more of an understanding of what person-centred care entails. They also gained knowledge from the experience, which they took with them into future caring experiences. They agreed that education was beneficial to them; however they agreed they could now see the value in continual education to assist them in their journey as caregivers.

7.5 Précis – Cycle One – Devise actions to facilitate inclusion of, and information sharing with resident families

Due to feedback from residents and their families in the initial action, the group revised the initial plan to reflect the feedback. The theme conceptualised from the data was “Equip caregivers with the skills and knowledge to ensure self-fulfilment for residents”. The nominal group technique applied in chapter four established the prioritisation of goals. Throughout cycle one, the group constantly reflected on the decisions they made. They stated that although they realised making the decision to educate resident families was not congruent with person-centred care, they were pleased they did realise and were able to take responsibility and move on to address the issue of listening to residents. This highlighted the complexities of person-centred care as well as the challenges faced in translating knowledge of person-centred care into practice for the group. The group reflected on their decision to provide an information session for caregivers as a way of moving forward, focussing on communication and listening. They agreed it was a good decision and deemed it a success because they agreed it promoted teamwork and engagement of all caregivers. They reflected on the appointment of Ron
in cycle one as the person-centred care champion, and participants agreed his appointment was a good decision as he was a natural leader, and was passionate about his work. The group agreed that Ron was also a good advocate for person-centred care as the participants reflected he had always placed the residents and their care and preferences first.

The outcomes achieved were more effective than the group had initially planned due to revising the action. They stated that some of the caregivers approached them days later to tell them how good the training session was. For the group, they realised the seriousness of becoming complacent, as well as the importance of working together and engaging as a team. They agreed that the actions of the cycle increased awareness and the importance of reflection on practice. They stated they were more willing to take responsibility for not listening to the residents and to look inwardly at the situation rather than blaming others (resident families). There appeared to be a shift in the way the group thought as they became aware of the ramifications of complacency.

The implications for the study were that of a newly motivated and collaborative team of caregivers following the training session, as well as a group who stated they were pleased with the way they had united to move forward in the face of adversity by accepting responsibility for their actions and being able to make some critical reflections about their practice. The group considered the aims of the study as well as the goals of the cycle, the training, which they agreed albeit small, was significant. The group agreed the cycle goals of; the inclusion of, and information sharing with resident families was achieved, as resident families were included in the morning tea and information session. To gauge the effectiveness of the session, feedback was then invited from the residents and their families. The group discussed the achievements resulting from cycle one;

- Increased awareness of the complexities of implementing person-centred care
- Focus on changing current practice
- Emphasis on collaboration
- Increased teamwork
- Evidence of collective change
- Improved relationships between residents, resident families, caregivers and managers due to inclusion and collaboration
Increased empowerment for caregivers

The group discussed what could have been done differently in the future;

- It is important for caregivers to take responsibility for their actions and practice and to work collaboratively to make changes
- Consultation of all people affected by changes
- To place the resident at the centre of care by listening to their needs and preferences

To conclude cycle one, the group discussed the second cycle of action, devise actions to maintain a cohesive team, with the goals and priorities determined in chapter four. They felt that cycle two would complement cycle one and were keen to apply their increased knowledge and awareness from cycle one.

Seaview - Cycle Two – Devise actions to maintain a cohesive team

Feedback from residents and their families in cycle one advised caregivers that they were not listening to the residents. The group decided to revise the plan to include communication skills training for caregivers. This revised planning brought the group closer together as a team due to the previous challenges they faced, which coincided with the prioritisation of goals as discussed in chapter five, where the group decided, through the nominal group technique, they would undertake a second cycle of action; Devise actions to maintain a cohesive team.

Management at Seaview had always prided themselves with low caregiver turnover. Mostly, any caregivers who left either retired or moved away. Caregivers at Seaview had enjoyed what they perceived as cohesiveness as a team, and many of them had worked at the facility for more than ten years. They knew each other well and there was a level of trust amongst them. The group also discussed how they felt that team cohesiveness would almost certainly impact on person-centred care, because a cohesive team would function better, therefore better able to implement person-centred care. However, the workforce was an ageing one and several planned to retire in the not too distant future, which would change the dynamics of the team, as new caregivers would
need to be employed. The group discussed that they needed to ensure that the cohesiveness the team enjoyed in the past continued into the future.

### 7.6 Planning – Cycle Two – Devise actions to maintain a cohesive team

Figure 7.7 A suggestions box

The goal for the second cycle was maintaining good relationships between caregivers and residents by; (1) gauging caregiver satisfaction, and (2) inviting suggestions from caregivers on how to enhance caregiver satisfaction. The group considered the importance of cohesiveness and how it affects person-centred care implementation. Colby agreed that cohesiveness impacts on the implementation of person-centred care stating:

*I think if the caregivers are happy and feel part of a team, then the residents must benefit from that, I mean, a cohesive team will work harder to make the residents happy.*

The group agreed with Colby's comment. They discussed that for caregivers to adopt a person-centred care approach, they needed to feel satisfied in their work and feel part of a team, the residents then being the beneficiaries of that satisfaction. Ron offered a suggestion to gauge the current satisfaction level;
How about we run a caregiver questionnaire? We could have a form for caregivers to fill out called the “Happiness Questionnaire” and ask them questions to gauge how happy they are in their work.

The group were supportive of Ron’s suggestion and devised the happiness questionnaire (Appendix 16). They decided to give every caregiver a happiness questionnaire to fill in and return. Ron also suggested having a suggestion box in the caregiver’s room to add any suggestions from caregivers to assist strengthening the team, called “Suggestions to make our great team even BETTER” Ron was enthusiastic about his suggestion;

The suggestions would help to gauge the satisfaction of caregivers through a different avenue (performance reviews) as well as finding out from caregivers what could be done to help strengthen the team.

The group were supportive of both Ron’s suggestions. They decided that “suggestions for the team” would be a voluntary contribution. Ron then called for volunteers for jobs in the cycle;

Ok, we need someone to organise the questionnaire; we need the questions typed, a box organised. We will need a box decorated and placed in the staff room. We will need to notify caregivers about what we are doing.

Holly volunteered to notify caregivers via notices on the caregiver’s board. Suma and Havanna volunteered to organise the boxes to be decorated and placed in the caregiver’s room. Colby volunteered to type the questions ready to give to caregivers. The group discussed they were ready to act on their plan.

7.7 Action – Cycle Two – Devise actions to maintain a cohesive team

Holly placed notices on the caregiver’s notice boards to inform them of the “Happiness Questionnaire” and “Suggestions” box. Caregivers were asked to fill the “Happiness Questionnaire” in by the following week and place them in the box provided. Colby typed the questions for the survey and placed them in envelopes for all the caregivers, and they were given to each caregiver member with their pay summary.
Suma and Havanna organised the boxes for the “Happiness Questionnaire” replies, and the “Suggestions” box. Both boxes were placed together in the staff ready for replies. The “Happiness Questionnaire” replies were not all received the following week and Holly asked caregivers to submit them as a soft copy as soon as possible into the box that was provided. The week following, 53% of caregivers had completed the happiness questionnaire. When the suggestions box was checked, there were no suggestions there. The group decided that they were not waiting any longer for responses to come through so they finalised the survey and suggestions. As the group perused the responses in totality, job satisfaction emanated through, as did overwhelming support for Holly and Colby. Ron posed a question to the group;

‘Let’s take what we found from the feedback and build on that. I would like us to revise the plan of action again, I know there is nothing wrong and the cycle is going well, but I think it would be good to keep our happy team happy by doing something nice together, maybe have a nice lunch together to add to the cycle’.

The group discussed Ron’s idea and agreed they were happy to revise the plan and action to include a lunch for the caregivers, and they decided to include the residents in the lunch as a way of implementing person-centred care. Colby offered;

‘Well, this is their [residents] home and we are like their family, so they should be included. I think inclusiveness is important for everyone’.

The group stated they were confident that the lunch would work as a strategy to enhance the already cohesive team at Seaview and also demonstrate how the team were also person-centred by including residents in the lunch. The group then set about revising the plan.

Reflection

The revision of cycle two showed that the group were looking at not only the goal of the cycle, but also at the broader desire to keep the team dynamics and cohesiveness strong in the face of upcoming changes, in order to be in a position to deliver high quality person-centred care into the future.
7.7.1 Revised plan – Cycle Two – Rebel against unhappiness

The group made the decision to undertake the revised plan and action without me as facilitator. They stated that they felt empowered enough to progress. They reflected on the first part of the cycle which they deemed a success. 53% of staff (n=8) responded to the questionnaire, and 100% of those commented positively. There were no negative comments. The group had aimed to gauge caregiver satisfaction so they were open to unbiased feedback. Responses include those below as evidence of the tone of the success;

Suma offered her thoughts on the success of the first part of the cycle;

‘I was not sure if we would receive any negative feedback or not, but I was blown away with the comments being so positive, every one of them’.

Ron nodded in agreement and offered his thoughts;

‘I was not surprised at all that the responses were so positive, the caregivers seem happy to come to work and I think this reflects in the positive tone of the facility’.

The group supported Ron’s suggestion to include a lunch in the second part of the cycle, and agreed a combined caregiver and resident lunch would not only serve as an intervention to strengthen team cohesiveness, but also serve as a demonstration of the benefits of applying person-centred care. Suma was very supportive of the combined lunch;

‘I think the caregivers will love it and it will be great for the team. We need things like this [lunch] to get to know each other better and have fun together, because most of the time it is just about work’.
Ron volunteered to organise the lunch and suggested;

‘What about late November, 2013 at Seaview in the dining room with fish and chips supplied by a local store? I am happy to pick up the lunch’.

The group were happy with the date, and Ron then called for volunteers to organise invitations on notice boards for the caregivers and special invitations for each of the residents. Suma volunteered to organise the invitations for the residents and Holly volunteered to organise the invitations to be placed on caregiver’s noticeboards. Havanna and Colby volunteered to prepare the dining room for lunch.

**Reflection**

Very impressed with this group, they are so enthusiastic and well organised. They work very well together; they trust each other, their confidence has grown, and they feel empowered.

**7.7.2 Revised Action – Cycle Two – Devise actions to maintain a cohesive team**

Suma organised invitations for the residents and delivered them, and Holly organised invitations for caregiver’s noticeboards. Ron took orders for lunch in the days leading up to it, and phoned through the day before ready for the 12pm pick up. Havanna and Colby prepared the dining room for lunch mid-morning adding streamers and balloons to the decorations. Ron picked lunch up as planned, and the fish and chips were placed on each table with servers so that everyone could serve their own. Colby offered;

‘This is lovely, getting to spend time with each other [caregivers] as well as the residents, makes it feel more relaxed and more like one big team. I love to hear other caregivers chatting and laughing with the residents’.
Reflective journal entry - Ron

These meetings have confirmed for me what I really already know. We have a fantastic team who support each other on a daily basis. We also have wonderful managers in Holly and Colby who continue to provide us with amazing support and opportunities to better ourselves on every level.

Reflection

I think this just tops it off for the group. They have combined team building strategies with person-centred care.

Caregivers reported hearing chatter and laughter from other caregivers and residents during the lunch, and following, other caregivers and residents were heard stating how much they enjoyed it. The group met immediately following the lunch to discuss the outcome. They stated they were very pleased with the lunch and had received many comments from both residents and caregivers on how nice it was to get together and their desire to do it again. Most of the caregivers and residents stated they wanted to have lunches like this once a month.

7.8 Observation – Cycle Two – Devise actions to maintain a cohesive team

In this, the observation section of the cycle, I am reporting on behalf of the group’s progress of developing and implementing a person-centred care approach. The group’s findings from the data collected from; the questionnaires, observations, audio recordings, and reflective journals are documented below including the data analysis, the group interpretations of the findings, and the theme conceptualised from the cycle.

7.8.1 Data analysis- Cycle Two – Devise actions to maintain a cohesive team

The group stated they had felt confident to undertake the revised plan and action without me; however they asked me to complete the compilation of their comments, in
consultation with them. The data collected by the group was analysed using thematic analysis following the step-by-step method proposed by Braun and Clarke (2006).

Transcribed data collected from the questionnaires, observations, audio recordings, and reflective journals was examined in collaboration with the group, and coding numbers placed down the sides to assist in the search for codes. I analysed each data set separately and then compared them for similarities and differences. Interesting words or phrases were identified and categorised by; similarities, for example; “I look forward to coming to work each day”, and “We have a great team and work environment”, and frequencies, for example; certain words were used frequently such as “happy” and “supportive”. Figure 7.8 below provides an example of how the codes were conceptualised.

The following is data relating specifically to feedback from the questionnaires that were provided to caregivers to gauge their satisfaction with their work, their Manager, and their team. There were fifteen (n=15) caregivers working at Seaview at the time of this study, and 53% (n=8) completed the questionnaire (Appendix 15) provided to them. Question 1 asked if caregivers were happy at work, and 100% of replies stated they were happy at work, and 62% (n=5) stated they were very happy, with one respondent stating it is an amazing environment to come to every day, confirming what the group had discussed earlier, that they felt they had a happy team. Colby responded to this positivity;

‘I thought the team were happy but I didn’t realise just how happy they are’.

Ron added to the delight;

‘I am not at all surprised at this result, we have always worked well together here and now this has confirmed it’.

Question 2 of the questionnaire asked that if caregivers were unhappy, what would make them happier. There was one respondent to this question, and that person stated they were very happy and content to come to work. Question 3 asked what management can do to assist, and 71% (n=5) stated they were happy, and had a good Manager who was always supportive. 28% (n=2) wanted management to try to keep the
team happy, and one respondent stated they wanted their roster unchanged. Question 4 asked how you would rate your team, 100% (n=8) transcribed either a symbol 10/10 or stated great, or excellent, or we have a great team. The results of this questionnaire were discussed with the group, Ron responded to the very positive results;

‘Wow, this is great and really confirms what I always knew; we have a fantastic team who support each other on a daily basis. We also have wonderful Managers in Holly and Colby who continue to provide us with amazing support and opportunities to better ourselves every week’.

Havanna was also very happy with the results;

‘Nice things are said about our managers all the time’.

Suma smiled and nodded her head in agreeance as she said;

‘I have always been happy here and I have been here for 8 years now, I am not going anywhere’.

Holly; however was a bit sceptical;

‘Well I want to know why only 53% of caregivers responded, I wonder they didn’t reply, I wonder if they couldn’t be bothered or if they are not as happy as the ones who responded’.

The group acknowledged that there were no responses to the suggestions box when Ron checked it. Havanna was puzzled;

‘I cannot understand why no one placed a suggestion in the box, I am puzzled. I wonder if it was because of where the box was placed because quite often I would go into the staff room and the toaster was in front of it or someone had the sandwich press sitting there, actually one day I went into the staff room and
someone had put it up on top of the lockers. Makes you wonder why someone would do that.

The group concluded that lack of suggestions must have been due to the placing of the toaster and sandwich press in front of the box as well as placing it on the lockers. Colby voiced her disappointment;

‘I would have been interested to hear some suggestions as to how we can improve on things around here. It pays to stay on our toes, after finding out that we don’t listen, I realise now that we have to be more aware of what is going on and not take anything for granted, otherwise the residents and the team could suffer’.

Below in Figure 7.8 is an example of the coding manual derived from direct quotes and questionnaire feedback on caregiver happiness and satisfaction at work.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of caregivers were happy at work</td>
<td>Of the 53% of caregivers who responded to the questionnaire, 100% were happy in their work and happy to go to work.</td>
<td>We have a great team and work environment. I look forward to coming to work every day.</td>
</tr>
<tr>
<td>Caregivers felt supported by their managers</td>
<td>The caregivers stated they were happy and felt that they were well supported by their managers.</td>
<td>The managers are very supportive. Happy with what management does for us Management is always supportive and open to new ideas</td>
</tr>
</tbody>
</table>

Figure 7.8 Example of coding manual derived from direct quotes from data collection.

The following quotes are from caregivers providing feedback about the lunch. The group conveyed they felt sufficiently empowered to organise the lunch without me; however when I asked them for feedback from the lunch, they realised they had not
provided any feedback forms. They were happy to discuss their personal experiences from the lunch.

Havanna expressed her enjoyment;

‘This [lunch] makes me feel really good about myself at work. It makes it even more worthwhile to come when we [residents and caregivers] can have a bit of fun together’.

Ron agreed with Havanna;

‘It is really nice as well to see the caregivers and residents enjoying time together. One of the residents just told me that she feels really special being included in this [lunch]’.

