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'A SENSE OF PLACE'
THE ROLE OF THE BUILDING
IN THE ORGANISATION CULTURE OF NURSING HOMES

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Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of Doctor of Organisation Dynamics

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Acknowledgments

Thanks to my family and friends for their understanding and enduring support and contributions;

to Roger for love, support and sustaining me and us through the process;

to Professor Susan Long and Dr John Newton for guidance and insight;

to my fellow doctoral colleagues and research students for advice, debate and friendship; and

to those staff, residents and family members of the nursing home forming the case-study.
This thesis is original work and has not previously been submitted for a degree or similar award at another institution.
ABSTRACT

This study attempted to identify and explore the role the building plays in the organisation culture of nursing homes. To do this a research plan was formulated in which the central plank was a case-study of a seventy-five bed high care nursing home. As part of the case-study, interviews were conducted at the nursing home with ten members of staff, two residents and a daughter of a resident. The study was also informed by interviews with two architects, who specialise in the design of nursing homes and aged care facilities. A theoretical model entitled the 'Conceptual Framework' was developed prior to the case-study. It was tested by applying it to findings related to the physical context and the organisation culture of the case-study venue. The hypothesis that the building does influence the culture of the nursing home environment was explored by studying the manner in which the building influenced the lives of those who work in the nursing home and those who live there. This challenge was met with the use of theoretical contributions from organisation theory and psycho-dynamics, which together provided a vehicle for analysis of the culture and the building's role in it.
A Sense of Place – The Role of the Building in the Organisation Culture of Nursing Homes.

Preface

The preface provides a background prior to the thesis proper being introduced.

Origins of the Thesis

This thesis is a defining point in my intellectual and professional development. It has sprung from my interest in health-care over many years and from my experience in many different roles. It probably had its germination in my early experiences of nursing elderly people when I was training to be initially an Enrolled and then later, a Registered Nurse. It began to form more deeply when I found myself after many years gap, working again in aged care. This experience came at the crest of the confusion related to the structural reforms implemented by the Federal Government. A pivotal aspect of these reforms was the objective to improve the overall building stock in residential aged care, by improving the design, lay-out and general quality of facilities. My experience working as a project manager of several consultancies together with an architect and an accountant, further generated a rudimentary interest in the role of the building. This led to the forming of the question this thesis serves to explore. That is, 'what role does the building play in the organisation culture of nursing homes’?

A major component of this consultancy work centred on the assessment of the building, for its current and potential ability to meet the recently implemented new building standards. These assessments were primarily functionally oriented in that they concentrated on room sizes, number of residents to rooms, traffic-flow, corridor widths, location of utility areas, kitchens and laundries. During this experience, the building began to mean more to me than its functional role as suitable shelter for adults and suitable work environment for staff. I began to think of it more as a landmark in the passage of people's lives. Not a landmark such as a light-house, which guides ships away from the shore and to safety, or the Tower of London, representing hundreds of years of history contributing to the cultural fabric of a society, or the Sydney Opera House, considered a feat of architectural and engineering brilliance, located in a position of prominence on a beautiful harbour. Yet, it seemed to serve a role of demarcation, between independence and dependence, between the wider
community and the community contained within its walls. Finally, it seemed to be the
terminus between life and death.

Associated with these images of the building as a landmark are the emotions which
accompany a person's moving into a nursing home and taking up the role of resident. The
counter-part to resident is the role taken up by those working in the nursing home building.
Both those who live there and those who work there might be said to have expectations of
the building, as does the building designer and the family members of residents. All groups
potentially help to shape the culture of the organisation, in part through their relationship
with and to the building. Moreover, the building itself influences the culture and how it
manifests, through its symbolic meaning amongst each of these groups.

What I hypothesise in this thesis is that nursing home buildings serve the interests of those
who work there more than of those who live there. At least this is apparent at a conscious
level. This hypothesis is explored through a case-study of one large nursing home, which has
seventy-five residents. There is no doubt that I have sought to study an area that has not been
adequately addressed through the studies of other disciplines. The literature search for this
study revealed few relevant publications that directly addressed the role of the building in
aged care settings. In constructing and informing this thesis, I have drawn upon personal
experience, interviews with architects, periods of observation and interviews conducted with
staff, residents and a relative of a resident of the nursing home forming the case-study.
Through these sources I have elucidated the dominant culture of the nursing home and the
manner in which the building influences how activities of those who live there and those
who work there are governed by the relationship with the building.

**Aim of the Research**

The aim of the research was to study how the physical context of the nursing home building
influenced\(^1\) the culture of the nursing home, the roles of staff and the lives of residents. The
research could have been limited to the study of the people who live and work in the
building. This would have yielded a rich picture of what happens in a nursing home,

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\(^1\) The power or capacity of causing an effect in indirect or intangible ways (Webster's New Ideal
Dictionary, p.265).
otherwise known as the 'lived experience'. Likewise, studying the building alone would have made for a definitive contribution to the literature on building construction, lay-out and factors to promote or avoid in building design. Neither area alone was substantial enough to meet the goal of the study, but the synthesis formed from combining the physical context with the human element, provided an opportunity to explore an area which could benefit many aspects of aged care. This included the current Certification requirements for buildings, management and organisation practices in aged care and cultural understanding of the environment for all aged care practitioners.

The culture of the nursing home environment is central to the study, as it is this on which the study of the building pivots. The findings of the study of the nursing home culture are discussed extensively in Chapter 5, whilst the findings of the physical structure and context in relation to nursing home culture are discussed in Chapter 6. In both Chapters 5 and 6, theory from the field of organisational culture and psycho-dynamics is employed to analyse findings of the study.

Some description of the most recent regulations governing size of rooms, number of occupants to rooms and ratio of residents to bathrooms and toilets has been necessary. More because this data represents the public policy agenda about residential aged care services, which in turns reflects attitudes in society toward aged care. It is in the rush to determine minimum room size, number of beds and other aspects of the building and building design that society focuses overly on measures that are both tangible and quantifiable determiners of residential life. It seems to me, that notwithstanding the basic fire and safety requirements of buildings, we are overlooking the more subtle relationship engendered by a building, any building, in its ability to influence the quality of living and the quality of working in the environment. Moreover the hidden dynamics created by the physical environment – that are not tangible nor quantifiable – are equally important in the living and working roles of nursing homes. In this thesis I attempt to draw out these dynamics, shining a light upon them and articulating them in order to identify their relationship to the organisation culture of nursing homes.
Perspectives informing the Research

This Preface provides a personal perspective about nursing, aged care, death and my experience of this work. The comments provide a backdrop to the field of aged care and to the direction and scope of the thesis overall. In Chapter 1 'Introduction and Rationale for the Research' I develop the personal aspects introduced here into a cogent series of issues affecting residential aged care, which in turn act as a rationale for the research. These issues include the building requirements for nursing homes, recent policy developments in residential aged care, the community's negative perception of aged care and nursing homes; the treatment by the media of aged care and the expectations on the aged care industry. These issues are taken up in the themes developed through the chapters comprising this thesis.

