Interinstitutional relocation of aged people

Irene Louise Stein
University of Wollongong


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INTERINSTITUTIONAL RELOCATION OF AGED PEOPLE

A thesis submitted in fulfilment of the requirements for the award of the degree of

DOCTOR OF PHILOSOPHY

from

THE UNIVERSITY OF WOLLONGONG

by

IRENE LOUISE STEIN, MA, BA, BAppSci (Nurs), DipNEd, RN, RGerN.

Department of Nursing
1996
For Olive Eileen Fisher, Annie Matilda Fisher, Marjorie Pearl Stein

and

Leslie Frank August Stein
Authorial Statement

This thesis is my own work except where I have acknowledged otherwise.

Irene Louise Stein
8.2.96
ABSTRACT

This purpose of this study is to examine the effect of a forced mass interinstitutional relocation on the quality of life for two groups of nursing home residents. A conceptual model for this study, The Relocation Adaptation Model (RA), was derived from both empirical and conceptual literature on social gerontology.

The study population was randomly selected from the more cognitively able nursing home residents. A combination of methodologies was used to collect the data necessary to make comparisons over a 17 week time period. Three recognised instruments were used: the General Health Questionnaire-20, The Affectometer 2 and the Katz Index of Activities Of Daily Living. Other instruments were developed by the researcher to collect relevant data. An audit of participant's records was included. Guided interviews were also carried out.

The study found that the quality of life of residents in a nursing home is effected following a forced interinstitutional relocation and that the level of medication usage by participants may have been a significant factor in the response to the relocation.

Few mass relocations of nursing home residents have taken place in Australia. These will increase as existing nursing home buildings age and deteriorate. This study is unique. The researcher believes it is the only Australian study of this nature to have been carried out.
ACKNOWLEDGEMENTS

I would like to thank Karina Arthur, Dr. Christine Ewan, Harboard Preschool, Bill Janes, Lynne Newman, Dr Harvey Newman, Neidra Hill, Melinda Martin-Khan, Dr. John McCallum, Mr Bruce Reilly, Dr. Ken Russell, Dr. John Sibbald, Dr. John Snowdon and Gerard Stephenson for their time, resources and support over the past four years.

I am indebted to Magda Heaslip, Heather Todd and Tania Harrison. Without their special expertise and unquestioning support they have given me this thesis would not be a reality. I would like also to acknowledge the help and encouragement I have received from Associate Professor Rhonda Griffiths who has made all the facilities I have required available to me.

I am very appreciative of the direction given to me by my first supervisor, Dr Carol Morse and then to her successor, Dr Charles Watson.

Ms Marian Martin has provided me with encouragement, good humour and constructive criticism throughout this time, her common sense helping to keep me focused.

Acknowledgement and thanks must be given to the administration, and all the staff and the residents of the nursing home in which this research was carried out. Without their help, time and encouragement this research would not have been possible.
Lastly, I want to thank my mother, father, grandparents and maiden aunts who believed I could do anything I decided to do.
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Appendix 3  Study Instruments

Appendix 4  Altered pharmacokinetics and pharmacodynamics in aging

Appendix 5  Media clippings regarding Telstra and the Harbord Community Kindergarten

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Appendix 7  Items relating to nursing home drug usage

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Appendix 9  Published paper

Appendix 10 Brief notes relating to the Brief Assessment Schedule (BAS) and The Geriatric Depression Scale (GDS) and medication usage amongst the participants
PROLOGUE
As the existing stocks of nursing homes deteriorate with age, renovation and replacement will become necessary. This will occur as the need increases to upgrade obsolete nursing home stocks in line with current safety and fire legislation and to respond to structural deterioration. The extent of the required renovations may determine that the demolition and rebuilding of the nursing home is a more cost effective and efficient way to proceed.

Renovation and rebuilding is a potential hazard to the quality of life and quality of care for the residents of the nursing home. The potential hazard will be created by the renovation and rebuilding necessary in order to relocate residents to another nursing home. This relocation may be a permanent one where the individual is relocated to another area and another nursing home (interinstitutional relocation fig. 1), or the relocation may be a temporary one where the resident is moved to another care area within the existing nursing home (intraintstitutional relocation fig. 2) or to another nursing home until the renovations or rebuilding has been completed (interinstitutional relocation). In this case, residents may be moved either individually or as an entire nursing home population if suitable premises can be found.
Rebuilding of existing nursing home stock $\rightarrow$ Forced interinstitutional relocation of the nursing home population $\Rightarrow$ Potential hazard or threat to resident

- temporary
  - Resident moved to another nursing home and then when new purpose built facility is completed, moved again to the new facility

- permanent
  - Resident moved to an alternate nursing home facility with no view to move to new facility
  - OR
  - Residents moved to new purpose built nursing home on a different site

**Figure 1** Interinstitutional relocation pattern as a result of nursing home rebuilding

Renovation of existing nursing home stock $\rightarrow$ Temporary intranstitutional relocation of residents to another care area $\rightarrow$ Permanent intranstitutional relocation of resident to another care area

**Figure 2** Intranstitutional relocation pattern as a result of nursing home renovation
Renovation and rebuilding programs provide opportunities to incorporate into the new architectural design of the nursing home the standards required by *The Outcome Standards For Australian Nursing Homes* (Department of Community Services and Health 1987a; Department of Community Services and Health 1989) (Appendix 1).

The temporary or permanent dispersal of an entire nursing home population is difficult to achieve. Existing nursing homes are not in a position to absorb large numbers of residents from another institution because of the high bed occupancy rates. One alternative has been to relocate the residents as a group to a temporary location. An alternate solution is the permanent relocation of the nursing home residents to a new building on a different site. However, this does not mean that there will be no impact on the residents, however it may mean that instead of two forced interinstitutional relocations the residents will only face one interinstitutional relocation.

This thesis aims to assist nursing homes facing this situation as they strive to reduce the impact of relocation on the residents and to meet the ongoing needs of their residents as they face one or more forced interinstitutional or intrainstitutional relocations. Little Australian research has been carried out in this area and the literature concerning relocation does not adequately address this contingency.
CHAPTER 1

INTRODUCTION

THE CONTEXT OF THIS THESIS
FORCES WITHIN THE NURSING HOME
THE DEMOGRAPHIC CONTEXT OF THIS THESIS
AGE-SPECIFIC SERVICES
QUALITY OF CARE AND QUALITY OF LIFE
HOUSING AND HEALTH
RATES OF INSTITUTIONALISATION
THE IMPACT OF INSTITUTIONALISATION
THE CENTRAL PROPOSITIONS OF THIS THESIS

"The connection between health and the dwellings of the population is one of the most important that exists."

Florence Nightingale (Conway 1995 p. 141)
1.0 THE CONTEXT OF THIS THESIS

This thesis examines the effect of a forced interinstitutional relocation on two groups of elderly nursing home residents who were forced to relocate from one nursing home to another. This non-consensual relocation was a consequence of an initial relocation from the community to a nursing home. The second relocation in 1992 came about because an old nursing home, which had been in operation since 1968, had to either close for demolition and rebuilding, or undergo extensive renovations in order to meet the current legislative standards required by government authorities for this type of long term residential setting for aged people. The 1968 nursing home to be replaced was home to 110 long term residents.

The result was that the residents in this condemned nursing home (who had to initially move from the community to the nursing home), faced a forced relocation from the condemned nursing home to temporary premises, and then another forced relocation to a new custom built aged care facility. In total, the residents that survived from 1992 until 1994 faced three moves, two of which were forced relocations. Trapped in a long term care system they had no choice but to suffer this forced interinstitutional relocation because they had no real alternative. Table 1.1 presents the dates of the institutional and intrainstitutional relocation of residents to various sites.
Table 1.1 Dates of the institutional and interinstitutional relocation of residents to various sites

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<th>No. of residents affected</th>
<th>Located from</th>
<th>Located to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre September 1992</td>
<td>100</td>
<td>Community, hospital or other referral agencies</td>
<td>Original Site</td>
</tr>
<tr>
<td>September 1992</td>
<td>49</td>
<td>Original Site&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Site&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td>September 1992</td>
<td>51</td>
<td>Original Site&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Site&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td>June 1994</td>
<td>100</td>
<td>Site 1 &amp; Site 2</td>
<td>Purpose built facility&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

1 Original nursing home that was condemned and required extensive rebuilding. Of its 110 bed licences, ten were transferred to another institution, leaving 100 bed licences to be relocated to Site 1 and Site 2.

2 Temporary sites which housed the residents from the Original Site.

3 Purpose built facility replacing the building on the Original Site.

In Australia, the aged who are institutionalised are disempowered; they have no power over their own circumstances, and cannot act as agents for change, either individually for themselves, or as a group for the collective. Between 1982 and 1994, the Federal Government commissioned various reviews into the nursing home industry (McLeay 1982; Giles 1985; Braithwaite, Makkai, Braithwaite, Gibson & Ermann 1990; Gregory 1993; Gregory 1994). These reviews acknowledged that change was necessary within the nursing home industry both in the way in which the Federal Government responded to the industry and in the way in which the industry responded to its residents.
1.1 FORCES WITHIN THE NURSING HOME

A number of forces exist within the nursing home which order the quality of life and well-being of the residents (fig. 1.1). These forces create an inertia that is reinforced on the one hand by most of the major stake holders (that is, the administration, the staff, family members/advocates and the public) and by the resident on the other who must passively accept the situation through lack of choice.

![Diagram showing the forces ordering the quality of life for residents in the nursing home]

**Figure 1.1** Forces ordering the quality of life for residents in the nursing home

The combination of these forces reduce the amount of autonomy and the degree of control that the institutionalised aged person can exercise in their own residential environment.
1.2 THE DEMOGRAPHIC CONTEXT OF THIS THESIS

Like other Western countries, the Australian population is an aging one (Jain 1994); each aging generation is larger than the one that went before it. This population growth is attributable to lower mortality rates, improved overall health of most Australians, post World War II migration trends, and reduced fecundity (Rowland 1991 p. 22). This means that each new generation is smaller than the one before it. In 1991, 11.4% of the population was aged 65 years or over. This figure is expected to rise to 12% in 1996 and to rise further to 12.3% by 2001 (Jones 1992 p. 12). This demographic trend can be measured by the dependency ratio and will impact on the levels of service provision for all aging Australians.

The dependency ratio is a useful statistical measure as it provides an index which demonstrates the impact an aging population exerts on the overall population of Australia. The formula for this dependency ratio adds the sum of all children aged 14 years and under and all adults over 65 years of age. This is then divided by the sum of all adults between the ages of 15 and 64 years (Kendig & McCallum 1986; Goodhall 1987; Beaglehole, Bonita & Kjellstrom 1993; Coggon, Rose & Barker 1993; Sax 1993; Abrahams, d'Espaignet & Stevenson 1995). The formula can be represented as follows:

\[
\text{Dependency ratio} = \frac{\text{children (<14)} + \text{aged (>65)}}{\text{adults (15-64)}}
\]

Application of this age dependency ratio reveals a predicted rise from 16.7% in 1991 to 19.7% in 2011 and then to 35% by 2041 (Tulpule 1992 p. 29). This
index expresses, in relative terms, the number of people the working population has to support. It is expected that in each decade until the year 2030 the dependency ratio will rise by 4% (Tulpule 1992; Sax 1993). This will have consequences for future public expenditure on age related health services.

A recent article in *The Economist* stated that...

"In 20 years time the proportion of most rich countries’ populations aged 65 and over will have doubled to 20-25%. Old people today consume a third of total health spending; the way things are going by 2000 they will be consuming half."


Even though Australia has a comparatively low dependency ratio compared with similar countries (Goss 1992), there is an imbalance in the allocation of finite resources which is weighted heavily toward the aged. Goss (1992 p. 97) states that for 1989-1990...

"Health expenditure per person rises beyond 50 years in all areas. In pharmaceutical’s and hospital expenditure, Australians over 65 years who are 11% of the population consumed 35% of expenditure."

Short, Sharman and Speedy (1993) claim that while "only 4% of the aged population live in nursing homes, 80% of Commonwealth spending on aged care is spent in nursing homes" (p. 153).

To manage this situation foresighting will be essential. Foresighting is active strategic planning that will provide opportunities to look ahead and plan for the
future of aged care in Australia (Australian Science and Technology Council (ASTEC) 1995 p. 3). As a stakeholder and potential future user in the aged care delivery industry, the public should have concerns about the demands an aging population will make on existing and future resource allocation. The concerns arise as most Australians approaching retirement age anticipate receiving some sort of a pension. A tension exists, because the pool of full-time workers paying tax is diminishing and is also becoming younger. This means that with an increasing aged population the capacity of the labour force to support this increase decreases. This section of the labour force is becoming younger as retirement ages decrease, down-sizing and out-sourcing of companies occurs and as fewer young people enter the full-time paid work force.

This demographic trend will accelerate the anticipated steady increase in the dependency ratio which will lead to significant reductions in the quality and level of service provision.

Compulsory superannuation, which will create a pool of resources for a person to draw on in advancing age, is a generational phenomenon. The full economic and social impacts of this will not be felt for three or four decades when the next generation reaches retirement age and has significant superannuation to draw on instead of receiving a pension (Bateman & Pigott 1992; Clare & Kehl 1992; Foster 1992; Tulpule 1992; Short et al. 1993; Sargent 1994; Rosenman 1995).

Alongside the productive baby boomers are the chronically long term unemployed who will never have a pool of resources to draw on. Some first wave unemployed youth will never have been in paid employment throughout their lifetime. These factors will alter the dependency ratio as the permanently
unemployed will have been dependant on government support throughout the 15-64 year period of their lives (Bateman & Piggott 1992; Sargent 1994).

1.3 AGE-SPECIFIC SERVICES

As the population of Australia ages, the demand for age-specific services will rise. To be aged in the Australian context means on average, that you are over 65 years of age, have worked up until retirement age, own your own home and receive a pension or other form of government support/entitlement (Jones 1992; Sax 1993). Jones (1992) described the 'young-old' as being between 65 and 74 years of age, the 'middle-old' as being between 75 and 80 years of age and the 'old-old' as being over 80 years of age.

Age-specific services are used more by the middle-old and the old-old groups than by the young-old. Services directed at supporting an aged person in their own home, in the majority of cases, provides a service that is less costly to the community than institutionalisation. Where the needs of the individual exceeds these provisions, institutionalisation may become necessary (Jones 1992).

This need for long term aged residential care will have to be offset against the Australian Government's policy of nursing home bed licence reductions and hostel bed licence and Community Care Package increases. The increases in numbers of hostel beds and in Community Care Packages aims to provide increasing levels of assistance and support to the disabled and frail elderly in order that they can remain in their own homes for longer periods of time before institutionalisation may become necessary. This does mean, however, that hostels now provide increasing levels of supportive care for residents with more
extensive needs. This reduction in nursing home bed licences with subsequent increases in other supportive measures is in line with the Federal Government policy of deinstitutionalisation. If any of the supportive measures are utilised within the institutional framework, such as in a hostel to provide additional services for the resident, then the value of such measures as a means to achieve deinstitutionalisation must be questioned.

A significant reduction has already taken place in Australia, with a loss of 18.5 beds per thousand of population for people aged 70 years and over since 1983 (Abrahams et al. 1995 p. 102). This means that those people waiting for a nursing home bed may have to wait a considerable time and those who relinquish a nursing home bed for any reason may not be able to regain the bed. This further eliminates any choice in an interinstitutional relocation.

Meyer and Speare (1985) have addressed the relationship between need and service provision in their propositions about residential mobility amongst aged people. They contend that there are three decremental stages in aged mobility patterns: a move to be close to amenities they may need in the future; a move to secure assistance as they age; and a move to ensure care in their frail age.

Ensuring the timely provision of aged care is difficult (Gregory 1991). A range of options exists for aged care, but at first the individual can be cared for at home by utilising community based services such as Meals On Wheels, Community Option programs, the use of community outreach programs, day care centres and respite services from time to time (Gregory 1991).

Care can also be provided in specialised residential settings such as a retirement village. Many of these retirement villages have graded services available and are
provided according to the needs of the individual, with a 24 hour on-call assistance being available (Edgar 1991). These settings provide the individual with some options about the level of care needed on entry to the facility. The independent living units allow the individual the advantages of living in their own home, but with the security of knowing assistance is available as, and if, required. Edgar (1991 p. 5) points out that on entry to a retirement village the resident receives:

"i) a set of housing goods and services;
ii) a set of non-housing goods and services;
iii) a set of property rights."

This means that the resident outlays a capital sum of money, pays an ongoing set management fee, and may not realise any capital gains over time from these housing goods and services and property rights. The non-housing goods and services provides the level of assistance and security the individual feels is needed. This system means entry to this level is often costly and irreversible. Generally, these independent living units are a part of an institution designated for aged care. (Coleman & Watson 1985; Minichiello, Alexander & Jones 1992; Sax 1993)

A second option is hostel accommodation which provides a higher level of supervision and assistance than an independent living unit. Hostel accommodation often follows living in a self care unit and precedes admission to a nursing home (Edgar 1991). New South Wales has 21,206 hostel places. Again these are concentrated in the Inner City and the Northern Suburbs of Sydney (McFee & Bray 1995 p. 63). Meals are provided, rooms cleaned and a linen service is provided. There is a continual personal care service available for the resident. Many hostels are located adjacent to nursing homes (Coleman & Watson 1985; Sax 1993; Short et al. 1993).
The most costly form of aged care, but albeit that most often considered as an option for care, is nursing home care. This generally involves the relocation from the individual's home to a nursing home, with minimal chance of discharge back to their own home. A nursing home is an institution that provides continual long term nursing care in a controlled residential environment. Even though this may be convenient for families, this type of institutionalisation raises the spectre of a reduction in the individual’s quality of life, personal control and autonomy (Goss 1992; Sax 1993; Short et al. 1993).

1.4 QUALITY OF CARE AND QUALITY OF LIFE

Not all Australian nursing homes have been reputable care deliverers and levels of care, and the quality of life experienced across nursing homes fluctuated greatly (Braithwaite, Braithwaite, Gibson, Landau and Makkai 1992 p. 1). Complaints from consumers and their families about poor care and poor quality of life forced the Commonwealth Government into a reform of the nursing home industry which was commenced in 1986. Friedan's (1993) impression of nursing homes "as death sentences, the final interment from which there is no exit but death" (p. 478) sums up the negative images that surround them. The Victorian Aged Services Peak Council in 1987 reported on 24 nursing homes. They found that only a small number of residents (20%) were washed/bathed or showered daily and the majority of residents were bound either to their chair or wheelchair. At this time, the monitoring process for Australian nursing homes consisted of regular checks on the physical conditions in which the resident was housed and on the adequacy of staffing levels (Sax 1993 p. 104). It was clear that reform was needed.
This need for reform was emphasised by the findings of the McLeay Report (In a Home or At Home: Accommodation and Home Care for the Aged, 1982) and the Giles Report (Private Nursing Homes in Australia: Their Conduct, Administration and Ownership, 1985) which were commissioned by the Federal government to investigate the standards of care provided for residents in Australian nursing homes and hostels.

To address these issues of quality of care and quality of life in Australian nursing homes, The Commonwealth Department of Human Services and Health, in 1987, introduced The Outcome Standards For Australian Nursing Homes as a part of the Quality of Residential Care subprogram (Department of Human Services and Health 1995 p. 152). This was produced as a result of the Nursing Homes and Hostels Review conducted by the Commonwealth Government in 1985 (Gregory 1993 p. 5). The Standards Monitoring of Australian nursing homes aimed "to optimise the quality of care and quality of life of residents in residential care for the aged subsidised by the Commonwealth Government" (Department of Human Services and Health 1995 p. 152).

These Outcome Standards For Australian Nursing Homes comprise seven objectives within which are 31 standards (Department of Community Services and Health 1987 p. viii) (Appendix 1). These objectives and standards represent the minimum standard of care expected to be given to a resident in a nursing home in Australia. The seven objectives cover health care, independence, freedom of choice, homelike environment, privacy and dignity, variety of experience and safety (Department of Community Services and Health 1987). This approach to monitoring Australian nursing homes was a huge change from the former inspection system which focused on matters such as the availability of clean linen and the number of bed pans. The new standards introduced an approach which
dealt with the effect of the outcomes for the residents. This meant that issues about the quality of life became central to the monitoring process which was carried out by trained Monitoring Teams (Braithwaite et al. 1992).

To invigilate the implementation of this quality program, the Monitoring Teams regularly visit Australian nursing homes and determine if the standards (*The Outcome Standards For Australian Nursing Homes*) are being met. Failure to comply with these standards can result in financial sanctions against the non-compliant nursing home (Department of Community Services and Health 1987; Gregory 1993; Gregory 1994; Department of Human Services and Health 1995).

Quality of life, however, is difficult to define (Braithwaite et al. 1992). In the context of this thesis, quality of life is defined as a participative sense of well-being that enables the individual to continue to grow and develop, taking advantage of whatever support mechanisms are available in their current environment. Quality of life can be said to represent the maximisation of an individual’s autonomy and control within the individual’s environment to provide optimal life-satisfaction for that individual (Department of Community Services and Health 1987; Johnstone 1989; Minichiello et al. 1992).

In an institutional setting, quality of life for the individual depends on many factors including the cooperation of other residents and harmony with and amongst the staff (Wagner 1988). Without this, individuals become the participants of external forces and tensions which militate against their quality of life. This was recognised by Braithwaite et al. (1992 p. 6) in their report *The Reliability and Validity of Nursing Home Standards.*
The report states...

"The most important role of standards is as mechanisms for focusing dialogue between the government and the industry, between consumer advocates and the industry, between directors of nursing and staff, between consultants and staff, between residents and staff and between educators and students about how to improve the quality of life in nursing homes."

Personal control and autonomy are complementary components of the quality of life (Wilson-Barnett 1983). In any nursing home this includes input by the individual into any decisions that are made concerning them. It should mean that the resident's wishes are just not overridden or disregarded, and that they have real choice. However, the long term care facility has often already judged the individual as being cognitively unable to make an informed decision. It is easy for the individual to become part of a situation where institutionalised tokenism and ageism occurs and where any decisions made by the individual are summarily dismissed or are made by others on their behalf (Johnstone 1989; Bytheway & Johnson 1990).

Where the individual is truly unable to make their own decisions because they are too cognitively or physically impaired, then the quality of their life becomes the de facto responsibility of the family or significant other. An open, honest negotiation process with these people is critical when issues relating to quality of life for them are raised (Wagner 1988).

In many circumstances, quality of life becomes dictated by others as they become the choice makers for the institutionalised person. The possible choices are
always limited by available resources. These choices are also difficult; for example, the residents' perception of a quality outcome for themselves may not match the subjective perception of the administration, the relatives or the staff.

The resident's perceptions about quality of life issues can be overtaken by a collective perception that is external to the resident. Each choice maker generates different levels of activity depending on their particular vested interest. A discriminating question to ask is: is what appears to be an issue for everyone else, really an issue for the resident? For example, a resident's family believes that the care being given to their mother is inadequate, but their mother is quite happy with the care. The family lodge a complaint with the administration that is directed back to the resident. The resident maintains there is no problem, but becomes involved in an issue generated by others external to themselves.

2.0 HOUSING AND HEALTH

A strong relationship exists between housing and health (Lowry & Bynum 1991; Conway 1995). In the context of this thesis health is defined as the "dynamic life experience of a human being, which implies continuous adjustment to stressors in the internal and external environment" (Miller 1990 p. 61). Health problems can be related to the physical environment. This applies to long term aged care institutions and for public or private housing (Wagner 1988; Smith 1989; Lowry & Bynum 1991). Not all nursing homes are newly built or aesthetically pleasing (Gregory 1994). Until the introduction of The Outcome Standards For Australian Nursing Homes, the physical surroundings of nursing homes did not often attract dedicated resources; however The Outcome Standards For Australian Nursing Homes forced attention to be paid to these aspects (Department of Community Services and Health 1987). In this document Standard 4.1-Homelike
Environment (1987 p. 31), refers to and describes the outcomes each nursing home is expected to meet in the provision of homelike physical surroundings. Since the introduction of these guidelines, they have in part, reduced the austerity of aged long-term care facilities (Braithwaite et al. 1992; Sax 1993).

3.0 RATES OF INSTITUTIONALISATION

In 1994 there were 55,092 permanent nursing home bed licenses in Australia (Abrahams et al. 1995; Department of Human Services and Health 1995 p. 162). This represents accommodation for 4% of the Australian population. One quarter of these aged people are aged over 80 years (Short et al. 1993 p. 153). New South Wales has 29,905 of these beds (McFee & Bray 1995 p. 63). The nursing home that participated in the research for this thesis is in the Sydney Inner City Region of The Department of Human Services and Health, which has 6,859 bed licenses or 23% of these beds (McFee & Bray 1995 p. 63). This is a high proportion of all the bed licenses in New South Wales (NSW).

The high number of bed licences demonstrates the relationship between frail age and institutionalisation. The frail elderly represent the part of the aged population which is least able to cope with and adapt to the restrictive environment of an institution, but with few or no other options available for relocation (Wilson-Barnett 1983). Aspects of these residents lives are controlled by staff who may have differing agendas to their own (Friedan 1993). This leads to ageist treatment where the residents are socially marginalised by the view the outside world has of nursing homes (Wagner 1988; Friedan 1993). Frequently this is a quite negative view, centring on the negative stereotypes which define a nursing home as an undesirable place to live and die in, as well as an unpleasant place in which to work (Wagner 1988).
4.0 THE IMPACT OF INSTITUTIONALISATION

The impact of institutionalisation on older people is powerful (Coffman 1981; Horowitz & Schulz 1983). Goffman defined an institution as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed formally administered round of life" (Goffman 1961 p. 11). Bennett and Nahemow (1965) identified ten criteria that characterise the degree of control an institution has over the residents. These are the:

1. permanency of the resident;
2. centrality of the activities provided for the residents;
3. fixed nature of all activities carried out at the centre;
4. imposition of rules of conduct by the resident;
5. level of observation of the residents by the staff;
6. manner in which good and bad behaviours are recognised and treated;
7. lack of resident involvement in decisions that impact on them;
8. absence of personal belongings;
9. non-consensual nature of the admission process; and
10. imposition of a communal lifestyle.

Nursing homes in Australia have many of these characteristics. In fact, any long-term residential aged care facility is an institution, but this is not to say that every new resident is adversely affected by this.

Some seniors who relocate to a nursing home adjust in a positive manner and maximise their potential by being able to achieve more of the activities of daily
living than before admission and by broadening their social base (Zweig & Csank 1975; Gutman & Herbert 1976; Kleemeier 1961; Belsky 1990). Others find the adjustment overwhelming and beyond their adaptive capacities (Cox 1987; Short et al. 1993). What is often forgotten is that prior to admission to a nursing home, the individuals all had different life experiences and different backgrounds (Tuan 1977; Rowles 1978; Csikszentmihayi & Rochberg-Halton 1989). All the individuals seeking admission had been judged as in need of long-term care. It is on these differences that the institution aims to confer homogeneity.

Admission to a nursing home also impacts on the family: some family members are relieved as the family collectively may no longer be able to look after their aged relative; some grieve for the loss of the person from their household and miss them and the role they played in their care; some are simply disinterested and do not miss either their relative or the role associated with being a carer (Wilson-Barnett 1983).

Irrespective of the impact of institutionalisation, and even if the worst statements concerning nursing home life are true and the residents are considered to be invisible, the institution and the resident remain a part of the broader socio-political organisation. The nursing home is a part of the health organisation of the community which deals with the increasing life expectancy of the individual resident. It is a part of an industry that deals in palliation. A silence surrounds the operational aspects of the nursing home as the residents become the victims of the tensions that function within it (Albrow 1970; Belsky 1990; Gibb 1990). The impact of institutionalisation on all those who are involved in the process of institutionalising an aged person is profound (Belsky 1990).
5.0 THE CENTRAL PROPOSITIONS OF THIS THESIS

This thesis aims to examine the inertia and passivity that surrounds the issue of forced interinstitutional relocation amongst aged people; the circumstances that surround a forced interinstitutional relocation; and the quality of life experienced by residents in a nursing home following a forced interinstitutional relocation.

Nursing home care is the most expensive form of aged care aside from acute hospital bed occupancy (Goss 1992). The high cost may not correlate with the quality of life an individual experiences or the quality of care they receive as a resident of a nursing home, although the *Outcome Standards For Australian Nursing Homes* have tried to standardise and address this. Despite this, an individual occupying a nursing home bed is unlikely to voluntarily relinquish it, no matter how difficult it becomes for them as they want the security of ongoing care and usually have no other options (Aarons, Went & Williams 1984).

This may be one basis for the inertia and passivity that prevails. The residents may contribute to this inertia themselves because they have no other options and so comply with the demands of their institutional environment. This compliance may therefore be seen as a secondary adaptive behaviour.

Those with a bed in a new facility may have to grapple with increased social isolation as a result of new architectural designs aimed at improving privacy (Department of Community Services and Health 1989). This reduces the numbers of residents in rooms and aims to provide a home-like environment. This reduction in the numbers occupying each room may lead to the loss of close friendships that had previously developed between residents. The uncertainties of
a new environment create anxieties even if the relocation is seen as a positive experience (Thomasma, Yeaworth & McCabe 1990). Relocation and institutionalisation are not accorded the significance they deserve and may be major catastrophes in the life of an individual (Moos 1980; Friedan 1993).

This overview raises issues which have differential significance for nursing home administrators, nursing home staff, the individual in a nursing home, the individual’s family and the public. Each of these are significant stakeholders in the situation. The administrators strive for a cost effective and profitable service that gives the appearances of a well run institution and one which meets the objectives and standards of The Outcome Standards For Australian Nursing Homes. The tensions that exist between the Outcome Standards For Australian Nursing Homes monitoring process and the nursing home industry has been well documented in the Review of the Structure of Nursing Home Funding Arrangements Stage 1 (Gregory 1993). This tension is compounded as administrators work with finite resources to meet the objectives and the accompanying standards that have been externally imposed upon them.

The nursing home environment is organised on a bureaucratic model (Albrow 1970). What this then dictates is an environment where all actions are dependant on the decisions of the administrators. Ironically, these administrators are predominantly males who are operational in a more predominantly female environment (Gibb 1990; Davis 1994). What this means for the resident is that they are part of a residential institutional culture that nursing home administrators have deemed to be appropriate.

The staff of a nursing home want a problem free environment that provides a reasonably predictable place to work (Castledine 1987). This environment is
organised around objectives: a rational management of the daily tasks and activities they are expected to carry out; and a resident management process that reduces any excesses of emotional involvement with the residents (Castledine 1987). The individual, or the participant of the processes surrounding them, has the greatest stake in terms of quality of life, autonomy, choice and power.

For the family, the burden of care has been alleviated by moving their aged relative into a nursing home, but however the feelings of guilt and inadequacy which often surround a nursing home placement have not been reduced (Friedan 1993). The family do not want to feel depressed when they visit. Rather, they would like the visits they make to the nursing home to detract from the pain they are feeling at having to passively endorse the practices that take place in the institution by creating an environment of non-complaint. When the family does complain, the wishes of the resident may be overlooked.

The public's stake is an enormous economic one which indirectly supports the institutionalised minority of aged people through taxation. This may, in turn, produce apathy to the issues concerning long term aged care that surround the appropriation of these resources.

Any relocation for an aged person is an upheaval (Gallagher & Walker 1990; Thomasma et al. 1990). Many who have remained in the family home throughout their lifetime who are contemplating relocation to an institution have an enormous transition to make as they consider the relocation. Those who are already in an institution and have to move to another institution (interinstitutional relocation) face uncertainty and destabilisation (that is, a disrupted homeodynamics where the person is unable to optimise their new surroundings). Little research has been carried out in this area as a nonconsensual interinstitutional relocation of this
nature is an unusual situation (Stein & Morse 1993). This may change however, as stocks of nursing homes age and will need replacement.

This thesis will examine the effect of a forced mass interinstitutional relocation on the quality of life for nursing home residents. The following Chapter sets out the aims and the hypotheses of the study. A literature review is contained in Chapter 3. Chapter 4 discusses the methodological issues which arose. A brief history of the forced interinstitutional relocation is contained in Chapter 5. The methodology used in the study is described in Chapter 6. Chapter 7 reports the results of the study and Chapter 8 discusses some relevant study outcomes and makes some recommendations for further studies in this area.
CHAPTER 2

STUDY AIMS AND HYPOTHESES

AIMS
HYPOTHESES
ADDRESSING THE AIMS
2.0 AIMS

The aims of this study are to determine:-

1 If the quality of life of residents in a nursing home is affected by a forced relocation.

2 Whether certain variables (gender, previous voluntary relocation, medication usage, affective status, and number of residents in rooms) have a strong influence on outcomes for the resident.

2.1 HYPOTHESES

It is hypothesised that:-

Hypothesis 1

Quality of life in a nursing home is affected by a forced relocation, from one nursing home to another nursing home, but the extent of the impact is strongly influenced by such factors as gender, previous voluntary relocation, orientation levels, medication usage and the number of people in each room.

Sub-hypothesis 1.

Quality of life in a nursing home is affected by a forced relocation from one nursing home to another nursing home, with the extent of the impact diminished by gender.
Sub-hypothesis 2.
Quality of life in a nursing home is affected by a forced relocation from one nursing home to another nursing home, with the extent of the impact strongly influenced by the number of previous voluntary relocations prior to institutionalisation.

Sub-hypothesis 3.
Quality of life in a nursing home is affected by a forced relocation from one nursing home to another nursing home, with the extent of the impact diminished by orientation levels.

Sub-hypothesis 4.
Quality of life in a nursing home is affected by a forced relocation from one nursing home to another nursing home, with the extent of the impact strongly influenced by medication usage.

Sub-hypothesis 5.
Quality of life in a nursing home is affected by a forced relocation from one nursing home to another nursing home, with the extent of the impact influenced by the number of residents in a room.

Hypothesis 2.
There is a difference in the forced relocation from one nursing home to another nursing home experience between the male and female residents of a nursing home.
2.2 ADDRESSING THE AIMS

To address the aims this thesis will:

1. Review the literature relating to the issues concerning:
   i) long term residential care;
   ii) relocation of the aged;
   iii) interinstitutional relocation; and
   iv) stress and ageing.

2. Evaluate a relocation and decision making model that takes into account the individual, the consensual and the non-consensual decision making processes surrounding relocation and the outcomes for the individual.

3. Develop and test a set of indicators that can assess the impact of relocation experienced by an individual in a nursing home.

4. Use a combination of methods to test the hypotheses.
CHAPTER 3

LITERATURE REVIEW AND DEVELOPMENT OF AN EXPLANATORY MODEL

OVERVIEW
VOLUNTARY RELOCATION OF THE AGED
LONG TERM RESIDENTIAL CARE
INTERINSTITUTIONAL RELOCATION
STRESS AND AGEING
A MODEL OF THE PROCESS OF RELOCATION BY AN AGED PERSON
3.0 OVERVIEW

This literature review is divided into four sections:

i) voluntary relocation of the aged;
ii) long term residential care;
iii) interinstitutional relocation; and
iv) stress and ageing.

A model, The Relocation/Adaptation Model (RA) - a model of the process of relocation by an aged person, has been derived from the literature and its application and uses are described. These four areas have been specifically chosen for the literature review as the relevant literature available contributes directly to the issues this thesis aims to examine.

3.1 VOLUNTARY RELOCATION OF THE AGED

This section will:

i) articulate the main reasons why older people relocate;
ii) consider the various types of aged relocation; and
iii) briefly review some of the relevant literature in this area.

3.1.1 Moving from the family home

Aged people move for a variety of reasons (Golant 1980; Wiseman 1980; Hugo & Wood 1984; Hartwigsen 1987; Rowland 1991; Jones 1992). Over the past twenty years aged relocation has been studied in North America (NA), Great Britain (GB) and Australia (A). Major NA studies (Van Ardsol, Sabagh & Butler 1968 (NA); Golant 1979 (NA); Aday & Mills 1982 (NA); Longino 1982 (NA); Meyer
& Speare 1985; (NA) De Boer 1985 (NA); Brent Hall, Roseman, & Joseph 1986 (NA)) were directed towards residential relocation amongst the well elderly.

These studies were informative: they revealed that aged people move less frequently than younger people (De Boer 1985); that a former centralisation of elderly people in metropolitan areas is breaking down (Fuguitt & Tordella 1980 (NA); Wiseman 1980 (NA); Ford & Warnes 1993 (GB)); costs of private sector retirement complexes militate against the poor seeking entry (Longino 1982; Clark & Davies 1990 (NA)); both public and private sector retirement complexes attract the very old and the single (Warnes & Ford 1993 (GB)); the elderly who move long distances are relatively well educated, have good incomes and do not come from population minorities (Meyer & Speare 1985; Hartwigsen 1987 (NA); Warnes & Ford 1993); there is a positive relationship between happy early life relocations and later life relocations (Wiseman 1980); there is an ongoing tendency for the individual to grow old in their own home (Ford & Warnes 1992; Ford & Warnes 1993); the dispersion of the aged population is selective over broad geographic areas (Warnes & Ford 1993); and the establishment of specific aged residential complexes creates alterations in aged population’s congregations and concentrations (Brent Hall et al. 1986; Warnes & Ford 1993).

Other studies (for example, Wiseman 1980; Lee 1980 (GB); Golant 1980; Hugo & Wood 1984 (A); Wilson 1988 (A); Baglioni 1989 (NA); Jones 1992 (A)) have included analyses of the motivations for relocation. These include a desire for increased personal security and safety (Wiseman 1980; Mullins, Tucker, Longino & Marshall 1989 (NA)); reduced health status and an accompanying decline in personal independence (Schultz & Brenner 1977 (NA); Ford & Warnes 1993); a desire to be near family members and/or medical services (Wiseman 1980; Ford
& Warnes 1993); following the death of a spouse or close family member (for example a sister) (Yawney & Slover 1973 (NA)); negatively perceived changes in the urban environment (Golant 1980); a need to realise capital and reduce home running costs (Wiseman 1980; Hartwigsen 1987) and a desire to be near recreational activities (Ford & Warnes 1993). Wilson (1988) particularly noted that there was an expressed desire for material comfort amongst relocatees, with possibilities for continuity of care if the individual moved to a tiered retirement village.

Golant (1980) felt that individuals who moved to retirement complexes experienced less ageism (that is, demonstrated prejudice from both the community and institutions) than those who remained in the broader community. This was attributed to the normative behaviours in a retirement community which are not work directed. Golant also noted the role of social learning, in that relocatees were often motivated by the positive expressions of satisfaction from acquaintances who had already relocated.

The need for the relocatees to be part of a network of friends, family and neighbours was also considered a motivation for relocation (Jones 1992). A specially designed environment was also considered an incentive to relocate so that services which met an ageing person’s changing needs over time would be available (Jones 1992). The literature, while identifying the reasons and the motives for relocation also examined the general and specific consequences of relocation to the individual, the existing service provision levels and the effects on the relocation target area. Most existing services were inadequate for high levels of aged migration. Specialist age specific services, for example, Meals On
Wheels, Home Help and Community Outreach programs would need considerable expansion in order to meet extra need.