Suma was overjoyed;

‘It was great, the residents all told me how much they enjoyed the lunch and how they would like them [lunches] to continue’.

Suma had tears in her eyes when she said;

‘Nothing pleases me more than to see our beautiful residents happy’.

Holly was also pleased with the atmosphere the lunch had created;

‘It just goes to show, everyone enjoyed themselves and they just had fish and chips, obviously it is not just the food, it is the company and the happy atmosphere’.
Ron had watched the residents and caregivers laughing and chatting just like friends and offered;

‘Things like this [lunch] are great for teamwork, I am all for them on a regular basis’.

Suma reflected on the team;

‘We really do have a great team here, I just hope it never changes’.

Ron agreed;

‘I think teams are one of those things, never take a good team for granted, it is something that needs constant work’.

The group agreed this cycle was about teams and team building and they concluded that good teams need to be nurtured. They realised the value in good strong teams in providing person-centred care and discussed their understanding of the connection between a happy team and person-centred care. The group reflected on the cycles and articulated how much they felt they had learnt from the cycles including; the importance of communication skills when applying person-centred care, they conveyed they realised how important a strong team is and how that impacts on person-centred care, and they conveyed an understanding of what they perceived as good management.

Below (Figure 7.9) is an example of the coding manual derived from verbal data and observations from the combined resident and caregiver lunch.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of caregivers felt part of a great team</td>
<td>More than half 53% of caregivers felt that they were part of a great team</td>
<td>We have wonderful team here at Seaview</td>
</tr>
<tr>
<td></td>
<td>It’s a great team environment, makes me happy to come to work everyday</td>
<td></td>
</tr>
<tr>
<td>Caregivers enjoy team building activities</td>
<td>Caregivers welcomed the combined lunch with residents, and realised the positive impact they [team</td>
<td>I can see how important these [lunches] are for our team</td>
</tr>
<tr>
<td></td>
<td>building activities such as the lunch] have on the team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I hope we can do this [lunch] again, everyone, including the residents is so happy. How good is this</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for our team.</td>
<td></td>
</tr>
</tbody>
</table>

Figure 7.9 Example from coding manual derived from direct quotes from caregivers and residents.

7.8.2 Thematic Map – Cycle Two – Devise actions to maintain a cohesive team

A thematic analysis of textual data was undertaken and a preliminary thematic map was constructed from direct quotes taken from the group, new residents and resident families using glue and pasting technique that showed conceptualisation of themes and other interesting parts of text that had the potential to develop into themes as the process continued.

Data relevant to each sub-theme and theme was re-examined, then either kept or discarded. A thematic map was constructed in consultation with the group, the theme defined, then named, all the while checking and re-checking the data. When discussing the theme, I encouraged the group to remain reflective, responsive, and open-minded, as well as remaining focussed on the goals of the cycle. Codes were checked against the transcripts and the theme; “Develop strategies to build a cohesive team” was conceptualised. The theme encapsulated something important, meaningful and significant about the data in relation to person-centred care. The thematic map (Figure 7.10) was a reflection of data from; the questionnaires, the group, audio, reflective journals, and observations.
Figure 7.10 above, provides a visual of the thematic map derived from group data demonstrating how four codes (at the bottom), merged into two sub-themes, with the theme at the top.

7.8.3 Review Theme - Develop strategies to foster cohesive team – Cycle Two – Devise actions to maintain a cohesive team

The theme “Develop strategies to build a cohesive team “was conceptualised from the two sub-themes; “a supportive manager is crucial for a cohesive team”, and “structured team building is crucial for a cohesive team”. Analysis suggested that although a team dynamic may be strong, and caregivers satisfied in their work and with their Managers, cohesive teams need ongoing effort from proactive Managers and caregivers to continue
to evolve, to maintain sustainability. Analysis also suggested that supportive management is a crucial component needed for a team to function as a cohesive team, to foster; support, trust, vision, empowerment, and autonomy. Managers need to collaborate with caregivers to undertake structured team building interventions; strengthening workplace culture and the application of person-centred care.

**Sub theme – A supportive manager is crucial for a supportive team**

To maintain a cohesive team was the goal for the second cycle. To achieve their goal, the group (1) gauged caregiver’s satisfaction and, (2) invited suggestions from caregivers on how to enhance caregiver’s satisfaction.

(1) Gauge caregiver’s satisfaction

The group planned to maintain a cohesive team, and in order to achieve that, they set about gauging caregiver’s satisfaction to see how satisfied the caregivers were in their jobs. Of the 53% of caregivers who responded, those who did expressed how happy they were in their jobs and how they felt part of a happy team. Some of the responses included;

- I am incredibly happy; it is an amazing environment to come to every day.
- Yes I am happy, I look forward to coming to work each day.
- Yes, I am happy; we have a great team and work environment and great managers.

The group were disappointed as to why only 53% of caregivers responded and they were asking the question why. When they discussed, they decided it could be due to either thinking they (caregivers) might be judged by their responses or possibly apathy. However, they agreed they would be surprised if it was apathy as they stated most of the caregivers at Seaview appeared motivated.
(2) Inviting suggestions from caregivers on how to enhance caregiver’s satisfaction.

The group invited suggestions from caregivers on how to enhance caregiver’s satisfaction. They were very disappointed that they received just one suggestion, and that was someone asking for the shifts they preferred. Again, they discussed why they would have received only one suggestion and agreed it may have been due to caregivers not understanding what the group were trying to achieve, and not being able to see the point in making suggestions.

It was expected that an intended effect of the action would be for several different and varying responses to the happiness survey. It was expected that some of the caregivers would be unhappy and take this opportunity to express their dissatisfaction with their work, the team, and or their manager. However, the happiness surveys were returned and overwhelmingly showed caregivers satisfaction with not only their jobs, but also their managers. This was an unintended, unexpected effect of the action. The group commented they thought there would be at least several unhappy caregivers as there are in a workplace; however they realised that this could have been the case with the caregivers who did not respond to the “Happiness Survey”.

Reflection

It is possible that the perceived privileged position of those in the group, which included managers, meant that those caregivers, who were unhappy, saw no point in responding to the survey possibly because it was not independently conducted.
Sub theme – Structured team building is crucial for a cohesive team

The group perceived they had always had a cohesive team, and following reflective discussions, agreed they were keen to learn more about cohesive teams. To continue with their new-found autonomy, Ron provided information about cohesive teams for the group which he had googled. From the information and following discussion, the group agreed they had already developed two strategies to foster cohesiveness; (1) the lunch, and (2) when they invited suggestions to enhance caregiver’s satisfaction. They realised the importance of developing strategies to foster a cohesive team as they reflected on the study aim: to support managers and caregivers at three rurally located residential aged care services implement and sustain a person-centred care approach. The group pondered as to why the team at Seaview had always worked so well together and agreed they had worked together for years, knew each other well, and trusted each other. This paired with their satisfaction with Holly and Colby, made for a satisfied team at Seaview.

Both residents and caregivers enjoyed lunch together in the dining room with nearly all residents and caregivers in attendance. The group undertook to develop a revised plan
and associated actions without my involvement. Unintended effects from the action were; the overwhelming satisfaction caregivers had with their jobs and their managers, and the level of autonomy seen from the action research group as they planned for the lunch without my involvement. The group applied a high level of reflection, collaboration, and inclusiveness to try and make the lunch a success.

Reflective journal entry - Havanna

I have found this study to be very enjoyable, nice things have been said about our team and managers and we seem to be achieving things, it makes me feel good.

Reflection

It is clearly very important for the staff at Seaview to have their efforts at work recognised. They were upset in Cycle one when they realised that some residents and their families felt they were not being listened to. Conversely, they were delighted with the success of the lunch in Cycle two and the ensuing positive feedback they received.

The confidence levels of the group appeared to strengthen throughout the trajectory of the study, demonstrated by their willingness to undertake the final cycle of action without my involvement. Their participation in the study realised the action research group’s evolving understanding of person-centred care. The training provided an opportunity for caregivers to establish and reinforce relationships with the residents, as well as each other.

Group reflection from this cycle demonstrated their capacity to work as a team and make changes that they felt complemented the facilities’ person-centred care aspiration. They agreed that Management gave them autonomy in their work to be able to carry out their tasks confidently that made them feel empowered. Maintaining a cohesive group dynamic was discussed. Having a voice, being heard and negotiating a common agenda were highlighted as strategies that underpin effective group processes.
7.9 Reflection – Cycle Two – Devise actions to maintain a cohesive team

The decision by Ron to revise the plan and action in cycle two was supported by the group. They decided that in order to keep the team (caregivers) motivated and cohesive, they needed to be proactive and maintain momentum gained from the initial luncheon activity. The group decided to hold resident and caregiver lunches once a month; an initiative supported by Management.

There was an overwhelming response from the caregivers who did respond to the survey that they were happy not only with their team, but they also spoke highly of their Managers. This led to the decision to revise the plan and action which included a special lunch for residents and caregivers in order to build on the existing strong team dynamics and cohesiveness. The outcome for both residents and caregivers was very positive in that the residents had increased social interaction with each other as well as caregivers, which is an action reflective of the principles underpinning person-centred care. The group advanced their understanding of person-centred care and were able to develop strategies to engage with and enhance resident’s lives that aligned to person-centred care principles. The participants gained skills that included reviewing the workplace and entrenched practices against new evidence, approaches to care and human rights. They also learned that change can be positive and understood that they can be a proactive force in facilitating agreed goals.

The lunches continued at Seaview for both residents and caregivers. Anecdotal evidence collected by the group indicated that these events had a positive outcome with caregivers and residents commenting how nice it was that they could spend time together to chat without having to discuss personal care needs. Anecdotally, the residents commented to caregivers on numerous occasions how it felt more like home to them to be included in special lunches. Following the initial lunch, the residents and caregivers were seen by the group chatting and laughing like they had a private joke between friends.

Ron, the person-Centred Care Champion, was an exceptional part of the study for Seaview. He displayed true leadership qualities of empathy, motivational, integrity, and visionary (Delgado & Mitchell, 2016). He was supportive of the group and assisted them to feel empowered and autonomous in the voicing of their opinions and in their decision making. Ron displayed vision and forethought to be able to guide the action research group. He demonstrated his understanding of the broader aims of the study by
suggesting to the group to include a lunch into the cycle. He conveyed that the study reiterated to him what he already knew about being part of a supportive team.

The group were cohesive and with strong leadership provided by Ron, they analysed the situation and developed strategies to promote a person-centred care approach. Team members accepted responsibility for tasks that ensured the plans developed were achieved. The group demonstrated how well they collaborate, and especially how they managed to move forward in adversity. They proved they were a resilient team and despite their initial perceived set back, they were able to take responsibility for their complacency, apply critical reflection and accept that for person-centred care awareness and implementation, they were the ones who needed to make changes to their practice. The group demonstrated that they could create opportunities for increased interaction between residents and caregivers and understood how important that is because it is the resident’s home.

7.10 Précis – Cycle Two – Devise actions to maintain a cohesive team

Chapter seven detailed two cycles of action for the group, the cycles were completed and progressed to realise the overall study aims. Cycle one described the actions that contributed toward the inclusion and education of resident families, and cycle two; “Rebel Against Unhappiness” described actions contributing towards keeping the already happy team (of caregivers) happy. The group overcame significant setbacks to forge ahead and become a stronger, empowered team, willing to take more responsibility for their actions.

Cycle two was completed. The findings from cycle two demonstrated teamwork amongst the group. As the cycle continued, the group felt confident to undertake a revised plan and action without me. The cycle showed that caregivers were satisfied in their jobs and they were also happy with their managers. The revised plan and action provided a better opportunity for interaction between caregivers and residents. This is important because it is meant to be the resident’s home. Ensuring an opportunity in a busy schedule for caregivers to have the opportunity to interact on a social level with the residents led to improving communications between caregivers and residents. It is also a way for caregivers to understand ways to rethink how they do their work in order to create opportunities for initiative such as, they don’t have to be busy all the time and think that there is no time for interaction. In order to create opportunity in a busy workplace to create an outcome to move people to a different way of thinking requires a shift of values from an action on doing to being together. To this end, the caregivers
achieved this, which was a good outcome for both the caregivers and residents. Part of the reason for the success of this was that the leadership was dynamic and supportive.

### CYCLE 1 - Educating Resident Families

**Theme:** Equip caregivers with the skills and knowledge to ensure self-fulfilment of residents

<table>
<thead>
<tr>
<th>Goals</th>
<th>Assist resident families to understand person-centred care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revised goal</td>
</tr>
<tr>
<td></td>
<td>Training for caregivers about the importance of communication</td>
</tr>
<tr>
<td>Actions</td>
<td>An information session for resident families incorporated into an afternoon tea.</td>
</tr>
<tr>
<td></td>
<td>Revised action</td>
</tr>
<tr>
<td></td>
<td>A training session for caregivers about communication, with a focus on listening</td>
</tr>
</tbody>
</table>

### CYCLE 2 - Rebel Against Unhappiness

**Theme:** Develop strategies to build a cohesive team

<table>
<thead>
<tr>
<th>Goals</th>
<th>Maintain a cohesive team.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revised goal</td>
</tr>
<tr>
<td></td>
<td>Build a cohesive team</td>
</tr>
<tr>
<td>Actions</td>
<td>(1) Gauge caregiver's satisfaction</td>
</tr>
<tr>
<td></td>
<td>(2) Invite suggestions from caregivers about how to enhance caregiver's satisfaction</td>
</tr>
<tr>
<td></td>
<td>Revised action</td>
</tr>
<tr>
<td></td>
<td>Lunch for both residents and caregivers</td>
</tr>
</tbody>
</table>

Figure 7.12 Summary of activities undertaken in cycles one and two for Seaview, as well as the themes arising from the cycles

Findings from cycle two demonstrated the importance of engagement and inclusion of all people involved in changes affecting them, and that change management strategies are important when proposing change within an organisation. The following chapter outlines two completed cycles of action undertaken by the Sandcastles Action Research Group; “Increase interaction opportunities for residents with minimal or no cognitive impairment”, and “Person-centred care training for new caregivers” as they were determined in chapter four through the nominal group technique. The plan, act, observe and reflect components of action research were applied, as was thematic
analysis resulting in the conceptualisation of two themes, one for each cycle. The cycles for Sandcastles below, will conclude the group cycles for all three facilities.
CHAPTER 8: SANDCASTLES

Figure 8.1 Photo of a beach

The Sandcastles Action Research Group

Eleven staff agreed to participate in the study at Sandcastles.

This chapter describes the two action cycles conducted at Sandcastles aged care facility. The first cycle “aimed to increase interaction opportunities for residents with mild or no cognitive impairment, with staff, other residents and visitors from the community. The second cycle sought to provide person-centred care training for new caregivers. An overview of the participants is presented followed by details of both cycles of action.

Cycle One – Increase interaction opportunities between residents with minimal or no cognition impairment and caregivers

The group prioritised the increasing interaction opportunities between residents who did not require high levels of essential care and caregivers. The group believed that because they prioritised the care of residents with cognitive impairment and dementia, they had limited opportunity for interaction with residents with minimal or no cognitive impairment.
8.1 Planning – Cycle One – Increase interaction opportunities between residents with minimal or no cognition impairment and caregivers

Figure 8.2 Photo of an outdoor area at The Sandcastles facility

The photo above shows a table and chairs nestled amongst the garden at Sandcastles that are utilised by residents. These spaces promote interaction between residents, their families and visitors from the community.

**Reflection**

The group have made a good start to the study and they seem enthusiastic. Sharron seems to have taken the lead, demonstrating empowerment as a caregiver in voicing her thoughts to the group, including the managers present; she has a lot to say and is very supportive of the group.

The group agreed that the majority of their time was spent attending to the personal care needs or essential care of residents with varying degrees of cognitive impairment. They agreed that because of this, minimal time was spent getting to know those residents with minimal cognitive impairment. Channel offered:
‘The residents who don’t have dementia are more self-sufficient and we don’t place these residents high on our priority list of cares’.

And Adira added;

‘I think we all feel guilty that we don’t have the time to sit and chat with residents. It feels like we neglect many of the higher functioning residents. I think it is only fair that residents should have an equal amount of time with staff’.