In Chapter 2 'Conceptual Framework and Theoretical Perspectives' a theoretical model of the three separate but inter-related elements of the physical context of the built environment related to living and working in residential aged care is discussed. These three elements are the building/physical structure; the spaces created by it (formal and informal); and the sense of place. The model is referred to throughout the thesis as the 'Conceptual Framework'. The purpose of the visual representation of the Conceptual Framework is to provide an image which links the physical and therefore tangible aspects of the built environment together with the non-tangible aspects associated with meta-physical qualities of felt properties. The Conceptual Framework is discussed at length in Chapter 6, which focuses on the building's role in the nursing home culture.

Chapter 2 also discusses the theory drawn from organisation culture and psycho-dynamics and applied to the findings of this thesis. Using an amalgam of theory from these two fields a working definition of culture was forged for use in this thesis. This working definition stands as those interactions occurring between people (i.e., the social enterprise) that are mediated by organisational task, organisational boundaries, organisational defenses against anxiety and the interaction between these and the organisational holding environment.
Past Experience – a convergence with the present

I cannot help but wonder if I have come full-circle, I started my career in health care in a geriatric ward and this thesis is about nursing homes. What follows are personal reflections on events that took place years ago, but are important to the development of this thesis for two reasons. First, they provide an insight into a nurse's perspective of working with aged people and second, they introduce a background to key aspects of aged care work, which are found today in nursing home care practice. These key aspects are supported by the data gathered for this thesis. In this thesis I will define these aspects as being:

- a routine task oriented culture, which dominates the work and care setting;
- a tension between a hospital oriented physical structure and associated model of care and a home oriented physical structure and associated model of care;
- the influence of the building on the role of resident and the role of nurse/carer;
- challenges to living in a nursing home.

Each of these aspects is addressed in the thesis.

Being Sixteen

I am sixteen years old. I am in Mount Gambier, 300 miles away from my family who are in Adelaide. I am with my half-sister. I have just been told that I will be working on 1A – female geriatric ward and I am beside myself with distress. The others in my particular nursing group have been allocated to wards which seem much more interesting, much more alive and anywhere but in that musty, old, blue, cold, isolated ward with old, old ladies who must be washed and dressed by 10a.m. every day. Not for me the activity of the surgical wards or the small babies and infants or even the casualty area, not at the beginning anyway. I was to work with the old. Me, someone who had no knowledge or experience of old people or their needs or how they behaved and reacted. My mother was in her fourties, my father had died when I was 13 and we lived 1,200 miles away from both their families.

I remember one evening shift where I help turn an old lady whose limbs are contracted. She is not 'with it' (as we might have said to each other). She is laying in urine and we must turn her from side to side on her water-bed, rolling the wet draw-sheet from under her and changing her night-dress. She is very light and frail. I don't remember my colleague helping
me, just of being there and doing the task, which is done with great efficiency, even though
the two of us don't know each other well. If we do not change the linen, the urine will bum
the patient's skin and if we do not turn her on a four-hourly basis, she will develop decubitis
ulcers (pressure sores). It seemed extremely important that neither of these things should
happen. Of the morning shifts, I retain a strong memory of how two of us worked alongside
each other, one at the shower, the other at the bath. We washed old ladies in full view of
each other, dressing them and sending them off to the next area – the solarium from where
you could see over Mount Gambier, if you were able to locate yourself in the right position.
This was difficult for the patient's of this ward who were invariably seated for long periods.

I remember the bain-marie being wheeled along the corridor to the solarium, where the
Charge Sister – and it could only be the Charge Sister – would dispense the patient's meals.
It was our signal to start going off to lunch, a short half-hour break, down to the hospital
dining room. We would be assigned first or second lunch break. If you went to second lunch
there was less than two and half hours left to work until the end of the shift. In the two years
I spent at this hospital I worked on this ward for two lots of day shifts and one lot of nights –
the night roster was for three months.

I was later to see the effects that result from failing to care for the older person's skin. I
helped another nurse (for whom I had a great deal of respect) lift dressings off enormous
open wounds, which had been de-sloughed (removal of dead-tissue, debris and exudate) and
must be kept clean. These huge wounds were over the bony prominences of a man's back.
We took great care to do the dressings as swiftly and gently as possible and to re-position
him so he was not laying on any vulnerable area. I remember he was not from the town, but a
smaller community some distance away.

I remember being in the four-bed ward where we cared for this man. It was at the other end
of the building to the female geriatric ward and where again it was possible to look out over
Mount Gambier and beyond. At night you could trace the out-line of the perimeter of lights
which ended where the town-ship ended and beyond which it was black. This black became
velvet black just before the sun-rise. I know this because I would look out to await its
coming, particularly in these lonely rooms at night and when I was on children's ward,
nursing babies. It was my symbol of hope.
**Being Thirty-Two**

I am thirty-two years old. I am now a registered nurse and I am working in a large aged care facility where I am responsible for at least two of the units. I work a variety of shifts, on a casual basis. It is the late 80’s, with spiralling interest rates and I am a supporting parent. I need the money. I am doing the extra work in addition to a full-time position as a lecturer at a University.

I am totally occupied in meeting the requirements of the drug-rounds, the specialised dressings, visiting pharmacists and doctors, conflicts which arise between staff and attending to needs of residents, being short-staffed and balancing the load. I remember my own fear of the locked ward that housed the dementia unit. I remember the over-weight bassett hound kept as a pet, which I constantly tripped over. I remember the absolute loneliness of several residents and my attempt to try to discuss things with them. I remember the alert and able people living in this place, who had physical needs that made it too difficult for them to be at home. I remember their almost constant state of ‘bon vivant’. I remember the palliative care area, separated from the other units by two doors and my fear. I could not volunteer for casual shifts in this area. I feared that I would not know what to do, or how to deal with needs. I felt these people required greater continuity from their carers and so I never worked in this area.