Another consequence of relocation, both to the individual and on the existing services, is the demand placed on underdeveloped public transport systems. Hugo and Wood (1984 p. 141) reported that with increasing age, car ownership amongst the elderly reduces. The difficulties of access onto buses and trains, for example, with fixed high steps, create a reluctance on the part of the aged to use them because of feelings of physical insecurity.

Rowland (A) (1991 p. 75) postulates that those who can not use public transport may need to relocate earlier than those who are able to use existing public transport services. In outer urban and rural areas of Australia, public transport is scheduled around the needs of peak hour working travellers (Minichiello et al. 1992 (A)). This means that older women who do not work are predominantly disadvantaged by the inadequacies of the public transport system because many did not learn to drive when younger, having relied on their male partner for car transport. The net effects of this restricted accessibility are an increase in the isolation of the aged, the increased potential for an early forced relocation and a rise in the demand for home provided services.

3.1.2 The different types of aged relocation

The various types of residential relocation in which the aged can engage are illustrated in Figure 3.1, The types of non-Institutional and institutional residential relocation. The types of relocation identified are based on declining levels of independence. A critical factor when considering the types of relocation is that any relocation creates stress for the mover (Creed 1987).
Relocation is either consensual (voluntary) or non-consensual (forced) and one useful organisational categorisation regards it as being:

i) utility driven;

ii) sunbelt in orientation; or

iii) institutional in nature (ie from the community to an institution or from institution to institution).

3.1.2.1 Utility relocation

Utility relocation is defined as relocation closer to facilities such as health services, public transport systems, family support mechanisms and leisure activities (Brown & Moore 1970 (NA); Wiseman 1980; Wilson 1985; Litwak & Longino 1987 (NA); Speare & Meyer 1988 (NA)). Rowles (1986 (NA)),

Figure 3.1 The types of non-institutional and institutional residential relocation
describes relocation target areas as being well serviced and reasonably accessible. Utility relocatees are characteristically ‘young-old’ couples, aged between 65 and 74 years, with a middle to high income level (Wiseman 1980; Wilson 1985; Speare & Meyer 1988). One of the main problems of this type of relocation is that when one spouse dies the partner tends to remain alone in the relocated area and this then creates future demands for previously unused services (for example, Meals On Wheels and public transport) (Hugo & Wood 1984).

3.1.2.2 Sunbelt relocation
Sunbelt relocation, an American term, is defined as a move to a more pleasant year-round climate, usually to eliminate the cold winter months and to avoid excessive summer temperatures (Krout 1982 (NA); Sullivan & Stevens 1982 (NA); Murphy & Zehner 1988 (A)). Krout (1982) described the phenomenon known as seasonal sunbelt migration, where a percentage of the aged population migrate to warmer areas for the winter. It has both social and economic consequences as contributions are made to the economies of the target sunbelt location (Marshall, Mullins & Longino 1993).

Hugo and Wood (1984), report that in Australia there is a demonstrable move north in winter to areas such as Queensland by the 60 plus age group. Other areas that are sunbelt relocation targets are the Hunter Statistical Division (SD), Mid-North Coast SD and Eurobodalla in the South Eastern SD in NSW, Australia (McFee & Bray 1995 p.100). These areas of NSW have undergone high growth amongst the population aged 65 years and over as a result of sunbelt relocation. Table 3.1 presents Older People by Statistical Division, NSW, 1993 (Australian Bureau of Statistics).
One ramification of this population move for the target area is a fluctuating, unpredictable demand for services. For the individual, though, a seasonal relocation provides an excellent compromise situation where old ties can be kept and new ones developed. The positive benefits to the relocatee are a reduction in the effects of chronic diseases due to a more temperate climate; a decline in the cost of living as they are living outside a major city area; and a chance to familiarise themselves with the area and others permanently residing there with a view to permanent relocation (Krout 1982; Hugo & Wood 1984; Murphy & Zehner 1988; Marshall et al. 1993 (NA)).
Overall, sunbelt relocation represents an important lifestyle choice for older people (Haas & Serow 1993 (NA); Hogan & Steinnes 1993 (NA)). Seasonal sunbelt migration is unlikely to continue after the death of a partner, or if declining health prevents the annual trip from being made (Daciuk & Marshall 1989 (NA); Marshall et al. 1993). Increasing age and the general effects of the ageing process also militate against sunbelt relocation (Daciuk & Marshall 1989 (NA); Marshall et al. 1993).

3.2 LONG TERM RESIDENTIAL CARE

The literature identifies the options for long term residential care for an aged person. These are:

i) relocation from the community to a sector of a retirement village complex;

ii) relocation from the community to a nursing home; and

iii) relocation from the community or other aged care facility to a psychiatric care setting.

3.2.1 Relocation from the community to a sector of a retirement village complex.

Any care level or sector of a retirement village can be classified as an institution (Goffman 1961 p. 11). In this situation, resident behaviours are controlled by contractual rules, which in turn prescribe the social norms of the institution. Wilson (1986 p. 3) has identified the following benefits from entering into these contractual arrangements:

i) physical safety and security;
ii) relative homogeneity of age, class, living status and sex;

iii) freedom from responsibilities for maintenance of the exterior environment;

iv) material comfort including new housing and fittings-designed with the needs of older people in mind;

v) a leisure lifestyle with facilities provided on site; and

vi) continuity of care with arrangements on site, or domestic and personal care from elsewhere for support in the event of increased dependency.

This set of expectations is supported through legislation (for example, in NSW The Retirement Villages Act 1989) which sets out to ensure those who enter into such contractual arrangements are aware of the implications.

The reasons given in the literature for entry into a retirement village reflect the individual benefits previously stated by Wilson (1986), Day & Harley (1985 (A)), Hunt, Feldt, Marans, Pastalan and Vakalo (1984 (NA)), Coleman & Watson (1985 (A)) and Freidan (1993 (NA)), and are consistent with the general relocation literature. What has been overlooked in the general Australian relocation literature is the gender bias of those who use retirement village services either at Independent Living Unit level or at hostel level (Bates & Linder-Pelz 1990: Gibb 1990). Females without partners are the biggest users of these facilities (McFee & Bray 1995).

3.2.2 Relocation from the community to a nursing home

Early research concerning the effects of relocation on the aged from the community to a nursing home centred on mortality rates post admission (for
example, Lieberman 1961 (NA); Aldrich & Mendkoff 1963 (NA); Ogren & Linn 1971(NA); Yawney & Slover 1973). While the literature does not deny the increased risk of mortality, extensive reviews (Aldrich & Mendkoff 1963; Shanhinian, Goldfarb & Turner 1966(NA); Jasnau 1967 (NA); Ogren & Linn 1971; Lieberman 1974 (NA); Coffman 1981(NA); Borup 1983; Horowitz & Schultz 1983 (NA)) of the various studies undertaken yielded inconclusive evidence that mortality rates were a useful index in the assessment of either positive or negative outcomes of such a relocation. This is due to the individual researcher’s inability to agree on methodological appropriateness, the exclusion of some articles from the review process, the subjectivity of mortality indices, and the differences in individual health status of the participants (Coffman 1981; Borup 1983; Horowitz & Schultz 1983; Thomasma et al. 1990 (NA)).

Coffman (1981) identified eight factors related to institutionalisation and mortality. He argued that age, gender, physical and mental status, the degree of choice about admission, the preparedness of the resident, the amount of environmental change experienced and the level of individualised care given effected the level of stress of the resident.

Recent studies (Thomas 1988 (A); Zlobicki 1988 (A); Thomas & Hayley 1991 (A)) have identified particular characteristics of relocatees that play an important role in promoting adjustment to and satisfaction with their move to a nursing home. These characteristics are feelings of personal control and autonomy (Thomas 1988; Zlobicki 1988; Thomas & Hayley 1991).

Studies conducted by Tobin (1980), Dooghe, Vanderleyden & Van Loon (1980), Ferraro (1982) and Stein, Linn and Stein (1985) revealed that negative attitudes
prior to relocation were related to subsequent dissatisfaction, low health status and personal distress. Watson (1980 (NA)) reported that cognitive deprivation as a result of living in an unstimulating environment with a low emphasis on exercise, led many relocatees into a mindless state which increased their morbidity and in some cases led to an earlier than anticipated death.

Dye and Erber (1981 (NA)) reported that intensive pre-relocation programs can impact on the negative attitudes held by relocatees and their families. Their study showed that such a program led to lowered self-reports of anxiety and greater feelings of internal control by the relocatees. Mertens and Wimmers (1987 (The Netherlands)) found that positive attitudes to being dependent held the key to a successful transition to a nursing home environment.

Zlobicki (1988) examined the individual’s perception of life quality on admission to a nursing home from the community. The study, conducted in Brisbane, Queensland, found that a resident's mood state on admission determined their reactions to their relocation. Zlobicki (1988 p. 58) suggests "that the respondent’s perceived happiness and life satisfaction have been affected not so much by their nursing home circumstances as by outside influences such as family/friend contact, attitudes brought into the nursing home and health/disability status."

Thomas (1988) studied a number of long-term care residences in Melbourne. Among indices examined, were perceptions of personal control and feelings of satisfaction of the residents. Those who felt they had autonomy, expressed feelings of satisfaction and control, and showed an increased incidence of social interaction with other residents. Those who experienced powerlessness and low control withdrew from those around them.
Thomas and Hayley (1991) also found that a positive attitude towards relocation was engendered by active involvement in the process itself. Those who were more involved in the process reported a high level of happiness and well-being compared to those who were not. This clearly supports the value of personal control (Langer & Rodin 1976; Rodin & Langer 1977; Lazarus & Launier 1978; Rodin, Bohm & Wack 1982; Lieberman & Tobin 1983; Holahan, Holahan & Belk 1984).

Langer and Rodin (1976) conducted a study that increased the level of decision making by capable residents in nursing homes. A control group and an experimental group were used for the study. The study group were given the right to make their own decisions about where they had their furniture and which movies they wanted to see. The control group had these decisions made by the staff. The results of this study showed a higher mortality rate for the control group than for the study group. In addition, the study group showed an improvement in both physical and mental well-being. The researchers concluded that "some of the negative consequences of aging may be retarded, reversed or possibly prevented by returning to the aged the right to make decisions and a feeling of competence" (p. 196).

Rodin et al. (1982) assert that nursing home settings deny the resident control over their environment. The resident responds to this by either seeking to reassert this lost control by a process of psychological reactance or by becoming helpless in the situation (Rodin et al. 1982 p. 154). Both are considered to be negative responses and to have an effect on the physiological well-being of the individual. When the individual's perceptions about their own levels of control
are enhanced, so to is their physical well-being. A reduction in stress and increased satisfaction also occurs (Langer & Rodin 1976; Rodin et al. 1982).

3.3 INTERINSTITUTIONAL RELOCATION

The effects of interinstitutional relocation prompted by factors such as renovation and facility closure have also been examined (Bourestom & Tars 1974 (NA); Watson 1980 (NA); Bonardi, Pencer & Tourigny-Rivard 1981 (NA); Wells & MacDonald 1981 (NA); Mirotznik & Ruskin 1984 (NA); Gallagher & Walker 1990 (NA); Thomasma et al. 1990 (NA)). Those clients who faced forced relocation exhibited more negative effects than those who were able to exercise some choice in their relocation and those who relocated as a part of a large group had a higher mortality rate than those who were moved either individually or as a part of a small group of two to four people (Bourestom & Tars 1974; Watson 1980; Wells & MacDonald 1981). Preparation programs that sought to reduce the impact of the relocation on the relocatee had some effect (Watson 1980; Thomasma et al. 1990).

Boursetom and Tars (1974) identified continuity as a relevant factor in relocation settlement. They found that a forced relocation to a new and a larger facility with unfamiliar staff led to a higher than anticipated mortality rate amongst residents.

Watson (1980) studied the relocation of a group of African American men and women from a sheltered community setting to various integrated and non-integrated facilities. Watson hypothesised that the degree of 'transplantation shock' would be governed by factors such as socio-economic status, the relative importance of religious beliefs and practices, the closeness of family relationships, and the level of prerelocation preparation the resident had received. Further,
Watson argued that the elderly who had a high self-image and positive outlook could be distinguished by high physical maintenance levels (that is, the ability to take care of their own physical needs), high mental status and a desire to socially interact. The results of the study supported these propositions; relocation mortality occurred only in women displaying characteristics such as high levels of loneliness, life dissatisfaction and disengagement with low physical self care abilities, and poor mental status.

Wells and MacDonald (1981) focused on the value of small group and primary relationships within an institution, confirming the positive role they play when interinstitutional moves are necessary. They studied those interpersonal networks and primary relationships that would be disrupted as a result of forced relocation following the closure of the relocatee’s current nursing home. To reduce the impact on the individual of this relocation counselling sessions were set up to keep the individuals informed about matters concerning their relocation and to identify and allay emotional stress. Strategies to enhance self-esteem and improve feelings of autonomy were introduced. The relocation was carried out in small groups after these counselling sessions. Where possible, the integrity of established interpersonal networks was maintained. Whilst the relocation was a major physical and social disruption to their lives, the impact was reduced by the pre-relocation counselling and the fact that small established groups were moved together to the same facility.

Coffman (1981) identified "disintegrative processes" which can produce discontinuity, within the support mechanisms as the cause of mortality following interinstitutional relocation. He argues that it is essential to integrate the residents
to the new settings as soon as possible by providing many new support mechanisms for the resident (p. 492).

Similar work led Lieberman and Tobin (1983) to conclude that "the larger the dissimilarity or discontinuity between environments, the more numerous are the personal changes required to re-establish homeostasis" (p. 93).

An Australian interinstitutional relocation study conducted in Perth by the Anglican Homes (Ferguson-Stewart 1994), aimed to measure the impact of such a move on both residents and staff. The forced interinstitutional relocation came about from a need to upgrade existing nursing home stocks. Follow-up measures confirmed that feelings of control in the relocation and preparation programs for the residents prior to relocation reduced the impact of the move for the resident.

From the limited literature in this area, it does seem that there are optimum conditions that will assist the resident facing a forced interinstitutional relocation. Helpful are providing the resident with thorough information at all times about the move, providing choices for the resident wherever possible (for example, in the placement of furnishings and other occupants for the room), moving the residents in small groups of no more than four to six people, the maintenance of established primary networks amongst the residents, and the provision of stress reduction programs after the relocation has taken place (Bourestom & Tars 1974; Watson 1980; Wells & MacDonald 1981; Coffman 1981; Lieberman & Tobin 1983; Ferguson-Stewart 1994).
3.4 STRESS AND AGEING

A considerable literature exists concerning the theoretical issues of stress and its effects (for example, Selye 1946; Lazarus 1971; Pearlin & Schooler 1978; Renner & Birren 1980; Mikhail 1981; Groer & Shekelton 1989; Wykle, Kahana & Kowal 1992). Selye (1946) maintained that no one can have a stress free existence, but he differentiated between the amount of stress needed to activate an individual and the amount of stress needed to debilitate an individual. Relocation, because of its unpredictable nature, can lead to stress levels that debilitate (Lazarus 1974; Moos 1980; Borup 1981; Coffman 1981; Rodin et al. 1982). Stress increases as the speed of the change being experienced increases (Janes 1990).

Some of the physiological responses to stress that have been noted from this literature are a rise in blood pressure, altered eating patterns and insomnia (Selye 1946; Lazarus 1971; Pearlin & Schooler 1978; Renner & Birren 1980; Mikhail 1981; Groer & Shekelton 1989; Wykle et al. 1992). Mikhail (1981) argues for an acknowledgment that a close relationship exists between the physical and the psychological dimensions of stress. Mikhail (1981) believes that the perception of the stress event is more damaging than the event itself. Lazarus (1974) defines stress as "some stimulus condition that results in disequilibrium in the system and produces a dynamic kind of strain, that is, changes in the system against which mechanisms of equilibrium are activated" (p. 12). In the specific context of ageing, Kasl (1972) identified three main categories of stress foci: the first involves the impact that a specific life experience or event can elicit from the individual; the second is representative of an accumulation of the total of life’s stressful events; and the third is the effect of long term socio-environmental
stresses. Each of these impacts on the individual according to their own coping abilities.

Janes (1990) states that "stress leads to a state of psychological arousal which may have psychobiological consequences through increasing the general susceptibility of the organism" (p. 217). This proposition is supported by Selye (1975) and Cassel (1970).

Loss is one stressor which manifests itself in many ways and as a result of the life cycle assumes importance (Parkes 1972; Kubler-Ross 1981; Christian 1988). Spatial loss can occur when the individual relocates. The most obvious reason for this is the lack of control by the individual over personal space. This results in passive and dependent behaviours by the individual which are often rewarded, as the staff view them as good behaviours (Baltes & Barton 1979; Short et al. 1993)

It is reasonable to assume from the literature that relocation of aged people is influenced by their general health status. Meyer and Speare (1985) described three stages of residential mobility amongst the aged. These are firstly, mobility to be close to amenities, secondly mobility to secure assistance and finally, mobility as a preparation for old age. Litwak and Longino (1987) related these stages to a developmental framework. In their framework, mobility for amenities occurred after retirement when a shift from the workplace was undertaken. Relocation targets were predominantly sunbelt and leisure areas. Few support services were needed at this time.

Mobility for assistance occurred when moderate levels of disability became apparent. This move brought aged people closer to family and services. The
onset of major disability precipitated the final move to assisted living conditions. It is possible to add a chronological dimension to the work of Meyer and Speare (1985) and Litwak and Longino (1987). Jones (1992) described the young-old as being aged between 65 and 74 years, as being able to function normally within the community. The middle-old, aged between 75 and 80 years, had reduced activity patterns and required some assistance with the activities of daily living. The old-old are aged over 80 years and are frail, disabled and in need of ongoing care. A comparisons of these models is presented in Table 3.2.

**Table 3.2** Comparison of patterns of relocation, ageing and relocation housing type choice

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<td>• Post-retirement</td>
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<td>Mobility for assistance</td>
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<td>• Moderate debility</td>
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<td>Mobility as a precursor to aging</td>
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Each of these patterns of relocation is a reflection of the bio-social considerations that accompany ageing. As normal ageing occurs and the related levels of debility that accompanies normal ageing also occurs, two future care considerations are faced by the individual. In the aged, these considerations generate a need for
relocation to an institution or a need for more assistance to be given to the individual in their own homes or in the home of a significant other. From this review of the literature on relocation, the researcher has attempted to define and describe the components of the decision making process prompted by this need to relocate. This decision making process, along with a description of the adaptations necessary when an aged person relocates, has been incorporated into a model which recognises the complex nature of any relocation for an aged person.
3.5 A MODEL OF THE PROCESS OF RELOCATION BY AN AGED PERSON

The Relocation/Adaptation model (RA)-a model of the process of relocation by an aged person attempts to take into account the complex nature of relocation of aged persons. As forced interinstitutional relocation has not been the focus of much research, the model has been derived from the existing relocation literature.

Several factors are central to the model that has been developed. Firstly, homeodynamic processes drive the relocatee. Homeodynamism is a term used to describe the ongoing process of adaptation when change is imposed. Homeodynamism recognises the ability of the aged person to optimise their situation within the framework of relocation. This means that when all matters that impinge upon the individual are taken into account, there is a theoretical optimum level of adaptation in the relocated setting. In this instance this is an institutionalised situation. This would be reflected in some measurable form, such as an improved Katz Index of Activities of Daily Living (Katz, Ford, Moskowitz, Jackson & Jaffee 1963) (Appendix 3) and an improved sense of well-being. This is also an intrinsic aim of The Outcome Standards for Nursing Homes in Australia (Department of Community Services And Health 1987) (Appendix 1).

Secondly, a decision-making cycle is entered into by the relocatee (and/or their advocate)(Brumell 1979) (fig 3.2). Thirdly, the reaction and adaptation to the entire process will have long term outcomes for the individual.
3.5.1 Description of the RA model

The individual enters the system represented by the model when some internal or external precipitating factor (catalyst) causes relocation to be considered. Triggering stimuli include the onset of acute ill health (for example, myocardial infarction, cancer, trauma related to a fall, cardiovascular-vascular accident) (Schultz & Brenner 1977; Meyer & Speare 1985; Ford & Warnes 1992), acceleration of chronic and encroaching debilities (for example, osteoarthritis, rheumatoid arthritis, diabetes related problems) (Hugo & Wood 1984; Ford & Warnes 1992), death of a significant other or of cohort members and the prospect of facing singlehood and loneliness (Yawney & Slover 1973; Hugo & Wood 1984), family pressure to relocate for a range of reasons (for example, to ensure a safer environment for the aged person, to lessen the family responsibility for the aged person, to free up capital to assist family members) (Wiseman 1980; Hugo & Wood 1984; Mullins et al. 1989 (NA)), diminished physical ability to cope with a large property; desire for more leisure time; desire for fewer responsibilities and concerns (Hartwigsen 1987; Jones 1992), the desire for the security offered by community living (Wiseman 1980; Lee 1980 (NA); Golant 1980; Longino 1982; Hugo & Wood 1984; Wilson 1988; Baglioni 1989; Jones 1992), and renovation, demolition or sale or transferral of beds in an existing institution (Bourestom & Tars 1974; Watson 1980; Bonardi et al. 1981; Wells & MacDonald 1981; Gallagher & Walker 1990; Thomasma et al. 1990).

The internal and external precipitating factors that trigger a potential move cause the individual to enter a process that involves both psychological and physical adaptation (Selye 1946; Guyton 1976; Mikhail 1981; Rodin 1986; Mikhail 1992). With this comes the need for both primary and secondary appraisal of the situation in order to reach an optimal homeodynamic state (fig 3.3) (Selye 1975;
Lazarus 1974; Lazarus & Launier 1978; Lazarus 1981; Mikhail 1992). It is unlikely that the aging individual is aware that these processes are likely to occur.

Adapted from Morse 1989.

**Figure 3.3** Primary and secondary appraisal mechanisms of the relocation decision making process in aged people
Once the individual’s consciousness about relocation is raised, what has been conventionally regarded as a rational decision-making cycle is entered (Brummell 1979). In Brummell’s analysis, this is the cycle of attainable goal setting. Self-inventory and a period of life review (Butler 1963; Butler & Lewis 1977; Molinari & Reichlin 1985) can characterise this period.

Where possible, the choice process should involve all the stake holders in the relocation. Ideally, the choice to relocate should be made by the person relocating. The best outcome will be achieved for that person where this is the practice. Involvement in the choice process and making the choice confers some level of control over the situation and makes the adjustment process less difficult for the individual. Where the individual has not been involved in the choice process and is unhappy that the choice was made for them, then adaptation difficulties will arise for them (Dohrenwend 1973; Lazarus 1974; Beaver 1979; Brummell 1979; Chiriboga & Cutler 1980; Lieberman & Tobin 1983; Rodin 1986; Baglioni 1989; Baldwin 1991; Reinardy 1991; Armer 1993).

For the aged person relocating there are five potential outcomes from this decision-making process. These will be considered in turn.

**Outcome 1: No relocation, acceptance of this, and the regaining of a homeodynamic state.**

The reasons for making this choice are many. They include financial pressures, a desire to remain in the same environment, or a decision to delay a relocation (Golant 1979; Wiseman 1980; Longino 1982; Hugo & Wood 1984; Meyer & Speare 1985; Rowles 1986; Litwak & Longino 1987; Baglioni 1989; Ford &
Warnes 1992; Jones 1992). Relocation is a major decision and the decision-making and choice process will disrupt homeodynamism. This disruption may be associated with insomnia, malaise, irritability and general restlessness (Guyton 1976; Carrieri, Lindsey & West 1986; Cox 1987; Groer & Shekleton 1989; Mikhail 1992). Once the decision not to move has been made then the individual can resume their normal pattern and quality of life and a homeodynamic state will be restored.

Outcome 2: No relocation, non-acceptance of this and disrupted homeodynamism.

If the individual really wants to relocate and cannot do so, then a disrupted homeodynamic state may result. The loss of this potential move can manifest itself in grief related experiences and behaviours; these include a varying sense of loss, disappointment and frustrated desires. Behaviours may include tearfulness, sad demeanour, sighing and reduced activity (Parkes 1972; Kubler-Ross 1981; Christian 1988; Belsky 1990). Grief is personal, difficult to quantify and consequential in terms of the stress it produces for that individual (Parkes 1975; Kubler-Ross 1981; Christian 1988). Loss in this situation relates to the unrequited perceived positive gains the individual believes they would have made by relocating. Grief may also be experienced because remaining in the present situation creates spatial discomfort for the individual (for example, dysfunctional dwelling layout and fond memories of a deceased person). The quality of life experienced in this situation will be limited.
Outcome 3: Consensual relocation, acceptance of this and the establishment of an optimal homeodynamic state.

Even though the move is accepted by the individual, a feeling of loss will still be experienced. These will be short or long-term in nature, depending on the strength of their emotional bond to their previous home. Neighbours, rituals and the general pattern of daily life become past experiences and an adaptation to the demands in the new environment occurs (Tuan 1977; Lazarus & Launier 1978; Rowles 1988; Csikszentmihayi & Rochberg-Halton 1989; Rubinstein 1989). An adaptation to the new environment takes place with a new homeodynamic state being reached in terms of feeling happy and experiencing a general sense of well-being. When this occurs a new quality of life will be possible for the individual.

Outcome 4: Non-consensual relocation, non-acceptance, and a disrupted homeodynamics.

Forced relocation can result in feelings of helplessness and powerlessness over the situation the individual is placed in. Related to the perceived loss of situational control, these feelings may be expressed as dismay, depression, anger, illness and fantasy (Rodin & Langer 1977; Watson 1980; Rodin et al. 1982; Schooler 1982; Carrié et al. 1986; Cox 1987; Eliopoulos 1987; Reinardy 1991). Forced relocation may come about as a result of the individual’s recognition of failing health and consequent efforts to seek support or protected care. Forced relocation may also be related to influences from the family who perceive the relocation to be necessary for the well-being of the individual. Forced relocation may be as a result of the closure of a long-term care facility or its extensive renovation. Forced relocation can also occur as a result of others making
decisions to relocate the individual. Here the individual may be relocated as a result of quality of life concerns by the family or significant others. Once this happens collective perceptions control the situation and the individuals choices are removed (Yawney & Slover 1973; Watson 1980; Bonardi et al. 1981; Wilson 1988; Gallagher & Walker 1990; Ford & Warnes 1992; Jones 1992).

If relocation occurs and the individual is unable to accept it, stress will be created, adaptation will be limited and homeodynamism will be disrupted. In this situation, the quality of life the individual experiences would be less than if they were able to accept the situation they were placed in. Primary and secondary appraisal mechanisms are both needed to deal with the situation (fig 3.3).

**Outcome 5: Non-consensual relocation, acceptance of this and the regaining of homeodynamism.**

Following a forced relocation, the individual may find themselves in a better situation. They may be able to maximise their potential and achieve the best possible outcomes in terms of the quality of life experienced in physical care, psychological satisfaction and social interaction (Dye & Erber 1981; Thomas 1988; Zlobicki 1988; Thomas & Hayley 1991). Again, this comes about as a result of decisions taken by others, not the individual concerned in the relocation. However, the individual can accept this and adjust in a positive way. The primary and secondary appraisal mechanisms are able to deal with the situation.

The actual relocation to the long term care facility requires sensitive handling. If the relocation is from the community to a sector of a retirement village the involvement of the individual is needed for the arrangement of possessions and
the settling in process. A relocation from the community to a nursing home is very difficult for everyone involved in the process (Jasnau 1967; Coffman 1981; Hartwigsen 1987; Gallagher & Walker 1990; Freidan 1993). An interinstitutional relocation may be a time of high institutional activity, which can lead to confusion on the part of administrators, staff, relatives and the individual being relocated (Jasnau 1967; Nelson & Winter 1975 (NA); Watson 1980; Coffman 1981; Wells & Macdonald 1981; Lieberman & Tobin 1983; Hartwigsen 1987; Gallagher & Walker 1990; Freidan 1993).

The model describes two potential outcomes that follow; they are optimisation or disillusionment.

Optimisation will result if the individual reaches a new level of independence and quality of life. The former factors which contributed to an increasingly dependent existence are lessened and do not retard independent activity. House maintenance, worry about personal safety and security, worries about institutional tenure and similar things are no longer active concerns. Rather, the individual’s reduced load of responsibilities promotes an enhanced quality of life (Hugo & Wood 1984; McDonald 1986 (A); Jones 1992).

Disillusionment emerges when the individual’s expectations about relocation are not met. This may occur in the area of physical care, psychological satisfaction and social interactions. Disillusionment manifests itself in behaviours ranging from anger and frustration to disengagement. The onset of new disease processes may occur due to the stress this disillusionment brings (for example, peptic ulceration, duodenal ulceration, cardiovascular-vascular dysfunction-hypertension, angina and compromised immune response) and the acceleration of existing degenerative patterns occurs (for example, gastro-intestinal disturbances,
headaches/migraine, osteoarthritis and rheumatoid arthritis) (Boas 1947; Lazarus 1974; Moos 1980; Kammann & Flett 1983a; Kammann & Flett 1985b; Carrieri et al. 1986; Spar & LaRue 1990; Linder-Pelz 1991; Rodin et al. 1982). Stress, therefore, can make the individual more vulnerable to the manifestations of and the exacerbation of disease processes. Kammann and Flett (1983b) state that "well-being is highly and inversely related to neuroticism, anxiety, depression and somatic complaints" (p. 259). This involves disruption to sleep, digestion, energy levels and normal biochemical measures with consequent deterioration of quality of life.

Frustration, anger and despair result from the person’s inability to be autonomous (Cox 1987; Sundeen, Stuart, Rankin & Cohen 1989). Frustration and anger can be exhibited in labile moods, irrationality, weeping, demanding, verbal abuse, obstreperousness and general malaise (Hall 1982; Eliopoulis 1987; Ebersole & Hess 1990; Goldhaber 1986; Spar & LaRue 1990). A fantasy, based on the ‘good old days’ is reinforced through enthusiastic reminiscences. Recalling past, enjoyable experiences assists the individual to disengage from the immediacy of the new situation, reducing the pain of the present. Conversely, other responses include withdrawing and acting out (Butler 1963; De Beauvoir 1977; Rowles 1978; Molinari & Reichlin 1985; Carrieri et al. 1986; Ebersole & Hess 1990).

Altered hyperactivated and hypoactivated states manifest themselves as a result of disillusionment. Hyperactivated states include aggressive behaviours and hypertension which may be manifested as gastrointestinal upsets and dyspepsia. Hypoactivated states include withdrawal, insomnia, anorexia and performance decrements (Seiligman 1975; Hall 1982; Kreigh & Perko 1983). For the individual who is unable to reach a new homeodynamism through the processes of
adaptation, the consequence of prolonged, irreversible stress may be death (Spielberger 1974; Coffman 1981; Ebersole & Hess 1990; Eliopoulos 1987; Carrieri et al. 1986).

This model attempts to address a wide range of factors that influence the individual. It recognises the role of autonomy and involvement that the aged person is, in most cases, capable of exercising in the decision making concerning relocation. It identifies the value of maximising the quality of life for the individual engaging in the relocation process. The external tensions that accompany a relocation are given acknowledgment are recognised. Relocation, whether of a consensual or a non-consensual nature, is a high activity, high stress period in an aged person’s life which ushers in huge life-style changes. Clearly, the best outcomes for the individual will occur if relocation is seen as a positive event and if the aged care facility does not underrate the individuals ability to make an informed choice within the framework of relocation.

3.5.2 Application of the RA Model to an example of interinstitutional relocation

In terms of this model, the individuals least able to exercise any choice or autonomy concerning their relocation are those already in an institution and who have to move to another institution. Such relocations occur for a number of reasons, but primarily because of rebuilding programs. For these individuals, for whom the precipitating factor is the forced closure of their long term aged care facility, there is no choice about relocation. The model presented is a useful way to describe the adaptation process they experience.
Because such individuals have become mere participants of that move, the choices that they can make in relation to the relocation are limited. The type of choice processes they can engage in relate to their sleeping arrangements and to the purchase of objects to add meaning to their new accommodation area. The individual then has to accept or not accept their new situation. The literature is clear about the relationship and meaning that older people have attached to their possessions and their space (Butler 1963; Tuan 1977; Lazarus & Launier 1978; Rowles 1978; Rubinstein 1987; Rowles 1988; Csikszentmihalyi & Rochberg-Halton 1989; Rubinstein 1989; Belsky 1990; Freidan 1993). The relationship is a strong one and breaking it is hard. Their possessions and their space define their personalities and in the nursing home situation personal possessions are scant.

In this situation, acceptance, whether willing or through resignation, is the most comfortable option an individual has. Non-acceptance creates difficulties for the individual, their families, the staff and the administration. The resistant individual may exhibit ill health, labile moods, unhappiness and general non-cooperation. The family, who want a good relationship with the institution, may attempt to appease the individual at the cost of how the individual feels or may endorse the use of medication to settle the individual down. The staff may not understand the difficulty that the individual is having in adjusting to their new environment, while the only aim of the administration is often to have the organisation run smoothly. The outcomes for the individual are either optimisation or disillusionment.

Optimisation will allow the individual to function at their optimum level in the new environment. Functional ability will not deteriorate and behaviours reflective of well-being will be exhibited (for example, increased quality of social interactions and improved general health).
If disillusionment is the outcome then the individual is in a precarious position. The inertia that surrounds the relocation itself can engulf the individual and apathy and despair will result. This will mean that the individual can no longer be an advocate for themselves in the situation. Conversely, if frustration and anger are exhibited, then the individual may be labelled as difficult and may be chemically subdued. A sooner than anticipated death may be inevitable.
"If we are primarily concerned with describing the quality of life experiences of the population, we will need measures different from those that are used to describe the objective circumstances in which people live. We will have to develop measures that go directly to the experience itself".

Angus Campbell (Kammann & Flett 1983a p. iii)
Kane and Kane (1988 p.1) have articulated three constructs that relate directly to any research involving aged people in long term care. These are:

"1) the elderly are participant to multiple diagnoses;

2) the physical, mental and social well-being of an elderly individual are very closely interrelated, so that multidimensional assessments of health status are necessary; and

3) measures of functional status that examine the ability to function independently despite disease, physical and mental disability and social deprivation are the most useful overall indicators to assist those who care for the elder."

This study addresses these three central propositions concerning research amongst residents of a long term care facility. No single methodological approach was considered adequate to examine an issue of the complexity of forced interinstitutional relocation.

This qualitative study was intended to "identify the properties existing in the real world" of the participants in their own setting (Field & Morse 1985 p.111). The forced interinstitutional relocation, multisite research, use of a unified sample and a new physical environment all increased the complexities associated with the research and made it unlikely that any single research approach could capture this reality. Methodological triangulation ("the combined use of two or more theories, methods, data sources, investigators or analysis methods in the study of the same phenomenon") (Burns & Grove 1987 p. 277), makes it possible to verify data and so increase the validity of the information gathered.
A qualitative approach is particularly appropriate in the context of forced interinstitutional relocation as little is known about this phenomena. The qualitative approach being used is an ethnonursing approach that was developed by a group of nursing theorists under the leadership of Madeline Leninger (Burns & Grove 1987). In this framework, ethnonursing "focuses mainly on observing and documenting interactions with people of how these daily life conditions and patterns are influencing human care, health and nursing care practices" (Burns & Grove 1987, p. 89).

The purposes of ethnonursing research are to add to limited knowledge about a phenomenon, to grasp the totality of a situation, to break new research ground, to obtain contextual meaning for a phenomenon, to produce new theoretical material concerning a phenomenon, to permit cross-cultural studies, to identify lifestyle patterns and to examine phenomenon that can not be examined by other methods (Burns & Grove 1987 p. 90).

In this theoretical framework, Leninger defined culture as "the learned, shared and transmitted values, beliefs, norms and lifeway practices of a particular group that guides thinking, decisions, actions and patterned ways" (Marriner-Tomey 1989 p. 152). This is an appropriate definition of the nursing home culture as values, beliefs and norms that are practiced and are part of the nursing home lifestyle inevitably direct the behaviours of the residents.

Each nursing home has its distinctive culture, one that is derived from its institutional characteristics and the characteristics of the residents, staff and administrators. It is shaped by the behavioural expectations that are transmitted both formally and informally to the residents.
The reason this particular ethnographic approach was used is that there is very little knowledge about the effects of a forced relocation on nursing home populations. The need to gather information and to make meaning of the information will increase as the existing stocks of nursing homes deteriorate and become dysfunctional. Within this framework it is essential for the nursing home personnel to understand some of the experiential dimensions of the residents or the relocation will not be as positive as is possible. To understand the residents' situation, the context has to be appreciated by those engineering the relocation. From ethnonursing research it should be possible to present a body of information that can and will assist many nursing home residents facing a forced relocation. Resident well-being and satisfaction are important factors that can be identified. Strategies for strengthening resident well-being and satisfaction should be defined in the context of the relocation of the new nursing home.

The social context of this research is the nursing home. The nursing home is the participants' real experience. For this reason an emic view will be taken and resident behaviours will be described in the context of the nursing home and its culture. This is important to the methodology as many of the environmental constraints in the nursing home environment would be viewed as extraneous variables in another research context. Contextual factors influence and determine the real experience of the participants.

The time series study was looking for some predictive relationships and outcomes that would be good indices for future forced interinstitutional relocations. The researcher was seeking through the interviews some interpretive results that would assist others in the same situation.
Because of the complexities of this study, and to ensure that as many aspects as possible of the participants' relocation experience were examined, methodological triangulation was used. This use of methodological triangulation was considered to be important in order to reduce systematic error and to allow more than one dimension of a concept to be examined (for example, affect assessment involved the use of The Affectometer 2, recording the participant's weight, measuring the participant's blood pressure and by carrying out a guided interview) (Burns & Grove 1993 p. 334).

Boyd (1993 p.455) states "research triangulation is a term that refers broadly to the research practice of combining methods within a single tradition (quantitative or qualitative) or across these traditions. The overriding purposes of triangulation are to increase the reliability and validity of a study and/or to increase the comprehensiveness of a study, including those studies that are carried out in phases in a protracted period of time."

In this study methodological triangulation was used. This is the use of "multiple methods in a single study" (Boyd 1993 p.460). In this study, both quantitative and qualitative methods were used. This form of methodological triangulation is known as "between or across method triangulation" (Boyd 1993 p. 460). The features of this are the use of "multiple statistical techniques" (Boyd 1993 p.464) and the analysis of interview data.