Following discussions and critical reflection on the existing practice of all residents dining in the same large room for meals, the group agreed that a special dinner for the residents to be held in the craft room at Sandcastles would be appropriate. The craft room was large and able to be closed off from the rest of the facility. The group asked the manager if they could provide a special dinner, and the Manager suggested that the residents would probably prefer to go out for dinner to a restaurant for an evening experience rather than staying at the facility. As a method for empowering the action research group and ensuring inclusion, I encouraged them to think about the roles they would each have in the cycle, including volunteering their time for the dinner. Sharron called for volunteers to undertake different roles.

‘Someone will need to talk to the residents to find out when and where they would like to go for dinner, and someone to organise invitations, oh and feedback forms. We need feedback forms to see how successful the night was’.

The group discussed the importance of including those who were most affected by the actions of the cycle, ensuring inclusion, and empowering the residents. Penny considered the role she wanted to play in the study and volunteered to speak to the residents involved to ask them if they would like to go out for dinner and if so, where and when they would like to go. She discussed with the group;

‘I think it is important to discuss this with the residents so they can decide if that is what they want and get to choose which restaurant they would like to attend as this is about them. This is what person-centred care is to me’.
Penny spoke with the residents who were being targeted to determine their preferences for the planned dinner. The residents unanimously agreed they wanted to go out for dinner. The group decided that all staff should also be invited to attend. Sharron and Joan volunteered to organise and distribute the invitations. The group discussed developing feedback forms to be provided to caregivers following their attendance at the dinner with room provided for non-specific personal feedback on the evening. The group discussed and agreed that the feedback forms they titled *My reflections on Dinner* would be provided to caregivers to complete after the event (Appendix 17).

To protect the privacy of the respondents, improve return rates and encourage authentic feedback the returned feedback forms did not require respondents to give any information that may be identifying. They debated how they would gauge the caregivers' thoughts about spending more time with the residents and if going out for dinner was an appropriate action. Sue-Ellen volunteered to organise the feedback forms and the group agreed the forms should be anonymous so that if they read them, they would not be able to identify the person. Reg volunteered to book the facility bus to transport the residents on the night. Remaining participants volunteered to assist residents to get ready for the night out and attend, assisting with resident safety and comfort. Penny offered;

‘They [residents] chose one of the most popular and most expensive restaurants in town, I couldn’t believe it’.
Figure 8.3 Example of one of the invitations for the night out

8.2 Action – Cycle One – Increase interaction opportunities between residents with minimal or no cognition impairment and caregivers

The group discussed how Sharron's enthusiasm and passion for her work inspired them. They agreed that she was a true person-centred care champion and stated that her star qualities should be acknowledged. They discussed how she literally devoted her life to Sandcastles and her passion came through in everything she did. They noted how she always had a vision for Sandcastles and this was evidenced in her reflective journal entry below which she shared with the group. They asked Sharron if she would be happy to be the person-centred care Champion for the study and she stated she was delighted to accept.
Reflective journal entry - Sharron

By shifting away from just the medical side, we make our residents feel valued. We enhance their lives with meaning, purpose, empowerment, and belief in themselves.

Sharron and Joan organised the invitations that were given to each of the nine residents. They also placed an invitation on the staff notice boards for all staff. Penny talked with the nine residents involved (the nine residents had either minimal or no cognitive impairment) about the idea for the evening. The group discussed how the residents would be transported to the restaurant in the facility bus. However, Reg reported back to them;

“This [transport] was discussed and agreed to by us, but oh my goodness. When I told the resident’s they would be going on the facility bus, they each stated they refused to go to the restaurant in the facility bus. Instead they said they would be taking a taxi both ways. I could not talk them around; they absolutely refused the bus. I can’t understand why’.

Reflection:

I think residents refused to take the facility bus to dinner for several reasons, including that:

- They did not want to be identified as living in an aged care facility
- They wanted the autonomy to travel in the mode of transport they chose
- They did not want to be told by management that they had to do something a certain way, rather, they wanted a choice

The group accepted the resident’s request for a taxi and Janice, the manager, stated she would provide the taxi fares for the night, and the residents stated they were delighted with her generous offer. Sue-Ellen printed feedback forms in readiness for the action research group. In the days leading up to the night out, residents had their hair done, and spent time choosing their outfits with assistance from staff. On the day, staff assisted the residents to get ready and they were all waiting early in the foyer for the taxis. Seven residents, nine group participants and one guest (family member of resident) attended the restaurant in October 2013. Residents were met with complimentary champagne on arrival and escorted to their seats. Guests were seated at two large round tables adjacent to each other, conducive for interaction. The restaurant offered a set menu with several choices at a discounted price and guests enjoyed a three course meal. Several participants took photos, and residents posed happily for the
photos. At the end of the evening a taxi was called to transport the residents back to Sandcastles and several of the group were there to assist them inside. The following day, Sue-Ellen placed the blank feedback forms on the staff noticeboard for those who attended the dinner, and they were asked to fill them out and return in the envelopes provided. All reflection feedback forms were received within days. Sharron sent photos to the local newspaper that were shown in the following week’s edition. Only group participants were provided with feedback forms because they had made the decision to take responsibility for their current practice and the need for change. Informal feedback was gained from residents to gauge the success of the evening. Review of the planning and actions of the group were;

- Invitations were organised and given to the residents.
- Invitations were placed on the staff noticeboards for all staff.
- The residents were spoken with about the idea for the evening.
- The action research group discussed the transport to and from the evening.
- Taxis were organised as per the request from residents and their cost discussed.
- Feedback forms were developed and printed.
- Residents were assisted to and from the taxis on the night of the dinner.

8.3 Observation - Cycle One – Increase interaction opportunities between residents with minimal or no cognition impairment and caregivers

The outcomes of the cycle are described including the analysis of the feedback data. As described in the methods in chapter four, my analysis of the process was reported to the group.

8.3.1 Data analysis

Seventeen people attended the evening event (seven residents, nine action research group participants, and one guest), 41% of attendance was residents, 53% were participants from the group, and the remainder was a guest. Due to caregivers only being provided reflection forms and asked to respond, the only way to gauge resident satisfaction was via any comments they made to participants on the night or the days following. 55% of participants provided feedback data to “My Reflections” (Appendix 17). I transcribed all the data collected from audio recordings of group meetings, reflective journals, and observational notes and reflections from dinner, to become familiar with them, list ideas and engage in reading. Interesting words or phrases were identified and categorised by; similarities, for example; “Plenty of laughter and
conversation on many topics”, and “The laughter, the stories and reminiscing was good”, and frequencies, for example; certain words were used frequently such as “talked” and “laughter”. Such words and phrases were considered significant because they link with the aims of the cycle.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents and staff enjoyed a social outing together</td>
<td>Both residents and staff conveyed their enjoyment of interacting socially together</td>
<td>Everybody had a great night.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It was nice to be able to spend some one on one time with the residents.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What a fantastic night with much laughter and conversation.</td>
</tr>
<tr>
<td>Staff felt they needed to do more for residents with minimal or no cognition issues and lower care needs</td>
<td>Staff stated that most of their time was spent with residents with higher essential care needs.</td>
<td>I feel so guilty when I pass them [residents without dementia] in the corridor because I just have not got the time to sit and talk to them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It’s terrible that we can’t spend time with those residents [without dementia], it makes me feel bad.</td>
</tr>
</tbody>
</table>

Figure 8.4 An example of the coding manual derived from direct quotes from data collection, not the full manual.

8.3.2 Thematic Map

Data that was relevant to each sub-theme and theme was re-examined, and then either kept or discarded. A thematic map was constructed in consultation with the group, the theme defined, then named, all the while checking and re-checking the data. When discussing the theme, I encouraged participants to remain reflective, responsive, and open-minded, as well as remaining focussed on the goal of the cycle; to explore ways to increase social interaction for residents not requiring high levels of essential care Codes were checked against the transcripts and the theme; “Create a safe space for residents
and staff to socially interact” was conceptualised. The theme encapsulated something important, meaningful and significant about the data in relation to person-centred care. The thematic map was a reflection of data from; the action research group, audio, reflective journals, observation, and memos.

![Thematic Map Diagram]

**Figure 8.5** A visual of the thematic map derived from group data, demonstrating how five codes (at the bottom), merged into two sub-themes, with the theme at the top.
8.3.3 Theme: Create a safe space for residents and staff to socially interact

The group reviewed the theme by reflecting on the codes and sub-themes supporting the theme. They agreed that each code and sub-theme represented what the data conveyed. They discussed that “creating an opportunity for the residents and staff to interact” was the overarching theme encapsulating the meaning in each of the codes and themes. The dinner facilitated social interaction between staff and residents without cognitive impairment. Residents spoke with participants who had been out to dinner and expressed to them how they enjoyed their time away from Sandcastles, as well as the social interaction with everyone including the restaurant staff. However, there were underlying issues expressed firmly by the residents, indicating issues surrounding self-stereotyping and/or stigmatisation at the thought of travelling in the identifiable facility bus, as well as wanting to attend a popular and expensive restaurant in town so that they could be seen to be just like all the other diners, to possibly disassociate themselves and assist destigmatisation. The group agreed that the residents needed a space, somewhere either in the facility or away from it, where they could go intermittently with staff to socially interact on equal terms without feeling stigmatised by others.

**Reflective journal entry - Reg**

*They were not the residents and we were not the staff, just a bunch of friends out for the evening.*

**Reflection**

I’m not sure if a night like this is sustainable. This is something for future discussion.

Below are two responses to feedback forms that capture the success of the event:

“I thought the night was a great success for both residents and staff. There was plenty of laughter and conversation on many topics. One of the residents told me the next morning that she woke up smiling and that it was a great night and she would love to do it again. My opinion is that the night went off very well and staff would really enjoy having a social outing again.”
"An amazing night was had by all, residents were excited in the days leading up to the night out, and staff also shared their keenness prior to the night. Good food, laughter, banter, camaraderie was shared by all. It was an excellent venue for residents. Residents were keen to reminisce after our evening and hinted they would really enjoy doing it again."

The group discussed how the residents expressed feeling empowered to make choices about the venue for the event and the mode of transport for getting to and from the event. The facility bus was rejected by the residents as it was identifiable as belonging to the aged care facility with “AGED PERSONS ON BOARD”, boldly displayed on the side of the bus. The group recognised that being stigmatised was a concern for residents that they had not been aware of. The manager (also part of the group) made the decision for the group to take the residents out for dinner, which they agreed was a good idea; however they stated it would have been better if the manager had included the group and the residents in the decision making. However, Penny undertook to speak with the residents involved and ask them if they would be happy to go out for dinner, to which they unanimously agreed.

The group discussed issues affecting future night time restaurant outings and they agreed there were several issues, including the major consideration of resident safety with minimal volunteers, the availability of caregivers and residents on an agreed night. They stated it was difficult for many caregivers as they were rostered on to work at Sandcastles either through the day or in the evening, therefore those shifts needed to be changed to accommodate that date, and many of the caregivers found it difficult to integrate a night out due to family commitments, also numerous caregivers lived on rural properties, and limited light at night made access in and out of their properties difficult and dangerous for night time driving. Caregivers added that it was difficult for them financially to add a restaurant meal into their budget when most of them earned a basic wage.

**Sub theme – Social outings facilitate social interaction for residents and staff**

The group recognised the importance of residents and staff being able to interact socially, which they saw as a way of facilitating person-centred care for those residents. This theme comprised three codes, being “residents and staff enjoyed spending time socially with each other” and “both residents and staff wanted to go out for dinner again” and "staff felt they needed to do more for residents without dementia".
**Sub theme – Residents wanting to interact**

The group noted that residents wanted to interact with their peers and the staff. This was especially true for those with minimal or little cognitive impairment. This theme comprised two codes, being “residents chose a popular and expensive restaurant” and “residents refused the facility bus, choosing to disassociate themselves”.

**8.4 Reflection – Cycle One – Increase interaction opportunities between residents with minimal or no cognition impairment and caregivers**

On reflection of the cycle, the group stated they felt that they had achieved the goal of spending more time with residents with minimal or no cognitive impairment, although acknowledged it was a one-off event. The group discussed sustainability issues, and were unsure if the dinner outings were practical on a semi-regular basis. The group agreed that the residents enjoyed the event so much that they would like to do something special like that again; however they acknowledged the time, financial, safety and accessibility issues. Retrospectively, the group had agreed that using the craft room at Sandcastles for the dinner would have been much easier to arrange taking and therefore events like that would be more sustainable. The group noted that, to date, there had not been another restaurant outing which was probably a consequence of the above issues. This presented a challenge to find other sustainable ways to satisfy resident desires whilst considering the identified issues.

**Reflection**

It is good to see the participants being aware of the need to individualise the care they provide. It was really pleasing to see their inclusion of residents in the decision making regarding event (barring the initial decision), and equally pleasing to see the way they critically reflected following the event and realised that person-centred care is not an event that occurs once and then ticked off. They also became aware of sustainability issues and realised there is much more to take into consideration that simply planning an event.

The group stated that they realised the importance of viewing residents holistically rather than with a task focus, for example, Reg stated he was happy to see one of the residents smiling the next day, and the resident stated that she was smiling because she
had had such a wonderful time and could not wait to do it again. Reg discussed the change he had noticed in his personal practice in the weeks following the dinner, stating that the night out changed everything between the residents and caregivers as he felt he had been able to get to know the residents just that little bit more as friends. Reg commented that when he passed one of the residents (who had attended the dinner) in the hall or in the dining room they smiled at each other and it was more than just a polite smile. They had shared a joke and personal conversation that night that made their relationship more personal. Other participants agreed with this and discussed how they were finding the same types of situations happening. The group agreed that the residents who had attended the dinner appeared happier within themselves.

8.5 Précis – Cycle One – Increase interaction opportunities between residents with minimal or no cognition impairment and caregivers

The outcomes achieved in this action cycle included increased awareness of; sustainability issues when organising outside events such as a dinner, reinforcing the challenges of translating person-centred care into practice. The group were also more aware that a one-time event was never going to be a solution to implementing person-centred care, and agreed there is no one way to implement person-centred care. It involves thinking outside the square to ensure residents still have their needs and desires met, within organisational constraints, availability of volunteers, and safety considerations, which was how the group rationalised using an internal venue for future dinners with residents desire to go out of the facility to dine. This presents a solid argument for the necessity of a staff and resident evaluation process regarding improved quality care.

There was a reported increase in awareness of the importance of an holistic approach to care demonstrated by the group, and the inclusion of people in the decision making process who are most affected by it. The group stated they had an increased understanding of the translation of person-centred care into practice following the special dinner. The group reviewed the achievements resulting from cycle one;

- The group were critically reflective of their personal practice as they recognised that they struggled to find time to interact socially with residents who did not have high essential care needs. They were willing to take responsibility and make changes which was organising and taking those identified residents out to dinner as a way of increasing social interaction between the residents and themselves.
- Increased teamwork evidenced by organising the special dinner
• Increased awareness of the complexities of person-centred care in practice
• The group involved the residents in the change, who were the people most affected by it, by involving them in the decision-making for the dinner.
• The group were able to recognise that having a one-night event was no one way to implement person-centred care
• The group stated they increased awareness of the importance of holistic care
• The group stated they were more aware of the importance of autonomy and empowerment for residents, as was demonstrated by the reaction from the residents to travelling in the facility bus to the restaurant

The group discussed the challenges they faced and what could have been done differently in the future;

• They agreed there were sustainability issues with this one-time event and decided that in the future, it may work better, and have more chance of continuing if they were to have the special dinners on-site rather than going outside the facility, though noted the resident’s desire to dine outside the facility and the need to discuss this with them.

Reflection:

It would be interesting to consult with residents and find out from them whether or not a special dinner on site would have the same impact for them as going out to a restaurant. I doubt it, as I believe that part of their delight was that they were able to dress up and go out to dinner somewhere nice, just like other people in the community.

Following completion of the first cycle, the group discussed the second cycle they had prioritised in chapter four and how it linked to cycle one. They agreed that cycle one focused on the group spending more time with the residents who had minimal or no cognition issues. It was about the group applying a person-centred approach to care for those residents. After agreeing that they were aware of the need for a more person-centred approach to care, group discussion then turned to the need for new staff to also receive training so that they might begin to understand the complexities of person-centred care and the importance of translating that knowledge into practice, which was the impetus for cycle two.
Cycle Two – Person-Centred Care training for new staff

Cycle one for the Sandcastles group had 11 residents volunteer for the study. That number continued in the second cycle; however the numbers of staff involved fluctuated due to changing rosters, personal commitments and work commitments on the day. The group meetings continued to be held in the staff room and several were also held outside in the garden on a picnic table due to building works being undertaken beside the staff room.