And yet I have seen death, nursed it, waited for it, helped colleagues 'lay out' bodies. I have stood with them, in ear-shot listening to the Cheyne-Stoking breathing (repetitive and laboured), waiting for it to stop and perversely hoping the person would not die on our shift, as it meant more work to do. At sixteen I had worked with porters who made light of our trip to the morgue – just a porter, me and a body – where we made sure it was safely in the morgue and we had made an entry in the book in the room. I feared what I might see on the other shelves of the morgue when the door was opened. And I had come across death in the night, unexpectedly, when sent by the senior nurse to do a ward round, into the darkness of the four-bed bays of ex-service men, breathing heavily, expectorating, calling out. And there it was, a body prostrate on the floor. It was later transported away by porters, on a trolley, down the open sided cover ways with little illumination, where staff rode around at night on
bicycles, odd figures with capes flying and one small lamp lighting their way and announcing their arrival.

In our dress, we were encouraged to wear something less formal, although I noted some staff stuck closely to a uniform style outfit. I chose trousers and a top which I felt were appropriate – but I would never and could never wear them for anything other than my work role at this place.

I remember soft colours and open areas and large arm-chairs and comfortable dining areas and gardens. I also remember the plaques in the garden outside the palliative care area for those who had died there.

It is the combination of factors outlined above, associated with living in a nursing home and with working in a nursing home which forms the decisive point at issue explored in this thesis. That is, ‘what role does the building play in the organisation culture of nursing homes’?

**Stepping Stones on the Research Path**

The origins of the thesis can also be traced to my changed work and life experiences over recent years. Although I am a registered nurse the amount of time I have dedicated to clinical roles is minimal. Instead I have branched into community health practice, health administration, and rural health and for a ten-year period worked in several universities as an academic. Here my interests were still squarely within the health field, teaching management and organisation theory. This work took me to several states of Australia. I left my home and rented accommodation where ever I was. The combination of rental experience, leaving my home, creating new places to live and work were powerful shapers of my inner thoughts. When my academic work ended I was faced with re-inventing myself and I found myself working in aged care. A significant proportion of this work was with private-for-profit providers, which educated me about business values that were often reflected in the quality or otherwise of nursing home buildings.
post the introduction of the 1997 Aged Care Act, I became a consultant engaged on the Commonwealth Government's residential re-structuring program. This work brought me together with an architect and an accountant. Alongside this, I had been influenced by documentaries focused on architecture and the role of the building. One other factor contributed to the generation of the research question, that of having a space of one's own, usually a private space. A physical space of one's own is frequently associated with a positive sense of place. Alternatively, this relationship may arise from things other than a physically bounded space of one's own, for example, kinship ties; a relationship with the land; spiritual devotion or creative pursuits. Cooper Marcus (1997) who has extensively researched the meaning of home to individuals, suggests that the issues of emotional attachment in person-place relationships has largely been ignored by those disciplines who do focus on this area, including architects (p.3). As architects design many residential aged care facilities developing an appreciation of this relationship between personal spaces and a sense of place for residents appears warranted.

An understanding of the strength of meaning attached to the spaces we use and our sense of place (in western societies) is readily identifiable when individuals reflect upon how they react to their spaces and the feelings aroused within them by these spaces. For instance a work space may give rise to both positive and negative reactions, another more personal space may give rise to creative feelings, excitement or alternatively leave an individual with a flat and heavy feeling which they find inexplicable.

As I went about visiting and working with numerous nursing homes, I found myself wondering about the transition from home to nursing home. A home, no matter how small is made up of a number of rooms, it is located in a community and the owner has exercised a degree of choice over the home and its location. The move to a nursing home re-defines a person's status from private individual to resident; from home to nursing home; from multiple room occupancy to single room occupancy. In a nursing home all areas beyond this single room - which is a bedroom - are public. Willcocks, Peace and Kellaher (1987) aptly depict this shift from home to nursing home through the title of their book 'Private Lives in Public Places', a research-based critique of residential life in local authority old people's homes.
As described in Chapter 1 'Introduction and Rationale for the Research', many nursing home residents travel a road which takes them from home to hospital, onto a hostel and then to a nursing home. Apart from the emotional and psychological stresses raised by these shifts, they also have the effect of taking the person into ever decreasing personal spaces. What cannot be ignored or avoided is the reality that this home, the nursing home, is their last (earthly) place of residence.

Cooper Marcus (1997, p.245) writing about ageing and memories from past dwellings captures the emotional person-place relationship in the following quote:

an elderly person who is moved from a much-loved home of many years may yearn not only for its familiar rooms, views and furniture, but also for the feeling of comfort and security it evoked. Feelings occur in space and inevitably become associated with various highly charged places; feelings cannot occur "out of space" any more than they can occur "out of time". Thus, any discussion of emotion and place must return to the observation that the two are inexplicably connected, not in a causal relationship, but in a more transactional exchange, unique to each person.

With all these aspects to consider I began to make my way down a path which required further enquiry in the field; consolidation of my thinking; formulation of the research question; development of a suitable research design; undertaking the research; and ultimately analysis and discussion of the findings. A heuristic enquiry, involving the discovery of things for oneself.

Statement of Approach to the Research

This thesis forms the major component of a doctoral program where the foundation is based on developing reflective practitioners in the sphere of organisation dynamics. The key process that suffuses all knowledge content of the program is the cycle of learning, applying, interpreting and reflecting. This cycle is applied to the experiential components of the program and is reflected in the framing of the thesis and its expected outcomes. Amongst these outcomes is the anticipated contribution of the work to the field of knowledge of organisation dynamics and to the application of this knowledge in practice. To this end, the construction of this thesis draws upon the following:
1) my experience as a nurse and a consultant in the field of residential aged care;
2) interviews with two architects experienced in the design and building of residential aged care facilities;
3) the development of a theoretical model - 'the Conceptual Framework' described in Chapter 2 and applied in Chapter 6;
4) a case-study conducted at a seventy five bed nursing home;
5) the extensive learning undertaken in the doctoral program, much of it experiential in nature.

The specific purpose of the thesis is to contribute to knowledge and practice in the field of residential aged care. Therefore both the perspective taken throughout the thesis and the method used to expedite this were oriented toward deepening knowledge within the context of practice and an applied framework within organisation dynamics.

Residential Aged Care – Strong Demand, Unclear Future

Internationally the proportion of aged people within the population is increasing. Governments of western nations are concerned about their ability to provide adequate care and resources as the needs become greater and are forced back upon the younger population. Coupled with these concerns are those accompanying shifts in ideology and public policy toward greater privatisation. In Australia this has meant more and more residential aged care beds (informally known as hostels and nursing home beds) being transferred to private for-profit operators. New regulations, that aim to improve the quality of the built fabric of residential aged care facilities as well as the provision of residential aged care services, have been introduced in the aged care industry. The last platform of concern is the increasing challenges to maintaining a professional work force in aged care. It is difficult to attract and retain a stable work force. Casualisation is rife and issues related to the ratios of unqualified to qualified carers are increasing.