A variety of instruments and a guided interview schedule were used to pursue the aim of obtaining an overview of the participants relocation experience. Jack, cited in Morse (1989 p. 211) state "triangulation, however can be something more than scaling, reliability, and convergent validation. It can capture a more complete, holistic, and contextual portrayal of the unit(s) under study."
The aims of this study made it important that the actual relocation experience itself was explored with the participants. Repeated measures over a 17 week time period provided the opportunity to examine many aspects of the relocation impact on the participants. A combination of methods involving a time series study and guided interviews, permitted the cross-validation of research materials collected (Burns & Grove 1993 p. 350).

The use of this combination of methodologies was aimed at putting together a picture of the individual and life in the nursing home. Some material that was collected is objective and quantifiable. Other material collected is a highly subjective representation of the private lives of the participants in the situation. Because of the private nature of the material, fictitious names have been used to protect the participants.
CHAPTER 5

THE HISTORY OF THE INTERINSTITUTIONAL RELOCATION


The two nursing homes used in this research were derived from a single nursing home which was demolished and rebuilt due to its poor condition. A Relocation Activity Timeline (fig 5.1), shows the events that followed the decision to demolish the original nursing home.

In 1992 the original nursing home was deemed uninhabitable as it did not meet the current statutory fire and safety requirements. Gregory (1994) sees this general trend not to maintain nursing home stock as being caused by a funding system "under which nursing homes receive a set amount for each resident, based on resident frailty, which is the same regardless of the age or condition of the building." (p. 3). Further, until 1987, the funding system did not allow for any depreciation on the building to maintain the standard of the stock.

The owners of the nursing home decided to demolish the facility and rebuild on the original site, rather than to extensively renovate the nursing home in a piecemeal manner.

To facilitate the rebuilding project, it was necessary to relocate the nursing homes 110 residents. A downsizing of ten bed licences was also to occur at this time. To do this, ten bed licences were transferred to another aged care facility owned by the parent organisation. Two relocation groups consisting of 49 and 51 residents were established. These two groups were based on physical ability levels and were housed at two different sites located some 30 kilometres apart. Those residents who were more mobile and less frail were housed at Site 1, while
those who were less mobile and more frail were housed at Site 2. The staff were generally given a choice as to the facility they would like to work in, however, at times, some of the staff were required to move between the two facilities.

The facility at Relocation Site 1 was owned by the New South Wales Department of Health.

A former geriatric hospital, this facility was closed and is no longer in use because of its age and its failure to meet the current safety requirements for an aged care hospital. A temporary approval was granted from the New South Wales Department of Health to use this facility as a nursing home while the demolition and the rebuilding of the original nursing home took place. Forty-nine residents were relocated to Site 1 in September 1992. This single storeyed
facility housed those in wheel chairs and those requiring less supervision than those residents being relocated to Site 2. This relocation to Site 1 occurred two weeks after the relocation to Site 2. This meant those residents relocating to Site 1 had undergone an intranstitutional relocation around the 10.9.92. This enabled the institution to consolidate the remaining 49 residents into fewer rooms in the interim and to close off care areas that became surplus to need.

The facility at relocation Site 2 was owned by the Anglican Church. It was a closed and disused twostory hospital which also did not meet current safety or health legislation.
Fifty-one residents were relocated to Site 2 in October 1992. These temporary conditions were both cramped and awkward for the staff and residents. Residents who were relocated to this facility required maximum supervision and containment. A temporary approval was granted from The New South Wales Department of Health to use the facility as a nursing home while the demolition and the rebuilding of the original nursing home took place.
The reunification of the two groups of residents to the new facility was postponed four times. This was due to the insolvency of the original builders. The new builders were unable to catch up with the original building schedule and the completion of the building was delayed on two subsequent occasions. The patient care areas were finished when the relocation took place, but some service areas were not and the firedoors failed to pass an inspection by the New South Wales Fire Brigades.

The new nursing home has three floors, two of which are resident housing. The basement is a service area containing the laundry, plant room and staff recreation and education areas. Each resident housing floor is divided into two wings. The fittings and appointments of the nursing home are modern and aesthetically pleasing.

The sleeping areas are single, double or triple rooms. The double and triple rooms have been designed so that an illusion of being in a single room has been
created. All rooms have ensuite bathrooms. Each room has its own balcony. Residents are able to purchase small refrigerators and have their own telephones installed.

Each time a move was imminent, the staff worked hard to prepare the residents for a change in their environment but, the plans to orientate the residents to their new home did not eventuate. These plans were put in place by ‘The Move Back Committee’ which was made up of the Director Of Nursing (DON), the Executive Officer of the parent body, two relatives (one from each site) and one resident. The ‘Move Back Committee’ was an ad hoc committee and has not met since the relocation took place.

‘The Move Back Committee’ planned that cognitively able residents would have an opportunity to visit the nearly completed building, locate their rooms, explore the new facility and have morning tea at the site with the DON. This became impossible as the completion date for the new facility was repeatedly delayed. Eventually, the residents were taken for a drive past the site in the week before the relocation.

When the participants in the time series study were finally relocated, the building was still not complete. The resident care areas were completed but some of the service areas were still being fitted out. For example, the basement area was untiled and painting unfinished and the laundry fittings were incomplete.

The temporary site licenses for Site 1 and Site 2 from the NSW Department of Health had expired and so had the leases from the NSW Department of Health and the Anglican Church. As relocation was imperative, it took place under these less than ideal circumstances.
The interinstitutional relocation to the new facility from Site 1 and Site 2 was scheduled to begin on June 28, 1994. Data collection began in the week prior to this.
<table>
<thead>
<tr>
<th>Dates</th>
<th>Residents</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/9/92</td>
<td>Site 1</td>
<td>110 bed licences</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
<td>51 bed licences</td>
</tr>
<tr>
<td>28/9/92</td>
<td></td>
<td>Separation of 110 residents into two residential sites. Intrainstitutional relocation of Site 1 residents. Ten bed licences* were transferred to another facility owned by the parent body. 49 beds to Site 1 and 51 beds to Site 2.</td>
</tr>
<tr>
<td>9/93</td>
<td></td>
<td>Reunification postponed as builder insolvent.</td>
</tr>
<tr>
<td>12/93</td>
<td></td>
<td>Reunification postponed as building incomplete.</td>
</tr>
<tr>
<td>1/94</td>
<td></td>
<td>Reunification postponed as building incomplete.</td>
</tr>
<tr>
<td>19/6/94</td>
<td></td>
<td>Official opening. Completed cost $7million.</td>
</tr>
<tr>
<td>21/6/94</td>
<td></td>
<td>Reunification Postponed as Fire Doors inadequate.</td>
</tr>
<tr>
<td>28/6/94</td>
<td>Reunification</td>
<td>Building incomplete.</td>
</tr>
<tr>
<td>29/6/94</td>
<td></td>
<td>Resident care areas complete. Some service areas incomplete.</td>
</tr>
<tr>
<td>6/7/94</td>
<td></td>
<td>T1 - Data Collection 2</td>
</tr>
<tr>
<td>10/94</td>
<td></td>
<td>T2 - Data Collection 3</td>
</tr>
</tbody>
</table>

* Bed taken to mean a resident occupying a bed. Given some residents have died since 9/92 this does not represent the original population in 6/94.

**FIGURE 5.1 Relocation activity timeline: September 1992-October 1994**
CHAPTER 6

METHODS

INTRODUCTION
SECTION 1 THE TIME SERIES METHODOLOGY
SECTION 2 THE GUIDED INTERVIEWS METHODOLOGY
6.0 INTRODUCTION

This chapter describes the methodology for the time series study and the guided interviews that were carried out. This is presented in two sections. Section One describes the time series methodology, whilst Section 2 describes the methodology used for the guided interviews.

6.1 SECTION 1 - THE TIME SERIES METHODOLOGY

The intention of this time series study was to examine the effects of forced relocation on the quality of life of nursing home residents. The first steps were to identify a suitable population and to gain access to that population.

6.2 FINDING SUITABLE PARTICIPANTS

Initial difficulties arose while trying to identify an appropriate population for this study. This was for two main reasons; firstly, the population being sought was unique because mass forced relocations were relatively rare; and secondly, administrative officers were concerned about adverse publicity resulting from a doctoral student conducting research in nursing homes. (See Appendix 2: Media clippings 23 April 1994, Sydney Morning Herald)

The search for a suitable population proved extremely difficult and the following opportunity was the only appropriate one to present itself in a two year period. Letters were written to 25 nursing homes. Nine replies were received either in writing or by telephone. Of these replies, only two were positive. The author
discovered that 110 residents in two nursing homes in the Sydney metropolitan area were to be forcibly relocated to a new facility in the inner city. This was a direct result of a necessary rebuilding program due to the deterioration of the existing nursing home.

6.2.1 Accessing the participants

Permission to conduct the study was gained through the recently appointed DON. The former DON, who had been housed at Site 1, resigned after the relocation of the nursing home population to the two temporary sites (Site 1 & Site 2). The newly appointed DON was not housed at either site, but her office was in the central administration offices of the parent body. The parent body was situated 10 minutes drive from the site of the new facility. The DONs office was situated 10 minutes drive from Site 2 and 40 minutes drive from Site 1. The overall management of Site 1 and Site 2 took place from there, whilst the daily management of the two temporary nursing homes took place at each site. The DON contacted the Assistant Directors Of Nursing (ADON) at each site to advise them of the study.

At Site 1 the ADON was helpful, though cautious. Access to the participants' documentation was difficult to obtain and the records were often not up to date. Access was denied to the facility when the ADON was not there. The staff had no idea about the study nor the research personnel so that it took a lot of work to secure any assistance from them, even for small things like resident identification.

At Site 2 the ADON was extremely helpful, giving access to all documentation at any time. She openly welcomed the research project and actively encouraged all her staff to assist. The staff were fully aware of the researcher and the project.
The time series study commenced during the week prior to the relocation of the nursing home population to the new facility.

6.2.2 The participants

Because of time constraints related to the imminent relocation, assistance in identifying potential participants was sought from the ADON at each Site. The reason for this request was the ADON had a greater knowledge of the nursing home residents than the researcher. The ADON at each site sorted the residents into two groups based on cognitive ability. One group included residents considered cognitively unable to participate in the research due to advanced dementia, communication pathologies, psychiatric illness, or extreme physical frailty. The second group included those considered cognitively able to participate in the research (that is, they were able to answer the questions, had few communication pathologies, no advanced dementia, no dysfunctional psychiatric disorders, or extreme physical frailty).

There were 88 potential participants from Site 1 and Site 2. Many of these participants had already been a part of the initial relocation from the old nursing home to either Site 1 or Site 2. Those who had moved to Site 1 also had experienced a intrainstitutional relocation as consolidation of care areas occurred when residents relocating to Site 2 had been moved. The participants were chosen by random selection with replacement. This is a technique that gives all potential participants equal and independent opportunity to be selected. No attempt was made to identify a cognitively elite group in this participant selection process.

Fifty-six participants was selected by random selection with replacement. Thirty-one participants were from Site 1 and 25 from Site 2. The participants comprised
seven males and 49 females. All residents selected were approached and all agreed to be involved in the research study.

Ethical approval for this study was obtained from The University of Wollongong Human Ethics Committee and the administrative board of the nursing home parent body. This was negotiated through the Director of Nursing (DON). Once this was obtained, voluntary written informed consent, privacy related to data collection, and the confidentiality and security of the data collected were then addressed.

A full explanation of the aims and the purposes of the research was given to each resident approached to be a part of the study. The resident was asked if he/she had any questions about the research. Once verbal consent had been given by the participant, written informed consent was obtained.

The families of the participants were informed about the research by the DON and were issued with an invitation to meet the researcher to discuss the research project at any time. One family took up this invitation. Once signed, the consent forms were stored in a locked cabinet in the DON's office.

At each data collection point the participant was given another explanation concerning the research and asked if he/she still wished to be involved with the study. An opportunity was given at that time for any questions to be asked concerning the research.

Though difficult at T, privacy was maintained for all data collection. Data collection took place in a single bed room, in a sitting room, in the dining room,
or outside in the garden. Privacy problems did not occur once relocation had been made.

Anonymity was guaranteed, with all responses being coded and each participant's identity was known only to the researcher. Data collected has been stored in a secure, locked room, well away from the participants and the nursing home. A back-up copy of the data entry and results has been made and is stored in a locked filing cabinet drawer with the original material. No material is stored on a hard disk drive.

6.3 MEASURES

It was regarded as essential to utilise measures of quality of life and health status which would be valid, reliable and appropriate to nursing home residents. To obtain relevant data to test the hypotheses a range of recognised instruments were reviewed and the following were selected:

- The General Health Questionnaire (GHQ-20) (Goldbey 1972)
- The Affectometer 2. (Kammann & Flett 1983a)
- The Katz Index of Activities of Daily Living (ADLs) (Katz et al. 1963).

In addition the following were constructed for this research:

- Pre-relocation Questionnaire
- Post-relocation Questionnaire.

An audit of the participants' records was also carried out to ascertain past surgical history, the number of residential moves prior to institutionalisation, current medication regimens and existing pathophysiological states. This was necessary to provide baseline information to measure any changes associated with relocation.
6.3.1 Rationale for the choice of the measures

6.3.1.1 General Health Questionnaire (GHQ)

The GHQ appears to be an efficient and sensitive instrument that aids "in the detection of non-psychotic psychiatric illness" (Finlay-Jones & Murphy 1979). Burvill and Knuiman (1983) indicate that it has been used "fairly extensively in Australia in a variety of settings" (p 237). This was considered important as the research was carried out in a long term aged care setting where a high proportion of residents have some degree of dementia. O'Riordan, Hayes, O'Neill, Shelley, Walsh and Coakley (1990 p. 60) report that "The presence of mild to moderate dementia did not appear to impair the accuracy" of the GHQ-28 and that "in depressed patients the presence of this level of dementia made no significant difference to the results."

The GHQ is available in a number of forms, based on the number of items each version contains. These forms of the GHQ range from 12-60 items (Goldbey 1972). Burvill and Knuiman (1983) state that "shorter versions have been used more frequently than the original 60-item version in Australian studies." (p 237). These Australian studies were carried out by Klugman (1975), Wing (1976), Shiraer and Armstrong (1978), and Henderson (1979) (Burvill & Knuiman 1983 p. 239). Burvill and Knuiman (1983) however, state the 60 item GHQ is considered to be the best version.

Goldberg (1978) identifies five validation studies for the GHQ-60. They are studies by Goldberg and Blackwell (1970), Goldberg (1972), Maguire et al. (1974), Tennant (1977), and Munoz (1978). Goldberg (1978) also identifies four validation studies for the GHQ-20. They are Goldberg et al. (1974), Harding
(1976), Tarnopolsky (1978) and Mann (1977). A later validation study was carried out by Finlay-Jones and Murphy (1979).

The original version of the GHQ contained 60 items. The shorter versions of the GHQ are reflections of the subsets contained in the longer versions. Further, it has been established that the averages and proportions scored on the shorter versions contain no bias (Goldbey 1972; Burvill & Knuiman 1983).

Regardless of the length of the GHQ selected for a target group, all items are reported to have discriminatory powers.

The GHQ was designed for medical care settings and is suited to predominantly female populations (Goldbey 1972; Hobbs, Ballinger & Smith 1983). This was considered to be an asset in this research situation, as most nursing home residents are females (Kendig 1989). Another reason for including the GHQ in this research was the standing it has as "the most popular screening method for affective disorder in general hospital studies" (O'Riordan et al. 1990 p. 59).

The ability of the GHQ to identify distressed moods (Goldbey 1972; Hobbs et al. 1983; Burvill & Knuiman 1983) was useful because distressed moods create a disruption to an individual's homeodynamic state (see Chapter 3.6).

The GHQ is easy to administer and has been found acceptable to a variety of respondent groups (Goldbey 1972). When responding to the GHQ, "the respondent is asked to compare his recent state with his usual state" (Goldberg, Rickels, Downing & Hesbacher 1976 p. 61). This fitted the methodological need of a time series study as it has been suggested that "the standard GHQ scoring
system fails to detect long-standing psychiatric morbidity because of the emphasis on recent changes in mental state." (O’Riordan et al. 1990 p. 59).

6.3.1.1.1 Reliability of the GHQ

The GHQ has a high test-retest reliability (Goldbey 1972; Goldberg et al. 1976; Burvill & Knuiman 1983) and good split-half reliability (0.95) (Goldbey 1972 p. 15). The high test-retest reliability is said to hold only when it is readministered after a minimum of two weeks has elapsed since its initial use.

6.3.1.1.2 Validity of the GHQ

The GHQ has a high construct, content and concurrent validity (Goldbey 1972; Goldberg et al. 1976; Burvill & Knuiman 1983), but little information is available about its predictive validity (Goldbey 1972 p. 16). As expected, the validity coefficients gradually reduce as the number of items reduces. However, Burvill and Knuiman (1983) report the reliability and validity coefficients of the 12 item version "are still surprisingly high" (p. 238).

The version of the GHQ selected for this research is the GHQ-20.

In summary, the reasons for selection of the GHQ-20 given the nature of the participants above the longer versions of the GHQ were:

- its efficiency and sensitivity
- its ability to identify changes over time
- its discriminatory abilities
- its suitability to a predominantly female sample
- its ease of administration
• the short time taken for its administration and completion
• the presence of mild to moderate dementia does not impair its accuracy.

6.3.1.2 The Affectometer 2

The Affectometer 2 was selected because it 'measures the overall balance of the positive and negative feelings' in an individual's recent experience (Kammann & Flett 1983a p. 43). To this end it measures the transient affective state that reflects variable impacts of daily life experiences and events. It is in two formats: i) a checklist of 10 positive and 10 negative adjectives scored on a 5 point Likert-type scale where 0 = not at all and 4 = all the time (Kammann & Flett 1983a p. 10); or
ii) a set of 10 positive and 10 negative short statements of mood state measured on the same 5 point Likert-type scale (Kammann & Flett 1983a p. 10).

The Affectometer 2 was developed in New Zealand and has been widely used in Australasia with a range of target groups of different age span and gender. For example, it has been used consistently for six years as an instrument in the Women's Midlife Health Study in Melbourne, carried out by The Centre For Women's Health In Society (Dennerstein, Smith, Morse, Burger, Green, Hopper & Ryan 1993; Dennerstein, Smith & Morse 1994). It takes about five minutes to administer and is designed to provide a comparative measure between different time points. The Affectometer 2 is an excellent tool for the target population of this study as omissions of up to one third of the items does not distort the results (Kammann & Flett 1983a & 1983b). Within the context of the Affectometer 2, well-being is said to exist when good feelings override bad feelings within a stated time frame. It recognises that happiness is not bound by the individual's environment and that individuals can and do experience happiness in a variety of
settings (Kammann & Flett 1983a & 1983b) and that "well-being is highly and inversely related to neuroticism, anxiety, depression and somatic complaints" (Kammann & Flett 1983b p. 259).

6.3.1.2.1 The reliability of the Affectometer 2

The Affectometer 2 has high test-retest and split-half reliability. It has low response artefact contamination (Kammann & Flett 1983 a & 1983 b).

6.3.1.2.2 Validity of Affectometer 2

The Affectometer 2 has high concurrent and construct validity (Kammann & Flett 1983a & 1983b).

The Affectometer 2 provides an overall "bottom line" measure of the quality of life for the individual (Kammann & Flett 1983b p. 259). The results reflect both the short term and the long term well-being of the participants.

In summary, the reasons for the selection of the Affectometer 2, given the nature of the participants were:

- its ability to identify changes in affect over time;
- its ease of administration; and
- the short time taken for its administration and completion.

6.3.1.3 The Pre-relocation Questionnaire

The Pre-relocation Questionnaire (Appendix 3) was developed specifically for this project. It is a semi-structured questionnaire that elicits both objective and
participative data about the participant and their knowledge about their impending relocation. It aimed to identify the level of understanding the participants had about the pending relocation and its anticipated effects. It also asked the participants about the number of previous residential moves they had experienced prior to admission to the nursing home. The number of previous moves was thought to be of use in predicting positive or negative relocation settlement patterns.

6.3.1.4 The Post-relocation Questionnaire

The Post-relocation Questionnaire (Appendix 3) was also developed for this project to be completed by the participant and the staff. It was also constructed to elicit both objective and participative data on whether there had been an increase in the number of health related complaints made by the participants. Changes in mood, mobility and patterns of social interactions and relationships were to be noted. These indicators were thought to be predictive when assessing the relocation satisfaction of the participants.

6.3.1.5 Retrospective audit of the participants' records

In addition, each participants' weight and blood pressure were measured to provide a base line measure for any change post-relocation. Indices such as weight and blood pressure measurements can be affected by anxiety and depression which can be regarded as indicators of the impact of perceived threats or stressors (Jarvis 1992). The audit of the participants' records provided information that would permit a comparison of their situation at the various data collection points. Knowledge of the participant's past surgical history and existing
pathophysiological status is necessary in order to identify acute exacerbations of chronic conditions. The number of residential moves may have significance in the adjustment patterns of the participant, with those who have had a number of moves experiencing fewer problems. Alterations to the participants' current medication regimens would easily identify new physiological or affective challenges they had to face.

6.3.1.6 The Katz Index of Activities of Daily Living

The Katz Index of Activities of Daily Living (ADL) (Katz et al. 1963; Kane & Kane 1987) was incorporated into the research measures to assess the level of independent activity of which the participants were capable (Appendix 3). The Katz Index of ADL rates six functions. These are bathing, dressing, going to the toilet, transfer, continence and feeding (Katz et al. 1963). Measured on a Guttman scale, it is based on the proposition that there is a progressive loss of ADL and that these losses may be recouped as the individual recovers. This is a very stable index with high coefficients of reproducibility which enables the nurse in a nursing home to monitor the progression or regression of a nursing home resident and to make quantitative judgements accordingly (Katz et al. 1963; Kane & Kane 1987).
The Katz Index of Activities of Daily Living.
The Katz Index of Activities of Daily Living rates the participants accordingly:

A. Independent in feeding, continence, transferring, going to toilet, dressing and bathing.
B. Independent in all but one of these functions.
C. Independent in all but bathing and one additional function.
D. Independent in all but bathing, dressing and an one additional function.
E. Independent in all but bathing, dressing, going to toilet, and one additional function.
F. Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
G. Dependent in all six functions.
Other. Dependent in at least two functions, but not classifiable as C, D, E, or F.

(Source: Katz et al. 1963: Kane & Kane 1987 p. 46)

Figure 6.1 The Katz Index of Activities of Daily Living Classification System

6.4 PROCEDURES

This section discusses the data collection, data analysis strategies and the attrition that occurred amongst the participants.

6.4.1 Data collection

Data was collected at three time points:

- During the week prior to relocation (T)
- Four weeks after relocation (T1)
- Twelve weeks after relocation (T2).

This involved daily visits to the nursing home during the week prior to relocation. At this stage of the relocation process, the established nursing home routine had experienced considerable disruption as the process of preparing for the move had become the dominant feature of the institution.
Data was collected from the participants as soon after breakfast as possible each day (T). This maximised the response rate as the participants' arousal levels declined as the day progressed. As a result of the physical conditions, the researcher collected the data in the dining room/activity area of the nursing home.

When data was collected following relocation at T1 and T2, the nursing home was visited each day, with the researcher again commencing data collection after breakfast to maximise the participants' arousal levels. The researcher was able to take the participant into their own room for the data collection, or if the participant shared a room and privacy was a problem, to a sitting room.

6.4.2 Data Analysis Strategies

At T (data collection point 1) two sites were visited and the following instruments were used to collect data from a total of 56 participants (31 from Site 1 and 25 from Site 2):

- The GHQ-20
- The Affectometer 2
- The Pre-relocation Questionnaire
- The Katz Index of ADL.

The data collected from Site 1 and Site 2 was kept separate at all times and the analysis is presented as being collected at T, and then the relevant site.
At T1 (data collection point 2) the participants from Site 1 and Site 2 had relocated to a single site. The following instruments were used to collect data from 52 participants (four participants had attrited since T):

- The GHQ-20
- The Affectometer 2
- The Post-relocation Questionnaire.

At T2 (data collection point 3) the following instruments were used to collect data from 47 participants (five participants had attrited since T1):

- The GHQ-20
- The Affectometer 2
- The Post-relocation Questionnaire
- Katz Index of ADL.

Data collected from the administration of the GHQ-20, The Affectometer 2, The Pre-relocation Questionnaire, The Post-relocation Questionnaire, The Katz Index of ADL, and the retrospective audit of participants' records were used to test Hypothesis 1, Sub-hypotheses 1-5 and Hypothesis 2.

The data collected at each data collection point and the instruments used are presented in Table 6.1.
### Table 6.1 Time series study data collection points and material collected

<table>
<thead>
<tr>
<th>Data collection point 1: (T) (n=56)</th>
<th>Data collection point 2: (T1) (n=52)</th>
<th>Data collection point 3: (T2) (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHQ-20 score</td>
<td>GHQ-20 score</td>
<td>GHQ-20 score</td>
</tr>
<tr>
<td>Affectometer 2 score</td>
<td>Affectometer 2 score</td>
<td>Affectometer 2 score</td>
</tr>
<tr>
<td>Pre-relocation Questionnaire</td>
<td>Post-relocation Questionnaire</td>
<td>Post-relocation Questionnaire</td>
</tr>
<tr>
<td>• weight/BP measurement</td>
<td>• weight/BP measurement</td>
<td>• weight/BP measurement</td>
</tr>
<tr>
<td>• current medication regimen</td>
<td>• changes to medication regimen</td>
<td>• changes to medication regimen</td>
</tr>
<tr>
<td>• past surgical history</td>
<td>• current surgical history</td>
<td>• current surgical history</td>
</tr>
<tr>
<td>• knowledge of impending relocation</td>
<td>• level of orientation to new facility</td>
<td>• level of orientation to new facility</td>
</tr>
<tr>
<td>• current pathophysiological status</td>
<td>• changes to pathophysiological status</td>
<td>• changes to pathophysiological status</td>
</tr>
<tr>
<td>• number of residents in same room</td>
<td>• number of residents in same room</td>
<td>• enhancement/decrement of ability</td>
</tr>
<tr>
<td>• number of previous residential moves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Katz Index of ADLs</td>
<td>• Katz Index of ADL</td>
<td></td>
</tr>
</tbody>
</table>

A descriptive statistical analysis of the population was carried out. An Analysis of Variance (ANOVA) was carried out to test Hypothesis 1 and Sub-hypotheses 1-5. The computer program JMP (SAS Institute 1989) was used for the statistical analysis.

A level of significance at p=0.05 was considered appropriate in this clinical setting as there was no potential harm to participants in terms of the study outcomes. It should be noted that if the outcomes had been related to clinical
interventions such as medication trials, a level of 0.01 would have been more appropriate (Roberts & Bourke 1989 p. 296).

6.4.3 Attrition amongst the participants

Of the 56 participants, 47 completed the study. This was due to the death of seven participants before Data Collection Point 3 (T2) and the advancing dementia of two participants at the time of Data Collection Point 3 (T2) which precluded them from further participation. The total attrition rate was nine participants. Seven participants died and two participants experienced advancing cognitive disability.

Thus, after data collection was completed there were 47 residents who participated in the entire study. This is an attrition rate of 16%. No participant voluntarily withdrew from the study.

6.4.4 Summary

The data collection procedures were carried out and the data was analysed using descriptive and inferential statistical procedures. This enabled the testing of Hypothesis 1 and Sub-hypotheses 1-5, and Hypothesis 2 to take place.
6.5 SECTION 2 - THE GUIDED INTERVIEW METHODOLOGY

6.5.1 METHODOLOGY

Guided interviews with 15 participants were carried out. The use of a guided interview in this study ensured all the participants were asked the same questions, but there was latitude for the participants to respond freely to them. Cues given by the participant could also be followed up. By using a guided interview the participants' responses could be coded, and relevant descriptive statistics could be compiled.

The aim of the interview process was to gather information relating to the participants' perceptions of the reasons for their initial admission to the nursing home, their own health status, their level of interaction in the life of the nursing home, their own levels of satisfaction or dissatisfaction with their residence, and their knowledge about the relocation.

In addition, objective information was drawn from previously collected data to supplement the interview data. Age, gender, marital status, GHQ-20 scores, Affectometer 2 scores, current medication regimens and the Katz Index of ADL were collated in order to compile an overall picture of the participants general well-being post relocation. The rationale for the use of the GHQ-20, The Affectometer 2 and the Katz Index of ADL has been discussed in a previous chapter (Chapter 5), as has the rationale for the collection of the demographic data and current medication regimens.
6.5.2 Selection of Participants

Fifteen participants were selected from the sample of 47 participants which remained at the completion of the time series study. Random selection with replacement was used to choose the 15 participants, comprising 13 females and two males. Given the time involved in conducting the guided interviews the number of participants was restricted to 15.

Informed written consent and ethical approval had already been obtained. A thorough explanation about the nature of a guided interview, including the intention to tape-record the interview, was given to each of the 15 participants. The participants were also advised that several interviews may be necessary. Participants could withdraw from the interviews or cease an interview at any time they wished to do so. Tape recordings and written notes from the interview were only accessible by the researcher and were secured in a locked filing cabinet. Pseudonyms were used in the interview notes and in this thesis.

6.5.3 The Guided Interview

The interview was carried out either in the participant's room, or if the participant shared a room with another resident in an empty room close to the participant’s room (for example, in the library or television room). Where possible, the interviews were conducted after breakfast to maximise the participants' attention levels. Each participant was interviewed on three consecutive days. The time taken with each participant on each occasion varied, based on their concentration span, but was usually about one hour.
The interviewer canvassed participants' reactions to originally having to move from their own home into a nursing home, having to move to a new nursing home, and the adjustments they had to make before and after the relocation.

6.6 DATA ANALYSIS

The data analysis aimed to identify the characteristics of the participants, to identify their place in their social context, and to describe the effect of the relocation on them. The audiotapes were transcribed and the transcription was then checked against the audiotape. A manifest content analysis was carried out by surveying the data for recurring words, phrases and themes. The frequency of these themes was noted. This involved a thick description of data which emphasised its contextual meaning and norms. This content analysis was necessary to ensure the validity of the process as it permitted significance to be given to the major intent of the material in its context. The content analysis sought to keep participants' ideas and comments in the context in which they occurred.

When establishing the validity and reliability of the data collected, the social context of the data is important and should be considered as the participants may choose to reveal differing levels of information to the researcher in different context (Field & Morse 1985 p.117).
CHAPTER 7

RESULTS

INTRODUCTION
SECTION 1 RESULTS FROM THE TIME SERIES STUDY
SECTION 2 RESULTS FROM THE GUIDED INTERVIEWS
7.0 INTRODUCTION

This Chapter is divided into two sections. The results for the time series study are found in Section 1. The outcomes for the guided interviews with participants are presented in Section 2.

7.1 SECTION 1 - RESULTS FOR THE TIME SERIES STUDY

The data which follows describes the characteristics of the participants in the time series study. Results relating to Hypothesis 1 and Sub-Hypotheses 1-5 are presented. Data relating to the male participants has been separated for the purposes of Hypothesis 2. The chief findings of the time series study are presented.

7.1.1 Description of the participants

A description of the participants is presented in this section.

7.1.1.1. The mean age of the participants

The mean age of the participants is:

T= Site 1 82 years 5 months
Site 2 84 years 3 months
T1= 83 years 3 months
T2= 83 years 2 months

The mean age reduced as a result of attrition amongst the participants.
7.1.1.2. The length of residence of the participants

The length of residence of the participants by mean, median and range at T (Sites 1 and 2), T1 and T2 are presented in Table 5.2.

**Table 7.1** Length of residence of participants by mean, median and range at T (Sites 1 and 2), T1 and T2.

<table>
<thead>
<tr>
<th>T (months)</th>
<th>Site 1</th>
<th>Site 2</th>
<th>T1 (months)</th>
<th>T2 (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>40.2</td>
<td>36.9</td>
<td>39.6</td>
<td>41.4</td>
</tr>
<tr>
<td>Median</td>
<td>35.5</td>
<td>29.5</td>
<td>37.3</td>
<td>37.3</td>
</tr>
<tr>
<td>Range</td>
<td>1-133</td>
<td>2-91</td>
<td>1-133</td>
<td>1-133</td>
</tr>
</tbody>
</table>

The attrition rate amongst the participants accounts for the changes between T (Sites 1 and 2), T1 and T2.

7.1.1.3 Number of voluntary residential moves prior to institutionalisation by the participants

The number of voluntary residential moves prior to institutionalisation by the participants by mean, median and range at T (Sites 1 and 2), T1 and T2 is presented in Table 5.5.

**Table 7.2** Mean, median and range of the number of moves prior to institutionalisation by the participants at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>T</th>
<th>Site 1 (n=31)</th>
<th>Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>4</td>
<td>3.6</td>
<td>3.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Median</td>
<td>3.5</td>
<td>3.5</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Range</td>
<td>1-15</td>
<td>1-8</td>
<td>1-15</td>
<td>1-15</td>
</tr>
</tbody>
</table>
There was one outlier who moved 15 times prior to relocation. When this outlier is removed the mean score is 3.6. The inclusion of this outlier does not significantly effect the outcomes.

7.1.1.4 Frequency of residential moves prior to institutionalisation by the participants

The frequency of residential moves prior to institutionalisation by the participants at T (Sites 1 and 2), T1 and T2 is presented in Table 5.6.

Table 7.3 Frequency of residential moves prior to institutionalisation by the participants at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>Number of moves</th>
<th>Site 1 (n=31)</th>
<th>Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>7</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>6</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>1</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The number of residential moves by participants peaked at four occasions. One to four moves netted a total of 91 moves. Participants who moved on six or more occasions netted 66 moves. Participants moving between one and four times moved one third more times than those participants that moved between six and 15 times.
7.1.1.5 Participants' knowledge of the move
Prior to the move, 46 participants (88%) stated they knew about the move. Of these 46 participants, 28 (61%) could not remember the details.

7.1.1.6 Looking forward to moving
Sixteen participants indicated they were looking forward to moving into the new facility.

7.1.1.7 The Pre-relocation Questionnaire
The amount of knowledge about the move that was retained by the participants varied from site to site. Those at Site 2 had retained more information than those at Site 1. Nine participants at Site 1 did not wish to move as they felt too sick, tired or worn out. The method of imparting the knowledge about the move also differed from site to site. The ADON at Site 1 became reluctant to give residents' information about moving in case it did not happen again and the residents would become upset and confused. The ADON at Site 2 kept the residents fully informed of all matters relating to the move.

Medication regimens reflected the participants' existing pathophysiological conditions. For example, participants with epilepsy were prescribed anticonvulsant medications such as Epilum (sodium valproate) and Dilantin (phenytoin) and those with diabetes were prescribed insulin or oral hypoglycaemic agents such as tolbutamide or chloropamide. Most participants (87%, n=41) were prescribed affect altering medication. The two participants that attrited from the study were prescribed topical corticosteroid cream and cloxacillin sodium for cellulitis.
Since the initial admission to the nursing home of the participants the level of surgical intervention had been low. One participant had an interocular lens replacement and one participant had a colostomy to relieve a bowel obstruction. There were several admissions for medical problems viz. cerebrovascular accident (CVA), pneumonia and influenza.

7.1.1.8 Pathophysiological status of the participants

The pathophysiological status of the participants at T (Sites 1 and 2), T1 and T2 is presented in Table 5.3.

**Table 7.4** Pathophysiological status of the participants at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>System</th>
<th>Incidence amongst participants</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Nervous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary diagnosis stated</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebrovascular Accident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fracture (femur)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The two major categories are the cardiovascular system and the central nervous system. This is consistent with the two major primary diagnosis groups of cerebrovascular accident and dementia.

All of the participants in the time series study suffered from more than one pathological condition.
7.1.1.9 Surgical history of the participants
The surgical history of the participants prerelocation and postrelocation by anatomical system is presented in Table 7.5.

Table 7.5 Surgical history of the participants prerelocation and postrelocation by anatomical system

<table>
<thead>
<tr>
<th>System</th>
<th>Incidence amongst participants prerelocation</th>
<th>Incidence amongst participants postrelocation unified sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site 1</td>
<td>Site 2</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Endocrine</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Respiratory</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

There had been no surgical interventions since relocation.

7.1.1.10 Katz Index of ADL
The Katz Index of ADL level assessments at T (Sites 1 and 2), T1 and T2 is presented in Table 7.6.

Table 7.6 Katz Index of Activities of Daily Living at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>Katz ADL level</th>
<th>Site 1 (n=31)</th>
<th>Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>C</td>
<td>7</td>
<td>3</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>D</td>
<td>10</td>
<td>4</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>E</td>
<td>9</td>
<td>11</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>F</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>O</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
The staff made no alterations to these Katz ADL level assessments between T and T2. Only three participants felt there was a positive change in ability levels after relocation, but this was not reflected in the staff assessments.

7.1.1.11 Weight of the participants at T2
There were no significant weight gains or losses amongst the participants in the study. The total weight gain of those participants that gained weight in the study was 37.1 kilograms. This represents a mean gain of 1 kilogram. The total weight lost of those individuals that lost weight in the study sample was 36 kilograms, representing a mean weight loss of 0.9 of a kilogram. The two participants that became cognitively unable to continue in the study experienced significant weight loss after being transferred to another care area in the nursing home.

7.1.1.12 Mortality rates
Between T and T1 two participants died. Between T1 and T2 5 participants died. A total of seven participants died during the course of the study.

7.1.1.13 Number of medications taken per day by the participants
The number of medications taken per day by the participants is presented in Table 7.7.

Table 7.7 Number of medications being taken per day by mean, median and range at T(Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th></th>
<th>Site 1 (n=31)</th>
<th>Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>5.6</td>
<td>4.4</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Range</td>
<td>1-12</td>
<td>1-9</td>
<td>1-12</td>
<td>1-12</td>
</tr>
</tbody>
</table>
The mean number of medications per participant per day is five, with a range between 1-12 medications per participant per day being taken.

7.1.1.14 Frequency of the number of medications being taken per day by the participants

The frequency of the number of medications being taken per day by the participants at T (Sites 1 and 2), T1 and T2 is presented in Table 7.8.

**Table 7.8** Frequency of the number of medications taken per day by participants at T(Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>Number of medications taken per day</th>
<th>T Site 1 (n=31)</th>
<th>T Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>5</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total per day</strong></td>
<td><strong>183</strong></td>
<td><strong>111</strong></td>
<td><strong>283</strong></td>
<td><strong>253</strong></td>
</tr>
</tbody>
</table>

At T2, with the exception of one participant, the participants in the time series study were taking more than two or more medications per day. The highest frequency of medication usage occurred when 11 participants were taking 4 medications per day.
7.1.1.15 Number of medications taken per day by anatomical system

The number of medications being taken per day by anatomical system is presented in Table 7.9.