8.6 Planning – Cycle Two – Person-centred care training for new staff

The group decided to continue with the data collection tools from cycle one; the group, reflective journals, and observation. Three new staff were identified by the group as appropriate to trial person-centred care training; two Clinical Registered Nurses and one caregiver (new to the industry). Sharron discussed with the other participants how they could facilitate the training;

‘There are several ways we can approach this. I think we should get each of them (new staff) to write their personal understanding of person-centred care and include an example of something they have either witnessed or implemented themselves that they perceive as person-centred care’.

The group, including Janice, agreed to Sharron’s suggestions. Sharron added;

‘What if we get the three new employees to provide their understanding of person-centred care first, then have a person-centred care presentation, and a month later, if we get the three new employees to provide an example or examples of how they applied a person-centred approach to care in the previous month, and ask them if the education assisted in their understanding of person-centred care’.

Reflection

Sharron is very focussed and passionate about her work. She displays leadership qualities and the group is looking to her for direction. As such, she has the potential to drive this cycle.
The group again agreed with Sharron’s suggestions and they then discussed volunteering for jobs. Adira stated;

“We will need someone to speak to the three new staff and ask if they would be willing to participate in the training and explain it to them, we will need volunteers to develop the person-centred care presentation, volunteers to present the person-centred care training session, then we need a volunteer to collect the responses from the new employees a month later.”

Sharron and Channel volunteered to develop the person-centred care presentation and accepted Janice’s offer of presenting it at the next caregiver meeting. Joan volunteered to speak with the new employees and she gained their agreement to participate, including conveying their understanding of person-centred care, to participate in the person-centred care presentation, and to provide examples of how they implemented person-centred care in the previous month. Sue-Ellen volunteered to collect the responses from the new employees.

8.7 Action – Cycle Two – Person-centred care training for new staff

Reflection

Group attendance was spasmodic at this time as there was upheaval within Sandcastles; several of the staff were retiring and Janice announced that she was leaving, relocating within the organisation. The staff had not long said goodbye to their previous manager of 20 years, and now were facing a new manager within weeks. I think this left the group feeling very unsettled.

Sharron and Channel developed the presentation and prepared to present it as a PowerPoint presentation. Janice advertised the person-centred care presentation with notification for the next caregiver meeting. Joan received the emails from the new caregivers conveying their understanding of person-centred care. Unfortunately, the day of the staff meeting, the group found out that the two new registered nurses had both left due to personal commitments. Reg explained the impact that this would have on the cycle;
‘This is very disappointing. We did not see this coming. It has really affected the cycle as we only have one new person left, which is going to make it hard to get a good result’.

The group acknowledged there was only one new caregiver left and she was new to residential aged care. Adding to this, Stewart and Penny were away the day of the meeting and presentation. Janice decided to deliver the training session herself as none of the other participants from the group were very keen. The new caregiver was present for the presentation. Following the staff meeting, the presentation went for half an hour and all caregivers who attended were provided a copy of the presentation to reiterate their understanding of person-centred care. Joan received the email from Gina a month later with four examples of how she had applied person-centred care in her work. Joan then organised to meet with Gina and discuss the outcome. Gina stated to Joan that she had definitely learnt a lot from the presentation and she stated that she had also re-read the presentation notes at home.

Joan offered;

‘She [new staff member] seems a natural. She gave really good examples and seemed to understand what we were trying to achieve. I noticed she put the residents first in all her examples’.

Below is a summary of the planning and actions the group:

- A person-centred care presentation was developed and advertised among relevant staff.
- The action research group discussed the impact of recent staff departures on their cycle.
- The new caregiver was asked for their understanding of person-centred care and follow-up was conducted seeking examples of how they had implemented it. A follow up meeting was also arranged.
8.8 Observation – Cycle Two – Person-centred care training for new staff

The findings of the cycle are documented below including the theme from the data collected in the cycle.

8.8.1 Data Analysis

The data collected from the previous and new members of the group via questionnaires was analysed using thematic analysis and following the step by step approach proposed by Braun and Clarke (2006). The patterns were chosen in collaboration with the group and were categorised by; similarities, for example, “treating residents as they wish to be treated”, and “the care required for one person is different to that of another”. The similarity here is treating residents as individuals. Frequencies were also used, for example, certain words were used frequently such as “care” and “person”. Similarities and frequencies were used to categorise the data because they allowed for a quick comparison of the words used.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description of Code</th>
<th>Example</th>
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| Building rapport with residents | Staff engaging in activities with residents to build rapport, including education for new staff and on the job learning | He [resident] gave me a list of about 5 aircraft names and asked if I could research them for him  
I am now researching cars for him [resident] that he has owned throughout his life  
He [resident] wanted to play a game of golf as he said he was feeling better |
| Informing new employees about person-centred care | Existing employees discovering ways to inform new employees about person-centred care | I don’t know that new caregivers realise that person-centred care is that each resident is treated individually to have their needs met rather than there being one set of rules  
Do new caregivers understand that [person-centred care] is individual care? |

Figure 8.6 An example of part of the coding manual derived from direct quotes from data collection
8.8.2 Thematic Map

Codes were checked against the transcripts and the theme; “Promote a culture that enables person-centred care” was conceptualised. The theme encapsulated something important, meaningful and significant about the data in relation to person-centred care. The thematic map was a reflection of the data collection.

![Thematic Map Diagram]

Figure 8.7 A visual of the thematic map derived from group data demonstrating how four codes (at the bottom), merged into two sub-themes, with the theme at the top.
**Theme-Promote a Culture that enables person-centred care**

The group identified the theme; “Promote a Culture that enables person-centred care”. This theme was conceptualised from the data and code development. The theme encapsulated the two sub-themes; “Placing the Residents' Needs and Preferences First”, and “Facilitate Person-Centred Care Awareness for New Staff”. With constant checking and re-checking of the codes and data, the group agreed that promotion of a culture amongst the staff including new staff, that enables person-centred care, was the appropriate theme to convey everything that came from the data. As existing employees were informing new employees about a philosophy that was new to them, the group agreed it was the manager’s responsibility to promote a culture of enablement amongst residents, rather than the antiquated paternalistic approach focussing on weaknesses and inabilities, and residents being compliant recipients of the care they receive.

**Reflection**

It is pleasing to see that the group recognised the importance of not forcing a paternalistic approach onto residents. If other groups had taken this approach their cycles may have been more successful.

**Sub Theme - Placing residents and their needs and preferences first**

The sub-theme: Placing residents and their needs and preferences first was conceptualised from the codes; “building rapport with residents”, and “staff facilitating resident interests”. The group discussed that the sub-theme was reflective of a person-centred approach to care, and this was highlighted by the responses that came from new employees, for example one of the new employees stated that she had assisted a resident to maintain their autonomy when helping them in their activity of daily living. They agreed that it was important for all staff, new and existing, to realise the impact on residents when someone acknowledges their lives and their interests and preferences. For example, Reg was able to facilitate the resident's interests in machines by providing him with information about cars and planes that he was familiar with. He had taken the time to listen to that resident and find out about his interests. Not only did Reg take the initiative to listen, but he also acted on that and was able to provide the resident with a way of maintaining his interests. Another response stated the resident had wanted to play golf and the staff facilitated this for him. Not only do those examples demonstrate the facilitation of resident’s interests, they also build rapport with them as the staff get to know them as they facilitate their interests.
Sub Theme - Facilitate person-centred care awareness for new staff

The sub-theme; Facilitate person-centred care awareness for new staff was conceptualised from the codes; “Existing employees discovering ways to inform new employees about person-centred care”, and “Informing new employees about person-centred care.” The group discussed the sub-theme arising from the codes and agreed that the codes were directly reflective of the sub-theme. As part of the action for the cycle, new employees were required to not only define person-centred care in their words, but also to provide examples of how they implemented it over a month. The new employee who was also new to the industry was a good example of someone trying to understand the person-centred care philosophy and also implement it. The group agreed that Sandcastles was possibly typical of many organisations that did not provide new employees with targeted person-centred care training, and new employees were expected to “stumble” along and learn on the job and from other staff. The group discussed and agreed that management needed to facilitate person-centred care awareness from the outset of employment so that new employees could then demonstrate their awareness and understanding of the philosophy in the care they provided.

Reflection

It is good that the group realise the important role management play in the facilitation of person-centred care. New employees cannot just be expected to “pick up and run” with the philosophy when they don't necessarily understand what it is. Managers can facilitate this through leading by example, working collaboratively and including caregiver’s decision making regarding changes.

Caregivers also have to take responsibility for this as well, to be active learners and to apply their knowledge.

The group included Wordle software to ensure nothing significant had been overlooked. The Wordle below (Figure 8.8) was constructed from the data collected from the group and new employees via the questionnaires was used as an adjunct tool to validate the findings. It provided rapid output and used a visually rich and quick way to visualise general patterns from the data.
Due to two of the new staff leaving prior to the cycle being completed, the effects of the action were disappointing, as the second part of the cycle was then limited to one response, that of Gina, the new caregiver. The intended effect was an increased awareness of person-centred care by the new caregiver. An added benefit was development of the presentation and the potential to use it again for other new caregivers as well as existing caregivers. Moreover, the new caregiver, Gina appreciated the presentation stating;

“I really enjoyed the presentation; it was interesting and made a lot of sense of to me. I am sure it will help me in my learning. I heard the other caregivers saying how much they enjoyed it as well as that they got a lot out of it” (Gina).

The group agreed that Gina demonstrated a good understanding of the philosophy and noted that making residents happy, then in turn makes her happy. The group agreed it was good to see how Gina demonstrated her understanding and awareness of person-centred care. Gina demonstrated that she was accepting and considerate of residents and their wishes whilst encouraging autonomy and empowerment.

The group discussed their disappointment at two new staff leaving prior to the cycle finishing, both having left not long after they emailed their responses to the first part of the action. This restricted the outcome of the cycle as the second half was based on Gina’s response. The course of action also changed due to there being just one new
employee remaining, therefore, the group agreed the training session should be presented to all staff at the next staff meeting.

8.9 Reflection – Cycle Two – Person-centred care training for new staff

The reflections on observations are documented below. Points that were made in the observation section are revisited to investigate the deeper meaning. These reflections take into consideration the decisions that were made during the cycle, the outcomes achieved, any problems encountered, and the implications for the study. The group discussed that retrospectively, the decision to provide person-centred care training for new staff was a good one; however the decision to continue with any training was not made at the time, and the group thought that could be due to the upheaval; change of management, loss of new caregivers, and Christmas preparations pending. Hence, no further training occurred, and when I returned to review, still none had been planned.

The problems encountered in the cycle were the loss of two new caregivers before the cycle finished. This caused a problem for participants in organising the remainder of the cycle as they only had one new caregiver left to work with, making the outcome less effective as there was limited input. The group agreed it was definitely worthwhile incorporating person-centred care training into the routine; however they discussed that continued training would need a concerted effort and support from management to ensure its continuation. There were change management issues arising from this cycle that needed addressing, such as sustainability and caregiver succession planning. Fortunately, Gina remained working at Sandcastles and to date appreciated the training she received and added that she felt more confident in her role as she not only knew what person-centred care was but stated that she felt she was also able to implement it in her daily work.

Participants revisited the original group definition of person-centred care which was discussed at the beginning of the first cycle; “accept the resident, who they are and their beliefs. Maintain respect of individuality, choices and care. We become the residents’ advocate. The resident becomes the centre of our care”. Participants agreed that they needed to adjust the definition to include families as they had omitted this important factor when they devised the definition. They agreed it was important to take responsibility for implementing person-centred care, and that it was interesting to compare their group definition of person-centred care with the three provided by new caregivers. The group discussed that one of the definitions highlighted the importance of holistic care of older people and reiterated the importance of including family. This
differed from their definition as it included family. It was interesting to note the importance this person placed on family pertaining to person-centred care and she included an example to reiterate that. The group compared another definition; they agreed the new caregiver from a different industry appeared to have a good understanding of person-centred care. The caregiver, in her definition, focused on the individual and the importance of meeting their needs in her definition, and stated that person-centred care makes her happy as well, suggesting that the implementation of person-centred care is aligned with staff satisfaction.

There were several positive outcomes from this cycle. The first one was the development and delivery of the person-centred care training session for all caregivers including the new caregiver. This effectively served as a pilot of a professional development initiative that could be adopted as part of the orientation process for all new staff.

The second positive outcome for the cycle was that the group had come through the cycle a more cohesive and empowered group demonstrated by their attendance at the group meetings even when the upheaval began and other staff were complaining about the upheaval and many caregivers took leave. There were never any less than five of the action research group present, and they continued with their preparations for the training right up until the day of the training despite ongoing interruptions. The action research group critically reflected on current practice, decided what they wanted change and set about making changes.

8.10 Précis – Cycle Two – Person-centred care training for new staff

Both of the cycles were completed for the group. Sharron, the person-centred care champion continued to be a source of inspiration to the group and she was relentless in her cause which was to make all the residents feel included, happy, safe, and comfortable.

The goals of the cycle one highlighted what participants believed impacted on the implementation of person-centered care at Sandcastles: (1) Increased social interaction with residents not requiring high levels of essential care. The group believed that facilitating a special event, namely taking residents to a restaurant for an evening meal would provide a time and space for social interaction between staff and residents. The group felt that this initiative would empower residents and promote their sense of
autonomy. The group agreed that the measure of success for this initiative was when they reported the residents expressed how much they valued the opportunity to go out to dinner; the group reported that the residents seemed to be happier and more willing to engage in conversation following the dinner. Moreover, they rationalized that staff would have heightened awareness of the importance of social interaction for the residents. Although the dinner was a one-off change to routine, it was something that the residents with minimal or no cognition issues looked forward to. The residents expressed their assertiveness in choosing the venue, mode of transport, meal and an alcoholic beverage with their meal, which allowed these residents to still feel in control of certain aspects of their lives even though they resided in a residential aged care facility. The group agreed that events such as this were something they would need to discuss further to ensure sustainability.

Management at Sandcastles stated it was presented as a home offering quality care and full support for frail aged residents, and claimed it offered a homely environment. What had become evident in this cycle was that caregivers had become task focused on residents with high needs at the expense of residents with minimal or no cognition issues, rather than caring for all residents equally. The environment was not providing equally for all the residents in what purported to be a home.

The actions of the first cycle refocussed the group’s perceptions of how they work and the implications for enacting person-centred care. The group recounted that by taking the residents out for dinner and asking them which restaurant they wanted to dine at. This facilitated a move from being task focussed in their daily practice to understanding and actioning a more holistic approach to caring for all residents. The group recognised that this move away from the task to the person not only looked at individualised needs but also recognised that their practice not only focused on physical care but started to move toward a focus more on the overall needs of the residents which, they stated, is more of what nursing is supposed to embrace. It was evident that there had been a fundamental shift in terms of the group understanding that they needed to look at the whole person, their wants, needs and desires.

Leadership and culture change had to be linked for the interventions identified by staff to enhance person centred care to be effective. The manager at the time was supportive of the idea of having a special dinner for residents with minimal or no cognitive impairment. The manager also supported staff empowerment by allowing participants to make decisions regarding the problems they wanted to address in the cycle and provided support by way of transport fares paid for by the organisation for the evening. There was evidence of culture change after this cycle was completed; the group
acknowledged the need to change how they perceived the care they provided, they became more aware of the importance of a person-centred environment supportive of the residents’ activities of daily living, their dignity, rights and freedom by spending time with these older residents in a social atmosphere away from the facility, and new behaviours were validated as evidenced when Reg commented on the smile between himself and the residents.

Cycle two although completed, had a major setback with two of the three new employees leaving. The results of this cycle support the view that person-centred care training can have positive benefits for new staff; however it needs to be ongoing to have broader benefits. The managers involved in the team recognised the need to train new staff in person-centred care.

The results supported the view that although only one new staff member completed the person-centred care training, the outcome was positive with Gina achieving what the participants had aimed for from the outset of the cycle. When Gina delivered her four examples of person-centred care, it was apparent that she a reasonable understanding of person-centred care in her responses. Gina had an increased awareness of individualising and tailoring care; she clearly demonstrated the inclusion of family and even demonstrated an understanding of person-centred care in dementia.