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2 This is not meant to imply that no attention was paid to ensuring the validity of the research design and process nor that measures were not taken to reduce bias in the interpretation of findings, rather that the knowledge built from these experiences was used constructively throughout the thesis and that feelings aroused within me during the research process were treated as data for interpretation alongside other findings.
Although the total numbers of residential places in Australia for both hostels and nursing stands at only 148,917 (Age Pension News 2000, p.16) of a population of approximately 19 million, the perception by the public toward nursing homes is not a positive one. Issues associated with nursing homes and their residents engender wide-spread community reaction. There appears to be deep-seated concerns related to ageing and the potential to become a nursing home resident.

The main aim of the thesis is to explore the relationship of the building to the organisation culture of nursing homes, and how this in turn influences the lives of those who live and work there. It is hoped that greater understanding of the purpose of the building from the perspective of those who live in it, can be obtained. It is anticipated that these outcomes will be incorporated by nursing home designers, planners and nursing home staff to better understand the intersection between the physical context of the nursing home building and living and working in its environs. It is also foreseen that findings will have relevance to policy-makers regarding both building standards and standards of residential care. It is also hoped that the research undertaken in these areas, will contribute to debate and ultimately inform the directions of public policy.
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Chapter 1  
Introduction and Rationale for the Research

1.1  Purpose of the Introduction

This introduction serves two purposes. First it provides information about the research topic and research process and how this unfolds in the individual chapters comprising the thesis. Second, a major component of this section is spent in the coverage and discussion of issues related to residential aged care, particularly those in the minds of the public. The objective of this coverage is to provide a context for this thesis and to introduce key aspects explored by the research.

This thesis is about 'living' and 'working' in a nursing home with the central focus being on how the physical context affects the culture of the nursing home. The scope of the physical context includes the building itself, the spaces created by it (both formal and informal), and the sense of place it gives rise to. These aspects are discussed in Chapter 2, ‘Conceptual Framework and Theoretical Perspectives’. A central aspect explored in this thesis, is how the physical context both suffuses and influences 'living' as a resident in a nursing home and 'working’ in a nursing home. Allied to this is the exploration of how the resident-carer relationship is affected by the building.

The context for the research is provided in this chapter through the introduction of key concepts and issues, that form the rationale for the research. These concepts and issues become themes that are pursued through the research process. These themes also inform the Conceptual Framework which is discussed in Chapter 2. The Conceptual Framework is pivotal to the analysis and discussion of findings from the research, that are discussed in Chapters 5 and 6. An overview of the content of each of the chapters of the thesis is located at the end of this chapter.

The overall aim of the thesis is to deepen our understanding about nursing homes by exploring the role the building plays in relation to the residents and staff and the organisation culture – the inanimate and the animate together. The intersection of these
elements is explored principally through psycho-dynamics and organisation theory, which are discussed in Chapter 2.

1.2 What are Nursing Homes and What Do They Do?

Nursing homes are buildings that house members of the community (in western societies) who cannot adequately care for themselves or be cared for any longer in their own home, the home of a relative or friend or another health care venue. Their care requirements extend beyond the social needs and daily life of individuals, to those associated with the provision of shelter and the intimate physical needs related to personal hygiene and nutrition requirements. The level of care required can be quite high corresponding to the dependency needs of individuals. Nursing homes are also organisations that organise staff and resources to provide a service. All are businesses, and with the growth in the number of aged persons, coupled with shifts in government ideology, increasing numbers of nursing homes are being operated as 'for-profit' companies. At the same time market forces are playing a greater role in influencing the aesthetic of nursing home appearance and design.

Nursing homes provide care at the higher end of the needs spectrum; however they are neither home nor hospital. This latter issue gives rise to myriad questions related to the suitability of the physical design of buildings and the values and principles held by building designers, operators and others about residential aged care.

Some residential aged care facilities provide for both low and high care need residents and others have an articulated and sequenced arrangement of care. Under this arrangement, it is possible for someone to enter an independent living unit and if needs be, move to the low-care area of the organisation (hostel) and onto the high-care area (nursing home). However, this sequenced arrangement of care is not the experience for many people. Instead, people enter from private homes or retirement villages via treatment in an acute care facility (hospital) for a health crisis e.g., a fractured neck of femur (hip region), resulting from a fall. The acute care setting's orientation is on life-saving and life-prolonging work, successfully returning patients to the community. This role can be inconsistent with the needs of aged persons. Hence, little value is placed on
their needs beyond treatment of the presenting problem. The individual and their families are encouraged (often pressured) to find a bed in a nursing home as quickly as possible.

1.3 Juxtapositions in Role and Place Identities

At the juncture where the family (usually the female members) is searching for a bed for their mother, father, or an in-law, a role reversal may occur. The adult child is now required to facilitate how and where the older person will be located, rather than the parent meeting the needs of the child. The physical, social and emotional needs exhibited by the older person, may closely resemble the basic needs of infants and children. Not surprisingly, this situation is often distressing for both the older person and the adult child; a situation exacerbated by the need to find a new home for a parent i.e., a bed in a nursing home. The inherent problems associated with finding and moving to a nursing home are anxiety provoking. They include, geographic location and distance from family and friends, assessing the quality of care and activities, adjustment by the older person and family to the nursing home setting and selecting the final home of the parent.

Nursing home residents do not go home (or rarely). Homes are sold and the nursing home becomes the last place of residence before death. Very often, the resident's home has been the family home, which adds to the distress of family members. The nursing home becomes the community for the resident. It replaces not only their previous domicile but their immediate community relationship and interaction with it. The wider community must manifest itself in the microcosm of the nursing home. The control over one's actions is re-framed through entry into a nursing home. The concepts of choice and decision-making, entry and exit to the building, participation or isolation, living and dying, take on different meanings in a new environment. The cycle of life is lived out and ultimately concludes in the nursing home building. In their own home environment, the older person had held control over their immediate domain but this control is frequently superseded by the demands and cultural expectations of the nursing home environment.
The state of Victoria has the second highest number of hostels and nursing homes in the country. They range from converted old homes to multi-storey buildings. Some are as small as 30 beds, housed on one site. There are plans afoot to develop a facility of 250 beds, which is very large by state standards. Within the aged care industry a minimum of 60 beds is considered to be economically viable, therefore all those facilities with less than 30 beds face a difficult future. Part of the reason for the high number of 30 bed facilities is a result of the surge in the 1960s and '70s to convert large Edwardian and Victorian private houses in leafy suburbs into nursing homes – these were considered to be quaint and more home-like. Paradoxically, in 1997 many of these 30 bed facilities failed the new building Certification requirements, established by the Federal Government under the Aged Care Act of 1997.