Table 7.9 Type and number of medications being taken per day by anatomical system at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>System</th>
<th>Number of medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site 1 (n=31) (%)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>48 (25) 12 (11)</td>
</tr>
<tr>
<td>Central Nervous</td>
<td>65 (35) 47 (42)</td>
</tr>
<tr>
<td>Endocrine</td>
<td>4 (2) 3 (2)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>29 (16) 15 (14)</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>7 (4) 16 (14)</td>
</tr>
<tr>
<td>Integumentary</td>
<td>4 (2) 0</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>24 (13) 15 (14)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>6 (3) 2 (2)</td>
</tr>
<tr>
<td>Total</td>
<td>187 111</td>
</tr>
</tbody>
</table>

1 consists of antipsychotic, antidepressant and benzodiazepine type medications.
2 levels of existing pathophysiology were reflected in medication regimens.

The highest frequency of medication usage was those affecting the central nervous system. The use of medications affecting the central nervous system was almost double that of the usage of drugs affecting the cardiovascular system. This represents a considerable gap between the two most prescribed medications for the participants, even though these two categories of medications account for 55% of the total medications being taken per day by the participants. A comparison of the medication levels per day at T, T1 and T2 reveals that at T there were 298 medications per day being taken, at T1 there were 283 medications per day being taken, and at T2 there were 253 medications per day being taken. This represents a decrease of 15 medications per day (5%) at T1 and a decrease on this figure of 30 medications per day at T2 (or an 11% decrease). There is an overall decrease
of 45 medications per day (15%) between T and T2. This decrease is attributable to the attrition of participants from the study.

7.1.1.16 Affectometer 2 results for the participants at T(Sites 1 and 2), T1 and T2

The results of The Affectometer 2 scores are presented in this section as the range, mean and median scores for the overall participants, and the range mean and median scores as positive or negative responses. A positive response was recorded when 0 or above was scored using The Affectometer 2. A negative response was recorded when less than 0 was scored using The Affectometer 2.

7.1.1.16.1 The range and mean and median scores for the Affectometer 2 at T (Sites 1 and 2), T1 and T2

The range and mean and median scores for the Affectometer 2 at T (Sites 1 and 2), T1 and T2 are presented in Table 7.10.

**Table 7.10** The range and mean and median scores for the Affectometer 2 at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th></th>
<th>T</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site 1 Site 2</td>
<td>Site 1 Site 2</td>
<td>Site 1 Site 2</td>
</tr>
<tr>
<td>Range</td>
<td>-6.3-2.6</td>
<td>-6.3-2.2</td>
<td>-6.3-2.2</td>
</tr>
<tr>
<td>Mean</td>
<td>-0.7</td>
<td>-0.3</td>
<td>-0.6</td>
</tr>
<tr>
<td>Median</td>
<td>-0.35</td>
<td>-0.2</td>
<td>-0.4</td>
</tr>
</tbody>
</table>
7.1.1.16.2 Affectometer 2 results for the participants at T (Site 1 and Site 2), T1 and T2 by positive and negative scores

Affectometer 2 results for the participants at T(Sites 1 and 2), T1 and T2 by positive or negative scores are presented in Table 7.11.

**Table 7.11 Affectometer 2 results for the participants by positive or negative response at T(Sites 1 and 2), T1 and T2**

<table>
<thead>
<tr>
<th>Result</th>
<th>Site 1 (n=31)</th>
<th>Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive</td>
<td>7</td>
<td>9</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>negative</td>
<td>24</td>
<td>16</td>
<td>40</td>
<td>35</td>
</tr>
</tbody>
</table>

At T, 24 participants (77%) at Site 1 and 16 participants (64%) at Site 2 had negative Affectometer 2 results. At T1, 40 participants (77%) had negative Affectometer 2 scores. At T2, 35 participants (75%) had negative Affectometer 2 scores. Comparatively, at T seven participants (22%) at Site 1 and nine participants (36%) at Site 2 had positive Affectometer 2 results. At T1, 12 participants (23%) had positive Affectometer 2 scores. At T2, 12 participants (25%) had positive Affectometer 2 scores.

Comparatively, at T Site 1 three times as many participants had negative Affectometer 2 scores and Site 2 a little less than one half of the participants had negative Affectometer 2 scores. At T1 and T2 two thirds as many participants had negative Affectometer 2 scores.
7.1.1.16.3 The range, mean and median positive and negative scores for the Affectometer 2 at T (Site 1 and Site 2), T1 and T2

The range, mean and median positive and negative scores for the Affectometer 2 at T (Site 1 and Site 2), T1 and T2 are presented in Table 7.12.

Table 7.12 The range, mean and median positive and negative scores for the Affectometer 2 at T (Site 1 and Site 2), T1 and T2.

<table>
<thead>
<tr>
<th></th>
<th>T</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site 1</td>
<td>Site 2</td>
<td></td>
</tr>
<tr>
<td>+ range</td>
<td>0.7-2.6</td>
<td>0.2-2.2</td>
<td>0.2-2.2</td>
</tr>
<tr>
<td>- range</td>
<td>-6.3-0.1</td>
<td>-6.3-0.1</td>
<td>-4.0-0.1</td>
</tr>
<tr>
<td>+ mean</td>
<td>1.46</td>
<td>1.05</td>
<td>1.03</td>
</tr>
<tr>
<td>- mean</td>
<td>-1.27</td>
<td>-1.04</td>
<td>-1.03</td>
</tr>
<tr>
<td>+ median</td>
<td>1.2</td>
<td>0.7</td>
<td>0.95</td>
</tr>
<tr>
<td>- median</td>
<td>-0.3</td>
<td>-0.2</td>
<td>-0.3</td>
</tr>
</tbody>
</table>

7.1.1.16.4 Recent Happiness

One other measure from The Affectometer 2 is that of Recent Happiness.

At T, Site 1 (n=31) no participants were very happy, one (3%) was happy, three (10%) were somewhat happy, 17 (55%) had mixed feelings, six (19%) were somewhat unhappy, three (10%) were unhappy and one (3%) was very unhappy.

At T, Site 2 (n=25) no participants were very happy or happy, five (20%) were somewhat happy, seven (28%) had mixed feelings, six (24%) were somewhat unhappy, five (20%) were unhappy and two (8%) was very unhappy.
At T1, \( (n=52) \) no participants were very happy, nine (17\%) were happy, 13 (25\%) were somewhat happy, 18 (35\%) had mixed feelings, seven (13\%) were somewhat unhappy, two (4\%) were unhappy and three (6\%) were very unhappy.

At T2, \( (n=47) \) one participant was very happy, seven (15\%) were happy, 15 (32\%) were somewhat happy, 14 (30\%) had mixed feelings, two (4\%) were somewhat unhappy, six (13\%) were unhappy and two (4\%) were very unhappy.

At T1 Site 1, more than half (55\%) expressed feelings about their recent happiness. Thirty-two percent expressed degrees of unhappiness, whilst only 13\% felt they were either somewhat happy (10\%) or happy (3\%).

At T Site 2, 56\% of participants expressed feelings of unhappiness. Twenty-eight percent were somewhat unhappy, 20\% were unhappy and 8\% were very unhappy. This is more than those participants who had mixed feelings of happiness (28\%) and those who were somewhat happy (20\%) combined.

At T1, 35\% of participants expressed mixed feelings of happiness. More participants expressed happiness (somewhat happy 25\%, happy 19\%) than those whom now felt unhappy (somewhat unhappy 13\%, unhappy 4\%, very unhappy 6\%).

At T2, 32\% of participants expressed somewhat happy recent feelings. Thirty percent expressed mixed feelings, 20\% expressed unhappiness (unhappy 13\%, somewhat unhappy 4\%, very unhappy 4\%). Nineteen percent expressed feelings of happiness (happiness 15\%, unhappy 2\%).
There is a clear trend away from unhappiness and mixed feelings of recent happiness to being somewhat happy, happy and very happy.

7.1.1.17 GHQ-20 results for the participants at T, T1 and T2
The results of The GHQ-20 scores are presented in this section as the range, mean and median scores for the participants, and the range, mean and median scores as positive or negative responses for the participants. A negative response was recorded when four or below was scored using The GHQ-20. A positive response was recorded when more than four was scored using The GHQ-20.

7.1.1.17.1 The range and mean and median scores for the GHQ-20 at T (Sites 1 and 2), T1 and T2
The range of GHQ-20 scores at T Site 1 was 5-12; the mean score was 6; and the median score was 6.

The range of GHQ-20 scores at T Site 2 was 8-10; the mean score was 3.12; and the median score was 4.

The range of GHQ-20 scores at T1 was 8-12; the mean score was 4.8; and the median score was 6.

The range of GHQ-20 scores at T2 was 8-12; the mean score was 5.6; and the median score was 6.

7.1.1.17.2 GHQ-20 results for participants by positive and negative results at T(Sites 1 and 2), T1 and T2
The GHQ-20 results for the participants by positive and negative results at T, T1 and T2 are presented in Table 7.13.
Table 7.13 GHQ-20 results for the participants by positive and negative response at T (Sites 1 and 2), T1 and T2

<table>
<thead>
<tr>
<th>Result</th>
<th>T Site 1 (n=31)</th>
<th>Site 2 (n=25)</th>
<th>T1 (n=52)</th>
<th>T2 (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive</td>
<td>27</td>
<td>16</td>
<td>37</td>
<td>39</td>
</tr>
<tr>
<td>negative</td>
<td>4</td>
<td>9</td>
<td>15</td>
<td>8</td>
</tr>
</tbody>
</table>

At T, 27 (87%) participants at Site 1 had positive GHQ-20 scores and 16 (64%) participants at Site 2 had positive GHQ-20 scores. At T1, 37 (71%) participants had positive GHQ-20 scores. At T2, 39 (83%) of participants had positive GHQ-20 scores. At T, four (13%) participants at Site 1 and nine (36%) at Site 2 had negative GHQ-20 scores. At T1, 15 (29%) participants had negative GHQ-20 scores. At T2, eight (17%) participants had negative GHQ-20 scores.

Comparatively, at T Site 1, seven times as many participants had positive GHQ-20 scores and at Site 2 half as many participants had positive GHQ-20 scores. At T1, just over half as many participants had positive GHQ-20 scores. At T2, nearly five times as many participants had positive GHQ-20 scores.

7.1.1.17.3 The range, mean and median positive and negative scores for the GHQ-20 at T (Site 1 and Site 2), T1 and T2

The range, mean and median positive and negative scores for the GHQ-20 at T (Site 1 and Site 2), T1 and T2 are presented in Table 7.14.
Table 7.14 The range, mean and median positive and negative scores for the GHQ-20 at T (Site 1 and Site 2), T1 and T2.

<table>
<thead>
<tr>
<th></th>
<th>T Site 1</th>
<th>T Site 2</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ range</td>
<td>4-12</td>
<td>4-10</td>
<td>4-12</td>
<td>4-12</td>
</tr>
<tr>
<td>- range</td>
<td>-5 - -2</td>
<td>-8-2</td>
<td>-8-2</td>
<td>-8 -2</td>
</tr>
<tr>
<td>+ mean</td>
<td>7.5</td>
<td>6.3</td>
<td>7.1</td>
<td>7.4</td>
</tr>
<tr>
<td>- mean</td>
<td>-3.5</td>
<td>-2.2</td>
<td>-1.5</td>
<td>-1.75</td>
</tr>
<tr>
<td>+ median</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>- median</td>
<td>-3.5</td>
<td>-2</td>
<td>0</td>
<td>-1</td>
</tr>
</tbody>
</table>

7.1.1.18 The Post-relocation Questionnaire

With four very notable exceptions there was no change in the general health-related complaints perceived by the staff or the participants (T-T2). The staff identified four participants who had a noticeable increase in requests for paracetamol (Panadol), magnesium compounds/simethicone (Mylanta) and similar medications. These four participants did not self report feeling ill, rather the staff noted this by the increased number of requests for these medications (T-T2).

With four exceptions there was no self-reported changes in the participants moods. The staff however, identified this time (T1) as one of general confusion and felt this may have masked mood swings as a result. Twenty-one participants (40%) reported feeling "homesick" for the old place (T1); 19 (37%) participants reported feeling lost and confused (T1); seven (14%) participants reported no change in moods at all (T1). At T2 nine (19%) participants still felt 'homesick' and eight (17%) still felt "lost and confused".
There was an initial general increase in mobility levels. Twelve (22%) of the participants said they felt apprehensive about moving around the new facility in case they got lost (T1). The initial increase in mobility was not sustained (T2).

There was an initial increase in social interactions (T1), but no new strong relationships were formed. The participants indicated they tried to keep old relationships intact (T2).

The participants initial orientation around the new facility was low (T1), but this improved over time as they became familiar with their own particular areas (T2).

With nine notable exceptions, the staff felt there was no change in the ability levels of the participants (T-T2). Of the nine, the staff believed six improved and three experienced a decline in general ability levels. Three of the six participants who improved did not self-report this. Only one of the three self-reported a decline in their functional ability levels. The remaining two participants self-reported no change in ability levels (T-T2). The staff did not alter the participants' Katz Index of ADL level assessments in line with their observations. Staff did report a need to give higher levels of reassurance and assistance to the female participants at bedtime.

There had been no surgical interventions since relocation for any of the participants. No alterations to the participants' medication regimen occurred (T-T2).
7.1.2 Results for the male participants.

To address hypothesis 2, the results for the male participants have been isolated and are presented in the section that follows.

7.1.2.1 The mean age of the male participants

The mean age of the male participants was 84 years and two months.

7.1.2.2 The length of residence of the male participants

The mean length of residence was four years and 6 months, the median length of residence was four years, and the range of the length of time of residence was 11 months - 8 years.

7.1.2.3 The number of voluntary relocations prior to admission of the male participants

The mean number of voluntary residential relocations prior to admission was 6. The range of voluntary residential relocations was 1-15 moves.

7.1.2.4 Knowledge of the move by the male participants

All the male participants stated they were aware of the move. Two (2) participants forgot the details.
7.1.2.5 Pathophysiological status of the male participants.

The pathophysiological status of the male participants at T, T1 and T2 is presented in Table 7.15.

**Table 7.15** Pathophysiological status of the male participants at T, T1 and T2

<table>
<thead>
<tr>
<th>System</th>
<th>Incidence amongst male participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T (n=7)</td>
<td>T1 (n=7)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Central Nervous</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Endocrine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Primary diagnosis stated</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular Accident</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dementia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fracture</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Respiratory, central nervous and cardiovascular disease were the most prevalent amongst the male participants.

7.1.2.6 Surgical history of the male participants.

Prior to relocation two male participants had undergone surgery. One procedure related to the gastrointestinal tract and the other procedure to the genitourinary system.
7.1.2.7 Katz Index of ADL assessments for the male participants

There were no recorded changes between T and T2 on this measure, even though there were self-reported improvements in three participants.

7.1.2.8 Weight changes experienced by the male participants

Weight-total weight gain for the male participants was 8 Kilogram, an average of 1.1 Kilogram each.

7.1.2.9 Mortality rate for the male participants

No male participants died between T and T2.

7.1.2.10 The mean number of medications taken per day by the male participants

The mean number of medications taken per day by the male participants was 4 medications. The range of medications taken per day was 1-8.

7.1.2.11 Affectometer 2 scores for the male participants

The Affectometer 2 scores for the male participants were all positive. The range of these scores was 0.4-2.6. The mean score was 1.5.

7.1.2.12 GHQ-20 scores for the male participants

GHQ-20 scores for the male participants were all positive. The range of these scores was 4-12. The mean score was 8.2.
7.2 HYPOTHESIS TESTING

The results of the hypotheses testing are presented in the following sections.

7.2.1 Hypothesis 1

Hypothesis 1 was treated as having five sub-hypotheses.

7.2.1.1 Sub-hypothesis 1

Gender had no apparent influence on changes in blood pressure, changes in weight, and results recorded on the General Health Questionnaire-20 amongst the participants. There was a significant relationship between gender the Affectometer 2 at 0.05 level (T1-T2 = 0.04; T2-T1 = 0.01 and T2-T0 = 0.002.). The male participants recorded a higher GHQ-20 mean score than their female counterparts. The male mean score was 7.4; the female mean score 5.9.

7.2.1.2 Sub-hypothesis 2

The number of previous voluntary relocations had no apparent influence upon blood pressure, changes in weight, and results recorded on the General Health Questionnaire-20 and the Affectometer 2. One outlier was removed from the sample (male, 15 moves) and the data reanalysed. After this analysis there was still no statistical significance between the number of previous voluntary relocations and blood pressure, changes in weight, General Health Questionnaire-20 and the Affectometer 2 results.

7.2.1.3 Sub-hypothesis 3

The orientation levels of the participant on self-report had no apparent influence when considering changes in blood pressure, weight and on the results recorded on the General Health Questionnaire-20 and the Affectometer 2.
7.2.1.4 Sub-hypothesis 4
Following relocation no new medications were prescribed for the participants. Medication usage had no apparent influence on the quality of life experienced by participants after a forced interinstitutional relocation.

7.2.1.5 Sub-hypothesis 5
The number of people in each room had no apparent influence upon changes in blood pressure, weight and orientation and on the results recorded on the General Health Questionnaire-20. The number of people in each room was not statistically significant in terms of the results recorded on the Affectometer 2 (T-T2) \( (p = 0.06) \). The number of participants was reduced following relocation in most instances.

7.2.2 Hypothesis 2
The male participants \( (n=7) \) had experienced 60% more voluntary relocations prior to their entry to a nursing home than did the female participants \( (\bar{x} \) for males 6 residential moves; \( \bar{x} \) for females 4 residential moves). The range of voluntary residential relocations prior to entry to a nursing home was 1-15 for the male participants and 1-8 for the female participants.

The mean age for the male participants \( (84 \text{ years 2 months}) \) was higher than for the female participants \( (83 \text{ years 3 months}) \) in this study.

There was no statistically significant difference between the scores of the males and the females on the GHQ-20.
The comparative gender scores on the well-being measure (Affectometer 2) showed that the male participants attained only positive scores on this measure.

The male participants had a lower incidence of self-reported illness than the female participants. This was gauged by self-report and the increased use of medications such as Paracetemol and antacids.

The male participants from Site 2 maintained existing relationships and included the males from Site 1 into their group. The female participants tended to retain former relationships and were reluctant to form new relationships.

Ability levels on self-report amongst the participants indicated no perceived alterations. On staff report it was seen that three (3) male participants experienced an improvement in functional ability levels while there was no reported improvement amongst the female participants. There was no change to the Katz Index of ADL for these male participants.

There were no significant differences in changes in blood pressure measurements for the male or the female participants.

Though the males made minor weight gains they did not reach statistical significance over time.

There was no difference in the levels of surgical intervention between the male and the female participants.

There were no differences in self-reported mobility patterns between the male and the female participants, while staff reported three males had increased mobility. There was no recorded change to the Katz Index of ADL for these male participants.
There was no change in the self-reported moods of the male participants. Of the female participants, two reported feeling depressed, however they did not view feeling depressed as a change in their mood. The causes of the depression were grief resulting from the loss of a sister who was also a resident of the nursing home and the other as a desire to die because she felt persecuted. These two female participants were identified as being depressed enough for referral for further treatment at T2.

There were no gender related changes in the medication regimens. No new prescriptions for medications such as tricyclic antidepressants or benzodiazepines were issued.

The orientation levels of the male participants were better on staff report than those of the female participants (T1). Over time the orientation levels of the male participants continued to improve (T2), whereas the female participants did not.

A comparison of the male and female participants relocation experience is presented in Table 7.16.
Table 7.16 Comparison of the male and female forced interinstitutional relocation experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male Experience</th>
<th>Female Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Voluntary Relocations</td>
<td>$\bar{x} = 6$</td>
<td>$\bar{x} = 4$</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Not significant</td>
<td>Not significant</td>
</tr>
<tr>
<td>Weight</td>
<td>Not significant</td>
<td>Not significant</td>
</tr>
<tr>
<td>Age</td>
<td>84y 2m</td>
<td>82y 8m</td>
</tr>
<tr>
<td>GHQ - 20</td>
<td>Not significant</td>
<td>Not significant</td>
</tr>
<tr>
<td>Affectometer 2</td>
<td>Significant (+)</td>
<td>Not significant</td>
</tr>
<tr>
<td>General illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Staff reported</td>
<td>Fewer complaints</td>
<td>More complaints</td>
</tr>
<tr>
<td>New Relationships</td>
<td>Inclusive</td>
<td>Selective</td>
</tr>
<tr>
<td>Ability Levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>Staff-reported</td>
<td>Improved</td>
<td>Declined</td>
</tr>
</tbody>
</table>

7.3 THE CHIEF FINDINGS OF THE TIME SERIES STUDY

The chief findings of the time series study are presented in this section.

Overall, the most sensitive instrument used was the Affectometer 2. The Affectometer 2 was statistically significant at 0.05 in relation to gender. The males in the sample had consistently positive Affectometer 2 scores at T1 and T2. The females had consistently negative Affectometer 2 scores at T1 and T2. This correlates with the findings across all variables, that the males experienced and expressed a higher level of well-being than did their female counterparts. Well-being in this context is seen to exist when good feelings override bad feelings within a stated framework. These results confirm Hypothesis 2 - that there is a difference in the forced interinstitutional relocation experience between the male
and female residents of a nursing home. The aspect of Hypothesis 1 dealing with gender is also confirmed.

The aspects of Hypothesis 1 that were not confirmed were the number of previous voluntary relocations, orientation levels, the use of medications and the effect of changes in room occupancy numbers. The number of previous voluntary relocations had no apparent influence on the quality of life experienced in the nursing home after a forced interinstitutional relocation of the participants. Orientation levels of the participants had no apparent influence on the quality of life experienced in the nursing home after a forced interinstitutional relocation. Medication usage had no apparent influence on the quality of life experienced in the nursing home after a forced interinstitutional relocation of the participants. Numbers occupying each room was not a significant factor.

7.4 UNEXPECTED RESEARCH OUTCOMES OF THE TIME SERIES STUDY

In the course of the data collection and analysis some unexpected research outcomes became apparent. These were:

1. Changes in body weight
2. The incidence of infection
3. Relocation mortality.

7.4.1 Changes in body weight

A weight loss trend was noted amongst the less cognitively able residents of the nursing home. This became obvious when the two participants who had become cognitively unable to continue in the study sample sustained considerable weight loss following transfer to another care area within the nursing home. On
examination, the resident weight documentation in this patient care area showed many other residents had also lost significant amounts of weight.

Fourteen of the 24 residents in this wing (now referred to as Group 1) lost a total of 73 kg. in the seven month period since relocation ($\bar{x} = 5.21$ kg). Records did not indicate the emergence of any new pathology or any exacerbations of existing pathologies which may have accounted for the situation.

Of the remaining 10 residents, one male maintained his weight, two males and 2 females gained weight. Of the remaining five, two were new admissions, two were unable to be weighed and one had no previous weight recorded.

The residents' weight changes are presented in Table 7.17.

### Table 7.17 The numbers of residents and their weight changes (Group 1)

<table>
<thead>
<tr>
<th>Number of residents</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>lost a total of 73 kg ($\bar{x} = 5.21$ kg)</td>
</tr>
<tr>
<td>1</td>
<td>male maintained his weight</td>
</tr>
<tr>
<td>2</td>
<td>males gained weight</td>
</tr>
<tr>
<td>2</td>
<td>females gained weight</td>
</tr>
<tr>
<td>2</td>
<td>new admissions-not effected</td>
</tr>
<tr>
<td>2</td>
<td>unable to be weighed</td>
</tr>
<tr>
<td>1</td>
<td>no previous weight available</td>
</tr>
<tr>
<td>Total=24</td>
<td></td>
</tr>
</tbody>
</table>

#### 7.4.2 An increase in infection rates

Data collection at T2, included data describing the medication usage of the two participants that had been transferred to another care area due to increasing confusion. Both participants had been prescribed a topical corticosteroid cream and an oral antibiotic (cloxacillin sodium) for cellulitis. Further investigation revealed six residents in this care area had cellulitis.
7.4.3 Relocation mortality

Seven participants died between T and T2. For the same period (10th month-2nd month) the previous year 16 residents died, three at Site 1 and 13 at Site 2.
"In all qualitative research the purpose of enquiry is to identify the properties existing in the real world and to gain a further understanding of what constitutes reality for the participants in a particular real-life setting."

(Field & Morse 1985 p. 111)

"In a phenomenological study, a person's meanings are what is valid, regardless of how participative they are, since the purpose of the study is to discover meaning. Truth is participant-oriented, rather than researcher defined."

(Speedy, 1990 p. 6)
7.6 RESULTS FROM THE GUIDED INTERVIEWS

The results are presented as a descriptive profile of the participants and as a discussion of the themes that emerged from the interviews.

7.6.1 Description of the participants

7.6.1.1 Age and marital status of the participants

The mean age, age range and marital status of the participants by gender is presented in Table 7.18.

Table 7.18 The mean age, age range and marital status of the participants by gender

<table>
<thead>
<tr>
<th></th>
<th>Females (n=13)</th>
<th>Males (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>79y6m</td>
<td>80y</td>
</tr>
<tr>
<td>Age range</td>
<td>63-87y</td>
<td>78-82y</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>widowed*</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>single*</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>divorced</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*80% of participants single females

The mean age and age range of the females interviewed was 79 years and six months and 63-87 years respectively. The mean age and age range of the males interviewed was 80 years and 78-82 years respectively. All participants interviewed were without partners.
7.6.1.2 Participants' length of residence

The participants' distribution of length of residence in months by gender is presented in Table 7.19.

**Table 7.19** Distribution of length of residence by gender

<table>
<thead>
<tr>
<th>Length (months)</th>
<th>0-6</th>
<th>7-12</th>
<th>13-18</th>
<th>19-24</th>
<th>&gt;25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female Male</td>
</tr>
<tr>
<td>Number</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2 2</td>
</tr>
</tbody>
</table>

7.6.1.3 Participants' awareness of the relocation by gender

The participant's awareness of relocation by gender is presented in Table 7.20.

**Table 7.20** Participant’s awareness of the relocation by gender

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Eleven (73%) participants were aware of the move. Seven (46%) commented that it was hard to remember all the details.

7.6.1.4 Participants' satisfaction/dissatisfaction with life in the nursing home by gender.

Participants' satisfaction/dissatisfaction with life in the nursing home by gender is presented in Table 7.21.
Table 7.21 Participants' satisfaction/dissatisfaction with life in the nursing home by gender

<table>
<thead>
<tr>
<th></th>
<th>Satisfied</th>
<th>Dissatisfied</th>
<th>Mixed Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>5</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Five (33%) female participants were satisfied with life in the nursing home, six (40%) were dissatisfied with life in the nursing home and two (23%) reported mixed feelings about life in the nursing home. Both male participants were satisfied with life in the nursing home.

Participants were also asked to rank their satisfaction with life in the nursing home from 1-10, where 1 was the lowest level of satisfaction and 10 was the highest level of satisfaction. The distribution of these ranks is shown in Table 7.22.

Table 7.22 Distribution of ranked scores for satisfaction of life in the nursing home

<table>
<thead>
<tr>
<th>Rank</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The mean, median and range of the satisfaction with life in the nursing home scores were 5.6, 6 and 1-9 respectively. Only three (20%) participants recorded a satisfaction score of less than five.

7.6.1.5 Katz Index of ADL assessments for the participants

Participants' Katz Index of ADLs assessments indicated no gains in independence were made as a result of the relocation.
7.6.1.6 Affect altering medication taken by the participants
Eleven females (85%) and 1 male (50%) were taking affect altering medication. The medications effecting affect taken by the interview participants are presented in Appendix 10.

7.6.1.7 Participants' Affectometer 2 and GHQ-20 Scores by gender
Participants' Affectometer 2 and GHQ-20 Scores by gender are presented in Table 7.23.

Table 7.23 Participants' Affectometer 2 and GHQ-20 scores by gender

<table>
<thead>
<tr>
<th></th>
<th>Affectometer 2</th>
<th>GHQ-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>negative</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>mixed</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

There were more negative female Affectometer 2 scores than there were for the total of positive and mixed scores between T and T2. Eleven (73%) of the female participants recorded positive GHQ-20 scores. Only one female participant had a negative GHQ-20 score and one had mixed scores. All the male participants recorded positive GHQ-20 scores.
7.7 THEMES EMERGING FROM THE GUIDED INTERVIEWS

Several clear themes emerged from the guided interviews. These were:
1. a lack of desire by most participants to be a resident of a nursing home;
2. the differences between the former nursing home and the new nursing home;
3. the social isolation and loneliness experienced by the participants; and
4. the powerlessness felt by the participants as residents of a nursing home.

The results of the guided interviews are organised around these themes.

7.7.1 The lack of desire to be a nursing home resident

Most participants did not want to be residents of a nursing home and further, did not view themselves as sick. Each of the participants had clear memories of their pre-admission morbidity. Most of them revealed a preference to be somewhere else, but apart from being with their family could not identify where that place was or could be. Many recognised the difficulties associated with living with their families. One third (33%) of the participants had turned down offers of support from family or had tried living with their family but could not cope with it so opted for nursing home admission (n=5). Two participants (13%) felt "dumped" in the nursing home by relatives. Eight participants (53%) were admitted as they were unable to manage at home, forgot their medications from time to time and had no other support that would maintain them at home.

The data collected from the participants about their own health status identified that they did not view themselves as being sick, but rather affected by their advancing age and chronic conditions. The GHQ-20 scores have been included
with the participants' summaries to show the level of congruence between their stated feelings about their own health and their GHQ-20 scores as the GHQ-20 was the tool used to measure their perceptions of their own physical well-being.

The participants were asked how they came to live in a nursing home and did they consider themselves to be sick. A summary of their replies follows.

Matilda does not want to be in a nursing home and would have preferred to die in her own home. Her children did not support this. She does not like being dependent on anyone, but admits she is better off in a nursing home than at home. Matilda said "I get so angry about being stuck here, and then I abuse the staff. I do it to my relatives at times too." Matilda admitted she was obese, a bit deaf and needed help. Matilda did not see herself as being sick. (GHQ-20 positive)

Annie could not manage at home as she was becoming frail. After a number of unsuccessful moves between her family and one hostel, a period of respite care was arranged. "I liked the respite care and so I asked them if I could stay on as a permanent resident in the nursing home." Annie said she "was frail and getting old' and that her skin bruises easily. She did not believe she was sick, just in 'need of care in my old age". (GHQ-20 positive)

Olive said she could not cope at home so asked her local doctor to help her arrange admission to a nursing home. "My children offered to have me live with them, but I refused. I can't see as well as I could and I didn't want to burden them with my problems." Olive admitted to being frail, old and going blind, but not sick, "just growing old". (GHQ-20 positive)
Eileen had a fall in her lounge room resulting in a fractured neck of the femur. She found the rehabilitation program too difficult and too fast for her to keep up with. Her family were unable to have her live with them for a range of reasons even though they "promised me I would never have to go to a home. They let me down badly." Eileen admitted to being obese and having a chronic cough. She does not think this is a result of smoking 20-30 cigarettes a day for many years. Eileen thinks she is "worse now because they won't let me smoke as much as before we moved into this place". (GHQ-20 positive)

Louise lost confidence in her mobility after a number of falls. The last time she fell she sustained a fractured neck of the femur. She really did not want to live with her daughter even though her daughter would have liked her to live with her and her family. Louise also had a lot of difficulty with medication compliance and became worried she might take too many tablets as a result of her bad memory. Louise said she "never quite got the dose right". After a lot of discussion between the family and the doctor, her admission was arranged. Louise thinks she is quite mobile even though she needs help with her frame from the nurses. Louise doesn't believe she is very sick, but admits she gets tired and has "a lie down during the day to keep me going". (GHQ-20 positive)

May had large, chronic, debilitating leg ulcers that led to almost total immobilisation. As she lived alone she had no one to care for her. She said she "reluctantly agreed with her sister that a nursing home would be appropriate, but just until the ulcers healed up". May admits "I am sick, it's these legs and the bunged up blood going through them, they are blocked. The doctor has explained it all to me and has told me I will probably die soon. I am taking tablets to thin my blood so more clots don't block the flow. I am not that old you know. My house is quite close to here. My sister looks after it for me. I would like to
think the leg ulcers will heal up and I can go home, but the problem is bigger than the ulcers. I get embarrassed about the smell of the ulcers”. May also believes if she could lose weight the leg ulcers would heal and she could eventually go home. (GHQ-20 positive)

Ronnie was living in a hostel. Over the few months before her admission to the nursing home she was experiencing an increasing number of blackouts. Ronnie had a blackout, fell and fractured her arm. She was admitted to the nursing home until she was able to go back to the hostel. Ronnie could not regain her independence, so she stayed in the nursing home. Ronnie doesn't think being "a bit frail is a real problem", rather, just a part of getting older. She lives for her weekend outings with the family. Ronnie is satisfied when she can manage to do little things for herself. She is worried she will have a blackout one day and really hurt herself - then she concedes she would be ill. (GHQ-20 positive)

David was homeless and living on the streets. He found one winter very hard to cope with. He had to go to the local hospital as he became very ill. The hospital social worker suggested it was time to give up hard living and move into a hostel or nursing home. He thought a nursing home would help him get back onto regular meals and a routine. David does not view himself as being sick, just a victim of his own lifestyle. (GHQ-20 positive)

Ethel had a few blackouts at home and one in Woolworths when she was shopping. She said "Even the smallest room was too big to look after, the piano had dust all over it and my grandson said my house smelt. I decided I really could not manage the house like I used to when my husband was alive. I know I'm not real well and if I have to go to a home I want to go to the one my sisters are in - it hasn't killed them." Ethel believes she is very sick, but "I try not to let
it get to me. I really want to live longer than my older sister. I am afraid to die, but she isn't". (GHQ-20 positive)

Gladys had been in and out of psychiatric hospitals and hostels over a twenty year period. She tried to kill herself so her local doctor thought it would be appropriate to admit her to a nursing home for her own protection. (Source: residents nursing home documents. The informant refused to discuss this with the researcher.) Gladys thinks she would "like to jump off the balcony and then she would be sick". She believes the Nazis have locked her up here because she escaped from them during the Second World War. She doesn't really think she is sick at all, but the tablets they give her makes her "head go around." (GHQ-20 negative)

Paul had "funny turns". "I moved to my eldest son's place so they could take care of me. I still had funny turns and was often left alone there". Paul felt it was the same as being in his own place with no one to look after him. "I know my son was upset with what I said to him-about being left alone-he said to give it a bit longer as he didn't want me here. I stuck to my decision and got the doc to fix it up. Besides I feel safer here." Paul is getting better every day, but "I don't think I'll be going back to my son's house again, it is easier for me here." (GHQ-20 positive)

Millie had neglected herself over a number of years and was unable to manage her own medications. The electricity had been cut off so she could not cook and she "flatly refused to have Meals On Wheels" because she thought they were all cooked in a microwave oven. There was no food in the house. Millie said "the neighbours thought I was mad - but I was taught to fend for myself-and that's what I tried to do." Recognising she was "going downhill too soon" she asked her
doctor to "sort" her out. Millie believes she will die soon and so is just waiting for it to happen. She doesn't believe she is sick. She does, however, think she is old and worn out and can not look after herself any more. (GHQ-20 positive)

Rose had constant falls at home and was unable to manage to take her medication. She lived in a Department of Housing unit in a large complex of over 200 units. The Department of Housing was not in a position to make her unit more user friendly as her case was not regarded as being urgent. Needing supervision and care with no real "savings in the bank" to fix her unit up herself, she moved to the nursing home. Rose maintains she feels well enough to go back to her Department of Housing unit. She does not acknowledge her physical limitations at all and seems unaware that her Department of Housing unit would have been reallocated to another person. (GHQ-20 positive)

Vera admitted she was becoming frail and was unable to cope in her own home. She didn't want to live with her family because she had problems with the "uncontrollable" grandchildren. Vera could not manage to "get my tablets right". Her sons found this nursing home for her. She would have preferred to stay at home, but her wishes were ignored by the family "and I wanted to keep them happy I suppose. There was no point falling out with them at my age." Vera admits to frail old age. She acknowledges she will die soon and hopes it will be soon and it will be quick. "This doesn't mean I'm sick, just realistic." (GHQ-20 T-T1 negative: T1-T2 positive)

Dolly was lonely and depressed when she was living at home. Her children did not keep in touch with her. She had attempted suicide after an argument with one of her children about money. Dolly was admitted to the nursing home from the
hospital. Dolly feels well, eats well and sleeps well. She doesn't think she is sick at all. (GHQ-20 positive)

In summary, the participants' perceptions about their own health status show they do not believe they are sick. Many believed they have the potential to improve and can acknowledge the effect the ageing process is having on them and their ability to manage outside the nursing home. The positive benefits of living in the nursing home were not overtly recognised by the participants, rather comments such as "I've really improved and could go back home now" and "I don't really need all this looking after" typified the gains made by the participants.

Even though most residents did not want to be a nursing home resident they recognised the nursing home could support their needs. When asked if they thought they were ill, two participants (12%) admitted to being ill, seven (46%) admitted to needing help but were not ill they were just getting old, three (20%) denied they required any assistance at all as they were not ill, one (6%) could not acknowledge life style factors as the cause for admission and subsequent poor health, one (6%) acknowledged life style factors as a cause for admission and subsequent poor health, and one (6%) considered his general health to be improving.
7.7.2 The differences between the former nursing home and the new nursing home.

The differences between the former nursing home and the new nursing home emerged as a clear theme. Seven participants (46%) could not understand why the relocation had to occur. Comments such as "the old place was all right really", "you did get used to it", and "why didn't they just paint it and get new beds" indicated a general reluctance to move to the new nursing home. When asked if they knew about the move the following information was gathered and responses given.

Matilda didn't know and she didn't care - "what can I do anyway?"

Annie and Olive knew all about the move, but had "forgotten" some of the details.

Eileen maintains no-one "told her anything" about moving.

Louise "thinks" she knew about the move. As she wants to die soon she doesn't really care where it happens.

May found the old place "squalid", so she was really looking forward to moving.

Ronnie, David and Ethel knew about the move. Ronnie wanted to share a room with her friend but was not allowed to.

Gladys was unable to remember if she knew about the move or not.

Paul knew all about the move. He thought it may not happen, but then decided it has to as the old place was ready to fall down.
Millie knew about the proposed move, but didn’t believe it would happen. She described it as a fantasy, like a made up story.

Rose knew about the move but did not want to move. She was happy where she was as she could see everything that went on.

Vera knew about the move but could not understand why the move had to happen. She liked to watch the people at the old place, which was something that was hard to do at the new place.

Dolly tried to keep up-to-date about moving. She knew it would happen eventually.

7.7.2.1 Participants' knowledge about their relocation.

Four participants (27%) knew about the move, but had forgotten the details; two (13%) maintained no knowledge of the move at all; one (6%) knew about the move and was looking forward to it; four (27%) knew about the move but did not elaborate; two (13%) knew about the move but expressed doubts it would happen; and two (13%) knew about the move but did not want to move.