<table>
<thead>
<tr>
<th>CYCLE 1 - Spending more time with residents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Create a safe space for residents and staff to socially interact</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
</tr>
<tr>
<td>(1) Staff felt they had minimal time for social interaction with residents not requiring high levels of essential care.</td>
</tr>
<tr>
<td>(2) Staff felt they neglected residents with mild or no cognition issues.</td>
</tr>
<tr>
<td><strong>Actions</strong></td>
</tr>
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<table>
<thead>
<tr>
<th>CYCLE 2 - Person-Centred Care (person-centred care) training for new staff</th>
</tr>
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<tbody>
<tr>
<td><strong>Theme:</strong> Promote a culture that enables person-centred care</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
</tr>
</tbody>
</table>
| **Actions** | Target new staff to convey their understanding of person-centred care.  
Organise a training session aimed at person-centred care aimed at new staff.  
Ask new staff to provide examples of how they implemented person-centred care in the previous month. |

Figure 8.9 Summary of activities undertaken in cycles one and two for Sandcastles, as well as the themes arising from the cycles
CHAPTER 9: DISCUSSION AND RECOMMENDATIONS

The aim of this study was to support managers and caregivers at three rurally located residential aged care services to implement and sustain a person-centred care approach. This action research study highlighted the interpretation of the person-centred care philosophy and its practical application at the three facilities. The contribution this study makes is discussed and the limitations are described. Finally, the strategies that supported the implementation of person-centred care by the action groups are presented, as are the recommendations arising from this study.

9.1 Background

Person-centred care is a social model of care (Desrosiers et al., 2014) with a focus on considering the person’s social situation as well as their medical and psychological needs (Hardy, 2015). It has a long association with nursing, and is often seen as being synonymous with ageing and aged care services (Caspar et al., 2009). Under a person-centred care model, residents are acknowledged and recognised as individuals in their own right and are placed at the centre of decision making about their personal health (Hardy, 2015). A person-centred care approach fosters continuous practice development and empowerment (Phelan & McCormack, 2016) as well as a deep respect for people (Martin & Félix-Bortolotti, 2014).

The facilities are located in a rural New South Wales coastal town and many of the residents came from surrounding farms and small rural towns and villages. The rural location added its own challenges, including the typical lower staffing levels of rural residential aged care facilities, along with fewer beds and being less likely to offer specialty services (Bowblis et al., 2013). Furthermore, most caregivers resided significant distances from their work place that limited their availability to attend out-of-work hour’s education, training and other events hosted by the workplace. For residents, the implications of the rural location included: differing levels of family involvement due to the remoteness of their homes and/or the demands of their farming life. For these people, weekly trips to town were the only opportunity to visit their loved one/s living in a residential aged care facility. The loneliness and stress experienced by residents who had left their small, familiar rural community and moved to a larger, busier location impacted on their health and wellbeing and ability to adjust to residential aged care living.
There is a dearth of literature on rurality and residential aged care generally and specifically addressing the challenges confronting older rural people faced with entering aged care.

9.2 Methodology

The methodology adopted was action research, a social research process leading to change through collaboration and transformative actions. Action research has a strong emphasis on democratic participation and achieving social change (Gregory et al. (2011)). It is a collaborative group process effecting change to achieve agreed goals (Moch et al., 2016). The setting of the study was three rural residential aged care facilities in NSW that catered for frail older people, couples, and people with varying degrees of cognitive impairment.

O’Leary (2010), contends that key elements of action research include addressing real-world problems, pursuing action, knowledge and participation. He further argues that Action research is frequently used in workplaces in rural communities and is an effective strategy when there is a strong desire to transform both practice and theory (O’Leary, 2010). Action research was the appropriate research approach for this study that aimed to support managers and caregivers at three rurally located residential aged care services to implement and sustain a person-centred care approach. The research questions were:

1. What is the understanding of managers and caregivers of a person-centred care approach?
2. What support is required to implement a person-centred care approach?
3. What assistance is necessary to sustain a person-centred care approach?

9.3 Research outcomes

The legacy I have left as the researcher and facilitator of the three action research groups is two-fold; an informed and empowered group of caregivers, who have the skill set to think, act and reflect in a person-centred way; and residents and families who feel more settled as the care being provided is more person-centred.
This study has provided a process for caregivers and associated staff within three residential aged care facilities to consider their practice within a whole of facility workplace model. Participation has enabled them to collectively align a person-centred care approach to service delivery that is reflective of the principles that underpin this model of care.

Caregiver’s awareness of what is person-centred care and how it can be embedded in practice was one of the significant outcomes of this study. It was through a grassroots-led change process and solid team work that the caregivers (assistants in nursing, those who also undertake kitchen, cleaning duties, and minor administrative roles) Managers, and Clinical Registered Nurses, at the three facilities developed their skills and competency in person-centred care. With the commitment and support of management they trialled innovative changes that reflected the philosophy of person centred care. Participants involved in the study reflected on their practice individually and as groups throughout the trajectory of the study. They acquired skills that enabled them to identify issues, work as teams to achieve collaborative goals, seek and interpret information and strategize. A response to the research questions follows.

1. **What is the understanding of managers and caregivers of a person-centred care approach?**

At the commencement of this study, the managers and caregivers showed a well-meaning yet somewhat limited understanding of person-centred care. The definitions developed by each of the three groups did highlight the need to place the resident at the centre of the care provided, as well as the importance of understanding the individual needs of residents. However, none of the groups acknowledged the need for continuous practice development and empowerment and none explicitly highlighted the need to focus on understanding the person’s social situation and their medical and psychological needs. The groups struggled to translate their understanding of person-centred care into practice when undertaking their cycles, with the lack of consultation with residents and the lack of understanding of their individual needs being clear oversights.

The Lighthouse group, despite being the only group to explicitly acknowledge the choices of residents in its definition, failed to consult with residents regarding the problems that they believed existed in the dining room. They consequently implemented several changes en masse, which the residents clearly saw as not only unnecessary, but also confusing for some and frustrating for others. This action showed
limited regard for the medical and psychological needs of the residents, for example, the need to eat at a certain time due to either timing of medications or because of psychologically based routine rituals. Conversely, the changes they implemented to the Welcome Pack showed a desire to focus on the residents' individuality by focussing on their life history.

The Seaview group learned early on in their cycle that it is important to not assume what it is that residents and their families want or need. In making the assumption that families needed to be educated on person-centred care, they very quickly discovered that it was they who needed the educating, with the feedback received indicating that caregivers were not listening to residents enough. The group had neglected to place the resident at the centre of the care they provided and had clearly not enabled residents to voice their opinions. In revising their actions and deciding that it was the managers and caregivers who needed to be educated, the group stumbled upon the need for person-centred care to incorporate continuous practice development and empowerment.

The Sandcastles group undertook consultation with residents, albeit after the group had already made the decision to take the residents out to dinner. When the residents voiced their refusal to travel on the well-labelled aged person’s bus, the group realised its mistake and revised their plans to implement taxi travel to and from the dinner. As a result of their consultation, a successful off-site special dinner was held. The group also recognised the need for person-centred care to include training and undertook to benchmark caregiver understanding to be able to then compare their level of understanding after having completed training, in order to determine if the training had achieved the desired outcome, which it had.

At the conclusion of the action research cycles for all three groups, the understanding of managers and caregivers of a person-centred care approach had grown to a large extent, sometimes through training and sometimes through learning how not to implement person-centred care. Through their omission to adequately consult with residents, the managers and caregivers learned the importance of consulting at the initial point of problem identification and well before implementing any changes, and indeed, in one instance, consulting when it is thought that all is going well and there are no problems at all. They also realised the importance of continuous practice development through ongoing training for all staff.
2. What support is required to implement a person-centred care approach?

The findings of the study highlight the fact that much support is needed for the implementation of a person-centred care approach, with the majority of the support required by caregivers, from managers. The Sandcastles group found that caregivers needed not only adequate training in person-centred care, but also time to implement a person-centred care approach, recognising that they felt they were neglecting those residents who did not require high levels of essential care. It is essential for caregivers to be attentive to residents’ individual needs, as well as to respect them for their individuality.

Again, continual consultation with, and feedback from, residents is necessary. Each facility could consider having a person-centred care champion who viewed the policies, work and actions of the facility through a person-centred care lens as they went about their daily work. Such a person would be able to highlight such things as facility signage which stigmatises the residents.

3. What assistance is necessary to sustain a person-centred care approach?

In order to sustain a person-centred care approach, ultimately what is needed is a person-centred care culture. This would enable such activities as ongoing training of all existing staff (such as refresher training) as well as initial training in person-centred care for all new staff to enable them to understand the approach and their employer’s expectations of them in this regard. It is important that any practice development include information about the inherent power imbalance that exists in a carer/caree relationship, as well as the importance of understanding that the care facility is the home of the residents, with most having limited choice of moving elsewhere if they are unhappy with the level of care being provided. It is important that residents truly feel at home where they are living, always having the opportunity to voice their thoughts and opinions and always being listened to. Residents should always have input into the possible solution for any issue which they identify, and this should be at the very commencement of the discussion, not at the tail end of it.

A person-centred care culture would also see sustainable person-centred care practices and innovations put into place, such as off-site activities for residents. The practices would include continuous improvement and would ensure that both residents and
caregivers are included in the decision-making process so that they feel they have ownership of changes.

### 9.3.1 Limitations

There were several limitations to the study. Firstly, it was undertaken in three residential aged care facilities which form part of one organisation, in New South Wales, making it a microcosm of residential aged care. Although findings provide insight for further research and development, the outcomes may need to be contextualised for other facilities. The second limitation related to the Sandcastles site. This facility had a change of management mid-way through the study, that impacted on the support provided to participants the changes introduced by the action research group. The third limitation was the timeline. The facilitator had limited time to invest with the action research groups, possibly impacting the overall outcomes of each group.

### 9.4 Recommendations

The recommendations arising from this study have been drawn from themes that emerged throughout each of the action cycles at each residential aged care facility. The recommendations have been grouped and are reported under the subheadings policy, practice or education. Each of the subheadings is inclusive of a brief discussion of relevant literature that was used to inform the crafting of each recommendation.

#### 9.4.1 Policy

*Enabling person-centred care*

The theme “Promote a culture that enables person-centred care” incorporated placing the residents, their needs and preferences first, and facilitating person-centred care awareness for new caregivers. By promoting a culture that enables person-centred care, caregivers are encouraged to feel challenged, be creative, to think differently, and to embrace different ideas and innovations (Manley et al., 2014). Organisational culture can be defined as the combination of values emphasised by an organisation. Performance is higher when organisations pursue value and suitability, and an organisation’s performance and results can differ depending on the organisational culture (Cho, Kim, Park, & Cho, 2013). Effective leadership and team stability are the two most important factors in determining culture change (Beckett et al., 2013). Ross et al. (2015) proffered that managers need to consider the necessity to strive for high
quality person-centred care by developing and promoting an organisational culture where caregivers are enabled and encouraged to see the individual needs of the person in their care as paramount through the use of education and practice development. Transforming culture is challenging and requires sustained effort and commitment from leaders at all levels of the organisation, as change, in itself, can be threatening, and may bring with it considerable uncertainty (Beckett et al., 2013). McCormack et al. (2011) described how the impact of the physical environment on culture and resident/patient outcomes has also been identified as an important factor in the development of person-centred care. McCormack et al. (2011)

Findings from the study indicated that promotion and development of a person-centred care culture is important for new staff. It is at the level of workplace culture that caregivers, residents, and service users interface. This is where relationships are built that enable person-centred care to be lived and experienced and also at the level where social norms have the greatest impact on the experiences of both caregivers and residents. In chapter 2.7.1 Muls et al. (2015) asserts that managers need to ensure that staff are part of the vision of an organisation and understand the need for organisational change, otherwise staff will believe that current practices are acceptable and change is not needed (Muls et al., 2015). This again reiterated the importance of strong guidance and leadership from managers to ensure the promotion of person-centred cultures.

Majerovitz, Mollott, and Rudder (2009) describe important components of good communication within a health care setting and stress the importance of attention to psychological and social needs along with medical consideration. A fundamental aspect of good communication is the importance of ‘mutuality’. If caregivers feel pressure to complete care tasks quickly, they are likely to use communication strategies that end conversations quickly and signal to residents and family that they do not wish to spend time with them or share information. The Seaview action research group took with them into cycle two a heightened awareness of the need to look within themselves, to reflect and consider the important aspect of communication and listening to residents and their families. This cycle was one that definitely changes a culture, demonstrating how it can be a difficult lesson to learn for caregivers when they perceive they are applying person-centred care, and they possibly are to an extent; however when reflective discussion is applied, they learn more about themselves and how they can change their practice to align further with person-centred care.

Through action research and practice development strategies, managers and caregivers can be encouraged to achieve culture change leading to the furtherance of person-centred care understanding and implementation; however managers need to be
equipped with the knowledge and skills to be able to achieve it, and this points to the need for organisations to provide necessary resources for managers and caregivers to use a reflective approach to personal practice within a group environment, so they develop an awareness of what they are doing and are able to take responsibility and ownership of their actions. With the complex nature of person-centred care, being able to articulate an understanding of what it is may be different to actions not consistent with person-centred care. O'Leary (2010) proffered that action research can produce knowledge and change in empowering ways, although the process itself is far from easy. The participatory, cyclical, and multi-goaled nature of action research can render it a difficult process to manage.

**Recommendation:**
Managers of aged care facilities need to enact facility policies which create a culture that enables person-centred care by setting up the expectation of, and allowing caregivers the time to, place residents at the centre of everything they do, consult with residents, provide options and choices to residents and actively listen to residents.

**Recommendation:**
Families should be empowered, through facility policy, to be involved in assisting their resident family members to transition into residential aged care, and this should be reviewed regularly by managers as an agenda item in staff meetings.

**Social interaction**

The theme “Create a safe place for residents and caregivers to socially interact” highlighted the significance of interaction between caregivers and residents, as well as residents being able to find a safe place to go where they did not feel stigmatised. The response from the residents regarding the facility bus, when planning an evening out at a local restaurant highlighted how the residents themselves felt about travelling in a clearly identified “aged persons” vehicle. It is important to clarify the difference between stigma and negative self-stereotyping. The residents wanted to dissociate themselves from being a resident in a residential aged care facility the night of the special dinner at a restaurant. Stigma is a mark of discredit that sets a person apart from others. Officer et al. (2016) proffered that negative attitudes and stereotypes about older adults being frail, out of touch, burdensome or dependent are pervasive in society, and unlike other forms of discrimination, including racism, ageism is socially acceptable, strongly institutionalised, as well as largely unchallenged. Moreover, older people are viewed as boring, weak, irritable, grumpy, debilitated, mournful, cognitively impaired,
and these negative stereotypes can actually be endorsed by older people themselves. This is called, negative self-stereotyping (Coudin & Alexopoulos, 2010). The findings from the study suggested that the residents were self-stereotyping as they wanted to disassociate themselves from the identifiable bus, instead choosing to travel by taxi, and also chose to dine at one of the most expensive restaurants in town.

Ageism is defined as actions and attitudes that are directed toward older people by younger people who hold stereotypes about ageing (Doyle, 2014). To be marked or labelled as old, or mentally ill, for example, carries both internal (secrecy, lower self-esteem and shame) and external (social exclusion, prejudice and discrimination) consequences for that person. These consequences are collectively understood as ‘stigma’. There is evidence that suggests negative stereotypes such as these perpetuate myths that influence public perceptions as well as practitioners. Negative stereotypes and attitudes such as these result in discrimination that can affect all aspects of daily living, including relationships. These experiences can have an enormous effect on how people come to view themselves and their capabilities (Koubel & Bungay, 2009).

Labelling provides a potential explanation as to why certain caregivers did not speak to residents unless asked a question. Person-centred care has always been defined as ‘valuing people as individuals’ (Brownie & Horstmanshof, 2012). It was discussed and agreed by participants that the introduction of the personalised placemats on the dining tables could assist in the valuing of residents as individuals and not just residents.

Residents with mild or no cognitive impairment demonstrated how they felt stigmatised because of their association with residential aged care and dementia. The residents wanted to be part of society and to be seen as a group of friends going out for dinner. They were, in effect, stigmatising themselves by refusing to be associated with the facility on the evening of the dinner by not wishing to take the facility bus to dinner. The residents emphatically stated that they would not go to the restaurant in the facility bus but rather, in a taxi, which indicated that the residents themselves were not only wishing to disassociate themselves from the facility for the evening but in essence were self-stereotyping. Negative stereotypes can be endorsed by the elderly themselves through negative self-stereotyping.