Major expansion in aged care in the 1970s led to the development of multi-storey, cream-brick type buildings, many constructed for the purpose of low-care 'hostel' living. Over time, the level of dependency amongst long-term residents has increased, as has the dependency level of new residents entering facilities. The buildings do not function well either as low-care or high-care facilities. The operators of facilities face difficult choices about up-grading and development. These choices are bound into the future requirements of residential aged care buildings under the Aged Care Act.

1.5 Certification of Nursing Home Buildings

In 1997, federal legislation entitled the Aged Care Act 1997 was enacted. Together with the Aged Care Act 1997 Principles, the Act specifies requirements in all areas of residential aged care provision. In all, the Act amounts to major structural reform initiatives in funding and provision of aged care services. The detail of these reforms addressed in the Act includes allocation of places; eligibility and funding of services; approval of providers of services; charging of fees by services; standards of residential aged care to be provided; the requirements for Accreditation of facilities; and Certification of facilities. This last requirement of Certification of facilities, addresses
the expectation of the built fabric of residential aged care facilities to meet set standards pertaining to the provision of a safe and secure environment for residents.

In the Commonwealth Department of Health and Aged Care's publication entitled 'Certification Procedures for Residential Aged Care Services' it is stated,

Certification involves a detailed inspection of a facility and results in an overall score being awarded. Independent consultants with expertise in the area of building quality carry out the inspections. The consultants consider a range of characteristics including fire safety, hazards, the provision of sleeping and common space, access to toilets and showers, and the provision of lighting, ventilation, heating and cooling. They use a rigorous assessment method that ensures accurate, fair and consistent appraisal across assessed facilities (1999 (a) p.1).

Certification is one of the five planks of Accreditation of Residential Aged Care facilities. Without Certification approval a facility cannot charge fees. More importantly, facilities that do not meet Accreditation requirements by the end of 2000, will be ineligible to receive Commonwealth subsidies for aged care provision. Commencing in 1997 all residential aged care facilities were required to undergo Certification assessments. This was designed to provide a benchmark process in the industry. Over 3,000 facilities nation-wide were assessed. The pass-mark for Certification at that time was 57 out of 100. In Victoria as at April 1999, 75% of high care and 96% of low care facilities had passed Certification. This translates as the failure of 111 high care and 15 low care facilities to reach the required 57 points (Commonwealth Department of Health and Aged Care 1999 (a), p.16).

During 1997, in response to the first wave of Certification results, the aged care industry responded harshly. The industry was vociferous in their claims that independent assessors reports were inconsistent and that interpretation by assessors of findings were subjective. There is a famous case of a building assessor marking a facility down by two points, resulting in their failure. The reason for this related to the nursing home not possessing an animal. The nursing home in question obtained a dog and called it two points! As a consequence of responses to papers produced by the Federal Government
on the Certification process, several major changes have been made in terms of requirements of facilities and consistencies in assessment procedures.

The aged care industry was aware that millions of dollars would be required in capital funds to up-grade the large number of facilities (in Victoria) which failed or stood to fail certification requirements. Businesses were placed in jeopardy. What followed was a range of initiatives sponsored by the Federal Government for which facilities could apply in order to obtain advice on how to reach the Certification benchmark. Underpinning the structural reforms are the accommodation charges for high-care facilities and the financial bonds for low-care facilities, designed to provide the capital for continuous improvement of the physical quality of residential aged care facilities. Accommodation charges were substituted for accommodation bonds in nursing homes (high care facilities) after an enormous political back-lash was generated in late 1997, where the public objected to the sale of the family home to generate the necessary bond monies.

One of the consequences of failure of Certification, which has beset both the Federal government and industry representatives, is the potential fate of residents in facilities that fail and cannot afford to improve their facility. This dilemma prompted the Federal government to promote achievement of Certification through a variety of forms of assistance to industry providers. The benchmark has been re-set from 57 to 60 points and the industry expects the bench-march to move inexorably upwards. If the Federal Government is accurate in their forecast of a growth in the number of discerning individuals in the aged care sector seeking care, then all providers (private and not-for-profit sectors) are forced to compete in new market-driven ways, i.e., by offering superior levels of accommodation.

According to the Commonwealth of Australia, space and privacy requirements are being met or exceeded in facilities which have been built or renovated in the last five years. The trend has been towards increasing the number of single and double rooms available. This would equate with superior levels of accommodation.
1.6 The Purpose of Certification

Key reasons for the implementation of major structural reform in aged care provision by the Federal Government are based on the ability of the growing percentage of ageing Australians to fund their own care in the future, thereby transferring responsibility from the state onto individuals. Notwithstanding political ideological reasons for these reforms, other changes have helped to shift the focus of aged care provision and funding. These include the increase in personal superannuation wealth, the emphasis on providing funding for one's own retirement and societal changes limiting the ability and willingness of families to provide 'in home' care. The Federal government claims the ageing of the Australian population is creating a strong market for high quality residential aged care accommodation. The market consists of a diverse range of individuals who are more discerning than previous generations and who are increasingly willing to pay for the kind of accommodation that suits their needs and preferences (Commonwealth Department of Health and Aged Care 1999 (a), p.1).

This sets the stage for an increasing number of 'Extra Service Places' to be approved by the Federal Government. Extra service places entitle approved nursing home providers to charge a higher rate for extra services, i.e., hospitality and cleaning services, but not nursing services. Issues surrounding the offering of Extra Service Places are taken up in Chapter 5.

Essentially, Certification focuses on improving the physical quality of aged care facilities. Facilities that demonstrate they exceed the essential Certification requirements, are more likely to be those facilities that want to compete for the kind of discerning resident the Federal Government has in mind in its statements.

1.7 Relevant Specifications

The case-study for this research was undertaken in a new building meeting the Certification requirements. The specifications for new buildings differ to those of old buildings, however older buildings will be required to up-grade by 2008. Below are the
relevant Commonwealth Department of Health and Aged Care Certification specifications for new buildings.

**Number of residents per room**
There will be an average for the whole service of no more than 1.5 residents per room. No individual room may accommodate more than 2 residents.

There are many facilities that operate multiple occupancy rooms of up to six beds. These are considered unacceptable in terms of current day expectations.

**Access to toilets and showers**
There will be a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath. These standards will apply to each floor, wing or separate part of a facility to ensure that all residents have the same level of access. Staff toilets and shower will not be counted when these averages are calculated.

There are facilities that cannot meet this requirement, having been built when the orientation to showering was a 'conveyor belt' style, where privacy meant little.