The participants were asked how much they were looking forward to moving to the new nursing home. A 1-10 ranking was used, with 10 being the highest ranking and 1 being the lowest ranking. The responses to this are presented in Table 7.24.
Table 7.24 Participants’ looking forward to the move ranking with GHQ-20 and Affectometer 2 scores

<table>
<thead>
<tr>
<th>Informant</th>
<th>Looking forward to the move</th>
<th>GHQ-20 (T-T2)</th>
<th>Affectometer 2 (T-T2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matilda</td>
<td>2</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Annie</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Olive</td>
<td>7</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Eileen</td>
<td>5</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Louise</td>
<td>5</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>May</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Ronnie</td>
<td>5</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>David</td>
<td>5</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Ethel</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Gladys</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Paul</td>
<td>9</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Millie</td>
<td>8</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Rose</td>
<td>5</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Vera</td>
<td>5</td>
<td>- +</td>
<td>+</td>
</tr>
<tr>
<td>Dolly</td>
<td>4</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

The mean and median scores are 5.7 and 5 respectively with the range of scores being 2-9. Those with high looking forward to moving rankings had positive GHQ-20 and Affectometer 2 scores. Those with low looking forward to moving rankings had either negative or mixed GHQ-20 and Affectometer 2 scores.

The Frequency of Looking Forward To Moving (LFTM) Scores are presented in Table 7.25.

Table 7.25 Frequency of looking forward to the move ranking

<table>
<thead>
<tr>
<th>LFTM ranking</th>
<th>Frequency</th>
<th>LFTM ranking</th>
<th>Frequency</th>
<th>LFTM ranking</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

143
Only two (13%) participants ranked LFTM less than five on this scale. The majority (13 or 87%) of participants ranked LFTM five or more.

With the exception of Gladys, regardless of the participants' ranking, all had a positive GHQ-20, indicative of physical well-being. The two participants who gave a ranking of less than five had negative Affectometer 2 scores. The remaining 13 participants recorded four positive Affectometer 2 scores and seven had negative Affectometer 2 scores and two had mixed Affectometer 2 scores.

When asked about looking forward to the move, the subject of possessions was raised by several participants. Staff had made arbitrary decisions about what was considered suitable to be taken into the new nursing home and what was too old or worn and therefore had to be discarded. No choice was given to the participants about their personal belongings.

The following comments indicated the participants' level of feeling about their possessions:-

"She just came in and said it wasn't good enough to take with me and out it went- she didn't even ask me how I felt about it. How would she know if I liked to wear it or not. She said it had stains on it-I liked that cardigan."

"It was my backscratcher they threw out and they didn't even replace it."

"It's like when you don't get your own clothes to wear even with your name on everything - they don't treat you with any dignity."

When asked to describe their new nursing home and to talk about what they thought about it, the participants had mixed reactions.
Matilda: “Well I think it would suit a businessman on a trip. It is bigger than I thought it would be, but its not like the old one - we all knew everyone else’s business - now we don’t even know where some of the people have gone”
“The nurses are still bossy and they talk about the others (residents) when they have finished with them”
“I get lonely, but I like to keep out of harms way”
“It’s all right in a clean way”
“The same silly business goes on you know”
“The food isn’t much good”
“Still, my family have told me how lucky I am to be here. I miss the old crowd - we were all silly together - you had to be. Sometimes I don’t see a soul all day”
“You don’t hear a lot of singing out at night anymore - all that’s stopped”.

Annie: “Do you mean what it looks like or what it feels like? Or do you mean what it is like outside - I can’t remember, but it feels new and empty”
“It smells like plastic”
“Well, it is big and the rooms are big. It feels big. I don’t have a lot of furnishings in my room, so it is bigger than at __________. Mrs ______ doesn’t stare at me anymore. I used to pull the curtain around so she could not stare at me. I’d tell the nurse you know”
“We’d sit on the verandah and talk you know”
“The staff got new pinnys - but they haven’t changed really except they have a lot just come in.”
“It’ll be all right when it gets a bit of character.”

Olive: “The room I’m in has a balcony. My family told me it has a view but my eyes are going, so I told them that was nice”
“It’s good to have a bit of space. I like that. I have my own phone now - you could not at ________”

“It feels funny - I began to wonder, you know, if it would ever come off. It was on and off, on and off. I forgot a lot of details - but it was forever on and off”

“The people here are the same as anywhere”

“I just forget the suburb we are in”

“Its nice and new”

“Its easy to lose yourself. I get a bit panicky if I lose myself”

Eileen: “I just got caught up in moving. It seems everyone had to move to the new home. Even if you wanted to stay you had to move”

“I felt tired and could not stir myself to get interested”

“My health hasn’t suffered from moving. It is a nicer place and the kiddies can come without upsetting the others in the room. It’s more private”

“I do get a bit worried about spilling things on the new carpet”

"I haven’t made new friends yet - you see they came from somewhere else. We were all strangers.”

Louise: Louise was reluctant to discuss the new nursing home. She stated “I wanted to die at _________. I had to come here. In the end it doesn’t matter where you die”.

May: “I was so excited about moving. My sister knew about the new building at _____ and said if I got in at ________I’d be assured of a place at ________.”

“The other place was a dump. It smelt and there were five others in my room.”

“This is beautiful - I have a phone and a fridge - see.”

“I don’t have to see anyone all day if I don’t want to. My leg ulcer keeps me in this chair or in my bed. This chair - my sister brought it from my house.”
"The nurses keep looking in my fridge - I said would they like it if I looked in their fridge without asking - some of them have to be watched".

"Do you want to see my ulcers - it’s cleaner here, so they have a better chance of healing the sister said.”

Ronnie: “I was looking forward to moving because another lady I had palled up with and I were going to share a room - we got on well you know. We asked Matron and she said yes, but then my family got ideas of their own. Anyway, it was called off - so there - it was taken out of my hands you know.”

“It’s very different from the old place. You were on top of each other there - here it’s a bit - well by yourself. Lonely. I don’t make friends easy you know.”

‘This place is modern, but empty, as I say, it needs to get old really, like we all are.”

David: (David was a man of few words) “The new place is very nice. We used to have a beer near the kitchen before. Now it’s on a trolley. I think the beer near the kitchen was more friendly, but this home is very nice.”

Ethel: “I know all about it - the old place and the new place.”

“We were talking about it the other day - the old place had character. This one still has the price tag on it.”

“I get very down because I used to help my sister - it was good because I was busy - now it’s a lot of empty time.”

Gladys: “I am going to die here so what does it matter what it is like. It’s jail. It’s prison. It’s like a trap.”

“You could help me to get out?”
Paul: “This is better than the old place. It’s got a lot of nice things. I feel better here - it’s not dark and old. I’ve moved a lot in my life - this is the nicest place I’ve ever lived in.”

“Everyone tries hard to make it good.”

“There’s no comparing the two.”

“Oh, they all talk, talk, talk - she said this, she said that, but we are all here aren’t we - there’s not much difference if your rich or not - we’re all here.”

“It’s more like a hotel or club than a home.”

“It’s a bit fancy really.”

Millie: “I like the new building. I have privacy and I can shut my door when I have visitors - anyway they don’t want to see old people wetting themselves anymore than I do.”

“I didn’t put up any objections to moving - it’s useless anyway - they had decided.”

“Sometimes when you see something happen and you know its cruel or something, you don’t complain because it takes energy.”

“All in all, they work hard and it’s not really nice work - we are all old, some of us are forgetful and the rest - well, we don’t see the rest - so I suppose that’s not bad is it. Anyway I can close my door.”

“I think sometimes there for the grace of God go I.”

“The games and the video are not much good”

Rose: “What’s it like - do you mean to live here - or what’s it look like - because it looks better than it is - at least I’m told it’s a nice building.”

“When I moved here I thought life might be different. It’s posh, but it’s better to feel good than to be rich.”
“I try not to criticise - but when you talk to others - it’s hard not to gossip about the things that happen, there’s not much else to do here. But not much happens. No-one really argues or complains. You just go along with it really.”

“My relatives - well they like this place, it’s closer you know for them - they say it’s fabulous and modern. You used to see the others quite a lot before, but now its accidental if you do - and it’s not the same as when were all in together.’

“I’d really like to go home. I used to on a Saturday sometimes, to my relatives, not my unit - but it’s too upsetting when they bring you back - I had to have a tablet to settle me down when they brought me back”

“I’d like it all to be happy here”.

Vera: “I’m a bit of a loner really, so I don’t mind what it’s like really as I have my own room, so I don’t have to be with them.”

“It’s supposed to be something special. How would I know. The nurses try to do the best for us all - some growl and complain - I know I do - but that’s how it is.”

Dolly: “It’s not too bad. I keep to myself as much as I can.”

“The family like it - I have a phone - it’s not a portable one like my nephews - but it’s better than being in the hall on the phone - when it worked.”

“Even though I like my room - its a bit scary at night - I got used to sleeping with other people - you do you know.”

The descriptions of the new home focused on the participants' attitudes about the staff, their interactions with the other residents, their feelings about their old nursing home environment, their feelings of loneliness and the lack of nonintentional contact in the new nursing home, their ability to have a telephone, fridge and some personal belongings, the lack of atmosphere in the new nursing home and loss of contact with others from the old nursing home.
Several participants expressed concern that had they complained or grumbled about any aspect of life (for example, the food, the communal dining area or any rough handling) their complaints would have been ignored or they would have become targets for reprisals from the nurses. When asked about these reprisals the participants were hesitant to comment. Several did comment:--

"Oh, they just leave you in the bathroom, on the toilet, for a long time. You sit there and ring the bell, but no-one comes, so you ring again, and then someone comes and tells you not to be impatient. It's not all that nice."

"You get ignored if you ask for help or something."

"They make you sit near a dribbler for lunch. It's awful really."

"They talk about you to other workers. You can hear them. They say you aren't cooperating today and you might be constipated."

These comments were balanced with many positive statements about the care they received and stressed only "some" workers behaved in this way. Two participants admitted being rude and aggressive to the staff but were not intimidated by the staff.

Others did not want to upset the staff. Participant's statements that reflect this are:

"I don't want the nurse to think I am ungrateful."

"Sometimes the staff are really cranky."

"If I complain they might not look after me."

"It's better to chew glue."
"I don’t like to speak in case they don’t like it."
"The girls are generally all right, but it’s hard to know some times with them-how they’ll be."
"Humour them that’s how I do it."
"I don’t think they’ll hurt you, but you never know."

With the exception of May, the participants gave little attention to the architecture of the new building, the appointments of the new building, the facilities in the new building and its geographic location. It was their social context that was very important to them. There was a consensus that the new facility lacked character and promoted isolation. The promotion of isolation is of interest as many of the participants have stated that they prefer to be able to read and eat meals alone. The participants clearly differentiated between being isolated and being able to make a choice to be alone for a period of time. A component of this isolation was identified by participants as the reduced chance to gossip and to know about what is happening in the nursing home. The long verandah at Site 1 typified this social context. The participants maintained that the dining room/activity room in the new nursing home had not taken on this function. A lack of closeness or intimacy was identified as being lost in the move and not replaced as the new architecture separated people from each other.

The differences in the physical surroundings between the new nursing home and the previous one also emerged as an important issue for participants. Most participants found it lonely and commented on the isolation. Four participants said it was an excellent move as they now had some privacy. Those who felt lonely said they missed the contact with those who had slept only a few metres away from them. They also noted that they no longer knew what was happening
in the nursing home as they were away from the 'action'. They identified the days felt longer and it was harder to fill time in.

7.7.3 The social isolation and loneliness expressed by the participants

Many expressions of social isolation and loneliness were made during the interviews. Comments such as those below demonstrate this.

"I was never this lonely at home, and I lived by myself."

"Sharing a room with another lady does not mean you aren't lonely."

"When I want to be alone-that's not being lonely-they are different you see."

"Being in a crowd does not mean you aren't lonely."

"I've got bad habits-but that don't mean I should be treated badly and left alone."

The participants indicated that the level of intellectual stimulation in the activities program of the nursing home actually contributed to their loneliness. Participants' comments included:

"I haven't made any friends by playing Bingo."

"Bingo, bingo and then more bloody bingo. Keno would be more suitable."

"We are all treated the same. The Kindergarten Teacher makes you feel like you are back learning to put blocks in the right place. Half of them don't know what day it is anyway."
"I was reading a novel and they told me to stop and play a game."

"I know my mind is better than this."

When the participants exercised choice about activities and wanted to be alone to read or watch television, they were reminded that the activity sessions were on. "It's like a round up. The nurse comes and takes us all to the dining room. Last time I said no, the doctor came because I was not being cooperative."

The participants felt that the activities program represented minimalist expectations of both their physical and intellectual capacity. This is supported by the following comments.

"They think we are dumb clucks and don't know how to do things."

"I don't know why the bright ones have to be in with the others."

"It's dull you know - and it smells like left over breakfast."

"I can do better than this. It makes me very annoyed to think they think we are all like this."

On an interactive level, participants generally wished to be alone, but felt obliged to join in the activity sessions to avoid conflict with the staff. This is reflected in the following interview material.

Matilda has general disinterest in the nursing home activities and is abusive to the other residents. Preferring her own company, Matilda openly dislikes the staff.
and is abusive to them in an attempt to keep them away from her. She watches her own TV as much as possible. Matilda does not talk to others at the meal table. (Affectometer 2 negative)

Annie has one or two friends. She doesn't want to meet "any more new people. I feel isolated in this new place and I do miss the close contact we all had in the old nursing home." "No, I don't enjoy the activity sessions at all." (Affectometer 2 positive)

Olive has no interaction with others in the nursing home. She likes to listen to audiotapes in her own room. She thinks staff are nosy. She keeps to herself as much as she can. (Affectometer 2 negative)

Eileen has no interactions with others and is abusive and aggressive to the staff and other residents. She likes to be alone, describing herself as "a loner as a child". She states she "hates" communal activities. (Affectometer 2 negative)

Louise maintains no interest in becoming involved with the others in the nursing home as she says "I have nothing in common with other people who live here too". She holds the view that the other residents are juvenile and noisy. "I don't like crowds" she said. (Affectometer 2 negative)

May has no real interactions because of her lack of mobility. She watches TV in her own room. May also feels that "the smell from my legs would drive people away anyway." (Affectometer 2: T-T1 positive; T1-T2 negative)

Ronnie enjoys company now and again. She doesn't like the food so keeps her own food supplies in her own fridge. Ronnie sees her fridge as a means "of
keeping to myself". Ronnie had one friend she has lost contact with since the move who she believes may be dead and "they don't want to tell me". (Affectometer 2 negative)

David keeps to his own group of friends. He likes to tease the ladies sometimes, but thinks they don't have a very "interesting sense of humour". David likes company some times. He watches TV with his male friends in the TV room near his room. (Affectometer 2 positive)

Ethel thrived on being able to help her sister. She didn't mix with any of the other residents. When not helping her sister she had "naps" on her bed. She shared a room with one of her sisters who died recently. Ethel misses her sister dreadfully and thinks she may be the next to go. Ethel will not go to the dining room for meals as she thinks it is too crowded and noisy. (Affectometer 2 positive)

Gladys doesn't interact as she believes staff and residents are Nazis and want to kill her. She remains in her room with the blinds down. (Affectometer 2 negative)

Paul has a few friends he talks to and watches the TV with. He likes to have an occasional beer with them when "Matron is not looking". (Affectometer 2 positive)

Millie enjoys the sing-a-longs, church services and bus trips. She likes to eat alone as the "others are all sloppy eaters". Millie finds the diversional therapy games belittling and doesn't join in because "if you do you'll end up like that". (Affectometer 2 positive)
Rose feels obligated to join in the activities. She hates the Diversional Therapist, calling her the Kindergarten Teacher. Rose also hates group games. She pretends to like the activities so the nurses don't treat her badly. (Affectometer 2 T-T1 negative; T1-T2 positive)

Vera avoids group participation. She hates eating with other people who "spill their food". Vera thinks she mixed with others more in the old home as "everyone was so close and you didn't have a choice". She prefers her own company. (Affectometer 2 T-T1 negative; T1-T2 positive)

Dolly finds the other residents dull. She doesn't talk to them as they "talk a lot of rot". Dolly does not like communal eating as it "puts her off her food". She likes to eat alone. (Affectometer 2 negative)

The comments made by participants show a general reluctance to become involved with other residents, a desire to spend time alone, a need to eat alone, the need to provide intellectual stimulation rather than minimalist activities such as Bingo, and a pattern of established and ongoing relationships involving a small number of people. There is a general reluctance to incorporate new people into existing relationships. The Affectometer 2 Scores have been included to show the level of congruence between the Affectometer 2 Scores and their feelings about interacting.

Four (27%) participants maintained they had no interactions with others in the nursing home; one (6%) maintained little interaction with others in the nursing home; two (12%) maintained disinterest in what went on in the nursing home and stated a preference to keep to themselves; seven (46%) selected the interactions
they participated in; and one (6%) felt obligated to join in activities even though not liking them.

Nine (60%) participants said they felt isolated and lonely. Two (13%) participants expressed mixed feelings about being lonely, one participant (6%) said "it's all a state of mind", whilst another said "if you can't mix with people here, you can't mix with people anywhere".

Isolation and loneliness were identified by some participants as being related to being satisfied with their life as a resident of a nursing home.

To gauge the level of satisfaction participants had, they were asked to assign a rank to their levels of satisfaction from 1-10 with life in the nursing home, with 10 being the highest level of satisfaction and 1 being the lowest level of satisfaction. The GHQ-20 scores and Affectometer 2 scores are noted here as participant satisfaction embraces both the physical and the affective aspects of well-being.

7.7.3.1 Participants' ranked levels of satisfaction of life in a nursing home

The participants' ranked levels of satisfaction with life in a nursing home is presented in Table 7.26.
Table 7.26 Participants' level of satisfaction with GHQ-20 and Affectometer 2 scores

<table>
<thead>
<tr>
<th>Informant</th>
<th>Satisfaction ranking</th>
<th>GHQ-20 (T-T2)</th>
<th>Affectometer 2 (T-T2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matilda</td>
<td>1</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Annie</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Olive</td>
<td>6</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Eileen</td>
<td>6</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Louise</td>
<td>3</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>May</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Ronnie</td>
<td>5</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>David</td>
<td>6</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Ethel</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Gladys</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Paul</td>
<td>7</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Millie</td>
<td>9</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Rose</td>
<td>5</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Vera</td>
<td>6</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Dolly</td>
<td>7</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

The mean of the satisfaction rankings is 5.6, the median score is 6 and the range of scores 1-9. Those participants with a high level of satisfaction ranking had positive GHQ-20 and Affectometer 2 scores, while those with a low level of satisfaction ranking had negative GHQ-20 and Affectometer 2 scores.

7.7.3.2 Frequency of satisfaction scores

The frequency of satisfaction scores is presented in Table 7.27.

Table 7.27 Frequency of satisfaction rankings

<table>
<thead>
<tr>
<th>Satisfaction ranking</th>
<th>Frequency</th>
<th>Satisfaction ranking</th>
<th>Frequency</th>
<th>Satisfaction ranking</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>
It is notable that with one exception (Gladys), all the participants recorded a positive GHQ-20 Score, yet, there was a wide range of satisfaction scores. Those participants with a satisfaction score of five or less all recorded a negative score on the Affectometer 2. Ten (66%) participants recorded a satisfaction score of six or more. Six (60%) of these had positive Affectometer 2 scores, three (30%) had negative Affectometer 2 scores and one (10%) had a mixed Affectometer 2 score.

It seems that despite experiencing physical well-being (GHQ-20 scores), at least five (33%) participants did not experience affective well-being also. This is reflected in their satisfaction rankings.

Individual participant’s comments also reflect these results.

Matilda dissatisfied: "I tell staff I am happy so they don't bother me". Level of satisfaction: 1

Annie satisfied: "as long as the nurses don't pry into your life."
Level of satisfaction: 7

Olive satisfied: "as long as I can keep to myself."
Level of satisfaction 6

Eileen dissatisfied: "I know I am rude, but I get frustrated when I am taken to the dining room to play games when I don't want to. I get aggressive with the staff and the others."
Level of satisfaction: 6
Louise dissatisfied: "I hate the place. I hated the other place. I tell the staff I’m happy to keep them away from me. My family just dumped me here."
Level of satisfaction: 3

May satisfied: "I don't mind it here. You have to be somewhere. It's not home though - I don't suppose it will ever be like home."
Level of satisfaction: 7

Ronnie satisfied at times, dissatisfied at others: "I tell the staff I'm OK even if I'm not. I don't want to cause trouble."
Level of satisfaction: 5

David satisfied: "You are either satisfied or you aren't. If you can't be satisfied here you won't be satisfied anywhere else."
Level of satisfaction: 6

Ethel satisfied: "I am satisfied if I can do something. Nights are very long and I don't sleep well. That makes you grumpy. I have one sister here. Some of the girls are a bit rough at times."
Level of satisfaction: 7

Gladys dissatisfied: "I asked the nurse in the slacks to give me many tablets - she said no. They won't help me die."
Level of satisfaction: 2

Paul satisfied. "It is a good place to live, they leave you pretty much alone here."
Level of satisfaction: 7
Millie satisfied: "I'm happy here you know. I don't let on to them nurses though - I give them a hard time so they don't take advantage of me. They have to stay on their toes in a place like this. On the whole I like the girls here".
Level of satisfaction: 9

Rose, a bit of both: " I have to be satisfied - I have got nowhere else to go. I go to the dining room, you feel you've got to join in or there'll be some trouble. Some of the girls try hard I suppose."
Level of satisfaction: 5

Vera satisfied: "The older place was, well, better. It was supposed to be too old - but you knew what was going on there, here you don't have any idea really - still, it's a home."
Level of satisfaction: 6

Dolly satisfied: "I'm satisfied well enough, but I don't tell the girls who work here because they aren't all nice girls you know."
Level of satisfaction: 6

The participants' perception about their own levels of satisfaction with life in the nursing home show that nine (60%) were satisfied with life in the nursing home, four (27%) were dissatisfied with life in the nursing home and two (13%) expressed mixed feelings. The participants' GHQ-20 scores and their Affectometer 2 scores support this.
7.7.4. The powerlessness of the participants' position as a resident of a nursing home

With the exception of two residents, all expressed feelings of being unable to do as they wanted to, make any independent decisions and were frustrated at having to do as they were told. Many of the participants complied with the nursing home routine to avoid conflict as they were unsure of the consequences. This was demonstrated by comments such as:

"It's better to go along with them-it's easier you know."

"They talk to each other about you if you don't do as they ask."

"I hate activities-but its easier to go-its expected."

"I often wonder what would happen if I just said no to something or other."

"Some ask you to do things in a nice way, others say come on and you know it's on."

"Trouble makers get it in the end."

"It's not a bad routine, I just let them think I'm stubborn. It adds interest don't you think?"

When talking about these feelings, participants made comments about being overlooked when decisions concerning themselves were being made. For example:
"They don't ask me anything, they just ask my daughter. How would my daughter know how I am feeling?"

"Being in here doesn't mean I can't make decisions about my own life - or what's left of it. When I ask for something they say we'll check with your daughter."

Activity sessions were problematic, with many comments like those below indicating a desire to exercise a choice about joining in or not. Many participants preferred to be alone, but joined in as they felt there was no choice or control over what they did. When asked if participants felt they had more control post-relocation three (20%) indicated they did have more control, six (40%) felt they experienced a decrease in levels of control and six (40%) felt there was no change in levels of control since relocation.

Obtaining information about treatment was also described as difficult by seven (46%) participants. Participants reported the following responses when they asked questions about their treatment:

"Just take it—it does you good."

"You don't really need to know."

"It all keeps you alive."

"Better to ask your doctor."

"You should know, they are what you had at home."

"Ask your daughter next time she visits."
Communal meals caused concern to the participants. Only three participants actively looked forward to eating with other residents. Several reasons were given for this. Firstly, participants became embarrassed with their own eating habits and those of other residents. Comments were made about "dribbling food", "spilling food", "watching nurses shovel food down some poor coot's neck" and the smell of the food.

The participants also felt they were being patronised by the staff and that the staff talked to them like children at meal times. Five participants said they became upset and dreaded going to the dining room to eat. These feelings are reflected in the following comments.

"I asked a nurse to move me away from the lady next to me because she made me feel sick when she ate. The nurse moved me next to someone worse."

"I just wanted to eat in my room. They said it wasn't good for me to be by myself-that eating in the dining room was good for me. It is awful in there."

"I asked the sister why I had to eat in that room. She said it was so I would not forget my table manners."

"They don't understand. You don't have much pride left by the time you come here. I don't want the others to see me shaking and spilling my food. I told the nurse that and she said that's OK, they all do it."
7.8 THE MAJOR THEMES THAT EMERGED FROM THE INTERVIEWS WITH THE PARTICIPANTS

The major themes that emerged from the interviews with participants were:

1. Most of the participants did not want to be residents of a nursing home and did not view themselves as being sick, rather, they viewed themselves as ageing.

2. The differences between the former nursing home and the new nursing home presented a challenge to the participants and the differences did impact on the quality of life they experienced.

3. Isolation and loneliness followed relocation for the female participants, whilst the male participants did not have the same experiences.

4. Powerlessness was experienced by most of the participants at some time since relocation.
CHAPTER 8

DISCUSSION

INTRODUCTION
MAJOR FINDINGS
SIGNIFICANT RESEARCH OUTCOMES
UNEXPECTED RESEARCH OUTCOMES
CONCLUSION
SUGGESTIONS FOR FUTURE RESEARCH
SUMMARY
8.0 INTRODUCTION

This research has significant implications for nursing home residents. Although participants of this research moved into a new institution, their quality of life did not improve. Those who manage the nursing home continued to control significant aspects of the day to day life experiences of these participants.

This Chapter discusses the significance of the major research findings and makes suggestions for further research.

8.1 MAJOR FINDINGS

The quality of life of participants in this research was affected by a forced interinstitutional relocation. The gender of participants effected reaction to relocation, with the male participants reporting higher levels of well-being than their female counterparts. The number of previous voluntary relocations, orientation levels, medication usage levels and the number of people in each room had no significance on the impact of the relocation. The relocation resulted in change to almost every aspect of the life of these participants, and this study found that many of these had a negative impact.

8.2 SIGNIFICANT RESEARCH OUTCOMES

The issues emerging from this research have been grouped under four headings:-
1. The appropriateness of the Relocation/Adaptation (RA) model as a theoretical framework for relocation.
2. The failure of the participants to object in any organised way about their lack of autonomy and choice in relation to the relocation.

3. The role of nursing home administrators in a nursing home relocation.

4. Unexpected research outcomes.

8.2.1 The appropriateness of the RA model as a theoretical framework for relocation

The RA model presented in Chapter 3 is a basis for a model which deals specifically with a forced interinstitutional relocation amongst nursing home residents. This is relevant as this type of relocation will increase steadily as the existing stocks of Australian nursing homes require replacement or significant upgrading.

The RA model provides an organised and structured approach to aged relocation. It is a model which takes cognisance of the difficulties associated with any relocation as well as considering the special difficulties associated with a forced interinstitutional relocation. Central to the adaptation process is the concept of homeodynamism which acknowledges that the individual is in a constant state of adjustment to external and internal tensions which are mediated through primary and secondary appraisal mechanisms. The RA model recognises that relocation can have both a positive and a negative outcome for the relocatee. This study supports many aspects of the model, however to be specific to the situation of an interinstitutional relocation some modifications (figs 8.1 & 8.2) were necessary.
Figure 8.1 Model 1: Voluntary relocation of an aged person

Precipitating Factor (e.g., death of spouse) → Search & Choice Process → Relocation → Settlement

inability to reach a satisfactory homeodynamic state

decrement in quality of life

new homeodynamic state

enhanced quality of life

Figure 8.2 Model 2: Forced relocation of an aged person

Precipitating Factor (e.g., facility closure) → Relocation → Settlement

inability to reach a satisfactory homeodynamic state

decrement in quality of life

new homeodynamic state

enhanced quality of life
There are similarities between the relocation experience for aged people but there are also some very important differences. A triggering event has caused both to relocate, however the search and selection process completed by the voluntary relocatees is critical to the outcome of the relocation. It is this choice factor and the autonomy that comes with that choice that seems to be a critical factor in the adaptation of the individual to the relocation itself and then the lifestyle that follows. Studies carried out by Langer and Rodin 1976, Rodin et al. 1982, and Belsky 1990 support choice as a critical factor in adaptation.

Choice, adaptation and a satisfactory homeodynamic state are closely interrelated. An individual may find it easier to adapt if given choices. This is described in the literature relating to choice, autonomy and control, and reinforced in the comments expressed during the interviews by the participants (Langer & Rodin 1976; Holahan et al. 1984; Rodin 1986; Belsky 1990).

In the context of limited autonomy, a satisfactory homeodynamic state is more difficult to attain than in a context of choice. When a relocatee is given a choice and is actually involved in discussions about the future, there is a much higher chance of adaptation in the new environment as feelings of control in that environment are enhanced (Rodin 1986; Baglioni 1989).

To increase the utility of the model for forced interinstitutional relocation two simpler models have been derived in the course of this study. The first model (fig 8.1) describes voluntary relocation where real, effective choice was exercised by the aged person and the second model (fig 8.2) describes forced interinstitutional relocation of an aged person. Inherent in the second of these models is an acknowledgment of the reasons why choice is limited. These are the individual’s powerlessness due to external forces (for example, medication or
poverty) and an awareness by the relatives or significant other that there is no alternative with the exception of taking the relative home to live with them. The relatives endorse the powerlessness as it is the only viable alternative for them.

A satisfactory homeodynamic state is critical to the quality of life the institutionalised aged person experiences (Lazarus 1974; Moos 1980; Rodin et al. 1982). Inherent in this satisfactory homeodynamic state are autonomy, control and affective well-being. This can be achieved in the right to adequate information from which it is possible to make informed choices, the right to choose friends and the clothes to wear, the right to be alone, the right to share and the right to personal possessions. Lack of choice has been identified as a cause of poor adaptation to nursing home life (Dohrenwend 1973; Lazarus 1974; Baglioni 1981; Baldwin 1991; Armer 1993).

Physical well-being and independence are also part of the homeodynamic process and the quality of life a resident experiences after an interinstitutional relocation. The interview material underscored the value of these to the aged institutionalised person. These findings were supported in studies carried out by Langer and Rodin (1976), Rodin and Langer (1977), Lazarus and Launier (1978), Rodin et al. (1982), Lieberman and Tobin (1983), Holahan et al. (1984), Thomas (1988), Zlobicki (1988) and Thomas and Hayley (1991).

There is a great deal of evidence that the participant was disillusioned. This response is supported by studies carried out by Rodin and Langer (1977), Moos (1980), Watson (1980), and Rodin et al. (1982). However, the participants (with one exception) had become accustomed to their former environments (Site 1 and Site 2). The participants did not perceive the physical limitations of these environments that were of concern to the licensing authorities. Once relocated,
many described loneliness, feelings of isolation and an inability to communicate with staff they had not seen before. Participants reported that the staff expected them to like the new nursing home and expressed surprise when told by the participants they preferred the old place. One reason for this was the lack of continuity between the old nursing home and the new nursing home and between the old nursing home staff and the new nursing home staff. This discontinuity caused problems during the settling in period and reduced the participant's quality of life. The subject of discontinuity will be discussed further.

Expressions of frustration were common amongst the participants. Anger was not directly expressed, but two participants stated they were often rude to the staff. Frustration about the lack of choices was voiced during the interviews but not in the questionnaires. These expressions of frustration were mostly statements about how things really were rather than angry, emotive responses. It was clear that the lack of alternate housing and lack of choice dominated in the participants' experience.

The material collected supported the concept of an optimal homeodynamic state. The two male participants made the most significant homeodynamic gains, with staff and self reported increases in social contacts and independent behaviours, though there were no gains on their Katz Index of ADL. The female participants either remained at the pre-relocation levels or their abilities on self-report decreased. For them, achieving a new homeodynamic state was difficult. Unresolved unhappiness and unrecognised grief made it hard for them to progress. Withdrawn behaviours were seen as bad behaviour by the staff, rather than as adaptive behaviours. A perceived increase in physical dependence levels on the staff as a result of the relocation made participants unhappy and increased their feelings of external control.
The potential value of primary and secondary appraisal mechanisms was consistently overlooked by those external to the participants who performed their roles in an accepted institutional manner. This manner denied the participants' ability to understand the relocation process they were experiencing or failed to recognise that mechanisms such as reminiscences and fantasy were important secondary appraisal mechanisms (Butler 1963; Lazarus 1974; Mikhail 1992).

One deficit within the RA model was its failure to stress the fact that the dissimilarity and high discontinuity between the old and the new environments made a satisfactory homeodynamic state difficult for the individual to achieve. The importance of continuity has been stressed in the relocation literature by Bourestom and Tars (1974), Coffman (1981), and Lieberman and Tobin (1983). Where continuity was given a high priority, adaptation was made easier for the resident.

Modifications to the model take cognisance of this. The behavioural outcomes of the RA model for the participant, such as optimism, fantasy and disillusionment were accurate ones which were described by the participant as ways they had thought about the move both before and after the relocation (Lazarus 1974; Mikhail 1992).

For the participants, looking forward to the move stimulated fantasy and optimism levels about their future and this may have helped to reduce their levels of anxiety about moving. Participants reminiscenced about the good times of the past as a part of this process (Butler 1963). Disillusionment was expressed after the move by those participants who felt it was not what had been anticipated by them.
When considering how much the participants were looking forward to the move, it is necessary to examine the reason for a mean score of 5.7 on this measure. Reasons for this include:

- the on-again, off-again nature of the move;
- forgetfulness-details slip from memory;
- the physical enormity of the relocation;
- the lack of social preparation for the move;
- enhanced feelings of loss of control; and
- the primary and secondary appraisal mechanisms that operated.

When deriving the RA model, the physical, affective and social dimensions of the individual were considered.

8.2.1.1 The physical aspects of the relocation.

Physical ability plays an important role in the well-being experienced by the participant. The restricted environment of the nursing home may lead to the deletion of some activities and the necessary inclusion of others. Those who are not residents of a nursing home and who make judgements about these issues on behalf of the residents may not appreciate how relatively good the resident's range of physical activities is. They may not also realise the resident is at peak physical activity level which is only possible in a long term care institution. That is, the resident is functioning at an optimal level amongst a segregated population with varying levels of debility. The resident may have reached a peak physical functional level.
8.2.1.2 The affective aspects of the relocation

Acute or chronic illness can effect the way a participant reacts in the research on the day. Medication usage can also exert an effect on participant response.

This is an important consideration as 87% of the participants in the time series study and 80% of the interview participants were taking affect altering medications.

In the context of quality of life and quality of care, it is important to avoid labelling a participant as being mentally or affectively deficient. Such labelling may create a set of expectations about the abilities of the participant that reach far beyond the control of that resident. One serious ramification of this type of labelling is the prescription of psychotropic medications as a remediation for this situation. This may, given the pharmacokinetics of the aging person, dull the affect rather than remediate it. However, if the resident was diagnosed as having a minor or major depression, anti-depressant medication may improve their affect.

The instruments used in the study attempted to identify the individuals' strengths in relation to the relocation. This was seen as important in terms of their activities of daily living. The participants' Katz Index of ADLs indicated functional areas and areas in which assistance was required. The contradiction between self-reported improvement and no adjustment to the Katz Index of ADL may be attributable to inconsistencies between assessors, but equally, it may have been because no significant gains were made by the participants.
Those participants identified by this study as requiring some medical intervention were, in the first instance, pointed out to the ADON who contacted the relevant General Practitioner for further advice. In a small number of cases, the initial negative affective reaction at T1 to the relocation reversed itself at T2. Affect can be altered by the general effects of ageing itself and the time taken to adapt to a stressful environment may have been a reflection of this.

A change in the environment can exert significant effect on the mental capability of the individual. This is important in the context of autonomy and decision-making, essential in terms of locus of control and hence quality of life and well-being (Langer & Rodin 1976; Rodin et al. 1982; Janes 1990). If denied these functions in regard to something as germane to life as a physical relocation, it is no wonder that the majority of participants had negative Affectometer 2 scores and expressed a lack of control over their circumstances. Without being able to exercise the right to make even minor decisions in relation to the interinstitutional relocation which is a major event in their lives, quality of life must be effected. This represents an external view held by the researcher. Again, the individual is the final arbiter in these matters. From the comments concerning fear of reprisals, it could be inferred that residents play the 'good-patient' game, not revealing their true feelings about their situation.

The initial identification of adaptation difficulties in these participants relied on the presence of indicators such as weight loss, disruptions to sleep, increases in the number of headaches and general malaise. Comments such as “I am just waiting to die”, “It’s no good I will die here anyway” and “We will all die here” were common throughout the interviews, though the participants making the comments were not identified as being depressed, nor did they lose weight, experience altered sleep patterns as they were sedated at night, or self-report feeling ill.
They presented to the researcher as lacking any interest in life and had resigned themselves to their inevitable death as a nursing home resident.

8.2.1.3 The social aspects of relocation

The relationship between the quality of life in a nursing home and the social well-being of a resident is a critical one (Belsky 1990). The relocation from one institution to another can rupture this relationship and upset patterns of existing friendship amongst individuals and small groups. The literature has suggested the ideal conditions under which an interinstitutional relocation should occur (Bourestom & Tars 1974; Wells & MacDonald 1981; Watson 1990). A primary condition was that small, established groups should be moved together after counselling with the groups being involved in the relocation process (Wells & MacDonald 1981; Watson 1990). Within this there remained some choices the individual could make. These included the choice of friends to remain with and the group to be moved with. This increased the locus-of-control and gave the individual a sense of involvement in the relocation process (Bourestom & Tars 1974; Wells & MacDonald 1981; Rodin et al. 1982; Watson 1990).

In this instance these ideal arrangements were not made. This could have had several, potentially serious ramifications for the relocatees. Firstly, it is recognised that physical and mental well-being is reflected in social interactions (Belsky 1990). Alterations in the patterns of social networks without consultation can precipitate mental and physical illness (Kreigh & Perko 1983; Belsky 1990; Spar & LaRue 1990; Stuart & Sundeen 1991). Depression, social withdrawal and non-cooperation (passive aggression) can occur (Belsky 1990; Kreigh & Perko 1983; Stuart & Sundeen 1991; Spar & LaRue 1990).
Secondly, physical health problems can increase as homeodynamic status is disrupted (Spar & LaRue 1990; Mikhail 1992). If recuperative abilities are dysfunctional, illnesses such as hypertension, gastrointestinal disruptions and anorexia occur (Lazarus & Launier 1978; Mikhail 1992). Acute exacerbations of chronic conditions can occur, for example, acute osteoarthritis (Lazarus & Launier 1978; Mikhail 1992). Reminiscence and fantasy serve as secondary appraisal mechanisms as a new homeodynamic state is reached (Butler 1963; Lazarus 1974; Lazarus & Launier 1978; Lazarus 1981; Mikhail 1992).