Life in residential aged care facilities often lacks appropriate stimulation, including people with minimal or no cognitive impairment (Kolanowski et al, 2011). Thomas et al. (2013) stated that social interaction and participation in leisure activities are in fact, positively related to the health and well-being of older people. Challenges to social interaction for older people include; poor health, limited contact with or no family, Lack of social interaction with caregivers, the facility they reside in, transport availability and
Researchers have consistently identified a relationship between social interaction and participation in leisure activities and the definitive health and wellbeing of older people (Thomas et al., 2013). Conversely, Thomas et al. (2013) stated that review evidence has suggested that social isolation is directly associated with an increased risk of all-cause mortality, re-hospitalisation, cardiac heart disease, cancer, poor nutrition, negative health behaviours, as well as the common cold.

Drageset et al (2013) proffered that depression and emotional loneliness have been strongly associated with nursing home residents without cognitive impairment. Loneliness is a subjective experience that occurs when a person feels they have limited or no satisfying relationships with other people (REFS). People who are lonely often don't feel they belong (REFS). Loneliness is a subjective experience resulting from inadequate social relationships. Findings from the study indicated overwhelming support for encouraging and providing opportunities for social interaction between residents, staff and their families and the wider community.

**Recommendation:**
It is important for aged care managers and leaders to be aware of how they may be inadvertently stigmatising the residents of their facilities and to realise the large negative impact that this may have on an older person. For example, an older person may never go shopping if their only means of transport is the well-labelled facility bus stating older persons are on board. It is recommended that managers implement a facility policy that ensures the eradication of stigmatising signage and labelling in their facilities.

**Recommendation:**
Off-site activities which offer an appropriate level of stimulation should form part of a facility policy that relates to safe off-site entertainment of residents due to the positive benefits they offer the residents of aged care facilities.

**Sustainable change**

The literature review (chapter two) highlighted (Manley & McCormack, 2008; McCormack et al., 2011) that person-centred care is not a one-time, special event; rather, it is a continuous development of nursing practice is required with sustained commitment from organisations, managers and leaders at all levels. McCance et al. (2011) proffered that the ongoing challenge for caregivers and managers is recognising person-centred care in practice. Both managers and caregivers may think they are delivering care that is person-centred, but in reality, often are not.
Change needs to be managed effectively in residential aged care facilities as the process and outcomes impact on both residents and caregivers. Sustainability of change processes are often afforded minimal attention despite considerable theoretical, empirical and practical contributions toward their initial development (Fleiszer, Semenic, Ritchie, Richer, & Denis, 2015b). Many authors have highlighted the dilemma that occurs when ongoing sustainability of practice changes are not adequately considered (Fleiszer, Semenic, Ritchie, Richer, & Denis, 2015a), aligning with the findings from this study whereby numerous changes were made to practice; however they were not sustained. While the external venue may not be sustainable on a regular basis considering alternatives that were sustainable was an important part of the process. The real legacy is that they are now able to think outside the box and come up with ideas that assure person-centred care is practiced and are able to convene groups to consider options for meeting residents’ needs.

Change for residents and staff can also lead to opportunities for creativity, new ways of working, career development and enhanced services. For older people moving into residential aged care, they experience many different types of changes which they may feel to a greater or lesser degree stressful. There is an impact on their autonomy, a change in their social status, feeling like they have no place to call home, changes in their previously enjoyed social life and social contacts, and the reduction of habitual activities. The experience in residential aged care is accompanied with a fight for autonomy and against having decisions made for them. Residents have experiences that they perceive as degrading, and they feel they have to obey staff commands in order to get on with them (Riedl et al., 2013).

This study highlighted that caregivers and residents will often resist change when they do not understand it, as evidenced in chapter 6.2, cycle 2, for The Lighthouse. It is important therefore to include all people in decision making so that they feel valued and have input into the changes. For caregivers, change is not always perceived negatively, as some readily embrace change and actively seek it out. Methods that support the acceptance of change include the way in which the change is communicated, preparedness of those impacted by change, as well as factors that are unique to the individual such as past experience of change, personal life situation, and self-esteem (Jones & Bennett, 2012). As the findings of this study indicated, caregivers who did not adapt to change resisted it and were averse to embrace advocated changes that led to negative feedback and reluctance to implement recommended changes. For example, the changes made to the dining room in chapter five cycle two, were largely rejected by caregivers and residents. Implementing change clearly required buy-in from the
caregivers and residents. Moreover, attention must be paid to how change is managed if successful implementation is to be achieved (Price et al., 2015).

This study reflected a change process that was concerned with improving the quality of care. The study reinforced the importance of evaluation as part of any quality improvement process and that the process must be continuous enabling innovation to be introduced, trialled, evaluated and modification made. Continuous quality improvement is an expectation enshrined in accreditation standards that must be considerate of workforce capacity, stakeholder needs (residents, family and community, Government), financial and environmental capacity.

Person-centred care can facilitate the building of strong relationships between managers, caregivers and residents within an organisation. An important part of this approach is to break down the leadership hierarchy and create a decentralised view of leadership, enabling a more nurturing environment where decisions are made collaboratively with caregivers and residents, and the needs of the residents are the priority (Corne et al., 2014). Findings indicated several instances where leadership hierarchy needed to be broken down and there needed to be more of a focus on collaboration with caregivers and residents. Again, a clear example of this was the changes made to the dining room without consulting caregivers, with the strategy evidently failing.

**Recommendation:**
Aged care facility policies should view aged care service provision as one of continuous improvement and the managers and leaders of the facilities should support caregivers with this by creating an inclusive and supportive culture of continuous change.

**Recommendation:**
Facility policies should ensure that caregivers and residents are included in decision making so that they feel valued and have input into changes. In order to support caregivers with change, it is necessary to also support residents with change, through consultation, collaboration and training about what changes are being proposed, why and what the expected benefits are for them.

**Recommendation:**
Policies need to be implemented by facilities, in collaboration with caregivers and managers, to ensure the sustainability of innovations within residential aged care. Without this, innovations will be lost. For organisations to evolve, innovations need to be nurtured to improve the experience of residential aged care.
9.4.2 Practice

Personal identity

The theme “maintaining personal identity” is closely linked to the concept of autonomy for people living in aged care facilities. Autonomy relates to both the freedom to determine one’s own actions and behaviour, and having the ability to function independently (Welford et al., 2012), being typically construed as an individual’s capacity to make informed, intentional choices without controlling influences (Hunt & Ells, 2011).

According to Riedl et al. (2013), aged care residents tend to be overly compliant. They do not tend to protest and they display a high degree of subordination. They try to pander to all levels of caregivers in the facility, subsequently dismantling their own competencies. As a direct result of this, care needs increase, mental and psychosomatic disorders occur, residents become socially withdrawn and they begin to lose their identity. As stated previously (chapter 1), staff need to honour an older person’s right to make decisions about their health care.

Welford et al. (2012) proffered that older people feel that autonomy is important for good quality of life. Older people living in residential aged care facilities represent a unique group of people largely because care is provided for them in their place of residence. However, ironically, their level of autonomy is often eroded in the very place they now call home. It is said that increased levels of autonomy lead to increased levels of resident satisfaction and decreased levels of routinised practice, thus contributing to the overall quality of the resident’s life (Welford et al., 2012). Many residents perceive institutionalisation as the beginning of their loss of meaning in life (Brownie & Horstmanshof, 2012). Additionally, Brownie and Horstmanshof (2012) added that many aged care residents lament the fact that they must do as they are told in these settings. Residents want to be able to participate in decisions such as what clothing they wear, what food they eat, and what activities they participate in, as was demonstrated in the findings of this study.

Barrie (2011) stated that empowerment encompasses the idea that people have the right to make their own choices. Empowerment involves giving a person the authority or power to do something, to make a person stronger or more confident, especially in controlling their life and claiming their rights (REFS). A person-centred care approach embraces empowerment as a fundamental principle. To make informed choices about health individuals must be health literate; that is they must have the capacity to obtain process and understand health information in order to make decisions. With aging,
cognition can be impacted; however creating opportunities for older people to make choices is possible and aligns with a person-centred care approach (Pulvirenti, McMillan, & Lawn, 2014). Empowerment through person-centred care needs to be conceived as something beyond the resident, beyond the individual and beyond a clinical relationship (Pulvirenti et al., 2014). Findings from the study suggested that when a caregiver made a negative comment about the changes to the dining room (implementing the breakfast trolley), this caregiver missed the meaning behind the trolley which was to give residents choice and empowerment even if they did choose the same tea, coffee or cereal; they were able to make that choice themselves. It makes a difference for a person’s well-being if they are able to take a bread roll, choice of tea, jam etc for themselves rather than it just being put on their plate. Such apparently banal details do have a considerable impact on the well-being of people whose scope for action is already quite limited (Portner, 2011). Furthermore, it is ineffective to treat people as a dependent child who follows submissively the orders of authorities (Cloninger, 2011).

Findings from the study indicated it is important to understand that autonomy and choice are intrinsically linked. Autonomy is the capacity for self-determination and a freedom of choice; essential requisites for independence and control over one’s life. Brownie & Hortsmanshof (2012) contended that residents want to be able to participate directly in decisions that affect their daily life and to still feel they are ‘in charge of their life’ (Brownie & Horstmanshof, 2012). While Portner (2011) proffered that having choices and the opportunity to make their own decisions influences people’s quality of life. There is a substantial benefit in not feeling ignored and organised by others, but in still having a say without other people having the control (Portner, 2011). This was evidenced by the residents’ in chapter cycle one, choosing the venue for their dinner out, choosing to drink alcohol with their dinner, making their own choices for the meals they ate, and also making the choice not to go in the facility bus; rather, choosing to go by taxi. This aligns with the point made by Portner (2011), that if older people still have a choice in even the smaller matters of daily life, there is a substantial benefit.

Ensuring that residents had was a major driver for the participants involved in this study. It is important to note that autonomy is often confused with independence. Independence pertains to a person’s level of physical functioning and their ability to perform activities of daily living unaided. Independence is defined as a person’s ability to function independently and make choices (functional independence) or to direct care and negotiate care requirements as in “executional” independence (REFS). Furthermore, independence and autonomy must not be confused with ‘capacity’ that influences an individual’s ability to be autonomous (Welford et al., 2012).
**Recommendation:**
In order to assist residents to maintain their identity, it is important to enable their autonomy. This can be achieved through managers and caregivers enabling residents to make even small decisions which impact on their daily lives through enabling policies.

**Recommendation:**
Residential aged care facilities should provide opportunities for residents to tell their stories through biographical conversation and be known and treated as individuals.

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**Creating a home for residents**

The theme “Support caregivers to create a home for residents” highlighted the importance of facilitating an older person’s lifestyle, including that of assisting new residents to create their own sense of home as they knew it prior to admission to a residential aged care facility, or continuing a life in accordance with their own values (Abma, Bruijn, Kardol, Schols, & Widdershoven, 2012). Relocating to residential aged care is considered one of the most significant sources of anxiety marking later life, and a source of stress, fear, and depression for older people. Lee, Simpson, and Froggatt (2013) argued that moving to residential aged care is perceived unfavourably by older people who would prefer to live in their own homes.

Moving into residential aged care requires adjustment to a new lifestyle as well as adapting to an environment that is completely different to that of an older person’s previous life. For older people who have lived and worked in rural settings such as farms and small towns, accessing a residential aged care facility may also mean moving from their community to a new location (Parmenter, Cruickshank, & Hussain, 2012). Support from caregivers and commitment from facility management to assist new resident’s transition to life in residential aged care following the significant disruption and loss of previous lifestyle is necessary (Falk, Wijk, Persson, & Falk, 2013; Lee et al., 2013). Caregiver support may include such things as getting to know the resident as a person, as well as often initiating conversation with them. The high level of commitment from facility management to assist the new resident to settle in would take such forms as supporting staff and resident autonomy. Older people, on relocation to residential aged care, want to live as they did in their own homes (Lee et al., 2013).

Findings from the study suggested that residents want to create a home like setting. Achieving attachment to place is believed to be assistive in creating a sense of home for residents and maintaining their self-identity. This can be somewhat achieved through a
homely person-centred care physical environment which contains the resident's personal belongings and furniture (Bergland, Hofoss, Kirkevold, Vassbø, & Edvardsson, 2015). The literature review in chapter two highlighted that the environment is the most crucial factor in facilitating or preventing person-centred care implementation (McCormack & McCance, 2006) as it directly affects the resident's quality of life and the quality of care that caregivers provide (Bergland et al., 2012). A complicating factor in creating a home like setting; however is the semi-public nature of a residential care facility, which is the primary site of care provided by professionals (Falk et al., 2013).

Findings indicated that the transition into residential aged care is a stressful time for older people and their family members. According to Eika, Dale, Espnes, and Hvalvik (2015), transitions are associated with emotional distress, uncertainty, and worry. Residential aged care staff can assist the transition by expressing kindness and concern, showing consideration and respect, as well as providing practical assistance and interaction opportunities (Ellis & Rawson, 2015). Participants in this study identified strategies to ease the transition for older people into residential aged care through encouraging family involvement and building a life history to assist the building of therapeutic relationships from the outset, as the two are inextricably linked. Encouraging family involvement is described as an element central to person-centred care (Edvardsson et al., 2010), and families can assist with various aspects regarding the older person’s likes, dislikes, interests, family history and expectations into care delivery (Buron, 2010). Working with a person-centred care approach in residential aged care means that staff aim to establish therapeutic relationships through positive interaction and communication with residents, and use the residents biography to individualise their care (Sjögren et al., 2015).

The review of literature in chapter two identified that inadequate training for caregivers can be a factor that inhibits the implementation of person-centred care and can mean that caregivers are not being adequately supported to create a home for residents. Orientation and ongoing professional development programs for caregivers and managers is equally important for both as developing person-centred care requires a sustained effort from the organisation (McCormack et al., 2011). This study also supported the view that person-centred care training can have positive benefits for new staff and the residents they care for; however it needs to be ongoing to have broader benefits. Findings indicated a positive experience when caregivers attended a training session in chapter six, as was evidenced by the feedback received; suggesting caregivers would appreciate opportunities to be involved in training supportive of person-centred care. Similar results came from a training session on person-centred care in chapter seven, evidenced by feedback that indicated caregivers enjoyed the training and that the manager delivered it well and delivered it in a way that made sense to them. Kirkley et
al. (2011) identified in the literature review in chapter two, the need for training, and stated that person-centred care training should focus more on understanding rather than just the transfer of knowledge.

**Recommendation:**
For residential aged care facilities to introduce a practice of creating a life history of the resident, with family involvement, to assist caregivers to get to know the resident and enable a better understanding of them as an individual.

### 9.4.3 Education

**The self-fulfilment of residents**

This study found that, in order for residents to feel self-fulfilled, caregivers needed to be equipped with skills and knowledge so that they were able to be attentive to residents to facilitate social involvement for the residents. Also, as caregivers work hard to satisfy residents care needs, again, they need the skills and knowledge to be able to do so. One of the findings from the study indicated that residents and their families wanted caregivers to listen to the residents; when they had a problem, to their requests, and to just listen to them when they had something to say. This aligns with Portner (2011) who stated that without listening there cannot be satisfying care or service. Listening is the foundation on which a person-centred attitude can form. All caregivers need to listen, it is the precondition to understanding how other people feel and what it is they need or want and finding the most appropriate way to respond. This remains the single most important access to the inner world and language of another person (Portner, 2011). Participants of the study recognised listening as an important component of person-centred care, and identified it as something they could improve upon.

The findings from the study highlighted that, taking the residents out for dinner and asking them which restaurant they wanted to dine at, facilitated a move from being task focussed in their daily practice to understanding and actioning a more holistic approach to caring for all residents. Holistic nursing is the delivery of excellent nursing care, by recognising the person as an individual with distinct needs and preferences, and caring for them in a responsive way to promote comfort and alleviate stress (Lansdell, 2016).
Manley et al. (2011) defined person-centred care in chapter two in as providing and promoting care that puts people at the centre of the care, involves residents, service users, their families and caregivers in the decision-making process, and helps them to make informed choices regarding their care and treatment. The study outcomes suggest that the expectation of care by management and caregivers in many residential aged care facilities is predominately task oriented. Completing the tasks within the shift hours is the primary focus of caregivers. This task orientation limits caregivers’ capacity to embrace other ways of doing their work. The employer in turn wants the tasks completed within the shift as they are driven by a managerial model (fiscal). When education and training are required to underpin a change, there is a cost to be considered. The challenge must be considered using a cost benefit analysis if it is to be successful. The other driver is meeting the accreditation standards which acts as the big stick forcing organisations to move from task completion to person-centred care.