**Resident sleeping space**
Minimum room sizes will not be mandated under certification. However, Accreditation auditors will have regard to space issues relating to access, mobility and occupational safety (e.g., where staff are required to lift and assist residents as part of their work). (Commonwealth Department of Health and Aged Care 1999 (a), p.6).

The overall design of buildings is toward individual bedrooms and limited numbers of two bed rooms, with attached en-suites.

The objective of improving the quality of the built fabric of nursing homes and other residential aged care facilities reflects changing standards and expectations in society. These standards include greater controls on basics such as fire and safety standards, through to increased privacy requirements, reflected in the trend toward single room
accommodation. They also reflect the increased amounts of money available in some sections of the community to put towards aged care. However there are two standards that are less tangible and cannot be measured as can bed numbers in rooms. These are the aesthetics of facilities and the sense of place they give rise to; what might be called the elusive qualities.

It is the specifications detailed above for sleeping and bathing and those of common space within a residential aged care building, that are closely linked to the elements forming the Conceptual Framework, discussed in Chapter 2. These elements are known collectively throughout the thesis as the physical context. They are:

1) the building/physical structure
2) the spaces created by it – formal and informal
   and
3) a 'sense of place'.

I contend that the Certification specifications fail to consider important aspects related to working and living in the nursing home environment, particularly those aspects of the environment which are not tangible and cannot be measured as can bed numbers and rooms. The elements forming the physical context outlined above, take account of intangible aspects of the nursing home environment. Nevertheless, Certification requirements have great bearing on the vitality of an organisation and the general welfare of those who reside there.

Building or renovating facilities to meet the required minimum standards adds to the overall floor area of a facility, increasing distances between key units and service areas for both staff and residents. Increasing floor areas adds another dimension to the carer-resident ratio, as having increased distances to cover reduces the amount of time available to provide direct resident care, by the carer. Most operating budgets in facilities do not provide for an increase of staff numbers when floor sizes increase, which would reduce the resident to carer ratio.
Laudable as the objective of single and two bed rooms may be as a public policy initiative, there are mixed views amongst staff and residents of aged care facilities as to how effective single and two bed rooms are over multi-bed rooms. Views gathered from nursing and personal care staff during my work in consulting to aged care facilities, indicate that single rooms with shared bathrooms are unnecessary, particularly for residents who experience some form of disorienting condition such as Dementia. This view by some staff appears to be directly related to the idea that residents with Dementia are in some way less requiring of a private bed-room as they will not appreciate it in the same way as a resident who is more cognitively able. It appears that staff are making judgements about who is worthy and therefore deserving of a private room. This raises concerns about the staffs views of residents and individuals right to privacy, however their views may well be founded on more practical concerns.

There is also an inherent tension in building facilities with single rooms, between privacy and isolation. This tension exists because private environments for residents are considered by many, at the same time, to be isolating environments. This isolation manifests in two ways. First, single rooms isolate residents from the general activity of the nursing home environment, sometimes leading a resident to live almost entirely in their rooms (the individual's choice to do this can be debated). The second aspect of this isolation is the difficulty staff experience in observing and where necessary supervising residents, as they simply cannot see them. A type of (unforeseen) institutional loneliness may be the result of these newly designed environments.

The functional difficulties associated with the isolation of residents, are a direct outcome of the built environment. Whilst the functional aspects affect the work practices of nursing and care staff, they are also interpreted into the daily life of residents. Both these issues are discussed in Chapters 5 and 6.

1.8 Nursing Home Staff

The largest staff group within a nursing home is the nursing and care staff group. This has responsibility for meeting the physical needs of residents, primarily the hygiene, nutrition and toileting needs. Much of this care is undertaken in facilities that have been
ill designed for the purpose and this results in less than adequate work environments, where injury for both staff and residents is frequent. Other staff groups in nursing homes are smaller in number. They include the lifestyle and activities staff, therapy staff and catering and cleaning staff. The working environment of many nursing homes is also often less than suitable for these staff, with inadequate rooms to work in, lack of storage and meeting space and little privacy for residents or staff. In this thesis it is the nursing and care staff and the lifestyle and activities staff who will receive the most focus.

1.8.1 Issues Related to Staffing Aged Care Facilities

Nursing describes itself as a profession, in that it has a discrete body of knowledge and regulates the entry process, practice and licensing of nurses, under the provision of the Nurses Act. A similar process exists in each state and territory of Australia. A registered nurse must hold an annual practising certificate and their name appears on the register. The nursing profession sees itself as entrusted by the public to practice in a safe manner and to protect the public's welfare. An Australia-wide Morgan Poll found that for the sixth year in a row, Australians have the highest regard for the honesty and ethics of the nursing profession, outranking pharmacists, doctors and school teachers (NBV 1999, p.11).

Nurses' registration boards, however, have no jurisdiction over the largest group of people employed in residential aged care, viz. personal carers or nurse assistants, as their roles fall outside the Nurses Act. This group of staff are generally referred to as unregulated workers, and make-up a large proportion of the daily work-force of nursing homes and other residential aged care settings. This issue is a conundrum for the profession of nursing and the aged care industry as a whole. Within the health care industry, aged care has the greatest difficulty in attracting and retaining staff. Many nursing homes have a high turnover level, operate many shifts with a percentage of 'agency' staff and have little success in attracting Registered Nurses (position in Victoria at the time of writing). Staff shortages in aged care are now recognised as a national and international problem. Casualisation is a work-force factor. Conversely, there are many nursing and care staff who have been long term employees of facilities.
The work of nursing homes is dependent on the physical labour of staff. To many it is not an attractive work option, being as it is about the end of life (and hence death). The industry and particularly the staff describe themselves as members of a caring industry. The roles of each group of staff are tightly prescribed with regard to work practices. Role and task boundaries are literally tangible in some nursing home settings, reinforced by the minutiae of industrial awards, which spell out such things as non-nursing duties.

Nursing homes are unique as organisations. Unlike service industries or manufacturing businesses, the out-puts cannot be measured in a way which provides an indicator about profits or market share. The out-put is death. Therefore the intrinsic reward for staff in this area of health care must be quite different to that of the acute care setting or even community nursing practice. The rewards for staff appear to be derived from optimising the residents daily life experience whilst in the nursing home, and (on occasion) sharing the death experience with the resident and with the family.

The future source of staff for nursing homes and the role both they and nursing assistants and personal carers will play, is in question. Alternative occupations in knowledge based service industries present options for school-leavers, which did not even exist ten years ago. Many of these roles are financially better rewarded than nursing. Couple this with the public image of nursing as a job being described as a glamour-deficit victim (The Australian 20 July 2000, p.1) and the future source of registered nurse staff in particular, is in question.