From a social perspective, the prescriptive nature of interactions within a nursing home often locks a resident into a range of activities with other people they would not, under normal circumstances choose to relate to at all. The activities promote a minimalist physical outlook and an equally depressing cognitive outcome. Participation is encouraged and the inertia that governs most routines attached to nursing home life dominates involvement (Bennett & Nahemow 1965; Friedan 1993). The high level of unhappiness about being involved with the activity program was evident from the interview material and is consistent with the literature which relates to being able to exercise choice and control in their environment (Thomas 1988, Zlobicki 1988, Rodin et al. 1982, Ferguson-Stewart 1994) Where control can be exercised a more positive adaptation is possible.

It is in this area of the social effects of relocation that subjective measures proved useful. Socially, the residents had little impact on the new environment. Ironically, the participant who preferred her own company and did not wish to participate in communal activities was the cause of concern and subsequent assessment as she was considered to be withdrawn by the nursing home staff caring for her.
This withdrawal was not viewed as a form of social adjustment, that is, a situation that allowed the resident to reduce tensions by satisfying her own needs. The qualitative aspects of her life were being decided by an external influence. This highlights the differential values placed on the social environment by the resident and the staff. It also highlights a lack of knowledge concerning the role of primary and secondary appraisal mechanisms.

8.2.1.4 Participant behaviours and research results

The limits of self-report as a research technique requires some discussion. Participants may adopt a compliant attitude, forget details necessary for a valid and a reliable result and exaggerate the real situation to avoid pain when recalling an upsetting situation. The adoption of a compliant attitude when responding to the researcher became evident during the interviews with the participants. Some participants admitted to providing incorrect information to the researcher when the time series data collection was taking place. The reasons the participants gave for this deception related to their need to maintain a positive relationship with the staff and the matron. The participants did not want to be seen by the staff or the matron as causing trouble.

Forgetting the details necessary for a valid and reliable result may be a valid criticism of self-report in this context. The normal aging process does cause some forgetfulness, whilst pathological processes accelerate this situation (Eliopolous 1987; Ebersole & Hess 1990). The consistency of the scores obtained on the GHQ-20 and The Affectometer 2 indicate that this may not be a confounding factor in this case. Distortion of the reality of the situation for the participant can portray a situation based on fantasy and produce unreliable results. No participants behaved in a manner that reflected this, however the researcher
believes that the strength of fantasy may have produced plausible, repeatable results.

The validity of responses in a total institution is an important methodological consideration. Discrepancies occurred between the results obtained on the GHQ-20 and the research material gathered from the interview participants.

These discrepancies may have resulted from issues related to time and dependency. The GHQ-20 was relatively quick to administer, taking only 10-15 minutes to do so. This did not allow the participant much time to develop any real relationship with the researcher. The pressure at time T to complete the data collection was great as the move was imminent. Also, there was some competition for the participants' attention as a result of the other research being carried out in the nursing home at the time. It was also a busy time for the participants as the nursing home prepared to relocate to the new facility.

The dependency factor is also an important issue. The interview material revealed that some participants were scared of reprisals from the staff if they did not acquiesce about the nursing home and the move. Many of the interview participants openly acknowledged they had nowhere else to go and relied on the staff to care for them. They also did not like to be in a position of dependence on the staff. This may have moderated their responses to the time series study.

The interviews also revealed an initial level of distrust in the researcher. This was raised by five of the interview participants. These ladies thought the researcher may have been working for the administration - “spying on me”, “trying to trip me up”, “repeating what I said in private”, “pretending you were
interested” and “working for the matron”. This undoubtedly would have biased the GHQ-20 results.

The Affectometer 2 results reflected the interview material more closely. For the Affectometer 2 scores, between time T and T2, seven interview participants recorded negative scores, six interview participants recorded positive scores and two interview participants recorded mixed scores. The Affectometer 2 in this research situation was the more sensitive instrument.

8.2.1.5 The research context

The context of these results is also relevant to the research outcomes. This research was conducted in a long term care institution (Chapter 1:5). The characteristics of a long term care institution impact on the physical and mental condition of the participants. The significant characteristics are the imposition of rules for conduct by the resident; the maintenance of a level of observation of the resident by the staff; operating in a manner in which good and bad behaviours are recognised and responded to; a lack of resident involvement in decisions that impact on them; having a non-consensual admission process; and the imposition of a communal lifestyle (Bennett & Nahemow 1965).

Contextually, these characteristics contribute to the physical and mental status of the participant. Another compounding factor may have been the high levels of affect altering medication being taken by the interview participants.
8.2.1.6 Conclusion

The usual considerations (Kane & Kane 1988) when conducting research amongst the aged were adhered to, yet still there were inconsistencies between material collected from the GHQ-20, The Affectometer 2 and the interviews.

In summary, the researcher believes this was the result of the participants' fear of reprisals from the staff if they said the wrong thing, the participants' mistrust of the interviewer, the participants' interview fatigue, the institutional nature of the nursing home, and the potential effects of the level of use of affect altering medications amongst the participants. The first three of these can be controlled; the fourth has the potential to always remain a problem; the last should certainly be addressed.

So, with modifications, the RA model was a useful descriptive tool that was supported by the relocation literature and more importantly, by the experiences of the participants.

8.2.2 The failure of the participants/ to object in an organised way about their lack of autonomy and choice in relation to the relocation

This study found that the participants were unable to protest in an organised way to bring about change in their environments. The participants had the potential to act as change agents, but did not. This was for a number of reasons. Since the relocation there was no formal mechanism through which the participants could mobilise their dissatisfaction. They had no formal or informal leader through which to do this, due in part, to the separation of those in previously established small groups by their care area placement in the new nursing home. Fear of
reprisals and failing health curbed any untoward comments or behaviours by the participants.

The relatives and significant others also failed to act effectively for their relatives and significant others. The reasons for this include the lack of alternative housing options for participants, the fear of neglect by staff of their relatives, and a genuine belief that the participant was not in any distress. The opinions being expressed to the participant by the relatives about how good the move was going to be for them may also have curbed any negative comments to them by the participant about the move. In the researcher’s opinion, the exclusion from the research of the relatives was an oversight and any future research in this area would benefit from this perspective.

8.2.2.1 Inertia and passivity

Inertia and passivity emerged as central characteristics of the participants’ interactions with each other, the staff, the administration and their relatives. Both the time series study and the interviews with the residents accentuated both the inertia that defined their existence and the passivity that this generated. Results of the time series study provided support for this passive outlook.

The GHQ-20 positive scores recorded by the participants indicated that they had experienced no adverse health effects as a result of relocation. A few participants recorded mixed scores which indicated that they either did not adapt as quickly as their peers or that they were unwell following relocation. The inertia may be reflected in this high number of positive GHQ-20 scores.
Many participants recorded negative scores on the Affectometer 2. This was in contrast to the GHQ-20 scores which placed emphasis on the physical aspects of well-being. The Affectometer 2 negative results indicate a level of emotional distress that was not evident to the nursing home staff. Some participants stated they did not want to upset the staff or the administration so they tried to accept their situation.

The combined results from the GHQ-20 and the Affectometer 2 for each participant presented a complex picture, with mixed results being recorded. The Affectometer 2 gave the participants the opportunity to express their feelings of uneasiness about their situation. These feelings of unease were later augmented in the interview situation.

Rhetorical questions posed by the participants during the interview such as “what can I do anyway”, how can I do anything’ and “if they chuck me out what will happen to me then” show the unwillingness of the participants to join with others to act collectively. At the same time, participants seemed unaware of the potential effect of their medication regimens on their mood and behaviour.

8.2.2.2 Affect altering medication

It is the researcher’s view that affect altering medication may have assisted the participant to remain compliant and controlled at all times.

Within the time series sample, 87% of the participants were prescribed affect altering medication, whilst in the interview sample 80% of the participants were prescribed affect altering medications. The participants were prescribed
hypoctics, antiolytics, tricyclic anti-depressant and anti-psychotic type medications.

The affect altering medications prescribed for the participants are presented in Table 8.1.

**Table 8.1** Affect altering medications prescribed for the participants

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxepin</td>
<td>Sinequan</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Serenate</td>
</tr>
<tr>
<td>Nitrazepam</td>
<td>Mogadon &amp; Alodorn</td>
</tr>
<tr>
<td>Oxezapam</td>
<td>Serapax</td>
</tr>
<tr>
<td>Temazepam</td>
<td>Normison &amp; Temaze</td>
</tr>
</tbody>
</table>

Some participants were prescribed a mixture of these medications. Taking these medications is compounded by the altered pharmacokinetics (that is, the action of the drug in the body) and the pharmacodynamics (that is, how the drug works in the body at cellular level) related to the normal ageing process. This complex set of interactions is summarised in Appendix 4.

These medications can dull the affective or emotional responses to any situation by exercising a sedative or tranquilising effect on the person taking them (Galbraith et al. 1994). In addition, the normal physiological degenerative processes related to aging and age related pharmacokinetic change increases the risks to the participant of experiencing unwanted and unintended side effects from such medications.

Whether intended or not, the prescription of affect altering medication can be interpreted in two ways: they may act as a control measure that helps to maintain
the inertia that is a part of nursing home life; or they may act as a substitute for additional nursing care as the use of these medications can induce a compliance amongst residents. These interpretations are supported by those of Waxman, Klein and Carner (1985) who reported some nursing homes in the United States of America deliberately sedating residents in order to satisfy the requests of the staff. Over a decade ago, Wade and Finlayson (1983) identified this trend in the United States of America. They concluded that psychotropic drug use in nursing homes served as control agents through which problems related to residents could be managed.

A recent study attempted to ascertain the level of psychotrophic drug use in nursing homes in Sydney (Snowdon, Vaughan, Miller, Burgess & Tremlett 1995). The area chosen for the study was the western area of the Central Sydney Area Health Service. This showed that 58.9% of all nursing home residents in the Snowdon sample used 'psychotrophic drugs regularly or as required' (p. 70). This placed the Central Sydney nursing homes as amongst the highest users of 'mind altering drugs' in the world (Larriera 1995 p. 3).

This timely study provided a relevant and important comparative benchmark for the use of affect altering drugs by the nursing home in this research. The Central Sydney sample had a 58.9% usage rate among all of the residents of the nursing homes used in that research (Snowdon et al. 1995 p.70). The time series study participants had an 87% usage rate and the interview participants had an 80% usage rate. One difference between the Snowdon research and this research is that this research did not survey all the resident’s medication usage patterns. This study comparison is useful as it does demonstrate a comparatively high level of these medications being used by the study participants. Table 8.2 has interrelated
the use of affect altering medication by the participants with their GHQ-20 scores, Affectometer 2 scores, and the Katz Index of ADL.

One, possible consequence of the high level of affect altering medication usage could be legal action by the resident or their family or significant other for negligence. This would be on the basis of the failure of the nursing home to meet their duty of care toward the resident. This could be based on the failure to recognise the signs and symptoms of drug toxicity, drug interactions and the side effects of the prescribed medications.
<table>
<thead>
<tr>
<th>Name</th>
<th>GHQ Score</th>
<th>Affectometer 2 Score</th>
<th>Katz ADL Index</th>
<th>Hypnotics</th>
<th>Anti-Psychotic</th>
<th>Anti-Depressant</th>
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<tr>
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<td>F</td>
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<td>C</td>
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<td>Millie</td>
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Table 8.2 Summary - GHQ Scores, Affectometer 2 Scores, Katz ADL Index and Affect Altering Medications for Participants
For example, a participant made drowsy might sustain a fractured neck of femur as a result of a fall and then die following after surgery. The family or significant others might then ask who was monitoring the residents for side effects of any medication that was prescribed, was the resident being adequately supervised at the time of the fall, and had serum levels for the medication been assessed.

One method of addressing the over prescribing of affect altering medications is reported by Parkes (1995) amongst a sample of the war veteran (returned or active armed forces personnel) population of Australia. In this study, Parkes examined regulatory control of the prescription of certain benzodiazepine drugs amongst Veterans receiving their drugs through the Repatriation Pharmaceutical Benefits Scheme (RPBS). The results were dramatic and "indicate that the prescribing of those drugs that now require 'authority' and also the drugs that have subsequently been unlisted, has fallen by over 50%" (Parkes 1995 p. 110).

It is possible that similar results may be obtained if an authority scheme was introduced into Australian nursing homes. Another means of containing the over prescribing of psychotrophic drugs may be for nursing homes to commission independent audits of medication usage, and if excessive, to review resident medications.

8.2.2.3 Autonomy, decision making and quality of life for participants

This lack of collective protest probably ensured the status-quo of the nursing home remained unchallenged. There was no evidence of an enhanced quality of life and quality of care. Rather, there was verbal evidence of increased control, reduced autonomy, independence and affective well-being.
For example, prior to relocation, two ladies indicated they wanted to room together in the new nursing home. They had established a friendship and enjoyed each others company. Both requested that this happen. The family of one lady was concerned about this request as the other lady was a little frailer and older than her mother, but as mentally sharp as her mother. The family asked that they not be in the same room. The administration acted according to the request of the family. The reason the family gave was that they felt when the older, frailer lady died their mother would be distressed as they were dependent on each other and helped each other. The family felt their mother would not cope with the loss. The ladies were therefore housed in separate care areas. The younger of the ladies became withdrawn, depressed and died eight weeks after the move. The older lady was not told and kept asking after her friend. External forces controlled the choices of these residents, reduced their autonomy and denied them any control over their new residential environment. Again the issue of control emerges as an important one and is reinforced by the literature that relates to it (Thomas 1988, Zlobicki 1988, Thomas & Hayley 1991, Ferguson-Stewart 1994). This literature reinforces that higher levels of relocation adaptation are achieved when control is perceived.

In Chapter 1, it was asked... is what appears to be an issue for everyone else really an issue for the participant? The answer seems clear. The participants cared little about the physical surroundings they were in. Value was placed on established friendships, a sense of community, contact with staff and the cheek by jowl existence of their old style nursing home. The outcomes for them of the relocation to a new modern facility meant change. Gains in personal control or autonomy were limited. Quality issues built into The Outcome Standards for Australian Nursing Homes (Braithwaite et al. 1992) were visible and measurable,
but these were not reflected in the feelings of the participants. The Outcome Standard (Braithwaite et al. 1992) relating to a homelike environment, for example, could be measured but most participants felt more comfortable in their previous environment.

The expectations of those people who were external to the relocation were fulfilled. The move took place in a situation of no choice and an atmosphere of total compliance. The administrators viewed it as an efficient and smooth transition; the staff found the physical surroundings more pleasant and the equipment more modern; and the relatives found the resident living in a modern building.

The participants involved in the relocation found themselves in an environment where they had no say in the decorations or the furnishings. They had been caught in a bureaucratic vacuum and whilst they were the participants of the relocation they were far removed from it. This may seem an insignificant factor, however, studies carried out by Langer and Rodin (1976), Rodin et al. (1982) and Thomas and Hayley (1991) indicate that a high level of involvement in the individuals relocation brings more positive results in terms of adaptation to a new environment, reduced mortality rates, and increased happiness and feelings of well-being. In this case, the participants felt powerless to react and were treated as inmates in a total institution. One possible outcome of this that was not noted in this study was the development of helpless behaviours that Rodin et al. (1982) found in their study. They found that when nursing home settings deny control to a resident, a process of psychological reactance or becoming helpless may occur (1982 p.154).
Through the interviews the participants talked about the lack of real choice left in their lives. They described a routinised existence in which all decisions had been made for them. Making choices became difficult for the participants. The lack of encouragement to be involved in everyday decision making was in contravention of *The Outcome Standards For Australian Nursing Homes* (Braithwaite et al. 1992). The participants did not want to make a fuss as they thought it might cause trouble later.

The actual relocation was viewed with denial and some suspicion. This was because the move had been cancelled a number of times. The question of choice about whether to move or not did not arise as the participants assumed no choice existed. Participants felt they had no option as they had nowhere else to go to.

8.2.2.4 Institutional invisibility

The relocation situation was predetermined by those external to the participants. No adverse comment was raised because of the invisible nature of nursing homes and of their residents. As residents of a nursing home, old people become invisible. They are relieved of the mainstream social responsibilities and obligations that those living outside an institution face. This removes them from the minds of those who fulfil their social roles in a regular setting. Secured in a total institution, the residents are out of sight, living in a segregated environment with others of similar circumstance. Rowles (1978) commented that some older people prefer this segregated life style as it reduces ageism and feelings of inferiority and incompetence amongst older people who live in an open environment. On one level this segregation may aid satisfactory homeodynamic adaptation by creating an equable situation for nursing home residents. On another level it may create and enhance existing levels of helplessness which
accentuate inertia and result in more passive behaviours. Invisibility and institutionalisation were mutual characteristics of this social isolation imposed because of frail health and advancing age.

The forced interinstitutional relocation went unnoticed by the society around them. The charitable owners ran a story about the opening of the facility on page three of their magazine, but that was the only media attention the relocation attracted. The opening was not attended by the majority of its residents as it took place several weeks prior to the relocation.

Compare this situation with the recent public controversy and debate concerning the location of a Telstra mobile antenna adjacent to the Harboard Pre-School. In October 1994, Warringah Council in Sydney, refused Telstra permission to erect a mobile phone base next to Harboard Kindergarten (Clipping One, Appendix 5). Despite this rejection, Telstra erected the antennas in May 1995. Community reaction intensified and based on the "proximity to the Harboard Diggers Youth Club, the baby health centre, St Marks playgroup, the kindergarten, Girl Guides hall and residential units" (Manly Daily 2.8.95). Telstra was forced to remove the antenna in August 1995.

This is a valuable comparison as it sharply contrasts social attitudes to the forced relocation of 100 old people from one nursing home to another nursing home with no community opposition, with the attitudes and ability to mobilise and consolidate reaction to a mobile phone installation that may impact on the future health of children. Children, it seems represent the future: aged people represent the past. Telstra stopped because of public pressure related to the anticipated consequences to children and the potential for economic reaction. The silence that surrounded the interinstitutional relocation states that ageism is endemic.
Embedded in this also is a gender issue as most nursing home residents are single women. Freidan (1993) argues that one reason most nursing home residents are women is that aged women are reluctant to be cared for by a daughter or a daughter-in-law. This is paradoxical, as the loss of independence is more dramatic on admission to a nursing home because it is a total institution.

Ironically, both groups had relatives to advocate for them. The parents of the preschool children also had the power of public opinion with them and the strong desire to bring about change because they believed their children were in danger.

8.2.2.5 Conclusion

It is clear the participants would have liked more involvement in the decision making processes involving them. The literature concerning autonomy and control emphasises that personal control, decision making and autonomy should be encouraged if positive outcomes are desired (Langer & Rodin 1976; Rodin et al. 1982; Rodin et al. 1982; Lieberman & Tobin 1983; Freidan 1993). Had the participants been more involved, the disillusionment and frustration being expressed may have been reduced.

8.2.3. The role of the nursing home administrators in a nursing home relocation.

Several administrative issues became evident as a result of the relocation:-
1. The critical need for appropriate planning to meet future long term care needs for nursing home residents (foresighting).

2. The need to reduce the discontinuity between the old nursing home and the
new nursing home.

3. The need for a protocol statement to assist other nursing homes in the same situation.

8.2.3.1 The critical need for appropriate planning to meet future long term care needs for nursing home residents

This research reinforces a need to look ahead and consider the matter of replacement facilities by a process of foresighting. As the buildings of the 1950’s and 1960’s become difficult to maintain and bring up to current safety and fire legislation standards, the matter of replacement or abandonment has to be considered by the owners. This is difficult because of the potential impact on existing nursing home residents. A close examination of the limited literature in this area does offer some suggestions as to how this can be achieved with minimum disruption to the residents (Bourestom & Tars 1974; Watson 1980; Wells & MacDonald 1981; Rodin 1986; Baglioni 1989; Gallagher & Walker 1990).

One successful interinstitutional relocation has taken place in an outer western Sydney suburb. A rebuilding program has been commenced that affords minimum disruption to the residents. Funds were secured for the building of a new nursing home on the site of the existing nursing home complex. Once completed the population of an older style nursing home on the same nursing home site was relocated to the newly built nursing home. The new facility was only 200 metres from the original one. The cognitively and physically able residents were told that this was their new nursing home from the day building commenced. These residents were able to watch the progress of the new nursing
home building, walk around the perimeter of the building site whenever they felt like it and could talk to the staff about it freely. On completion of the new nursing home, the residents were moved into their new facility at a leisurely pace in a happy atmosphere. The interinstitutional relocation was a success for all involved.

A second aged care facility on the same site was also replaced. This long term aged care facility was for hostel residents. The rebuilding of it took place on the site of the first nursing home which was demolished. A similar attitude was developed amongst the residents to their new home. This appears to be a better option than piecemeal renovation. Site to site mass movement has been avoided, the cohort has been kept together and the trauma associated with relocation has been minimised.

Foresighting is critical to harness emerging technologies and incorporate them into designs that will last a significant period of time. One exciting value of foresighting in this context is that it will permit building designs that will complement best gerontological nursing practice. This is important because gerontological nursing does have a professional image problem (Pearson 1992).

Many aged care workers and professionals have become identified with an image which relegates gerontics to the bottom of the nursing job hierarchy in terms of work recognition. Those residents in the care of gerontic nurses do not make improvements of a huge magnitude that will facilitate their discharge from the nursing home. Rather, residents remain in the nursing home until they die. This type of palliative care does not contrast favourably in image with other nursing work such as accident and emergency or neonatal intensive care nursing. The often austere and deteriorating surroundings that characterise many nursing
homes adds to this image problem. Foresighting can assist in changes to both nursing practice and the minimal views held about such practice.

8.2.3.2 The need to reduce the discontinuity between the old nursing home and the new nursing home

Continuity amongst personnel and other residents is important to reduce the disintegrative processes that the resident experiences on entering a new environment (Bourestom & Tars 1974; Coffman 1981; Lieberman & Tobin 1983).

The researcher’s observations confirmed the discontinuity that the participants experienced. Many participants could not understand why they had to leave the old nursing home as they had grown to like it. The discontinuity existed in issues such as accommodation, staffing and nursing home routines.

There was little time for orientation programs either for the residents or the staff. This was because the central administration were keen for the move to occur as soon as possible as they were paying rental at two other sites and a further delay would be costly and would necessitate further lease agreements with the New South Wales Department of Health and the Anglican Church. Consequently, the residents were moved into an unfinished building with little or no orientation to their new environments as a matter of financial expediency. No general health status reviews took place in this hurried climate.

The changes that followed relocation created discontinuity for the participants in relation to their accommodation, their nursing home routines, the staff that cared for them and in the design of the building. Studies carried out by Bourestom and
Tars (1974), Coffman (1981), Rodin et al. (1982), Lieberman and Tobin (1983) and Ferguson-Stewart (1994) reinforce these findings. They found that where continuity is present, then the resident adapts in a more positive manner, interacts at a higher level and integrates into the new environment at a faster rate.

8.2.3.2.1 Discontinuity created by the changes in participant's accommodation

Prior to relocation, residents were grouped according to ability and dependency levels and were placed in care areas according to this classification. This meant that a mixing of residents from Site 1 and Site 2 occurred in the care areas, with people being expected to share common areas with people previously unknown to themselves. Primary relationships were shattered and small groups ruptured.

Following the relocation, nursing home staff encouraged participants to form new friendships and relationships. Both the staff and the participants reported that there was a general reluctance to do so. The individual participants did not seem to have the energy or willingness to do so. This reluctance demonstrated the strength of pre-existing relationships and the unwillingness of the participants to try to form new ones. The passive acceptance that pre-existing primary relationships had been disrupted was another indicator of the inertia that existed. The participant did not seem distressed about their isolation, preferring it to forming new reference groups or single friendships.

8.2.3.2.2 Discontinuity created by changes in nursing home routine

New routines led to initial confusion about what behaviours were acceptable and what behaviours were unacceptable. One example that clearly demonstrated the new routines being experienced was the alteration to the meal service delivery.
Participants said they disliked having to eat in a communal dining area with residents who were not sufficiently dexterous or competent. They felt embarrassed and uneasy about the situation and also about their own limitations. At no time though did they collectively complain to the staff or persistently request meals alone in their own rooms. They viewed that as being an example of behaviour that the staff would not like. This passivity and their acceptance of an uncomfortable situation demonstrates the inertia that surrounded their daily routines. The fact that communal areas were used for activities that some participants did not enjoy or wish to be involved in was also passively endorsed through the participants' participation in the activities. Again, the participants said this was because they did not want to displease the staff.

8.2.3.2.3 Discontinuity created by changes in staff

Staff changes as a result of the relocation created a discontinuity and change between the old staff at the former nursing home and the staff at the new nursing home. A high level of temporary agency staff compounded this. The use of agency staff was necessary to fill in the gaps in the roster created by absenteeism and the inability of casual, on call staff to come into work at short notice. This included registered nurses, enrolled nurses and assistants in nursing.

The high staff absentee rates could be attributed to an inadequate staff to resident ratio. This left care areas with many dependent residents with not enough staff to carry out the basic care required for them. The staff reaction to this was to take time off work in order to cope.

To cover these absences, agency staff were employed. This created other tensions in the nursing home as agency staff seldom worked in the nursing home more than once, were paid a higher hourly rate than permanent staff, were not
accountable to the organisation as it was not their employer, did not have a professional knowledge of the residents and relied on the permanent staff for information and assistance.

To illustrate this tension, the researcher witnessed one agency registered nurse take six hours to give out the afternoon medications in a 25 bed care area. The registered nurse was slowed down by her lack of knowledge of the residents, lack of orientation to the facility, and no real incentive to work faster. The agency nurse was constantly interrupted with requests for help from the enrolled nurse and the assistant in nursing. She was accountable to no-one else in the nursing home on that shift. These tensions were particularly noted by the researcher immediately after the relocation. At this time, staffing levels were augmented by agency staff to represent a ratio of four residents to one nurse on the day preceding the relocation and for four days after the relocation.

8.2.3.2.4 Discontinuity created by changes in architectural design

The architecture of the new building was very different to that of the old buildings. The initial confusion in the nursing home was also a result of the new territory participants and staff had to negotiate. Initial curiosity waned quickly as the participants learnt enough about the new architecture to manoeuvre their way around the nursing home in accordance with their minimal needs. This lack of curiosity reduced the participants' spatial range and could be interpreted as another sign of passivity and inertia.

Most participants could find their own way from their room to the dining room and back again. In the new facility the dining room served as the activity room also. Once established in the dining room, the participants did not have to leave
that area until after the activity session was over unless they required the use of
the bathroom.

Most participants found it lonely and commented on the isolation. The participants
that did not feel lonely felt the relocation was good as it afforded them more
privacy. Those who did feel lonely had lost the intimacy of those around them.
Curiosity was heightened though, as they complained they no longer knew what
was going on as they were away from the action.

Those from Site 1 missed the long verandah that ran from one end of the nursing
home to the other. This observation post was the focal point of all the interactions
that took place. It was the focus of interest for all the daily comings and goings.
Similar comments were made about Site 2. There the activities centre was the
hub of life. It was impossible to be left alone there, yet it was the activity centre
that created anxiety for the participants in the new nursing home.

Changes in the patterns of intentional and nonintentional resident contact altered
dramatically following relocation and created further discontinuity for the
participants. The participants were no longer reassured by the nonintentional
contact they had experienced in their more crowded and cramped former living
conditions. Ironically, prior to the move some participants had felt that this
nonintentional contact was a nuisance and a disturbance for them. After the
relocation it was missed. Several participants expressed an inability to deal with
the isolation they felt as a result of the relocation. Again, none of the participants
created any disturbance as a result of their feelings.

There were no adverse comments or complaints received from the families or
significant others of the participants. The participants all thought that their
families were pleased about the move as they thought the other nursing home was old and run down. The participants commented that the relatives felt that they would be happy in their new nursing home as it was new and modern. The participants did not complain because their ‘family was happy’ about the move and they did not want to upset the staff or appear to be ungrateful.

The participants did not attempt to exercise any choice about moving because there was none offered to them. They felt that going against the decisions of the staff and the matron would only cause trouble and they did not want to do that. There was a feeling that the longer participants did not have to make decisions for themselves the harder it became for them to make decisions. It became easier not to make decisions and just accept whatever situations arose as a result of that.

8.2.3.3 The need for a protocol statement to assist other nursing homes relocate

A practical outcome of the research has been the development of a protocol manual to facilitate a forced interinstitutional relocation (Appendix 8). This manual is a valuable part of the research as it is a statement of outcomes for the project. It is a useful publication for any nursing home placed in the situation of an interinstitutional relocation.

8.3 UNEXPECTED RESEARCH OUTCOMES

There were three important unexpected research outcomes. They were:
1. Changes in body weights of residents
2. Infection rates in one care area
8.3.1 Changes in body weight

The nursing home staff became aware of there being a problem related to body weight loss. A number of factors were identified that contributed to this weight loss.

The first was the lack of an appropriate nursing care plan that described and outlined the residents individual nutritional/feeding needs. A nursing care plan is an essential means of communicating the needs of residents between nursing home staff (Phipps, Long, Woods & Cassmeyer 1991; Jarvis 1992). It is compiled from a thorough assessment of the resident which is reviewed at regular, specified intervals. A plan of care is developed in conjunction with the residents (where possible), the relatives/significant others, the attending medical officer and the team of nurses and allied staff caring for the resident. If this nursing care plan is implemented correctly then it should ensure continuity of care, communication between staff caring for the resident and regular assessment of the residents overall needs (Phipps et al. 1991; Jarvis 1992; Pearson 1992).

This nutritional assessment should show an understanding of the factors that influence the eating habits of the residents such as poorly fitting dentures, impaired vision, reduced gastrointestinal efficiency, and a decrease in the ability to taste and smell (Jarvis 1992). In addition to these more practical considerations, the type of medication being taken by the resident is an important consideration as the affect altering medication (such as antidepressants and anxiolytics) can cause reduce caloric intake due to drowsiness (NHMRC 1994 p. 16). Similarly, some medications have specific side effects with long term use. For example, phenytoin (Dilatin) causes gum over-growth, which in turn
produces mechanical difficulties with eating (Galbraith, Bullock & Manias 1994 p. 284).

In this context, the nursing care plan would have indicated the level of assistance required, the type of diet that was suitable for the resident and how often the resident should be weighed. Medications that should be taken meal times would also be recorded.

The nursing home policy in relation to nursing care plans is that they are compiled and kept current by the registered nurses in the care area. As this was inadequately done, it indicates that the staff may have directly contributed to the residents level of risk by not making a thorough, correct and accurate initial assessment of the existing nutritional needs. This was compounded by the lack of routine monitoring of the residents nutritional status by the staff. It also indicates that the original nursing care plans had not been evaluated on a regular basis as stipulated. Whilst the normal rate of change in a residents condition in a nursing home is slow and gradual, there still remains a duty of care on the part of the registered nurse to complete the required documentation in an appropriate manner. Failure to do this clearly puts the resident at risk (Staunton & Whyburn 1990).

Another contributing factor was a change in nursing home policy concerning meals. This included changes in the size of the meals and the way the meals were distributed. After relocation residents had to adapt to different practices and routines related to meals.

These changes in policy meant real changes were made in the service delivery of meals to residents. This had a large impact on the residents in this care area as
they were considered by the staff to be highly dependant on them for all aspects of care. All residents in this care area had a tray service. The Katz Index of ADL rated all the residents in this care area as being dependent for feeding. The policy changes implemented placed these residents at a nutritional disadvantage.

The introduction of tray service to these residents meant that they had all their meals delivered to their rooms and placed on their bed tables, often out of their reach. This frequently led to cold, unattractive meals by the time the nursing staff arrived to assist or to feed them. The size of the meal served to residents was standardised. This meant that those with big appetites were not getting enough to eat and that additional time was spent by the staff trying to get those residents with small appetites to eat a standard sized meal which was larger than they could eat or enjoy.

This later situation created tensions for the resident and the staff member. The resident did not want to eat as much as the staff member felt they should according to the size of the meal they were given, and so the resident was regarded as being non-cooperative. No individual consideration had been given to the needs of the residents in this regard. No consultation with any nursing home resident occurred before this important policy change was implemented. This created further tensions between the nursing home administration, the staff and the residents.

The policy changes that were implemented did not enhance independent behaviours. Strategies that increased resident independence on the Katz Index of ADL were not in place. Some examples of this include keeping residents in bed instead of being sat out of bed to eat their meals; leaving the bed table out of the residents reach, leaving the resident to struggle to reach it; isolating the resident
in their room for meals without active encouragement and help to actually eat their meal (for example, cutting up the food); isolating the residents when they could have been taken to the dining room to eat with other residents; and creating an impression amongst the staff that all the residents in this care area were totally dependent on them for their nutritional needs, when if given preliminary assistance some could manage to eat the rest of the meal themselves. Those residents who required specially designed eating utensils were not provided with them. Without these utensils they had to wait until a staff member was available to assist them with their meal. This increased their dependence and meant that in most cases, cold unattractive meals were offered to them.

Prior to relocation, supper was served throughout the nursing home. This practice was discontinued after relocation to the new facility. The outcome of this was that residents went from the evening meal through to breakfast without a formal opportunity to receive any food or fluids. This could be for a period of up to 14 hours between dinner (5.30pm) and breakfast (8am). This policy change would impact most on those unable to help themselves to drinks from their locker.

Unfortunately, staff behaviour may have contributed to the weight loss. The nursing work in this area was regarded as being heavy, with many residents that required almost total care in their ADL. Because of this, registered nurse turnover was high. The nursing home policy was to employ agency nurses, that is, casual nurses from an employment agency, to fill staff absences. Often these agency registered nurses would only work a single shift in the nursing home and never return. This created unfamiliarity with the workplace which led to inconsistencies related to nursing practice. This also meant that the weight loss problem went undetected for a significant period of time because the agency
registered nurses were not familiar with the residents. The use of agency registered nurses also made accountability for the weight loss situation difficult.

One reason for the high registered nurse turnover in this area was the inadequate staffing levels given the Resident Classification Index (RCI) of those residents in this care area. The RCI is an "assessment of the resident’s nursing and personal care needs’ and operates on 1-5 ranking, with 5 being the lowest level of resident need and 1 being the highest" (Commonwealth Department Of Human Services And Health 1995 p. 6-4 - 6-6). Commonwealth funding to any nursing home relates to the RCI classifications across all residents. Residents with an RCI of 1 receive funding from the Commonwealth Department Of Human Services And Health for 27 hours of funded care per week, while those residents with an RCI of 5 receive funding for only 9 hours of funded care per week (Commonwealth Department Of Human Services And Health 1995 p. 6-4 - 6-6). In care areas with high RCIs, the workload was considered too great by the staff, so the registered nurses went elsewhere to work. The permanent registered nurses resented the agency registered nurses, as they believed the agency nurses came to and went from work without being made accountable for the quality of their nursing work.

The use of agency registered nurses created inconsistencies in resident care. Care often differed from shift to shift. This was because the agency staff did not know the residents' abilities and the nursing care plans, a tool which communicated residents' needs to staff, were inadequate.

The staff that did know the residents worked on the assumption that it was quicker for them if they fed the residents rather than encourage the resident to feed
themselves. The outcome of this was that the resident’s ability levels in this area decreased and they, in turn, exhibited more dependent behaviours.

Once the problem was recognised, nursing administration put the following remedial strategies in place to rectify the situation.

Remedial meal service strategies and their rationale are presented in Table 8.3.

**Table 8.3** Remedial meal service strategies and their rationale

<table>
<thead>
<tr>
<th>Remedial strategy</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking residents to the central dining room.</td>
<td>i) greater level of supervision available; ii) enhanced opportunities for social interaction; and iii) placement in a normal eating environment.</td>
</tr>
<tr>
<td>Ensuring meals were accessible to bedfast residents.</td>
<td>i) accessibility would improve chances of resident eating meals; and ii) accessibility would improve chances of resident receiving a hot, palatable meal.</td>
</tr>
<tr>
<td>Identifying poor or slow eaters and offering them meals of their choice rather than standardised meals.</td>
<td>To allocate staff to spend time encouraging and assisting these residents to eat.</td>
</tr>
<tr>
<td>Retaining meals in the kitchen for those residents that required assistance rather than distributing all the meals at one time</td>
<td>i) to keep meals hot so the resident found them attractive and palatable; and ii) to ensure the meals of the residents requiring help were not cleared away by the kitchen hands before they were used.</td>
</tr>
</tbody>
</table>

The interim evaluation which was carried out in April, 1995 showed that the residents had gained weight and had sustained the weight gains made. As a result of this both resident and staff morale improved.

A relevant research question would be “how did this situation compare with that of the time series participants?”.
In total the weight gain of the time series participants for the same period was 37.1 kilogram and the total weight loss was 36 kilogram. To ensure this was not unique to this group, the weights in a third resident care area were checked for the same time period. The total weight gain from Wing 3 was 37.7 kilogram and the total weight loss was 37 kilogram.

A comparison of weight gains and losses for Groups 1, 2 and 3 is presented in Table 8.4.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Total gain (kg)</th>
<th>Mean gain (kg)</th>
<th>Total loss (kg)</th>
<th>Mean Loss (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19</td>
<td>11.4</td>
<td>0.6</td>
<td>73</td>
<td>5.21</td>
</tr>
<tr>
<td>2 (study)</td>
<td>37</td>
<td>37.1</td>
<td>1</td>
<td>36</td>
<td>0.9</td>
</tr>
<tr>
<td>3</td>
<td>22</td>
<td>37.7</td>
<td>1.7</td>
<td>37</td>
<td>1.68</td>
</tr>
</tbody>
</table>

Clearly a problem existed that required intervention for the safety of the residents in Group 1. Groups 2 and 3 were consistent in both weight loss and weight gain. Group 1 had comparatively high weight losses and low weight gains. Group 1 needed some interventions to resolve the problem. It would seem that the action taken was appropriate and timely. Had the action not been instigated the secondary problems associated with poor nutritional status in the aged would have emerged.

A salient feature of this situation was the lack of complaint and passivity by the relatives of the residents or the residents themselves, further illustrating the inertia that pervades the daily existence of the residents.
8.3.2 Infection rates

Cellulitis was identified in the same resident care area as the weight loss had occurred. Cellulitis is an "acute infection of the skin and subcutaneous tissue characterised most commonly by local heat, redness, pain, and swelling, and occasionally by fever, malaise, chills and headache. Abcess and tissue destruction usually follow if antibiotics are not taken" (Anderson, Anderson & Glanze 1994 p. 286).

The cellulitis was thought to have been caused by cross infection between residents. This would have been as a result of inadequate hand washing by nursing and other staff when moving from one resident to another, causing cross-infection between residents to occur. This placed the residents at risk of developing cellulitis by direct contact between infected and noninfected residents (Kozier, Erb, Blais & Wilkinson 1995). This disregard for infection control principles was reflected in the nonuse of an aseptic technique when carrying out treatments for residents with cellulitis. This, coupled with inadequate general wound care (for example, allowing a build-up of cream on the lesion rather than removal of any residue present at each treatment) placed the resident in a vulnerable situation. On each occasion when appropriate infection control strategies were not used and nursing home policy followed, duty of care had been violated (Staunton & Whyburn 1990).