Institutionalisation often results in increased dependence, inactivity, and loss of personal identity (Abma et al., 2012). The concept of self-worth or dignity, according to Oosterveld-Vlug et al. (2014) is individualistic and subsequently tied to personal goals and social circumstances; it is subjectively experienced and relates to a sense of worthiness. However, many residents see their own self-worth at risk because they are confronted on a daily basis with the increasing need for care, and support from other residents (REFS). Furthermore, in principle, the self-worth of residents appears to be based on social relationships, but it is actually those relationships with other residents that present the greatest challenge. The abovementioned highlights how residents at Sandcastles felt when they wanted to go out for a special dinner away from the facility and other residents. The findings from that cycle highlighted how the residents still wanted to hold on to their self-worth, dignity, and what independence they had left. They showed they were adamant they could still make choices and decide for themselves the: if, when, what and where of a situation. As suggested by the findings, the words choice, autonomy and empowerment are inextricably linked. When the residents in the study were provided a choice they also felt empowered that they could make a choice, and they also felt as though they were able to do the things they wanted to do, suggesting they had more control over their lives. Whether the residents felt empowered to make a choice or after making choices they felt more empowered is not known.

Personal dignity, according to Oosterveld-Vlug et al. (2014) can be preserved or enhanced by upholding a person’s autonomy and by giving individualised care, restoring control, showing respect, performing advocacy and listening sensitively, which are all directly related with what the resident families stated under the heading of respect. Adding to this, they stated it is important to find out who the resident is as a person, what is important to them, and what they value, be it shopping trips to the local shopping centre or card games with friends as this conserves the dignity of residents.
According to Koubel and Bungay (2009), empowerment and the way in which power is understood within the relations between practitioners and individuals seeking health and social care intervention is vitally important. With any relationship, there is potential for an imbalance of power to exist. Power is a difficult concept to define. In itself it is neither good nor bad, but rather, it depends on how it is used and by whom. They state that power over others can be positive or negative with the potential for caregivers to exert power over the cared-for-person who is already so vulnerable. The sharing of power and responsibility is included in the principles of person-centred care from chapter one. The shift of power is seen as co-production which means delivering services in an equal and reciprocal relationship between professionals, service users, their families and significant others. Even small changes, such as those from the study, give power back to residents over their choice of breakfast condiments, and are crucially important for resident’s well-being.

Oosterveld-Vlug et al. (2014) asserted that self-worth preserves and enhances a person’s autonomy through individualised care, restoring control, showing respect, performing advocacy and listening sensitively. An example from the study of treating residents as individuals was creating personalised placemats for each resident that contained each person’s favourite photo. The placemats provided an easy segue into conversation for residents to be able to discuss their lives and the lives of the other residents.

Listening was highlighted in the study as an important element of person-centred care facilitation, with residents and their families identifying that they wanted the caregivers to be there to listen to them when they had a problem, to listen to their requests and to simply listen to them. Without listening there cannot be satisfying care or service. Listening is the foundation on which a person-centred care attitude can form. Findings from the study suggested that all caregivers need to listen, it is the precondition to understanding how other people feel and what it is they need or want and finding the most appropriate way to respond. To listen with all senses-paying attention to reactions, feelings and sensations that are not verbally expressed. This remains the single most important access to the inner world and language of another person (Portner, 2011). Edvardsson et al. (2011) stated the provision of person-centred care represents what caregivers really want to provide, and that high levels of person-centred care are directly linked with higher job satisfaction. Training programs can be a successful tool for improving communication within a residential aged care facility. Although at times lengthy, structured programs can be difficult to implement in the average facility given the time constraints and varying schedules of families and caregivers.
**Recommendation:**
To enable the self-fulfilment of residents, caregivers need to be equipped with skills and knowledge so that they are able to be attentive to residents to facilitate social involvement for them.

**Recommendation:**
Caregivers need to be trained to understand the power imbalance that exists in the caregiving relationship, with an emphasis on the importance of listening to residents and ensuring to enable them to make their own decisions.

**Recommendation:**
That caregivers receive ongoing training in the major life adjustment that aged care residents endure when transitioning from their home to a residential aged care facility, to better understand how they can assist in, and ease the stress of, this transition. This is particularly important when a resident is relocating out of area such as a rural area. This could be provided as interactive and self-paced training tailored to the varying schedules of caregivers. Orientation training and ongoing professional development programs could be the best way to achieve this.

**Recommendation:**
The implementation of a pilot training program for all new residential aged care staff regardless of their role, with a specific focus on person-centred care training and translation into practice. The training program would incorporate interactive powerpoint presentations, and supportive facilitation of person-centred care into practice, with the benefit of creating baseline person-centred care knowledge for all new staff.

**Team work**

The theme “develop strategies to build a cohesive team” incorporated having a supportive manager as well as structured team building to sustain cohesive teams. Findings from the study suggested that caregiver satisfaction cannot be sustained without having team building strategies in place. Additionally, it is important to continuously work on team building and effectiveness (Ericson-Lidman & Strandberg, 2015). Team building can improve communication and interpersonal relationships, identify strengths and weaknesses, provide greater job satisfaction and thus enhance the quality of care provided (Homem, Filomena, Cardoso, & Cruz, 2012).

Chi et al. (2011) state it is plausible that transformational leaders in healthcare bolster team performance by shaping members’ positive attitudes toward the team. Transformational leaders are capable of using rapport building and empathic language
to increase team member’s affective attachment to their teams. Through their verbal and symbolic behaviours (idealised influence and inspirational motivation), transformational leaders assist their team members to view their tasks as more meaningful (Dignam et al., 2012). Therefore, it is expected that more transformational behaviours in the future will lead team members to achieve higher levels of team satisfaction with members who are highly satisfied with their team, hence they are more likely to become involved in team activities and take action to support team functioning. The positive feedback received in cycle two for Seaview suggested that staff found their managers to have transformational leadership qualities, also finding them approachable and supportive, assisting positive moods within the workplace.

Leader positive moods, as indicated by the findings in cycle two of the Lighthouse, can influence positive behaviours. Positive moods are defined as the extent to which a person feels enthusiastic, active, and alert and in a state of high energy, full concentration, and pleasurable engagement (Chi et al., 2011). Positive moods can have a significant impact on individual cognition, judgement, and behaviours. When individuals experience positive moods, they are more likely to perceive information favourably, be more prone to remembering positive information, and are more confident and motivated which was relevant to this study, with the motivation of the groups to, help residents by making changes to practice.

Within leadership literature, empirical studies have found that leaders with positive affective traits such as extraversion and positive affectivity tend to perform more transformational leadership behaviours. This could be due to leaders who constantly experience positive moods becoming increasingly more positive, ambitious, inspirational, and influential when interacting with others (Chi et al., 2011). Transformational leadership encompasses leadership characteristics and behaviours that have a positive influence on organisational performance and resident outcomes (Fischer, 2016). Furthermore, Chi et al. (2011) state it is plausible that transformational leaders bolster team performance by shaping member’s positive attitudes toward the team. Transformational leaders are capable of using rapport building and empathic language to increase team member’s affective attachment to their teams. Through their verbal and symbolic behaviours (idealised influence and inspirational motivation), transformational leaders assist their team members to view their tasks as more meaningful. Therefore, it is expected that managers who exhibit transformational behaviours will lead team members to achieve higher levels of team satisfaction with members who are highly satisfied with their team, hence they are more likely to become involved in team activities and take action to support team functioning. Findings from the study indicated that managers need to be supported in their roles and it is important for organisations to provide appropriate training to across the board.
**Recommendation:**
Ongoing and sustainable professional development programs are important for both managers and caregivers and should be part of the individual performance plans of all people who work in residential aged care regardless of their role.

**Recommendation:**
The provision of ongoing interactive training that promotes a culture of respect for older people who still have so much to offer society, to view them as the resourceful and wise people that they are, and to promote them in a positive, respectful light.

**Recommendation:**
The development of both mandatory and non-mandatory practice development programs with the flexibility to include rural caregivers.

**Recommendation:**
The development of a staff and resident evaluation program that involves their input on a regular basis to identify any problems, issues and suggestions, facilitating increased ownership and empowerment.

### 9.4.4 Research

As mentioned previously, more research is required to understand the issues facing both consumers and employees within the aged care sector in rural communities. In addition research investigating issues associated with supporting family involvement with residents living in aged care facilities is required. Groups from The Lighthouse and Seaview discussed the importance of family involvement, for example, The Lighthouse action research group in chapter five agreed they wanted to encourage the involvement of families from the outset of admission of new residents. It is widely accepted that families play an important role in the support and care of older people living in residential aged care (Bauer, Fetherstonhaugh, & Lewis, 2014). Some family members like to remain involved in, and committed to maintaining the well-being of their family member, despite assumptions that the caregiving role is relinquished once an older person enters residential aged care (Irving, 2015).

### 9.5 Final reflections on this research journey

I found this action research study to be an incredible life-changing journey. I am now more aware of the daily challenges faced by residents in residential aged care and the importance of supportive management to guide, encourage and collaborate with
caregivers to enable them to work with residents to develop therapeutic relationships. These relationships facilitate caregivers having the capacity to identify resident needs and develop strategies to address these and incorporate them into daily practice.

As the research lead and each of the AR groups facilitator the challenges were many. Setting and meeting timelines, managing the overall process, dealing with participant negativity, and my own vulnerabilities were some of the issues that caused me to feel overwhelmed at times by the sheer enormity of the project. I realise as a researcher I needed to draw on my strengths to achieve the final goal of completing the research. I believe that I was organised, motivated, timely, personable and efficient throughout the project.

I found many challenges in using action research as it is open to interpretation and as stated by Francis & Taylor (2015) is not straightforward, rather projects evolve over their lifetime. I was very appreciative of the support and guidance of my supervisors. I truly believe action research is a very powerful tool in addressing many challenges and issues within health services due to its potential for change, it’s unique application and inclusiveness of people affected by decisions. I found the role of researcher enjoyable as well as challenging. I worked with three different action research groups and realised that each group came with its own challenges for example; Sandcastles experienced a new manager mid-way through the research which affected the caregivers as a whole and impacted on the action research group because of the different ideas and management styles provided by the managers. I had never undertaken anything like this study before and found it difficult to take a step back when I could see at times the action research groups were either digressing or making decisions without collaborating with other caregivers and residents. I learnt that it is just as important to see what does not work as it is to see what does work as long as you can learn from the mistakes you make and move forward. I learnt to refine my skills as a reflective practitioner and how this improves personal practice, as I found reading back through not only my own reflections but those of the action research groups an interesting journey. In conclusion, I would thoroughly recommend action research to anyone in a position who is passionate about making changes that liberate and empower people.

9.6 Conclusion

This study aimed to support managers and caregivers at three rurally located residential aged care services implement a person-centred care approach.
Through researching the six principles of person-centred care, being: getting to know the resident as a person; sharing power and responsibility; sharing decision making; ensuring flexibility and accessibility; encouraging autonomy; and environment, this study highlighted that there is not only no organisational definition of person-centred care against which the project outcomes can be compared, there is also no one way to implement person-centred care. Person-centred care, by its very nature, requires continual adaptation and implementation, which is why action research lent itself to addressing the issue and empowering participants to keep improving.

The findings of this study contributed towards a deeper understanding and awareness of the complexities of actioning person-centred care, including power differentials that can exist within residential aged care and how they can affect an outcome, as well as the need for interactive training, change management strategies, and the importance of sustainability for innovations. Efforts to improve person-centred care in residential aged care need the support of management, as well as the inclusion of residents and the diversity of staff that exists and the varying roles they have within an organisation in decision making regarding innovations.

The study demonstrated that when caregivers are involved in the decision-making process, they have a greater sense of ownership evidenced by their reflection on action. The entire process empowered participants to actively participate in activities that impacted them directly on a daily basis. Through the processes of action research, there was evidence of culture change through a greater awareness of how person-centred care is translated into practice, reflection, working collaboratively, and being involved in decision-making.

The findings support the quality improvement agenda in Australia with key considerations to ensure a sustainable person-centred approach is applied to the care provided and further support the shift from task-centred care to person-centred care. Organisations in their development of person-centred care need to ensure their policies make the move away from individual, one-off experiences of person-centred care, to a consistent and sustainable person-centred care approach in everyday practice. The vision of the Director of Care was for the organisation to evolve and take with it the people who work within the organisation. This study empowered staff and gave them the opportunity to learn and apply their learnings. It was not particularly onerous on the organisation, being cost effective, and showed that organisations can implement person-centred care if they face the challenge of the facilitation and guidance of the process to make it credible and acceptable to the workforce. This study also provided the opportunity for staff to engage with literature with support and as such, to become
reflective critical practitioners who applied the literature to their work practices and reflected upon how care should be provided.

A positive addition to the study, and one that strengthened the outcomes was the active involvement of caregivers as participants. The inclusion of these people fitted with the aims of the action research processes of collaboration, democracy and participation. Their grass roots participation was strengthened and made easier as they were work colleagues and well acquainted with each other. This involvement highlighted strong satisfaction levels of staff, which flows from an organisation that is investing in the workforce. Good leadership is vital when implementing person-centred care, and contented caregivers, while not necessarily knowing anything about leadership, are reaffirming what makes someone a good leader. Even if caregivers do not use the terminology, they can provide examples of good leadership.

The study highlighted how the sharing of knowledge and communication with the people who are directly affected by them are vitally important when proposing changes. If caregivers and residents are included in the sharing of information about the importance and significance of the changes for them, outcomes would certainly be positive. The findings from the study also demonstrated the importance of being united when moving forward and introducing changes, again highlighting the importance of a change management strategy.

This study is important given the paucity of literature on rural residential aged care residents and caregivers. Anecdotal evidence from Beaches Care of the Aged indicates that rural aged care facilities can face issues when trying to involve staff in ongoing professional development or other activities outside usual shift hours due to the distances some rural staff may have to travel. Studies such as this may be useful in devising strategies to develop a more skilled workforce in rural areas, reinforces the need for ongoing practice development programs both mandatory and non-mandatory. Given that the majority of the staff profile in residential aged care is caregivers, it is important to develop a qualified and skilled workforce able to deliver person-centred care tailored to the needs of older people.

The main conclusions to be drawn from this study are firstly, when changes are proposed that are deemed to be person-centred, collaboration and inclusion of all people affected by them, including residents, is important, as is the sharing of knowledge and effective communication, reinforcing the importance of change management strategies within organisations. Additionally, the study highlighted that
the residential aged care facility is the home of the residents, and if residents are to feel empowered and valued as people who belong, then their views must be sought. It is little wonder that residents may engage in self-stigmatising if they are treated as though they and their opinions do not matter. It is also little wonder that some residents may engage in behaviour that, while frustrating to others, is actually a display of the last remnant of power that they may feel they have at their disposal.

Action research provided a methodology that engaged staff to reflect on person-centred care and offered opportunity for them to develop initiatives that realised changes that reflected the principles of person-centred care. Participation in the study built workforce capacity, created opportunities for residents and staff to negotiate care and achieved a quality improvement process that was facility specific.
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APPENDICES

Appendix 1: Ethics Approval

22 July 2013

Ms Bronwen Ashcroft
PO Box 2732
Port Macquarie NSW 2444

Dear Ms Ashcroft,

Thank you for the additional information forwarded in response to a request from the Human Research Ethics Committee (HREC).

The CSU HREC reviews projects in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Research Involving Humans.

I am pleased to advise that your project entitled “Implementing a new model of care reflecting the principles of person-centred care” meets the requirements of the National Statement, and ethical approval for this research is granted for a twelve-month period from 22 July 2013.

The protocol number issued with respect to this project is 2013/138. Please be sure to quote this number when responding to any request made by the Committee.

Please note the following conditions of approval:

- all Consent Forms and Information Sheets are to be printed on Charles Sturt University letterhead. Students should liaise with their Supervisor to arrange to have these documents printed;
- you must notify the Committee immediately in writing should your research differ in any way from that proposed. Forms are available at: http://www.csu.edu.au/__data/assets/word_doc/0010/176833/ehrc_annrep.doc (please copy and paste the address into your browser);
- you must notify the Committee immediately if any serious and or unexpected adverse events or outcomes occur associated with your research, that might affect the participants and therefore ethical acceptability of the project. An Adverse Incident form is available from the website: as above;
- amendments to the research design must be reviewed and approved by the Human Research Ethics Committee before commencement. Forms are available at the website above;

www.csu.edu.au
CRICOS Provider Numbers for Charles Sturt University are 00005F (NSW), 01947G (VIC) and 02968B (ACT). ABN: 83 676 708 851

Last updated: February 2013
Next review: February 2014
• if an extension of the approval period is required, a request must be submitted to the Human Research Ethics Committee. Forms are available at the website above;
• you are required to complete a Progress Report form, which can be downloaded as above, by 16 May 2014 if your research has not been completed by that date;
• you are required to submit a final report, the form is available from the website above.