1.9 Nursing Homes – An Issue in the Public Arena

In Australian society, front-page headline status is invariably given to issues concerning the care and treatment of the aged, more particularly poor care and treatment. During the first half of 2000 all state and national papers have carried numerous articles related to nursing homes and aged care. The impetus for this flood of reports stems from the events at the Riverside Nursing Home in Victoria, which came to the nation's attention for bathing its residents in a bath of diluted kerosene, to rid them of scabies. This practice is considered arcane as a treatment. Public reaction has been dramatic and political decisions soon followed. The Riverside Nursing Home has been closed; residents have been transferred to public hospital beds or other residential aged care
facilities. This incident opened a flood-gate of reports about nursing homes and aged care.

The antics at Riverside Nursing Home seem to have acted as the pressure-release valve for an avalanche of concerns to be reported to the media by families, staff, residents, providers and industry representatives. In turn these concerns are brought to the attention of the community at large.

As staff of nursing homes will attest, the community does not see nursing homes in a positive light. Once made public, the residents of Riverside (and their relatives) have been subjected to national coverage of the nursing home's living environment and standards of care. The anxiety provoked from members of the community and members of parliament by the incident in this nursing home and the fact that national coverage of it was automatic, indicates the depth of emotion within the community and the severity with which nursing homes are measured by the nation. And yet, in the middle of the media furore, and the emotional responses of relatives, a resident of Riverside stepped forward to say she was happy living in the environment. Several times the wonderful care provided by the nurses has been acknowledged and praised by residents and their families.

On-going reporting of the state of Riverside residents continued, with the after-math including coronial enquiries into the deaths of two residents shortly after their (diluted) kerosene bath and revocation of the license for beds and operation of the business by the Federal Government, which the owners are fighting to have over-turned.

The final public chapter in the Riverside Nursing Home debacle appeared on a nationally broadcast current affairs television program. In this program it was revealed that many residents would be re-housed in an outer suburban brand new low-care facility. The Director of Nursing of Riverside would be held accountable for her actions (of approving the use of kerosene) under relevant state nursing legislation and as such stands to lose her registration, thereby stopping her ability to earn a livelihood. Riverside had a history of sanctions being in place and an administrator and nursing consultant had been appointed prior to the kerosene bath incident. However, the owner,
while having his bed license revoked for Riverside, still operates several other aged care
facilities in Melbourne and unlike the Director of Nursing, is unlikely to be held to
account for any aspect of the Riverside Nursing Home's operation.

Between March 1997 and September 2000, a selection of newspaper articles, editorial,
advertisements and cartoons related to residential aged care were collected. Full details
of the articles are located in the reference section of this thesis. The reference list
provides a snap-shot of the issues being addressed in the media, the powerful and
emotive headlines used, what issues were making news and how, over time, many of
these issues continue to re-surface. The time-frame in which these various pieces were
collected includes the reporting of events at Riverside Nursing Home.

Table 1 provides details on the categories of articles, the period articles were collected, a
brief summary of the content of the categories and the number of articles appearing in
each category.

Whilst the information in the table below is drawn from print media sources alone, it
reflects other reports which appeared in state and local newspapers, radio reports and
television programs. Although this analysis is surface level and factors such as
circulation, target-market and media ownership cannot be overlooked, it remains
difficult to ignore a number of facts which stand out from this media source. The
headlines are arresting. Many are emotively phrased, whilst others emphasise political
or bureaucratic shortcomings. Most are negative in tone, blameful and accusatory,
calling providers and politicians to account. The cost of caring for the aged and
financing the system are frequently mentioned. Few are written in a hopeful voice,
although some take a whole of community position on responsibility for aged care.
Letters of response to articles mostly discount claims made in articles and argue that
high levels of care are provided, often without the necessary resources. In short, the
tenor of the articles resembles practices associated with Dickensian times. It must be
remembered that these articles are part of the popular culture, read by the wider
community. Whether factual or not, the articles and representation of issues forges
opinion and fuels feelings.
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<td>Federal Government Responsibilities</td>
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<tr>
<td>Food and Culture</td>
<td>21 March 2000 – 25-26 March 2000</td>
<td>Cost and poor quality of meals</td>
<td>4</td>
</tr>
<tr>
<td>Hospital or Home?</td>
<td>19 July 1997 – 19-20 August 2000</td>
<td>Searching for suitable home; effects of relocation of residents; variable quality of built fabric and home-like atmosphere; hospital or home-like; residents' happiness; standards and Accreditation check and reforms; dementia: building designs.</td>
<td>18</td>
</tr>
<tr>
<td>Staffing or Work Practices</td>
<td>23-24 August 1997 – 28 March 2000</td>
<td>Inappropriate physical and chemical restraint of residents; use of kerosene; shortage of staff and shortage of qualified staff. role of nurses: medication; quality of care; wound care; inappropriate lifting and transferring residents; relationship between funding and quality of care: inappropriate admissions; assaults; shortage of beds.</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 1 Cross-section of Portrayal of Ageing by the Media
In my experience many of the situations and events reported in the media are accurate, albeit sensationalised (for the purpose of sales, perhaps?) Dilapidated buildings do exist where fire and safety issues are of concern and where residents cannot safely move about. Food quality, variety and amounts vary from facility to facility. Daily life of residents can be quite literally boring, with few quality activities planned for the day. Management roles and clinical roles are often blurred, owner-operators frequently confusing role responsibilities and failing to provide adequate funding to resource such things as incontinence pads.

Media reports of nursing home practices draw attention to and make overt reference to what is going on behind closed doors. They reinforce the need for transparency about practices in nursing homes, arguing that it is in the interests of the public for this to be the case. Interventions such as the bathing of elderly people in kerosene reinforce this need for transparency. This is not consistent with contemporary nursing practice and demonstrates that in the case of Riverside Nursing Home, they do not comply with the Standards of Residential Care mandated under the Aged Care Act 1997.

It can be argued that a triangle of relatedness is formed by the community psyche, the reports in the media and nursing homes.

It appears that 'splitting' is evident in the community. Halton (1995, p.13) describes 'splitting' as the process of dividing feelings into differentiated elements. The purpose of 'splitting' is to gain relief from internal conflicts. Children gain relief from internal conflicts by splitting emotions during play, e.g., the good fairy, the wicked witch. Bad feelings are split off and located in someone else. In this case the 'splitting' is occurring at the level of the community. The bad feelings are myriad and include, self-loathing
about ageing, fear of ageing, lack of ability to care for older people. The nursing home is a symbol of all these feelings and what they represent for individuals in the community. The bad feelings are deposited in someone else, as not belonging to the community. In this instance it is the nursing homes themselves, their staff and operators, who should be 'doing good' and in political and regulatory bodies, who should ensure that good is being done.