Another causative factor was the aggressive approach to scabies prevention/treatment carried out prior to the move. Scabies is a contagious disease caused by the itch mite (Anderson et al. 1994 p. 1395). It causes intense skin irritation and scratching. The scratching can lead to secondary infections of the
skin. As it is highly contagious, scabies is a serious problem in a nursing home. To prevent the transmission of scabies into the new nursing home, every resident was given two treatments of a lice and scabies treatment, Quellada (lindane), whether there were any signs of lice or scabies infestation. The active ingredient in this lotion is lindane (gamma benzene) 1% (Galbraith, Bullock & Manias 1994 p. 624). The use of this lotion is indicated for scabies infestation.

All residents were given two treatments of lindane, regardless of whether they had any signs of lice or scabies. The consent of the residents was not sought, rather arbitrary treatment was given. While acknowledging that scabies is a problem for nursing homes, the resentment by the residents towards that scabies treatment was high. A notable adverse reaction to lindane is eczematous skin eruptions which manifests itself as small watery blisters (MIMS Annual 1994 p. 15-737). The elderly are more prone to skin reactions because of age related changes to skin tissue. The skin becomes thinner and paperlike, easily tearing or becoming infected (Brown 1992 p. 26). Lindane is an organochloride and as such it should have been contraindicated for use on an aged persons skin (Galbraith et al. 1994 p. 624).

Chemicals irritate elderly skin more easily than in younger people. It appears from the residents notes, that no skin patch tests were done for sensitivity or allergic reactions to lindane so it is conceivable that the two treatments of lindane may have caused eczema, resulting in a secondary infection and that advanced to serious cellulitis. Interestingly, the active ingredient in lindane lotion (Quellada Creme Rinse) for the treatment of head lice was an organochloride (gamma benzene hexachloride) but has been altered to a non-organochloride, pyrethrin. The arbitrary decision to treat all residents for scabies, whether infected or not, is
to assume that all residents had scabies. This could be interpreted as the institution holding ageist attitudes and exhibiting ageist behaviours. The administrations response to this situation was to exchange the nursing staff from another resident care area with the existing staff. The Nurse Unit Manager (NUM) was left in place.

8.3.3 Relocation mortality

The literature is divided about the relevance of mortality figures amongst an aged population which experiences a relocation into a nursing home (Lieberman 1961; Aldrich & Mendkoff 1963; Miller & Lieberman 1965; Shaninian et al. 1966; Jasnau 1967; Lawton & Yaffe 1970; Watson 1980). The physical and psychological condition of these people on admission varies and some experience better health as a result of the move, no apparent change in their health as a result of the move, whilst others die. For those who die, frail age and ill health often precipitate their admission into a nursing home, so the admission is viewed as a palliative measure.

Little has been written about the forced interinstitutional relocation that involves a significant number of residents (Watson 1980; Ferguson-Stewart (abstract only) 1994). Such a relocation was thought likely to pose a threat to the participants' health. Between T and T2, seven residents died. For the same period the previous year, 16 residents died. Thirteen of these died at Site 1 and three at Site 2. This was a 56% increase on the number of deaths between T and T2.

One problem in discussing the comparative mortality rates is that there were serious flaws in the record keeping at Site 1 and it was only after the data collection was completed that these flaws became obvious. It seems the ADON at
Site 1 did not know that it was organisational policy that Morbidity Forms had to be completed. As a consequence, 27 deaths at Site 1 over a 27 month time period were not recorded appropriately. At Site 1 the death of a resident was recorded on their index card and then archived. A retrospective audit was then required to gather data about the deaths.

At Site 2 Form PR 14 (a provision of The Private Health Establishments Act 1984) was completed for each death. Whilst not a legal requirement for nursing homes, it was the policy of the parent body that this be done. It was only after the audit of the records that the disparity in the death rates between each site became obvious.

In an attempt to answer the question "What could cause such a difference in morbidity and mortality between Site 1 and Site 2?" a comparison of some of the relevant characteristics of Site 1 and Site 2 was made. From this evaluation two profiles of the differences between the sites became clear.

8.3.3.1 The physical conditions at Site 1 and Site 2

The physical conditions at Site 1 and Site 2 were poor. Each site needed painting and a great deal of superficial maintenance to cover cracked walls, ill fitting doors, inadequate bathroom facilities and cramped kitchen areas. Site 1 was a single storey building located in a large outer urban hospital that had been considerably down-sized. It was two rooms wide. One room was the sleeping areas opening onto a single closed verandah running the length of the building. The small common activity area was located next to the servery and kitchen area. Residents who smoked had to leave the building to do so. The outlook for the
residents was a series of drab looking factories. The outside area was not secured and residents could wander away. It was lonely and isolated at night.

Site 2 was a double story brick building. It provided cramped conditions that minimised the living space of residents. It was located in an inner-city residential area which was surrounded by many blocks of flats. The common activities area was located on the ground floor and was larger than that at Site 1. This activity area was located next to the kitchen. Site 2 was contained, though the fence was in poor repair and had some holes in it and palings missing. A recreation area for smokers was established outside in the back garden.

8.3.3.2 The relative distance from the parent body of Site 1 and Site 2

Site 1 was 40 minutes drive in reasonable traffic from the parent body. Site 2 was 8-10 minutes drive from the parent body. Staff at Site 1 described their feelings about the distance as increasing a sense of isolation and as reducing their day to day understanding of what was going on with the relocation. The staff indicated that one positive factor was that the central administration staff did not visit often, but rather relied on the telephone for contact. This left them to manage the situation as they saw fit.

8.3.3.3 The characteristics of the residents at Site 1 and Site 2

The characteristics of the residents at Site 1 would lead to an assumption they would have greater longevity than those at Site 2. This was not the case. Those at Site 1 were younger, less frail and more mobile and therefore with greater survival potential.
8.3.3.4 The accommodation of the residents at Site 1 and Site 2

There were less people, on average, in each room at Site 1 than at Site 2. Those living at Site 1 experienced less crowding and had more living space than those living at Site 2. The average number per room at Site 1 was four persons, whilst at Site 2 it was six. For the residents at Site 2, this meant there was a higher level of nonintentional contact with the staff than at Site 1 due to a higher resident concentration.

8.3.3.5 The number of falls experienced at Site 1 and Site 2

The number of falls was greater at Site 1 than Site 2. In this situation this indicates that those who are more mobile were at a greater risk of falling than those who are less mobile. Staff surveillance at Site 1 would have been more difficult due to its layout. The layout at Site 2 created many more opportunities for nonintentional contact, and therefore incidental supervision, with all residents because of its cramped conditions. Site 1 was spread over a greater floor area than Site 2.

A number of issues relating to these falls should be noted:-

- Most falls do not cause major injuries, but falling is the leading factor precipitating death among adults aged over 75 years of age (Reinsch, MacRae, Lachenbruch & Tobias 1992 p. 450).
- Five-ten percent of falls result in fractures, with the prime sites being the femur, the arm and the ribs (NHMRC 1994). In 1992, 966 deaths were identified as being a result of a fall (Jain 1994 p. 17).
• Falls have a psychological dimension in that loss of mobility confidence occurs and mobility is reduced, rendering the resident increasingly dependent, and anxious (NHMRC 1994).

• There is a strong relationship between falling and the use of antidepressants, antipsychotics or anxiolytic medications (Cumming, Miller, Kelsey, Davis, Arfken, Birge & Peck 1991 p. 458).

8.3.3.6 Gender and mortality at Site 1 and Site 2

More males and females died at Site 1 than at Site 2. This was an interesting finding as those who were more older and more frail were housed at Site 2. From this it could be assumed that a higher death rate would occur at Site 2 than at Site 1, but this was not the case. Another variable which may have influenced this situation that was not considered by this study was the standard of care given by the staff at Site 1 and Site 2.

8.3.3.7 The staff at Site 1 and Site 2

The average age of the permanent staff at Site 1 was older than Site 2. The staff at Site 1 had obtained their nursing qualifications less recently than those at Site 2. This may have impacted on morbidity rates as attaining higher education levels may result in an enhanced understanding and care delivery.

A comparison of Site 1 and Site 2 is presented in Table 8.5.
Table 8.5 Comparison of Site 1 and Site 2

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Site 1</th>
<th>Site 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>physical surrounds</td>
<td>condemned</td>
<td>condemned</td>
</tr>
<tr>
<td>distance from parent body</td>
<td>greater</td>
<td>lesser</td>
</tr>
<tr>
<td>physical condition of residents</td>
<td>less frail</td>
<td>more frail</td>
</tr>
<tr>
<td>mean age of residents</td>
<td>lesser</td>
<td>greater</td>
</tr>
<tr>
<td>mobility</td>
<td>greater</td>
<td>lesser</td>
</tr>
<tr>
<td>number in room</td>
<td>fewer (x=4)</td>
<td>greater (x=6)</td>
</tr>
<tr>
<td>number of falls</td>
<td>greater</td>
<td>lesser</td>
</tr>
<tr>
<td>gender &amp; morbidity</td>
<td>more males &amp; females died</td>
<td>fewer males &amp; females died</td>
</tr>
<tr>
<td>staff-mean age</td>
<td>older</td>
<td>younger</td>
</tr>
<tr>
<td>staff-qualifications</td>
<td>obtained less recently</td>
<td>obtained more recently</td>
</tr>
</tbody>
</table>

Some inferences can be drawn from this comparison.

- A younger, more recently educated staff was a more adaptable and capable staff who were better able to deal with the characteristics of the particular sites.

- The physical layout of Site 2 might have facilitated greater containment of problems by more frequent intentional and nonintentional resident contact and therefore enhanced general resident safety.

- Distance from the parent body and a perceived feeling of disinterest by the parent body may have introduced a sense of apathy amongst the staff at Site 1.
These inferences could benefit from further detailed research of the issues.

8.4 CONCLUSION

A mass relocation of nursing home residents between institutions is a complex matter. The literature dealing with a forced interinstitutional relocation is scant. There is however, sufficient to formulate guidelines that, if followed, will reduce the impact for the residents.

Some basic questions that should be asked are:-

- Are existing primary relationships considered important enough to be maintained?
- Is it possible to move the residents in small groups of no more than four to six people moved at a time?
- Is there continuity of staff at the new nursing home after relocation and is there continuity of routine after relocation?
- Can the resident be involved in the arrangement of their room, and in the placement of their furnishings?
- Did the resident choose the person they are sharing a room with?

In the researcher's opinion, the ideal conditions for an interinstitutional relocation exist when good communication, adequate orientation and continuity between facilities are central to the process. Examples of these include keeping the residents and their families up-to-date with news relating to the move, utilising a design that reflects some continuity between the old facility and the new one (for example, colour schemes and style), providing the resident with as much real choice as possible about the move, relocating small groups of residents over a period of time, not as a mass movement of residents, maintaining primary relationships amongst the residents, negotiating sleeping accommodation with the
resident, ensuring there is a continuity of staff, and involving the family or significant other(s) in the relocation process.

8.5 SUGGESTIONS FOR FUTURE RESEARCH

This study has highlighted the following areas for future research:-

1. The role of the family or significant others in the interinstitutional relocation process.

2. The levels of psychotrophic medication usage in nursing homes.

3. The medico-legal implications of psychotrophic medication usage in nursing homes.

4. The appropriateness of The Protocol Manual as a tool for nursing homes facing a forced interinstitutional relocation.

5. The utility of the RA model.

6. The needs of male nursing home residents.

7. The relevance of mortality rates in nursing homes following relocation in relation to pre-existing multiple pathologies.

8. Whether a younger and more recently educated nursing home staff were more adaptable, capable and better able to deal with day to day running of a long term care facility.
8.6 SUMMARY

This purpose of this study was to examine the effect of a forced mass interinstitutional relocation on the quality of life for two groups of nursing home residents. A conceptual model, The Relocation Adaptation Model (RA), was based on both empirical and conceptual literature on social gerontology.

The study population was randomly selected from the more cognitively able nursing home residents. A combination of methodologies was used to collect the data necessary to make comparisons over a 17 week time period. Three recognised instruments were used: the General Health Questionnaire-20, The Affectometer 2 and the Katz Index of ADL. Other instruments were developed by the researcher to collect relevant data. An audit of participant's records was included. Several guided interviews were carried out.

The study found that the quality of life of residents in a nursing home is effected following a forced interinstitutional relocation and that the level of medication usage by participants may have been a significant factor in the response to the relocation.

Few mass relocations of nursing home residents have taken place in Australia and none have been examined in detail from the point of view of the quality of life of residents. However, the number of such relocations will increase as existing nursing home buildings age and deteriorate.
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Roseman, C.C. & Williams, J.D. 1980, 'Metropolitan to non-metropolitan migration, a decision-making perspective', *Urban Geography*, 1, 194-283.


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Alphabetical Listing.


Marten, L. Aged homes in 'cover-up'. Daily Telegraph, 30 May, 1994, p.12.

Northern Beaches Weekender. Harboard locals fight mobile tower. 4 Aug, 1995, p. 11.


**Publication Listing.**

*Daily Telegraph.*


*Illawarra Mercury.*


*Manly Daily.*


*Northern Beaches Weekender*.

*Northern Beaches Weekender*. Harboard locals fight mobile tower. 4 Aug, 1995, p. 11.

*Sydney Morning Herald*.


APPENDICES
APPENDIX 1

THE OUTCOME STANDARDS FOR AUSTRALIAN NURSING HOMES

Table 1.1: Objectives and outcome standards for Australian nursing homes

Please see print copy for image
APPENDIX 2

MEDIA CLIPPINGS RELATED TO YOU SAY NOTHING, YOU THINK NOTHING AND YOU ARE NOTHING

Source:

Clipping 4: Illawarra Mercury  30.5.94.
APPENDIX 3

STUDY INSTRUMENTS

1. The Affectometer 2.

2. The General Health Questionnaire-20 (GHQ-20).


4. Pre-relocation Questionnaire.

5. Post-relocation Questionnaire - Staff.

6. Post-relocation Questionnaire - Residents

7. Guided Interview Schedule.
1. The Affectometer 2.

Please see print copy for image
Please see print copy for image
Please see print copy for image
2. The General Health Questionnaire-20 (GHQ-20).

GENERAL HEALTH QUESTIONNAIRE (GHQ-20)

Please see print copy for image
Siegert RJ, McCormick IA, Taylor AJW & Walkey FH. (1987)


Katz Index of ADL

Please see print copy for image
Evaluation Form

Please see print copy for image
4. Pre-relocation Questionnaire.
PRE-RELOCATION QUESTIONNAIRE

(Q 1-7: Information from subjects notes.)

1. Subjects classification  1  2  3  4  5 (circle)
2. Year of birth:
3. Month & year of admission:
4. Current weight:
   Current blood pressure:
5. Existing pathophysiology: (List)

6. Surgical history: (List)
7. Medications being taken currently: (List)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Doseage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. How many people in your room?

9. Have you always been in this room?

10. What do you own in this room? (List)

11. Do you know you are moving?  Yes  No

(If No, then cease interview. If Yes, then proceed to end)

12. Who told you you were moving?

13. When are you moving?

14. Do you know what your new home will be like?  Yes  No
    (add details given verbatim if possible)
15. Do you know what your new home looks like?  Yes  No
   (add description if any offered)

16. Have you seen any pictures or drawings of it?  Yes  No

17. Have you seen your new home?

18. What does moving mean to you? (verbatim if possible)

19. What does your family think about the move? (verbatim if possible)
20. Will you be in a room with friends?

21. What 'things' would you like to take to the new nursing home from here?

22. What would you like your new home to be like? (verbatim if possible)

23. Can you recall how many other places you have lived in throughout your life?

24. Do you want to ask me any questions?
5. Post-relocation Questionnaire - Staff.
POSTRELOCATION QUESTIONNAIRE - STAFF

Subjects name:

Have any of the following changed since relocation?

1. Complaints of: (circle answer)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Increase</th>
<th>No Change</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>nausea</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>diarrhoea</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>constipation</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>headaches</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>aches &amp; pains</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
</tbody>
</table>

2. Noticeable changes in: (circle answer)

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Increase</th>
<th>No Change</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>negative moods</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>positive moods</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>sleep patterns</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>relationships</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>level of activity</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>eating patterns</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>interest in life</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>communication</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>mobility</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
<tr>
<td>curiosity</td>
<td>increase</td>
<td>no change</td>
<td>decrease</td>
</tr>
</tbody>
</table>
3. a) What is this client’s B.P. since relocation?
   b) What is this client’s weight since relocation?
4. Is this client able to find their way around this facility? Yes No
5. Is this client more independent than before the move? Yes No
   If yes, in what ways? (List)

Thank you for all your help.
6. Post-relocation Questionnaire - Residents
POST-RELOCATION QUESTIONNAIRE - RESIDENTS

Subject's name:

1. Do you like this place?  
   Yes  No 
   What do you like best about this place?

2. Have you met new people here?  
   Yes  No

3. Did the staff help you to move and settle in?  
   Yes  No

4. Were you shown around?  
   Yes  No 
   Do you know how to find the things you need?  
   Yes  No 
   Can you find your friends' rooms?  
   Yes  No

5. Were you able to bring your own things from the other place?  
   Yes  No 
   What did you bring from the other place?

6. What is different here?

Thank you for your assistance.
7. Guided Interview Schedule.
GUIDED INTERVIEW SCHEDULE

1. Introductions.

2. Ice breaking conversation.

3. Reminder about the research topic and obtain verbal consent from informant about their participation and the use of an audiotape.

4. Can you remember when you originally came to live in the old nursing home?
   Can you remember why you came to live in the nursing home?
   How did you feel about going to live in the nursing home?

5. What did you think about having to move to the new nursing home?
   What did you know about the move before it happened?
   Did you know where the new nursing home was?
   How did you move here?
   How much did you look forward to moving to the new nursing home?
   Explain ranking 1-10 and ask to nominate a ranking.

6. Do you think you are well at the moment?
   Have you any illnesses that cause you a lot of trouble?

7. Do you mix with the others living here very much?
   Do you have any particular friends here?
   Have you managed to make some new friends since you moved?

8. Thank you for talking to me, do you have any questions you would like to ask me?
APPENDIX 4

ALTERED PHARMACOKINETICS AND PHARMACODYNAMICS IN AGEING

Sources:


1. **Definitions: pharmacokinetics and pharmacodynamics.**

'Pharmacokinetics literally means the movement of drugs inside the body.' (Galbraith et al. 1994 p. 77).

'Pharmacodynamics is the mechanism whereby drugs exert their effect on the body; that is what the drug does to the body in order for a therapeutic action to happen.' (Galbraith et al. 1994 p. 96).

2. **Age related changes in pharmacokinetics.**

Age related changes that effect pharmacokinetics are:

- 'decline in lean body mass;
- increase in body fat stores;
- decline in total body water;
- decline in renal mass;
- decline in hepatic blood flow; and
- decline in glomerular filtration.' (NHMRC 1994b p. 4)

(See also Table A4.1-Altered Pharmacokinetics in Ageing)

3. **The half life of selected benzodiazepines.**

**Table A4.2 Age related change in elimination half-life (T1/2) of selected benzodiazepines**

Please see print copy for image

Sources: Galbraith et al. 1994, p. 262, 267; Spar & LaRue 1990, p. 33
### Table A4.1 Altered Pharmacokinetics in Ageing

<table>
<thead>
<tr>
<th>DRUG ENTRY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABSORPTION</strong></td>
<td>- slowed peristalsis and gastric emptying → ↑drug absorption rate&lt;br&gt;→ ↑plasma drug levels. Polypharmacy &amp; GIT surgery alter drug absorption.</td>
</tr>
<tr>
<td><strong>DISTRIBUTION</strong></td>
<td>- age related reductions in <em>plasma protein concentration</em> → ↑unbound drug plasma levels → ↑drug activity and potential for toxicity. Age related ↑fatty tissue → ↑drug concentration levels as drug stored in inactive fatty cells → ↑action as drug going to be stored, not used.&lt;br&gt;* Changes in distribution based on alterations in levels of body water and mass.&lt;br&gt;→ ↑plasma concentrations as a result of prolonged plasma half life.</td>
</tr>
<tr>
<td><strong>DRUG ELIMINATION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>METABOLISM</strong> (predominantly in the liver)</td>
<td>- the metabolism of drugs such as barbiturates, some tricyclic antidepressants and some benzodiazepines deteriorates because the efficiency of the microsomal enzymes deteriorates with age → initial reduction in wanted effect, but a prolonged effect over time.&lt;br&gt;chronic illness and poor nutrition → ↓serum albumin concentrations → ↑drug availability → ↑toxicity.</td>
</tr>
<tr>
<td><strong>EXCRETION</strong> (predominantly in the kidney)</td>
<td>- deterioration in renal drug clearance → ↓action of drugs → toxic effects if not monitored (eg. digoxin, gentamicin, lithium, the penicillins).</td>
</tr>
</tbody>
</table>

NB. The practice of polypharmacy can lead to drug interactions at a pharmacokinetic level. An interaction at this level can interfere with the therapeutic effect of one or more drugs and further increase or decrease drug serum levels.

The altered responsiveness to drug levels in ageing may be caused by changes at receptor sites and target sites and changes in compensatory mechanisms.

4.1 Changes at receptor and target sites.

Changes in drug receptor numbers, affinity at receptor sites and transduction of the signal alter the responsiveness to drug levels in an aged person. Age related changes in the target site tissue also effect the responsiveness to drug levels in an aged person.

Some examples of this include an increase in the sensitivity to benzodiazepine which results in reduced psychomotor skills and an increased sensitivity to warfarin which results in the use of smaller doses to achieve a therapeutic level.

There is also a reduced beta-adrenoreceptor response to drugs such as propanolol. This means the beta-blocking effects of the drug reduce because 'there is evidence of reduced beta-adrenoceptor numbers, decrease in high-affinity binding sites and changes in post-receptor transduction mechanisms.' (NHMRC 1994b p.8).

4.2 Changes in compensatory mechanisms.

Changes in compensatory mechanisms are caused by impaired secondary compensatory mechanisms such as homeostasis and homeodynamism and a reduced threshold for the development of confusion.
5. Drugs and homeostasis in older people.

The manner in which drugs can adversely affect older people is summarised in the following table.

**Table A4.3: Drugs which can adversely affect homeostatic mechanisms in older people**

*Source: National Health and Medical Research Council 1994b, Medication and the Older Person-Series on clinical management problems in the elderly No.7, Canberra: Australian Government Publishing Service.*
APPENDIX 5

MEDIA CLIPPINGS REGARDING TELSTRA AND THE HARBORD COMMUNITY KINDERGARTEN

Source:
Clipping 1: Belessis, M. 'No' to Telecom plan, Manly Daily, October 1, 1994.
Clipping 2: Cook, D. Councils seek control over phone towers, Sydney Morning Herald, October 25, 1994.
Clipping 4: Wainwright, R. Chain reaction at the 'radioactive' kindy, Sydney Morning Herald, August 3, 1995.
Clipping 5: Northern Beaches Weekender, Harbord locals fight mobile tower, August 4, 1995, p. 11.
Clipping 8: Belessis, M. EPA head calls for Telstra data, Manly Daily, August 8, 1995.
Clipping 10: Belessis, M. Repairs no problem, Manly Daily, August 9, 1995.
Please see print copy for image

Clipping 10: Manly Daily 9.8.95.
Clipping 13: Sydney Morning Herald 19.8.95

Please see print copy for image
APPENDIX 6

SUMMARY OF THE INTERVIEWS HELD WITH FIFTEEN INFORMANTS
Matilda.

**Sex:** F  **Age:** 78

**Family Support:** 6 children (4 sons, 2 daughters)

**Marital Status:** Widow

**Rationale for Initial Admission:**

Had a stroke nine (9) months ago. None of the children had room in their homes for her. Unable to be discharged from hospital to her own home as house needed significant work and the children would not pay for that to be done (for example, the building of ramps, fitting of grab rails and general maintenance such as renewal of guttering, painting and fence repairs). Insufficient extra money herself to have it all done. Did not want to go to nursing home, but had no choice. Wanted to have a go at managing in her own home, but her children felt she would not cope and then they would have to assist her. Has not seen her children or her grandchildren since she sold her house. Has had requests for financial help from her children which she has ignored. One son attempted to have her affairs put under the control of The Guardianship Board. This failed.

**Length of Residence:**

8 months

**General Health Status:**

Obese. Left sided paralysis.

**Katz Index of Activities of Daily Living:**

Pre-relocation (T) G: Dependent in all six functions.

Post-relocation (T2) G: Dependent in all six functions

**Participation in Nursing Home Life:**

General disinterest in what goes on around her. Knows she is abusive to other residents and on occasions to the staff. Prefers to stay in her own room and watches TV constantly. Refuses to participate in group activities.
Introduction.

Fifteen summaries are provided which will provide evidence of the lived experience of the informants. Pseudonyms have been used to ensure the anonymity of the informant. Each summary is a valuable insight into the quality of life and well being of the informant, highlighting their feelings about communal living, their need for physical assistance and their perceptions about their own social interactions and their social context.

Interestingly, not one subject used the term ‘institution’ in the interview. Most referred to it as ‘the home’, ‘the new place’ or ‘here’. Sites 1 and 2 were referred to as ‘the old place’, ‘the other place’, or ‘before’. This construct was not fully pursued in this study because of time constraints, but residents concepts of what their nursing home ‘is’ would make a worthwhile further study in the context of the tensions that operate within a nursing home.

An important aspect of these interviews is the transferral of the institutions low expectations of the informants ability to make even simple choices. For example, the informant who really wanted to be with her friend on relocation. She was denied this choice based on a quality of life and wellbeing decision by those external to her. Perhaps the institutions low expectations of her social, cognitive, and affective domains is reflected in this. Further, this low expectancy of the informants is reflected in the low rates of expectancy the informants felt for the relocation in general. What could have been a high point in their experience became something that had to be endured. All the clues contained in the relocation literature about successful forced relocation were ignored.

The strongest message from the interviews is that the informants consider quality of care and the impact of this on their day to day comfort critical to
their overall wellbeing. To be quality care it must be given in a nonthreatening and honest manner. The surroundings are not of paramount importance for the wellbeing of the informants. What is important to the other stakeholders is the driving force in this situation and the informant is left with no voice in the matter.
Pre-relocation Understanding:
Didn’t know. Doesn’t care.

Looking Forward to Moving:
2.

Satisfaction/Dissatisfaction:
States she is very dissatisfied. (1)

GHQ - 20 Score:
T - T1, T2 positive.

Affectometer 2 Score:
T - T1, T2 negative.

Medications:
Alodorm tab 5 mg ·/i nocte (Nitrazepam)*
Amoxycillin Cap 500mg ·/i tds until finished (Amoxycillin)
Methyl-Sal Oint prn (Methyl-Salicylate)
Pandeine - Ft tab ·/i prn (Codein/Paracetamol)
Pilopt Eye Drop 2% 15ml with ·/i bd (Pilocarp-HCl)

* indicates affect altering medication.
Annie.

Sex: F Age: 84

Family Support: 1 son, 1 daughter.

Marital Status: Divorced

Rationale for Initial Admission:
'Plain old age'. Managed for as long as possible at home. Son and daughter wanted her to take turn about living with them. Tried with son but fell out with the grandchildren who she found too noisy and very rude to their parents. Decided to go to a hostel. To be able to do this she sold her house and bought a hostel unit. She found she didn’t like it after the first few months because she felt isolated and lonely at times. The routine meant she was in her room, by herself by 7.30 p.m. each night. Decided to move back to her daughters home. Unable to cope with the noise and pace of life there. Daughter and her family going on holidays Went into respite care and really liked it. Refused to leave.

Length of Residence:
19 months

General Health Status:
Frail. Knock lesions on her skin. Some small bruises.

Katz Index of Activities of Daily Living:
Pre-relocation (T) G: Dependent in all six functions.
Post-relocation (T2) G: Dependent in all six functions.

Participation in Nursing Home Life:
Has one or two ladies she likes to sit with for meals - but is a bit shaky so doesn’t want to meet new people as she sometimes drops her food. Likes the new place - but feels a bit isolated - no hustle and bustle to keep her going. 'When someone dies they take you back to your room so you don’t find out about it - but everyone knows. It is better if they tell you because then if you don’t see the person about you don’t wonder about them.'
Pre-relocation Understanding:
Knew - but forgot where it was and when it was to happen

Looking Forward to Moving:
7

Satisfaction/Dissatisfaction:
Satisfied as long as nurses don’t ask a lot of questions. (7)

GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁, T₁ - T₂ positive.

Medication:
Bactrim-DS tab 160/800 ·/i bd (Co-Tiromoxazole)
Megafol-S tab 5mg ·/i mane (Folic-Ac)
Pertofran tab 25mg vi/iiiiii nocte (Desipramine - HCl)*

* indicates affect altering medication.
Olive:

Sex: F  Age:  81

Family Support: 3 children (2 sons, 1 daughter).

Marital Status: Widow

Rationale for Initial Admission:
Frail age. Unable to see to do things and had a few falls at home. Cooking became very difficult. Tried to manage with the help of Meals on Wheels and Home Help. Got very lonely and frightened when by herself in the house. Asked her General Practitioner if there was anything she could do. Her General Practitioner asked the ACAT team to visit her. Admission to the nursing home arranged with her consent. Her children offered to have her with them on a six monthly rotation. She refused because she knew she would have to be left alone at times and this frightened her. She did not think it was reasonable for the family to live their lives around her old age.

Length of Residence:
18 months

General Health Status:
Fair. Royal Blind Society have visited her since the relocation at the family’s request.

Participation in Nursing Home Life:
Keeps to herself. Knows her way around her room, so feels comfortable in there. Likes to listen to audio-stories and going to Mass. Prefers to eat in her room.

Katz Index of Activities of Daily Living:
Pre-relocation (T) F: Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
Post-relocation (T2) F: Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
Pre-relocation Understanding:
Knew about relocation - but forgot. Likes her room as she can get around it - not as cluttered as old place.

Looking Forward to Moving:
7.

Satisfaction/Dissatisfaction:
Satisfied. (6)

GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁, T₁ - T₂ negative.

Medications:
Aproxin tab 500mg ·/₁ (Ciprofloxacin)
Canestan Vag-Crm 1% 35g prn (Clotrimazole)
Clonea Crm 1% 20G (Clotrimazole) As per Medication sheet.
Granugen Pst 50g (Zinc Ox/Titan-Diox)
Mogadon tab 5mg ·/₁₁ nocte (Nitrazepam)*

Sorb & Glyc

* indicates affect altering medication.
Eileen.

Sex: F Age: 78

Family Support: 9 children: 4 deceased, 5 living (2 sons, 3 daughters).

Marital Status: Widow

Rationale for Initial Admission:
Fell over in the hallway, resulting in a fractured neck of femur. Found the rehabilitation program too hard to keep up with physically. She felt she had no interest in the rehabilitation program so gave up trying. Unable to return home as immobile. Family unable to have her live with them as their homes not suitable. Felt very let down by this as they had promised her she would never have to go into a home. Said she was angry with her family and did not want to see them again. She said she wanted to die.

Length of Residence:
5 months

General Health Status:

Katz Index of Activities of Daily Living:
Pre-relocation (T) F: Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
Post-relocation (T) F: Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.

Participation in Nursing Home Life:
None. States she is angry. Is aggressive and rude to the staff and to the other residents.

Pre-relocation Understanding:
Maintains the relocation was never explained to her.

Looking Forward to Moving:
5

Satisfaction/Dissatisfaction:
Dissatisfied. (6)
GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁, T₁ - T₂ negative.

Medication:
Alprim tab 300mg /i daily (Trimethoprim)*
Avomine tab 25mg /i nocte (Promethazine-Theoc)
Betaloc 50mg 1/2 bd (Metaprolol-Tartr)
Burinex 1mg /i nocte (Promethazine-Theoc)
Canestan Crm 1% 20g prn (Clotrimazole)
Celestone-M Cmr 100mg prn (Betamethas-Val)
Chloromycet Eye-Drp 10mg /i drop left eye 4/24 prn (Chloramphenicol)
Diprosone Oint 0.05% 15g prn (Betamethas-Dip)
Imdur-Durules tab 60mg /i mane (Isosorbide-Mononit)
Normison 10mg /i nocte (Temazepam)*
Pinetarsol Ltn prn (Pine-Tar/Triethanol)
Tofranil 25mg /iī nocte (Imipramine HCl)*
Zantac tab 150mg /i bd (Ranitidine-HCl)
Zinc/Starch/Talc Powder

* indicates affect altering medication.
Lou.

Sex: F  Age: 78

Family Support: 1 daughter.

Marital Status: Widow

Rationale for Initial Admission:

After a succession of falls all confidence in mobility lost. Scared to move around her house, but was more frightened at the thought of having to move into a nursing home because she had friends who had died in them. Her house had become run down and needed a lot of odd jobs done to it to bring it up to saleable standard. Her son-in-law was too busy to do any of the jobs, but had offered to pay to have them done. This offer was refused as she didn’t want strangers in her home. She admitted that her memory was not as good as it had been in the past. She kept plenty of tablets on hand in case she forgot to take them. She fell down the back steps (3) and fractured her collarbone and bruised her face badly. Found that afternoon by her daughter who called the ambulance and she was taken to the local hospitals Accident & Emergency department. The hospital admitted her overnight as she was vague about the details of the fall and was incontinent. The next day she went home to her daughters for a week and then decided to go home again. Two days later she fell again and fractured her femur. After discharge from hospital following surgery she was admitted to the nursing home.

Length of Residence:

6 months

General Health Status:

Mobile on frame with assistance.

Katz Index of Activities of Daily Living:

Pre-relocation E. Independent in all but bathing, dressing, going to toilet, and one additional function.
Post-relocation E. Independent in all but bathing, dressing, going to toilet, and one additional function.

**Participation in Nursing Home Life:**
Stated she held no interest in becoming involved as she has nothing in common with other residents. ‘They get up to tom-foolery’. Felt she had lost a lot in coming to the nursing home and didn’t want to make new friends, who like her would die soon.

**Pre-relocation Understanding:**
Thinks she knew about the move. As she wants to die soon she doesn’t really care where it happens.

**Looking Forward to Moving:**
2

**Satisfaction/Dissatisfaction:**
Hates the place. Hated the other place even though she was only there for a short time. Tells the staff she is happy to keep them away from her and to stop them annoying her. Feels her daughter ‘dumped’ her in the home and she can’t understand why she’s not living with her daughter. (3)

**GHQ - 20 Score:**
T - T₁, T₁ - T₂ positive.

**Affectometer 2 Score:**
T - T₁, T₁ - T₂ negative.

**Medication:**
Aurorix tab 150mg ··/i₁ tds (Moclobemide)
Neulactil 10mg ··/i₁ tds (Pericyazine)
Normison Cap 10mg ·/i₁ nocte (Temazepam)*
Zantac tab 150mg ·/i₁ bd (Ranitidine HCl)

* indicates affect altering medication
May.

Sex:  F  Age:  63

Family Support:  1 nephew.

Marital Status:  Single.

Rationale for Initial Admission:
Very chronic, debilitating leg ulcers that immobilised resident. No one to care for her at home. Admitted to nursing home from hospital.

Length of Residence:
7 months

General Health Status:
Very obese. Large, chronic leg ulcers. Circulatory insufficiency.

Katz Index of Activities of Daily Living:
Pre-relocation E. Independent in all but bathing, dressing, going to toilet, and one additional function.

Post-relocation E. Independent in all but bathing, dressing, going to toilet, and one additional function.

Participation in Nursing Home Life:
Very limited as could only sit in a chair in her room. Did not like to be with other people.

Pre-relocation Understanding:
Was really looking forward to the move as she found the old place very squalid.

Looking Forward to Moving:
7

Satisfaction/Dissatisfaction:
Satisfied. (7)

GHQ - 20 Score:
T - T1, T1 - T2 positive.

Affectometer 2 Score:
T - T1 positive, T1 - T2 negative.
Medication:

Aldactone tab 25mg (Spironolactone)
Ciproxin tab 500mg ·i nocte for 2 weeks (Ciprofloxacin)
Coumadin 2mg as prescribed (Warfarin)
Panamax tab 500mg ·jj qid (Paracetamol)
Trental tab 400mg ·j bd (Oxpentifylline)
Ventolin Nebul 5mg (Salbutamol-SO4)

* indicates affect altering medication.

DCD 14 weeks after relocation.
Ronnie.

Sex:  F  Age:  82

Family Support:  Some nieces and nephews.

Marital Status:  Single.

Rationale for Initial Admission:
Was experiencing an increasing number of blackouts. Was previously a resident in a parent body hostel. She had a blackout, fell and broke her arm. Admitted into nursing home until fracture healed. Decided to stay in the nursing home as she didn’t ‘come right’ again.

Length of Residence:
2 years

General Health Status:
Frail.

Katz Index of Activities of Daily Living:
Pre-relocation G. Dependent in all six functions.
Post-relocation G. Dependent in all six functions.

Participation in Nursing Home Life:
Enjoys company now and again. Is taken out every weekend by nieces and nephews. Not keen on the food. Has her own fridge with supplies in it that she enjoys. Has one particular friend she hasn’t seen since the move. Got lost trying to find her, so hasn’t tried since and the staff are too busy most of the time to show her.

Pre-relocation Understanding:
Knew about move. Wanted to room with a friend but was not able to as her friends relations complained to the Matron.

Looking Forward to Moving:
4

Satisfaction/Dissatisfaction:
Tells the staff she is happy even if she isn’t as she doesn’t want to cause trouble.
GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁ negative, T₁ - T₂ negative.

Medication:
Adalat tab 20mg ·/i bd (Nifedipine)
Agorol-Vanil Mixt 500ml 10-20ml nocte prn (Paraffin-Phenolph)
Atrobel-Fort tab ·/i bd (Bellad-Alk)
Betaloc tab 50mg ·/i bd (Metoprolol-Tartr)
Chlortride tab 500mg ·/i mane (Chlorothiazide)
Ibilex 500 cap ·/i tds until finished (Cephalexin)
Normison cap 10mg ·/i nocte (Temazepam)*
Panadeine-Ft tab ·/i or ···/ii qid for 7/7 (Codein/Paracetamol)
Sone tab 5mg ···/ii daily (Prednisone)
Sorb & Glyc

* indicates affect altering medication.
David.

Sex: M Age: 82

Family Support: Nil.

Marital Status: Single.

Rationale for Initial Admission:
Was homeless, but had been for many years. One winter was too harsh and he became ill and was admitted to hospital. The hospital doctor suggested to him that it was time to give up the hard living and sent him to a nursing home.

Length of Residence:
5 years

General Health Status:
Improving.

Participation in Nursing Home Life:
Likes to talk to his friends and watch TV. Doesn’t like playing games in a large group.

Katz Index of Activities of Daily Living:
Pre-relocation B. Independent in all but one of these functions.
Post-relocation B. Independent in all but one of these functions.