YOU ARE REMINDED THAT AN APPROVAL LETTER FROM THE CSU HREC CONSTITUTES ETHICAL APPROVAL ONLY.

If your research involves the use of radiation, biological materials, chemicals or animals a separate approval is required from the appropriate University Committee.

The Committee wishes you well in your research and please do not hesitate to contact the Executive Officer on telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries.

Yours sincerely

Julie Hicks
Executive Officer
Human Research Ethics Committee
Direct Telephone: (02) 6338 4628
Email: ethics@csu.edu.au
Cc: Dr Judith Anderson Professor Kevin Francis

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007)
Appendix 2: Information for Participants

INFORMATION FOR PARTICIPANTS

ACTION RESEARCH STUDY

CCA

PhD Student: Bronwen Ashcroft

Charles Sturt University

Supervisors:

Doctor Judith Anderson

Professor Karen Francis

The proposed action research study aims to increase awareness and apperception of person-centred care, to empower residents and care caregivers, and to generate new knowledge and effect culture change. This will be achieved by exploring the quality of care provided to older people by care caregivers in The Lighthouse, Seaview, and Sandcastles. Opportunities to promote best practice will be identified by implementing a new model of care reflecting the principles of person-centred care.
POTENTIAL CONTRIBUTION OF THE PROPOSED STUDY

The study proposes to make an original and substantive contribution to the body of nursing knowledge and further research. It aims to be of significant value to aged care, including residents, clinicians and academics by: Improving care standards and practice, offering greater understanding, awareness, and opportunity for practitioners to enhance their practice and providing academics with a better understanding of the principles of person-centred care.

Action research has been chosen for the study because of its collaborative, democratic and participatory nature and a process that effects change. Action research occurs in cycles and several action research cycles will occur, although it is unknown how many cycles there will be as following cycles will arise from the evaluation of the previous one. The timeframe for this study will extend for twelve months, although participants may continue with further cycles of action as the intent of action research is to empower participants to make further change.

Action Research Groups

Participation in the study will involve groups which will be conducted at each facility over a limited period. Each group will consist of approximately 6-8 participants. Participants will be required to attend group sessions on a regular basis. Group sessions will take approximately 1 hour per session. The number of sessions, session times and dates will be a negotiated process between group participants so that the number of sessions, session times and dates are suitable for each participant. Participation will be entirely voluntary with participants able to withdraw from the study at any time and without any consequence.

All participants must be current employees of Beaches Care of the Aged. They will be involved in action research and be active participants in the cyclical research process.

The study will consist of purposeful investigation through locating a problem, planning and implementing an intervention, gathering data to provide evidence of success in addressing the problem, and analysis and testing of emergent theories. Multiple data generation approaches are likely to be adopted that may include the following: observation, photo elicitation, reflective journals, memos, self-assessment, field notes, audio tapes and checklists. It is likely that each of the groups will use different data
collection methods as there will be three separate groups (one for each facility) with each group deciding for themselves which tools they use. Data collected will most likely include: photos, reflective journals and memos. Data will be analysed by the group as each cycle of the study progresses. Group meetings will be digitally recorded and subsequently transcribed to gather information for data analysis. The four elements of action research will apply to both data collection and analysis: plan, act, observe, and reflect.

You are invited to participate in this study which involves your current workplace Beaches Care of the Aged. The study is being conducted as part of a PhD from Charles Sturt University (CSU). The principal researcher is Bronwen Ashcroft, a Registered Nurse currently employed by Beaches Care of the Aged. Supervisors are Dr Judith Anderson and Professor Karen Francis. If you experience any discomfort from this study I would encourage you to contact Beaches Care of the Aged who are aware of this study and will assist in trying to rectify any problems or concerns you may experience as soon as possible.

Please understand that you have a right to withdraw from participation in the study at any time and that withdrawal will not affect your working relationship with Beaches Care of the Aged. You will not be subject to any discrimination. Groups will continue even if a participant decides not to continue.

The principal researcher will record group sessions as part of the study. Please understand that anonymity and confidentiality cannot be guaranteed in a group setting and that individual contributions cannot be withdrawn if a decision is made to withdraw participation after the group has been held. Any information that could identify you will not be used further without your written permission. It is to be understood that any images used by group members will not include photos of residents.

If you are interested and would like to participate in the study, please complete the attached consent form and you will be contacted in due time to organise an initial meeting. If you would like more information, please contact Bronwen Ashcroft on 04507 84997.

**Name, Address and Phone number of Supervisors:**

**Dr Judith Anderson**  
Charles Sturt University  
Senior Lecturer, Postgraduate Program Leader
School of Nursing, Midwifery and Indigenous Health
Panorama Ave.
Bathurst, NSW 2795
Australia
Tel: +61 2 6338 4640

Professor Karen Francis
Charles Sturt University
Head of the School of Nursing, Midwifery and Indigenous Health,
Building 2/312,
Wagga Wagga, NSW 2650
Australia
Tel: +61 2 6933 4110

Note: Charles Sturt University’s Human Research Ethics Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

Executive Officer
Human Research Ethics Committee
Office of Academic Governance
Charles Sturt University
Panorama Ave
Bathurst NSW 2795

Tel: (02) 6338 4628
Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Sue McCann
CCA Director of Care

CCA Director of Care

PO Box 1736
Port Macquarie 2444
If you are interested in participating in this study, please contact:

Bronwen Ashcroft

MOB: 0450784997

E-mail: gawne_ashcroft@bigpond.com

Or

Bronwen Ashcroft,

P.O Box 2732,

Port Macquarie,

NSW

2444
Appendix 3: Consent Form

CONSENT FORM

PhD Student: Bronwen Ashcroft

Name:

Position:

Phone:

Supervisors:

Doctor Judith Anderson
Professor Karen Francis

269
Name of research project:
A whole new world: Facilitating person-centred care, an action research study

Name, Address and Phone number of principal researcher and student:
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The purpose of the research has been explained to me and I have read and understand the information given to me. I have been given the opportunity to ask questions about the study and have received adequate answers.

I understand that I am free to withdraw from my participation in the study at any time without consequence and my employment at Catholic Care of the Aged will not be negatively affected.
I agree to the principal researcher recording action research group meetings. I understand that anonymity and confidentiality cannot be guaranteed in a group setting and that individual contributions cannot be withdrawn if a decision is made to withdraw participation after the group has been held. Any information that could identify me will not be used further without my written permission.

I understand that any images used by group members will not include photos of residents.

Charles Sturt University’s Human Research Ethics Committee has approved this study.

I understand that if I have any complaints or concerns about this research I can contact:

**Executive Officer**
**Human Research Ethics Committee**
**Office of Academic Governance**
**Charles Sturt University**
**Panorama**
**Bathurst NSW 2795**

Phone: (02) 6338 4628
Email: ethics@csu.com.au

Approval has been sought and granted by Catholic Care of the Aged Issues Committee.

*Sue McCann*

**CCA Director of Care**

![CCA logo]

**PO Box 1736**

**Port Macquarie 2444**

📞 (02) 6589 9818   ☎️ *Mob: 0419 972 635*

📞 (02) 6583 5919
☐ I agree to the recording of groups.

Signed by.............................................

Print name........................................... Date.................................................
Appendix 4: The first action research group meeting

FIRST ACTION RESEARCH GROUP MEETING

Welcome to all

- Welcome everyone and thank you for agreeing to participate in this action research study.
- Meetings are typically 1 hour in length.
- Action research group meetings, times and frequency are to be negotiated by you as a group. You are driving the study and you make the decisions. I would expect that we will have some sought of change in place by the end of the year and then we can evaluate.
- I understand that you may not be able to attend every group meeting.
- Meetings will be informal and morning/afternoon tea will be supplied.
- Meetings are recorded to facilitate analysis.
- The four elements of action research are planning, action, observation and reflection. (This is followed by group discussion and any questions)
- It is important that each of you has an opportunity to voice.

Outcomes from first action research group meeting

- By the finish of the first action research group meeting, I would like to see each of you and all of you to collaborate to have an increased awareness and understanding of person centred care and to feel that you are able to reflect upon your own practice and to share this reflective notion with the other participants.
- Ways in which management could support caregivers in the furtherance of a person centred care environment.
- Understanding of the constraints that hinder person-centred care.
- To identify what you as individuals and collaboratively as a group want to change and what opportunities there are for change.
- A group understanding of person-centred care or group definition.
- How you could effectively introduce a model of care.
- To be able to describe the setting you are aiming for and what person-centred care looks like to you and how you would like it to look.
- To choose one or two actions that could increase the furtherance of person centred care within the organisation.
- For participants to have ownership of all outcomes. Ownership will come from involvement and decision making.
THOUGHT FOR NEXT MEETING....

How would you describe a place that has person-centred care and how would you make those changes?

Appendix 5: Action Research Group Discussion Questions

Question (1): What is your understanding of person-centred care and what it means to you?

Question (2): What are some of the constraints that hinder person-centred care?

Question (3): What is your group understanding of person-centred care?

Question (4): How do we effectively introduce a model of care?

Question (5): What does person-centred care look like? How would you like to see it look?

Appendix 6: Recommendations and questions to assist in the observation phase

Adopted from Taylor and Francis (2013)

(1) What were the effects of the action, both intended and unintended?

(2) What were the circumstances of, and constraints on action?

(3) How circumstances and constraints changed planned action?

(4) Any other issues?

Appendix 7: Reflection questions

Reflection questions adopted from Taylor and Francis (2013) (action cycles, operationalisation of cycles, method chapter 4.7)

(1) Decisions made?
(2) Outcomes achieved?
(3) Problems encountered?
(4) Implications for the study?

**Appendix 8: Practice Development Questions**

Practice Development Questions adopted from FitzGerald and Armitage (2005) and used as part of the reflective discussion in data analysis.

(PD1) What is happening here?
(PD2) What do we want to achieve?
(PD3) Who are the key players?
(PD4) Who benefits from the current situation?
(PD5) Who is disadvantaged?

**Appendix 9-New resident documents**

**Expectations of Care - Resident**

What are your expectations when coming into care?
What is your understanding of person-centred care?
What are your needs? Please list below.

**Expectations of Care - Relative**

What are your expectations for your family member when coming into care?
What is your understanding of person-centred care?
What outcome would you like to see for your loved one?

**Appendix 10-Principles of Person Centred Care-Information Sheet**

Encourage residents to make their own choices and decisions by listening to and treating them as individuals. To have an understanding of; resident rights, the importance of building mutual trust, respecting dignity, privacy and confidentiality.
Without three crucial elements of (1) Acceptance, (2) Congruence and (3) Empathy, person-centred care cannot be achieved according to Portner (2011). Portner (2011) defined the three elements as (1) Acceptance: To accept another person without judgment, including any imperfections. Recognise their potential and be aware of their values. (2) Congruence: To be in harmony with others and aware of their feelings and experiences, being true to yourself. (3) Empathy: Recognising the emotions and experiences of other people and having the ability to imagine what someone else is thinking or feeling in an objective manner. The three principles of person-centred care although adopted from Portner (2011), participants discussed and placed their own words to describe acceptance, congruence and empathy.

Appendix 11-The Welcome Pack

The “Welcome Packs” included information about the facility as well as forms to be completed and returned, including three sections as delineated below;

Information

- Admission introductory letter
- Clothing brochure,
- Carer support brochure
- Food safety tips brochure,
- Pastoral care brochure.

Forms to be completed prior to admission

- Admission form
- Privacy form
- Medication consent form
- Dietary analysis form
- Pharmacy admission
- Resident valuables
- Interim care issues
- Respite agreement
- Key to me (this is information for the new resident to fill in pertaining to their personal likes, dislikes, preferences etc)

Forms to be completed by Doctor when notified of bed vacancy

- Medical history
- Medication chart
- Advanced care directive.

**Key to me**

- Personal details: name, place of origin, studies undertaken, occupation.
- Family abilities/Activities-Parent and siblings: details of parents, family members, spouse and relationships with these people.
- Abilities/activities: personal interests such as music and reading.
- Habits/routines/social relationships: personal hygiene, diet,
- Leisure/interests: favourite time of day, favourite month, activities that relax the person
- Intimacy/privacy: need for privacy, comforted with hugs and touch, additional information.
Welcome to all participants

- Welcome everyone and thank you for agreeing to participate in this action research study.
- Action research group meetings; times, venue, driven by participants. I understand that you may not be able to attend every group meeting. Meetings will be informal and I will provide morning/afternoon tea. Meetings will be recorded to facilitate analysis, following your approval.
- Practice development.
- The importance of reflection.
- The four elements of action research are planning, action, observation and reflection. (This is followed by group discussion and any questions)
- Problem identification and prioritisation of goals will be achieved using the Nominal Group Technique.
- Data collection tools
- It is important that each of you has an opportunity to voice.

THOUGHT FOR NEXT MEETING....

How would you describe a place that has person-centred care and how would you make those changes?

ACTION RESEARCH GROUP DISCUSSION QUESTIONS

Question (1): What is your understanding of person-centred care and what it means to you?

Question (2): What are some of the constraints that hinder person-centred care?

Question (3): What is your group understanding of person-centred care?

Question (4): How do we effectively introduce a model of care?

Question (5): What does person-centred care look like? How would you like to see it look?
Appendix 13 - Person-centred care feedback-Residents and resident families

What is your understanding of person-centred care?
Residents
Resident families

How do you believe we can achieve this?
Residents
Resident families

What is important to you?
Residents
Resident families

Can we improve? If so, how?
Residents
Resident families

Appendix 14 – Questionnaire provided to caregivers

What did you like the most about the training?
What did you learn?
What could be added?
Appendix 15 – Questionnaire Results

What did you like the most about the training?

17% liked the honesty

34% liked the listening and communication component of the training

17% Liked the training itself

17% liked how it was related to both staff and residents

17% liked the interaction

What did you learn?

90% said listening

10% said they did not learn anything new

What could be added to this training?

72% said they would like more of this type of education

9% said more caregivers

9% said they would add to it, it was fun and helpful

9% said more interaction
HAPPINESS QUESTIONNAIRE

Please complete and return

1. Are you happy at work?
2. If unhappy, what will make you happier?
3. What can management do to assist you?
4. How would you rate your team?
Appendix 17-My Reflections on dinner

My reflections on dinner at Sails Resort 30th October 2013...........

“There was a lot of talk before the night out (from staff and residents). Everyone participating was very much looking forward to the night. The night out gave residents and staff an opportunity to interact outside the home/work environment. The outlook of the venue gave more talking points amongst us all (marina). All involved talked about the night for days after, not a bad word spoken. A lot of laughing and a fun night was had by all. I would love to do it again”

“The residents were very excited on arrival. Remember the laughter the most (residents and staff). Everyone had a wonderful night. Residents continue to talk and laugh about the evening. Food-wonderful, company-excellent”

“What a fantastic night that was had by all residents and staff alike. It was like they were no barriers; they were not the residents and we were not the carers (staff). We were just a bunch of friends out for tea. The laughter, the stories and the reminiscing
was good for the soul and the fine dining experience exemplified what an eating experience should be like. I would definitely do it again. Thanks so much to all”

“The night was a great success. Everybody had a great night, staff as well as residents. There was lots of laughter. It was nice to be able to spend some one on one time with the residents. Should be done again”

“What a special evening it was. This kind of event is so important when we don’t have a lot of time at work to socialise with the residents. We laughed and talked all night. The residents loved it as much as we did and they really did get what they wanted. They were able to make choices as they chose the restaurant, they chose the taxi and they chose to drink alcohol which I think is just so important that these people can still make choices. Let’s do it again soon”
REFERENCES


Bauer, M., Fetherstonhaugh, D., & Lewis, V. (2014). Attitudes towards family-staff relationships in Australian residential aged care settings: Development and psychometric evaluation of the 'Family and Staff Relationship Attitude Tool' (


286


institutionalization in the community dwelling population aged 65 years old or older. *Physical Therapy Reviews, 17*(1), 37-44. doi: 10.1179/1743288X11Y.0000000050