Pre-relocation Understanding:
Knew, but it didn’t really matter much. ‘After streets anything is good.’

Looking Forward to Moving:
5

Satisfaction/Dissatisfaction:
Very satisfied (6)

GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁, T₁ - T₂ positive.
**Medication:**

Capoten 25mgm bd (Captopril)
Celestone-N cream 100gm (Betamethas-Val)
Ferro-Gradumet 1/1 daily (Ferrous SO4)
Lasix 40mg 1/1 mane (Frusemide)
Melleril 10mgm nocte (Thioridazine HCl)*
Normal Saline Eye Drop prn.
Panamax 500mg 1/1 nocte (Paracetamol)
Prothiaden 25mgm 1/1 nocete (Dothiepin HCl)
Senokot 500 1/1 nocte (Senna)
Transiderm-Nit Pad 25m 1/1 daily (Glyceryl-Trinit)
Zantac 150mgm 1/1 bd (Ranitidine HCl)

* indicates affect altering medication.
Ethel:

Sex:  F  Age:  87

Family Support:  No children.  2 sisters, also in nursing home, 1 died since relocation.

Marital Status:  Widow.

Rationale for Initial Admission:
Had a few falls and blackouts and wasn’t coping with the family house. Knew she was unwell but was not certain how sick she really was. Thought she would make the decision herself about entering a nursing home. Both her sisters were in the same nursing home, so she thought it would be a good thing for them all to be together. Approached her General Practitioner who helped her arrange the admission.

Length of Residence:
17 months

General Health Status:
Anorexic at times. Insomnia. Thrives on helping older, frailer sister.

Katz Index of Activities of Daily Living:
Pre-relocation C Independent in all but bathing and one additional item.
Post-relocation C Independent in all but bathing and one additional item.

Participation in Nursing Home Life:
Only interacts with her sister. Before the death of her older sister she spent a lot of her time assisting her. Used to share a room with her. All her activities are fairly self-contained. Does not go to dining room. Has become very withdrawn since her sister died.

Pre-relocation Understanding:
Good.

Looking Forward to Moving:
7

Satisfaction/Dissatisfaction:
Satisfied. Though finds some of the staff a bit rough at times. (7)
GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁, T₁ - T₂ positive.

Medication:
Amfamox 20 ·/₁ bd (Famotidine)
Atrovent Inhaler AER200 (Ipratropium-Br)
Bealoforte Aero 250mcg (Beclomethasone)
Cardizem tab 60mg ·-/ⅱ tds (Diltiazem HCl)
Imdur-Durules 60mgm ·-/ⅱ mane (Isorbide-Mononit)
Liquifilm Eye-Drp Tears (Polyuinyl Alc)
Oroxine tab 50mcg ·/₁ mane (Thyroxine-Sod).
Serapax 30mgm ·/₁ mane, ·-/ⅱ nocte (Oxazepam)*
Sinequan Cap 25mg ·/₁ at noon (Doxepin HCl)*
Solprin tab 300mg 1/2 in mane with water (Aspirin)
Sorb & Glyc l
Ventolin Inhaler 200PR (Salbutamol)

* indicates affect altering medication.
Gladys.

Withdrawn from sample as advancing dementia obvious.

Sex:  F  Age:  78

Family Support:  Nil.

Marital Status:  Widow, Jewish refugee.

Rationale for Initial Admission:
Unable to look after herself at home. Previous history of psychiatric illness and multiple admissions to psychiatric hospital. Lived in a hostel with other friends from psychiatric hospital. Attempted suicide by stealing other residents medications and collecting a lot of them to take at once. Admitted to the nursing home from hospital.

Length of Residence:
2-1/2 years.

General Health Status:
Sometimes refuses to eat. Hypertension.

Participation in Nursing Home Life:
Very limited as she believes the other residents want to kill her.

Katz Index of Activities of Daily Living:
Pre-relocation C. Independent in all but bathing and one additional function.
Post-relocation C. Independent in all but bathing and one additional function.

Pre-relocation Understanding:
Very hard to assess. Appears aware of her surroundings and coherent at times.

Looking Forward to Meeting:
1

Satisfaction/Dissatisfaction:
Dissatisfied. Wants to die. Asks staff to assist her to die. (2)
GHQ - 20 Score:
T - T₁, T₁ - T₂ negative.

Affectometer 2 Score:
T - T₁, T₁ - T₂ negative.

Medication:
Alprim tab 300mg /i mane (Trimethoprim)
Lasix 40mgm mane (Frusemide)
Melleril 25mg bd (8, 12) (Thioridazine HCl)*
Melleril 25mgm nocte (Thioridazine HCl)*
Midamor 5mgm mane (Amiloride HCl)
Panamax 500mgm ./ii prn (Paracetamol)
Periactin tab 4mgm prn (Cyproheptadine-HCl)
Solprin 300m prn (Aspirin)
Tears-Plus Eye Drop (Polyvinyl/Povidone)
Voltaren 50mg morning after meal (Diclofenac Sod)
Zantac 150mgm nocte (Ranitidine HCl)

* indicates affect altering medication
Paul.

Sex: M Age: 78

Family Support: 2 sons.

Marital Status: Divorced.

Rationale for Initial Admission:
Found 'knocked-out' by grandson on his way home from school. He doesn't know what happened but he had a funny-turn. His grandson rang the ambulance and then wouldn't let the ambulance take him anywhere unless he went with him. The hospital told him he hadn't had a stroke but that they would like to do some tests. He stayed in the hospital for a few days and then had to leave as they couldn't find out what was really the matter with him. He told them it was just old age. 'Anyway I went home and it happened again - this time in the yard. My daughter-in-law found me this time and rang up another ambulance who took me to the same hospital. The doctor said it might be old age but he was going to find out why. They did more tests but still couldn't tell me why. So I said to him again he'd just have to believe me when I said it was old age. Anyway he didn't want me at home by myself, so I told the boys who said come to their place. I said no fear, not unless the wives asked me. They both did - so we had a roster. Anyway, it happened again and no one was home so I could have been in my own place. I asked the doctor then to put me in a home because it was no good for anyone else. This new one isn't too bad.'

Length of Residence:
4 years

General Health Status:
Good. Doesn't need a lot of help.

Katz Index of Activities of Daily Living:
Pre-relocation B. Independent in all but one of these functions.
Post-relocation B. Independent in all but one of these functions

Participation in Nursing Home Life:
Has got a few male friends whom he talks to and watches TV in the lounge with. They have an occasional beer ‘when matron is not looking’.

**Pre-relocation Understanding:**
Good - knew all about it - thought it may not happen - but then decided it had to as ‘the old place was ready to fall down.’

**Looking Forward to Moving:**
9

**Satisfaction/Dissatisfaction:**
Satisfied. (7)

**GHQ - 20 Score:**
T - T1, T1 - T2 positive.

**Affectometer 2 Score:**
T - T1, T1 - T2 positive.

**Medication:**
Capoten 25mgm ·/i tds (Captopril)
Diprosone crm 0.05% 15G (Betamethasone)
Isoptin Tab 240mg 1/2 mane (Verampamil HCl)
Lanoxin 250mcg ·/i mane (Digoxin)
Tears - Natural EyeDrops
Zyloprim 300mgm ·/i mane (Allopurinol)
Millie.

Sex: F Age: 80

Family Support: Nil - siblings deceased.

Marital Status: Single.

Rationale for Initial Admission:
Found in a neglected state by neighbour who had not seen her around for awhile.

Lived in a Department of Housing house. The neighbour called her General Practitioner who sent her to local hospital for a full assessment. She had not been taking her blood pressure medication and there was no evidence of food in house. The electricity had recently been cut off. Geriatrician recommended admission to a nursing home.

Length of Residence:
3-1/2 years

General Health Status:
Thin, frail, alert.

Participation in Nursing Home Life:
Enjoys sing-alongs, church services and bus trips. Likes to eat alone as others are sloppy - finds communal meals difficult.

Katz Index of Activities of Daily Living:
Pre-relocation F Independent in all but bathing, dressing, going to toilet, transferring and one additional function.
Post-relocation F Independent in all but bathing, dressing, going to toilet, transferring and one additional function.

Pre-relocation Understanding:
She didn’t really believe it would ever happen. It nearly happened so many times it was ‘like a fantasy - like a made up story.’

Looking Forward to Moving:
Satisfaction/Dissatisfaction:
Satisfied, but gives staff ‘a hard time to keep them on their toes.’ She doesn’t like to let them know she really likes them. (9)

GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.

Affectometer 2 Score:
T - T₁, T₁ - T₂ positive.

Medication:
Capoten tab 50mg ·/i bd (Captopril)
Cilamox Cap 500mg as ordered (Amoxycillin)
Ibilex-500 cap ·/i tds (Cephalexin)
Lasix tab 40mg ·/i mane (Frusemide)
Norvasc tab 5mg ·/i mane (Amlodipine)
Panadeine-Ft tab ·/i qid (Codein/Paracetamol)
Panamax tab 500mg ·/i · ·/i ii qid prn (Paracetamol)
Serenace tab 500mg ·/i bd (Haloperidol)*

* indicates affect altering medication.
Rose.

Sex: F Age: 86
Family Support: Nil.
Marital Status: Single.

Rationale for Initial Admission:
Constantly falling over. Unable to adequately look after herself. Often forgot to take her tablets. Wanted to be left alone in her Department of Housing Unit. A neighbour told the Meals-on-Wheels person who told her local doctor. Visited by a social worker who arranged her admission.

Length of Residence:
20 months.

General Health Status:
Good. Walks with frame. Incontinent at times.

Katz Index of Activities of Daily Living:
Pre-relocation Other. Dependent in at least two functions, but not classifiable as C, D, E or F.
Post-relocation Other. Dependent in at least two functions, but not classifiable as C, D, E or F.

Participation in Nursing Home Life:
Feels obligated to join in. Hates the Diversional Therapist as she treats her like a child - wishes she would leave. Hates Bingo. Pretends she likes it so nurses don’t treat her badly.

Pre-relocation Understanding:
Did not want to move. Was happy as she could see everything that went on.

Looking Forward to Moving:
5

Satisfaction/Dissatisfaction:
A bit of both - but has nowhere else she could go. (5)

GHQ - 20 Score:
T - T₁, T₁ - T₂ positive.
Affectometer 2 Score:
T - T₁ negative, T₁ - T₂ positive.

Medication:
Alprim tab 300mg ·/i daily (Trimethoprim)
Biquinate Tab 300mg, as ordered (Quinine-Bisul)
Canesten Vag-Crm 1% 35, as directed (Clotrimazole)
Cilamox Cap 500mg as ordered (Amoxycillin)
Citravescent Sach 4g ·/i qid (Sodi-Citro-Tart)
Dermacort-O Oint 1% 50g, as ordered (Hydrocort-Acet)
Durotuss Linct 200ml, 5- 6/24 (Pholcodine)
Ibilex-500 cap 500g ·/ii qid (Cephalexin)
Keflex Cap 500mg ·/i qid (Cephalexin)
Macrodantin Cap 50mg ·/i nocte (Nitrofurantoin)
Nilstat Vag-Crm 75g, as ordered (Nystatin)
Norgesic tab 500mg ·/i ·/ii 6/24 prn (Orphenad/Paracetamol)
Panadein-Ft tab ·/i or ·/ii qid prn (Codein/Paracetamol)
Panadol tab-sol 500mg, as ordered (Paracetamol)
Panamax tab 500mg ·/i ·/ii qid prn (Paracetamol)
Sorb & Glyc
Staphylex Cap 500mg ·/i qid (Flucloxacillin)
Temaze Cap 10mg ·/ii nocte (Temazepam)*

* indicates affect altering medication
Vera.

Sex:  F  Age:  82
Family Support:  2 sons.
Marital Status:  Widow.

Rationale for Initial Admission:
Unable to cope at home any more as becoming very frail. One son needed some money to buy his house as he'd been retrenched so if she sold her house she could help him out. Thought she would become a burden to family. Didn't want to live with her family even though she felt she got on well with daughters in-law. Thought her grandchildren had no respect for their parents and this upset her. Got her tablets mixed up and couldn't remember what she had taken. Often did not take her pills in case she doubled up and then became sick as a result. Had a few falls at home, but hadn't hurt herself. Both sons felt it was better for her to be in a nursing home in case she fell and couldn't get up. They offered some sorts of alarms, but she couldn't understand how to work them. Sons looked around and explained that a new home would open soon and she would only have to put up with poor situation for a short time. Reluctant agreement. Would have preferred to remain at home despite the risks to herself.

Length of Residence:
18 months.

General Health Status:
Frail, walks with assistance. Not confused.

Katz Index of Activities of Daily Living:
Pre-relocation G. Dependent in all six functions.
Post-relocation G. Dependent in all six functions
**Participation in Nursing Home Life:**
Little participation. Hates eating with other people who spill their food. Prefers her own company. Mixed more in old home as there was no real choice because of layout of home.

**Pre-relocation Understanding:**
Knew about impending move. Didn't fully understand why the home had to move. Liked to watch the people.

**Looking Forward to Moving:**
5

**Satisfaction/Dissatisfaction:**
Satisfied. (6)

**GHQ - 20 Score:**
T - T₁ negative, T₁ - T₂ positive.

**Affectometer 2 Score:**
T - T₁ negative, T₁ - T₂ positive.

**Medication:**
Agarol-Vanil Mixt 500ml prn (Paraffin-Phenolph)
Chloromycet Eye-Drp 10m ·/₁ tds (Chloramphenicol)
Granocol Granu 250g prn (Sterculia/Frangula)
Macrodantin Cap 100mg ·/₁ mane (Nitrofurantoin)
SlowK tab 600mg ·/₁ bd (Potassium-Chlor)
Sorb & Gly
Urex 40mg ·/₁ daily (Fumesemide)
Zinc/Starch/Talc Powdr (Zinc/Starch/Talc)
Dolly

Sex:  F  Age:  78

Family Support:  8 children (6 sons, 2 daughters).

Marital Status:  Widow.

Rationale for Initial Admission:
Got tired of being alive. Children didn’t visit very often. Was lonely and depressed. Took a handful of mixed pills and then became frightened about what she had done. She then rang the ambulance. Dolly become ill as a result. The ambulance took her to hospital and they told her she was a danger to herself. Had a consultation with a psychiatrist who suggested she move to a nursing home as she wasn’t eating regularly or taking her medication properly. They contacted her children who came to see her and they reprimanded her, so she told them not to come back. Stayed in hospital for a few days then went to the old nursing home. Then a little while ago she moved here.

Length of Residence:
2 years.

General Health Status:
Good. Eats well. Sleeps well.

Katz Index of Activities of Daily Living:
Pre-relocation G. Dependent in all six functions.
Post-relocation G. Dependent in all six functions.

Participation in Nursing Home Life:
Finds the other residents a bit dull. Doesn’t talk to them much as they ‘talk a lot of nonsense.’ Likes current affairs and the newspapers. Doesn’t like communal eating as it puts her off her food. Likes to eat alone where possible. Likes to sit on the balcony and listen to the races.

Pre-relocation Understanding:
Kept up well with all the activities related to move. Knew it had to happen eventually.
Looking Forward to Moving:

4

Satisfaction/Dissatisfaction:

Satisfied but said she wouldn’t tell the staff if she wasn’t because they aren’t all nice girls. Was annoyed about having a douche for scabies as she always kept herself clean. (7)

GHQ - 20 Score:

T - T₁, T₂ positive.

Affectometer 2 Score:

T - T₁, T₂ negative.

Medication:

Coloxyl-Senna Tab ··/iı noctē (Docusate-Na/Senna)

Ibilex-500 Cap 500mg ·/i qid (Cephalexin)

Keflex Cap 500mg ·/i qid (Cephalexin)

Temaze Cap 10mg ·/i nocte (Temazepam)*

* indicates affect altering medication.
APPENDIX 7

PSYCHOTROPIC DRUG USEAGE

Source:

Media Clipping:

Journal Article:
APPENDIX 8

PROTOCOL MANUAL
PROTOCOL
MANUAL
1. **Reason for this Protocol Manual**

As the stocks of nursing homes age, renovation and replacement will become necessary. This will occur as the need increases to upgrade general safety requirements in line with current legislation and as age related deterioration occurs to the existing building stocks. The extent of the required renovations may determine that the demolition and rebuilding of the nursing home is a more cost effective and efficient way to proceed.

Renovation and rebuilding creates a potentially hazardous threat to the quality of life and quality of care for the residents of the nursing home. The potential hazards relate to the need that will be created by renovation and rebuilding to relocate residents to another nursing home. This relocation may be a permanent one where the individual is relocated to another area and another nursing home, or the relocation may be a temporary one where the resident is moved to another nursing home until the renovations or rebuilding has been completed. In this case, residents may be moved either individually or as an entire nursing home population if suitable premises can be found. Figure 1 and Figure 2 illustrate the intrastitutional relocation patterns that occur as a result of nursing home renovation and rebuilding programs.
FIGURE 1
Interinstitutional relocation pattern as a result of nursing home rebuilding

Rebuilding of existing nursing home stock → Forced interinstitutional relocation of the nursing home population = Potential hazard or threat to resident

<table>
<thead>
<tr>
<th>temporary</th>
<th>permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident moved to another nursing home and then when new purpose built facility is completed, moved again to the new facility</td>
<td></td>
</tr>
<tr>
<td>Resident moved to an alternate nursing home facility with no view to move to new facility OR Residents moved to new purpose built nursing home on a different site</td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 2
Intrainstitutional relocation pattern as a result of nursing home renovation

Renovation of existing nursing home stock → Temporary intrainstitutional relocation of residents to another care area → Permanent intrainstitutional relocation of resident to another care area
Renovation and rebuilding programs provide opportunities to incorporate into the new architectural design of the nursing home the standards required by *The Outcome Standards For Australian Nursing Homes* (Department of Community Services and Health 1987; Department of Community Services and Health 1989)(Appendix 1).

2. **A Review of Some Relevant Literature**

The effects of interinstitutional relocation prompted by renovation and facility closure in Australia have been the subject of limited research and as a result there is little literature available concerning this. From the North American and the British literature that is available about interinstitutional relocation several clear themes do emerge.

These themes are:

- residents who are facing a non-consensual or forced relocation exhibited more negative prerelocation and postrelocation effects than those residents who exercised choice in their relocation destination (Lieberman & Tobin 1983; Rodin 1986; Baglioni 1989);
- residents who relocated as a part of a large group had a higher mortality rate than residents moved as a part of a small group (Bourestom & Tars 1974; Watson 1980; Wells & MacDonald 1981);
- pre-relocation preparation programs reduced the impact of moving exerted on the resident (Watson 1980; Thomasma et al. 1990);
- the maintenance of small group and primary relationships during the relocation process assisted in a positive adjustment (Bourestom & Tars 1974; Watson 1980; Wells & MacDonald 1981);
- continuity amongst personnel and other residents is important to reduce the distintegrative processes that the resident experiences on entering a new physical environment (Bourestom & Tars 1974; Coffman 1981; Lieberman & Tobin 1983);
• forced relocation will cause some degree of stress for the resident (Gallagher & Walker 1990; Mikhail 1992);
• the effects of a forced relocation of nursing home residents is influenced by their general health status (Watson 1980; Lieberman & Tobin 1983; Gallagher & Walker 1990).

3. **A Description of the relocation process**

When faced with a forced interinstitutional relocation the nursing home resident is placed in a vulnerable position. The resident has to either move to a temporary nursing home with the existing nursing home population or relocate permanently to another nursing home as an individual move.

Once the resident (or the residents advocate) has made this decision then the prerelocation preparation phase begins. The excellence of the preparation will determine the outcomes for the resident, the staff and the nursing home. The relocation phase involves the move itself and is a period of discontinuity for everyone involved in the relocation. Early establishment of continuity and routine during the postrelocation phase is critical to reduce the impact of the relocation on the resident.

A good outcome for all concerned is one in which the resident maximises the new environment and adjusts to the changes that it will necessarily bring. These changes can be positive ones which will enhance the overall wellbeing and quality of life of the resident or they may be negative ones which will create stress and a reduction in the residents level of overall wellbeing and quality of life.

Some of the positive changes for the resident are the establishment of new relationships with others, increased mobility, increased independence and a
sense of general wellbeing. All of these changes will increase the residents quality of life.

If the resident is unable to adapt to the new environment then behaviours that reflect this may include anger, frustration, loss of appetite and apathy. It is important that these behaviours are reversed as quickly as possible because if they are not reversed then a reduced overall wellbeing and quality of life will result.

4. Phases of the relocation process

This manual will now outline the process of interinstitutional relocation. It is divided into three sections, each dealing with a phase of the process:

   Section 1: The Pre-relocation Phase
   Section 2: The Relocation Phase
   Section 3: The Post-relocation Phase

Section 1: The Pre-relocation Phase.

A. Reassurance.

Reassurance is critical at this time, not only to the resident but to all levels of staff. Uncertainty creates insecurity, which in turn makes people and their actions unpredictable. Positive reinforcement and the giving of constant reassurance when needed will reduce some of the uncertainty and unpredictability inherent in the situation. Being realistic and honest about the anticipated time events will occur is an important part of this process.

B. Communication.

Good communication is essential to alleviate the anxieties of every one who is involved in the relocation. This involves informing the resident (or their advocate) about all their residential options available to them as a result of
having to relocate. This includes the option of relocation to another nursing home as a permanent measure. The staff need to be kept up to date with all matters that relate to the move. The staff need to be able to talk to the resident and the resident’s significant others about the progress of the move. Any potential problems that may be able to be identified at this stage (for example, a resident’s reluctance to move), should be openly and honestly discussed with all involved in the matter. Fears about the future that surface at this time can then also be addressed.

Drawings, photographs and floor plans of the facility should be displayed in a prominent place and time made to show them to those residents unable to view them from the notice board. In addition, any current information about the move should also be displayed and communicated to residents. Regular meetings at all staff levels and with residents and their significant others should form a regular part of the preparation to relocate. The initiation of a newsletter which deals with the relocation is an excellent medium of communicating the latest information about the move. It is inexpensive and means that everyone receives the same information at the same time. Residents should be invited to submit material to the newsletter about their reactions and thoughts about the relocation. If any letters are sent to the residents significant others concerning the move, then the resident should receive a copy first. If a committee is overseeing the relocation, then the minutes of that committees meetings should be available to the residents and their families on request.

C. Continuity.

No two residential environments will be the same. The resident has become used to their current environment and any change will cause some discontinuity for them. A visit to the new environment before relocation will assist the resident to adjust.
The discontinuity can be minimised by, where possible, involving the residents in decisions that impact on their new environment. For example, is it possible to give the resident a choice about where their furniture will be placed in the room, or the colour of curtains? Can residents select companions they would like to share a room with? This recognises the existing pattern of relationships that are very important to the resident.

Possessions are important to the resident. The resident should be given the choice about what they would like to bring with them to their new environment. Undue influence to throw possessions away will increase the discontinuity and violate the residents right to retain their own possessions. What one person deems as unsuitable is often very precious to the resident and will cause a lot of distress if discarded. It is a good time to discuss the need for new items of clothing and other shopping to take to the new nursing home.

Continuity is also very important in the area of resident information. Change affords an opportunity to review existing treatments and medications. Indicators such as residents weight and blood pressure and some form of Activities of Daily Living assessment should be carried out. This will provide a baseline from which comparisons can be made after the relocation has occurred. Nursing Care Plans should be updated and evaluated.

**Section 2: The Relocation Phase.**

The relocation is a strenuous activity for all involved. Remaining positive, communicating well, providing support for everyone involved with the move, providing continuity and observing the resident for any changes in their health status are necessary at this time. At this time, residents, staff and families may exhibit stressful behaviours, for example, crying, anger or frustration. Where possible, established groups should be maintained and the
resident observed carefully for any signs of distress. Recording the residents weight and blood pressure is essential at this time. Residents need to be familiar with the staff that will be caring for them at this time. The use of unknown agency or casual staff will only increase the residents anxiety about the relocation. It may be necessary to cancel all staff leave for the period of time surrounding the relocation. As the environment is new to the resident, additional assistance will be needed for them as they negotiate their new surroundings. Becoming lost in the new facility will cause stress for the resident. This can be minimised by providing a well signed environment. Continuity can be achieved by recognised staff who know the resident, a quick establishment of a routine similar to the old routine residents were accustomed to and by spatial orientation to their new environment. Additional staff should be available to talk to residents about the move.

C. The Post-relocation Phase.

Reassurance, communication, continuity and regular resident assessment remain the key factors in reducing any negative effects associated with relocation.

Some examples of strategies that can be employed at this time are:

* the provision of a forum for residents and their families to express their feelings about the relocation and the new facility;

* frequent observation and assessment of the residents and updating of their nursing care plans;
* the provision of post-relocation counselling if the need arises; and

* arranging for groups that can no longer be together to spend time with each other;

* maintain a routine that is like the routine these residents were previously accostomed to.

5. **Evaluation of the resident**

The physical impact of the relocation process on the resident may not be evidenced immediately. It is necessary to record observations during the week prior to relocation, within a week of relocating, and then at two weekly intervals for eight weeks, returning to the normal practices of the nursing home after that.
**Baseline Physical Measurements Pre-relocation and Post-relocation**

Suggested time frame:
During the 7 days prior to relocation
During the week following relocation
Each two week following for eight weeks

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>blood pressure</td>
<td>To note if any significant alterations have occurred since relocation which require further investigations.</td>
</tr>
<tr>
<td>weight</td>
<td></td>
</tr>
<tr>
<td>Katz Index of ADL’s</td>
<td></td>
</tr>
</tbody>
</table>

**Affective Indicators Post-relocation**

Suggested time frame:
During the 7 days prior to relocation
During the week following relocation
Each two weeks following for eight weeks

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>increased requests for medications such as paracetemol, Mylanta</td>
<td>increased anxiety resulting in stress related symptoms (e.g. headache, hyperacidity)</td>
</tr>
<tr>
<td>behaviour swings (e.g. weeping, obsturerousness, withdrawn behaviours)</td>
<td>uncertainty resulting in distressed behaviours</td>
</tr>
</tbody>
</table>
6. Outcomes

Measurable activities to monitor each phase of the relocation process have been developed.

Information Dissemination:

Pre-relocation Phase
Where possible ...

- do residents know there will be a move?
- do residents know the new location?
- have the families/significant others been given the same information - verbally, in writing?
- do the residents receive a newsletter which keeps them up to date about the move?
- are there photographs posted in the nursing home to show the residents their new nursing home?
- are less mobile residents shown the photographs?
- does the resident know where their room will be and who will be sharing it with them?

Relocation Phase

- does the Director of Nursing or nominee talk to the residents about how the move will take place?
- does the Director of Nursing or nominee talk to the relatives/significant others about how the move will take place?
- are opportunities given to the resident to talk about the way they are feeling about moving - to the staff, other residents, family/significant others?
**Post-relocation Phase**

- is the relocation newsletter an ongoing production - to the resident, family/significant others?
- have informal talks been held with each resident about the relocation at - 1/52, 2/52, 4/52, 8/52, 12/52 post-relocation?
- has a meeting been held with the relatives/significant others to discuss the relocation and the effect on - the resident, relatives/significant others?
- have appropriate written feedback mechanisms been instituted for the resident, family/significant others?

**Spatial Orientation**

**Pre-relocation Phase**

Where possible ...

- has a staff member described the physical design to the resident, relatives/significant others of the new nursing home?
- has a staff member shown the resident and the relatives/significant others photographs/drawings of the physical layout of the new nursing home?
- has the resident and relatives/significant others seen the new nursing home?
- has the resident and relatives/significant others been able to see scale models of the new nursing home?
- have all permanent staff members familiarized themselves with the spatial design of the new nursing home?
- have all permanent staff members attended an on-site orientation program at the new nursing home?
- were residents permitted choice in the furniture placement?
Relocation Phase

- are residents shown to their rooms by the most direct route?
- do residents know the name of their care area and their room number?
- can residents identify common areas within their care area (for example, dining room, library)?
- can residents locate and activate their call system?
- can residents locate and activate their light switches?
- can residents locate their ensuite?

Post-relocation Phase

- can residents locate and return to their room from:
  - common areas within their care area?
  - common toilets?
  - nurse’s station?
  - public telephones?
  - lifts?
  - outside courtyards?
- can residents locate and return to their own room from visiting friends in another area of the nursing home?
- are the residents offered this actuity?

Continuity

Pre-relocation Phase

- have the differences between their current nursing home and their new nursing home been explained to residents, family/significant others?
- have the relatives/significant others been given the opportunity to assist in the relocation of their relative from the current nursing home to the new nursing home?
- will the staff from the existing nursing home be working prior to the move and immediately after the move?
• have the residents been consulted about what personal items they wish to take with them?
• have all personal items been cleaned prior to the relocation?
• have the residents been given a choice about other occupants of their room?
• have primary relationships been kept intact in room allocations?
• has transportation been arranged in small groups of up to six people?
• for residents requiring ambulance transportation, has a staff member or family member/significant other from their care area been allocated to travel with them?
• has recognition been given to the fact the resident may grieve for the loss of the existing nursing home?
• have all the personal effects that the resident wants to take with them of the resident been packed and sent ahead?

Relocation Phase: Day of Relocation
• have the resident’s personal belongings been placed in their room?
• has the resident been asked where they would like their belongings placed?
• has a staff member/family remained with the resident since the arrival at the new nursing home?
• has the resident been shown the toilet?
• call button explanation?
• has the resident had a cup of tea?
• has the resident had a conducted tour of their immediate care area:
  • dining room?
  • toilet?
  • library?
  • nurse’s station?
  • entry/exit points?
• has the resident located friends?
Post-relocation Phase

Is the resident able to (either independently or with assistance):

- move around the nursing home without becoming lost or disorientated?
- operate the lift?
- visit friends within the nursing home?
- locate common areas?
- are other residents brought to visit the resident?
- are reminiscence sessions carried out as a part of the activities program?
- are there any photographs of the residents taken at the former nursing home?

Conclusion

There are strategies that can be used to reduce the hazardous outcomes for residents of nursing homes facing a forced interinstitutional relocation. In summary these are:-

1. provide an abundance of current information to the resident and the relatives about the move;
2. ensure good orientation programs are in place for the resident and the relatives at the time of the move and subsequent to the move;
3. ensure continuity occurs between the old nursing home and the new nursing home. This continuity is reflected in attitudes to residents’ personal effects, staffing matters, daily routine and activity programs.

The positive outcomes that will occur are:

- a better understanding by all those involved in the process of relocating the residents from one nursing home to another nursing home. This will reduce anxiety for all concerned, reducing the negative impact for those relocating
- spatial orientation will maintain existing living skills and encourage increased mobility within the new facility
• continuity will assist in the relocation of the apprehension being felt by residents relocating.

Acknowledgements

John McCallum

Charles Watson
APPENDIX 9

PUBLISHED PAPER

Stein, I. & Morse, C. 1993, 'Relocation of the aged - a literature review, Australian Journal on Ageing, 13, 1, 41-43. (Major author - I. Stein.)
Relocation Of The Aged –
A Literature Review

Please see print copy for image
APPENDIX 10

Brief notes relating to the Brief Assessment Schedule (BAS) and The Geriatric Depression Scale (GDS) and medication usage amongst the participants.
Brief notes relating to the Brief Assessment Schedule (BAS) and The Geriatric Depression Scale (GDS) and medication usage amongst the participants.

The BAS is 'popular for the rapid assessment of dementia and depression among the elderly in all forms of residential care' (Mann, Ames, Graham, Weyerer, Eichhorn, Platz, Snowdon, Hughes & Ticehurst 1989 p. 221).

The GDS 'is a reliable and valid measure of geriatric depression' (Yesavage, Brink, Rose, Lum, Huang, Adey, Leirer 1983 p. 45). The primary purpose of the GDS 'was to provide a reliable screening test for depression in elderly populations that would be simple to administer and not require the time or skills of a trained interviewer" (Yesavage et al. 1983 p.45).

In an Australian validation study the GDS 'significantly differentiated between residents with (a) no depression, (b) depressive features, and (c) Major Depression' (Lesher 1986 p.21).

The GDS 'is a 30 item, yes/no, self-rating scale' (O'Riordan et al. 1990 p. 60).

The BAS, GDS, GHQ-20 and Affectometer 2 scores, together with a psychiatric diagnosis have been presented in Table XX. This provides a measure of cognitive impairment (BAS), depression (GDS), non-psychotic psychiatric illness (GHQ-20), and affect (Affectometer 20).
The psychiatric diagnosis and the BAS and GDS scores have been made available to the researcher by Professor John Snowdon. These measures indicate concurrent validity of research measures and observations of depression.

A comparison of the BAS, GDS, GHQ-20, and Affectometer 2 scores with psychiatric diagnosis for those participants seen by a psychiatrist is presented in Table 1.

Twenty-one participants (64%), on psychiatric diagnosis, were not depressed. Of these 21 participants, there were 6 males and 15 females. Seven participants recorded positive GHQ-20 and Affectometer 2 scores. One participant recorded negative GHQ-20 and Affectometer 2 scores. Six participants recorded a positive GHQ-20 score and negative Affectometer 2 scores. Seven participants recorded a negative GHQ-20 score and a positive Affectometer 2 score. The range of GDS scores was 0-11, the BAS 0-20, the GHQ-20 0-12 and the Affectometer 2 -0.4-2.6.

Three participants (9%), on psychiatric diagnosis had a minor depression. The three participants recorded negative scores on the GHQ-20 and the Affectometer 2. The range of GDS scores was 6-16, the BAS 8-11, the GHQ-20 -2-1 and the Affectometer 2 -0.6 - -0.2.

Four participants (12%), on psychiatric diagnosis had major depression. The four participants recorded negative scores on the GHQ-20 scores and the Affectometer 2. The range of GDS scores was 8-22, the BAS 9-26, the GHQ-20 -8 - -4 and the Affectometer 2 -6.3 - -1.6.
Five participants (15%), on psychiatric diagnosis had dementia and major depression. The five participants recorded negative scores on the GHQ-20 and the Affectometer 2. The range of GDS scores was 5-12, the BAS 12-23, the GHQ-8 - -2 and the Affectometer 2 -2.6 - -1.1.

The mean male GHQ-20 score was 8.2 and the mean male Affectometer 2 score was 1.5.. The female mean GHQ-20 score was -0.3 and the mean female Affectometer 2 score was -0.6.

**Medication use amongst those participants seen by a psychiatrist.**

All the participants seen by a psychiatrist were prescribed affect altering medication.

**Medication use amongst the participants not seen by a psychiatrist.**

No participant was prescribed above the normal dose of any affect altering medication. Participants had been taking these medications at the time of relocation and the amounts had not been altered since. No interview participants were prescribed anxiolytics, however three were prescribed oxazepam and six temazepam (see Table 2). Within the time series participants nine were prescribed diazepam, sixteen were prescribed oxazepam and twenty-one were prescribed temazepam. A comparision with the total nursing home population at this time was not possible.
Table 1  BAS, GDS, GHQ-20, and Affectometer 2 scores with psychiatric diagnosis for those participants seen by a psychiatrist.

<table>
<thead>
<tr>
<th>BAS</th>
<th>GDS</th>
<th>GHQ-20</th>
<th>Affectometer 2</th>
<th>Psychiatric diagnosis*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>7</td>
<td>8 (+)</td>
<td>-0.4 (-)</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>22</td>
<td>-4 (-)</td>
<td>-1.6 (-)</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>7</td>
<td>12 (+)**</td>
<td>1.2 (+)</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>12</td>
<td>-5 (-)</td>
<td>-2 (-)</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>5</td>
<td>-3 (-)</td>
<td>-1.1 (-)</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>10 (+)</td>
<td>-0.3 (-)</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>8 (+)</td>
<td>1.1 (+)</td>
<td>-0.4 (-)</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>6 (+)</td>
<td>-0.1 (-)</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>0 (-)</td>
<td>0.7 (+)</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>6</td>
<td>1 (-)</td>
<td>-0.6 (-)</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>4 (-)</td>
<td>0.9 (+)</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>0 (-)</td>
<td>0.8 (+)</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
<td>5 (+)</td>
<td>-0.2 (-)</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0 (-)</td>
<td>0.2 (+)</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>6 (+)**</td>
<td>0.4 (+)</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>6 (+)**</td>
<td>2 (+)</td>
<td>1</td>
</tr>
<tr>
<td>23</td>
<td>10</td>
<td>-2 (-)</td>
<td>-2.6 (-)</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>0 (-)</td>
<td>-0.3 (-)</td>
<td>2</td>
</tr>
<tr>
<td>0</td>
<td>4 (-)</td>
<td>-0.1 (-)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>2</td>
<td>6 (+)</td>
<td>-0.1 (-)</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>4 (-)</td>
<td>0.4 (+)</td>
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<td>0.8 (+)</td>
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<td>12</td>
<td>-4 (-)</td>
<td>-1.9 (-)</td>
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<tr>
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<td>12 (+)</td>
<td>2.2 (+)</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>10 (+)**</td>
<td>1.8 (+)</td>
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<tr>
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<td>1</td>
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<td>-6.3 (-)</td>
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<td>26</td>
<td>8</td>
<td>-6 (-)</td>
<td>-2.8 (-)</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
<td>-8 (-)</td>
<td>-1.6 (-)</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>16</td>
<td>-2 (-)</td>
<td>-0.2 (-)</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>11</td>
<td>10 (+)**</td>
<td>2.6 (+)</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>13</td>
<td>10 (+)</td>
<td>-1.8 (-)</td>
<td>3</td>
</tr>
</tbody>
</table>

* 1= not depressed, 2= minor depression, 3= major depression, 4 = dementia and depression.
** males in the sample with a psychiatric diagnosis (n=6).
<table>
<thead>
<tr>
<th>Group</th>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Factors Relating to Affect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butyrophenes (Anti-psychotic drugs)</td>
<td>Haloperidol</td>
<td>Serenace</td>
<td>tremor, rigidity, sedation, mental confusion</td>
</tr>
<tr>
<td>Phenothiazines (Anti-psychotic drugs)</td>
<td>Thioridazine</td>
<td>Melleril</td>
<td>sedation, mental confusion</td>
</tr>
<tr>
<td>Tricyclic Anti-depressants</td>
<td>Doxepin</td>
<td>Sinequan</td>
<td>insomnia, depression, blurred vision, sedation, mental confusion, altered appetite, dependence</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>Nitrazepam (Hypnotic)</td>
<td>Alodorm</td>
<td>altered appetite, sedation, mental confusion, fatigue, muscle weakness</td>
</tr>
</tbody>
</table>
|                               | Oxazepam (Antiolytic)        | Mogadon     | * when altering dosage  
Benzodiazepine withdrawal syndrome may occur |
|                               | Temazepam (Hypnotic)         | Serepax     | Normison  
Temaze |
| Anti-convulsant               | Orphenadrine & Paracetemol   | Norgesic    | drowsiness, blurred vision                                    |