The overt, negatively oriented representation of nursing homes in the media of nursing homes must exert a powerful force over staff of nursing homes. Potentially, this powerful force may serve two purposes. First it gives rise to (unconscious) feelings such as the dislike of the aged and fear of death, which in turn stimulate social defenses within the nursing home environment. Second, it acts as the catalyst for solidarity amongst staff, who then perceive the nursing home as the best there is, which may be a deflection or denial of public opinion. At the group level, within the nursing home, this second action of generating solidarity in perspective and action, may also reinforce the strength of ties within a group. The milieu of a nursing home requires effective team work and collaboration around a jointly understood task, making it an environment in which identificatory ties in relation to the task, are strong (Long, 2000). Members of the group feel identified with one another. However this state of solidarity and identificatory ties may activate basic behaviour where members of the group hold the unconscious task of defending the group from an enemy (Bion 1961). The enemy in this case is the community on the other side of the boundary, that is, outside the nursing home.

1.9.1 What Do We Want from Nursing Homes?

Given the points raised in this chapter related to buildings, level of care and community expectation, it would seem reasonably straight-forward to list what is wanted from nursing homes; the concerns having been made apparent through the media articles. Comments garnered from interviews with residents during the case-study for this thesis revealed a negative perception about nursing home environments. Residents expressed a preference to live at home and noted that prior to entry, a nursing home is the last place to which you would want to come. Considering the (frequently) distressing re-location of someone from their home or hospital to a nursing home, the ever-changing faces of
staff and the negative perception held by the community about nursing homes, what then do designers, staff and family consider is the primary task of a nursing home? Is it a place to live in or a place to die in? How is this influenced by the physical context? These questions are explored in Chapters 5 and 6.

The following extracts from an article in *The Weekend Australian* (March 4-5 2000, p.7) provide an insight into the selection and assessment of nursing homes and nursing home care. It also demonstrates the articulation of the building in the choices. The extracts are from an article about a woman seeking care for her mother, that she believes she finally found after moving her to a fourth nursing home. One which has only twelve rooms and is only half occupied.

> It was a dispiriting journey. There is always a discrepancy between the exterior of a home and interior, with many smart on the outside and hospital-drab inside. But even the most luxurious can be sad and depressing.

> My mother was horrified by the first two she entered. The first was clean but soul-less - a square of corridors with nowhere to sit, talk and watch the world go by. The nurses were quiet and passive, unable to understand that my mother’s primary need was for companionship.

> The next was as luxurious as a five-star hotel but for my mother it was a hellish prison. She was bothered by a man who insisted she knew his wife and was shouted at by an aggressive night nurse to get back into bed when she wanted to go to the toilet. When I visited, she could not even raise a smile.

> The problem for my mother was that, despite her dementia, she was still lucid. But she needed more care than was available at a retirement village.

> Late last year a place came up at a nursing home that seemed okay - an old house with a veranda where residents could sit in the sun. It was a disaster. She had hallucinations and her anxiety became crippling. The nurses, who hid in staff rooms, had no idea how to help her.

> I had almost given up hope when I read in the local paper that Aged Care Services Minister, Bronwyn Bishop had just opened a home in the next suburb. After visiting a dozen or so homes, I think I know what makes this such a special place - the skill and spirit of the nurses. They are happy and laughing. They talk to the residents, even the gaga ones, on equal terms. And they are incredibly patient, ensuring that whatever skills remain are used.
The staff have shown their true colours in recent weeks, since my mother fell and fractured her hip. One sat with her for 90 minutes helping her to feed herself with a spoon, so that she didn’t lose the skill.

All this comes at a price, of course. The weekly fee is about $900, which no doubt is why the 12-room facility is still only half-full. But for my mother, it is, if not happiness, then comfort and safety.

Inherent in the comments of this daughter searching for a suitable nursing home are several of the issues which are addressed in this thesis. They include –

- the tension between a hospital environment and a home environment;
- the dubious notion that a good building equates with good care and vice-versa;
- the expectation that an attentive, skilled and caring staff group will be provided;
  - the expectation that lifestyle, activity and therapy services will be available;
- the expectation that a high level of care will be provided;
- provision of suitable personal space for the resident and for staff.

The extracts from the article above, demonstrate that it is not practical to argue that a good building means good care. A recently (so-called) purpose built nursing home, may be judged to be a less caring environment by residents, families and authorities, than the shabby old building, where any available space is used to store equipment. It is not the equation of good building=good care or the reverse, bad building=bad care that is being argued in this thesis. Rather, it is the physical context, which includes the building, the spaces created by it and the sense of place it evokes, that is being considered in the light of the organisation culture of nursing homes.

1.10 Chapter Arrangement

Briefly, the thesis is arranged as follows:
In Chapter 2, Conceptual Framework and Theoretical Perspectives, the Conceptual Framework which evolved from a study of the relevant aged care literature and my observations and experience in the aged care field is presented and discussed. The Conceptual Framework is applied to findings in Chapter 6. The theoretical perspectives
are drawn from organisation theory and psycho-dynamics that together are applied to
analysis and discussions in Chapters 5 and 6. In Chapter 3 - Method, the choice of
qualitative research design and the research process is discussed. This includes
discussion of the case-study method. In Chapter 4 – The Case-Study Venue, detailed
descriptions of organisation and physical aspects of the venue are provided. Included in
this chapter are floor-plan details to guide the reader through Chapters 5 and 6 of the
thesis. In Chapter 5 – An Analysis of the Nursing Home Culture, the findings from
the data related to the culture of the environment are discussed. In Chapter 6 - An
Analysis of the Role of the Building in Organisation Culture, the Conceptual
Framework is applied to findings from the data. Links are drawn between the culture
and the building. In Chapter 7, Conclusion which forms the final chapter I draw
together the origins of the thesis, the significant findings related to the culture of nursing
homes and discuss the veracity of the Conceptual Framework as a model for use in other
nursing home settings. The chapter closes with reflections on the research process, my
learning from the experience and the potential benefits to others arising from the
research.
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Chapter 2  
Conceptual Framework and Theoretical Perspectives

2.1  
Introduction

This chapter is integral to the thesis as it provides the foundation for the conceptual basis for analysis and discussion of findings presented in Chapters 5 and 6. In this thesis it is argued that the physical context of most existing nursing homes is conducive to a routine-task oriented culture which favours staff, whilst residents needs with regard to lifestyle and 'a sense of place' are overlooked and further, that residents introject the routine-task oriented culture. In the preceding chapter, 'Introduction and Rationale for the Research' this argument was introduced through the discussion of current expectations of nursing home buildings that focus on functional aspects of design and the meeting of certain (prescriptive) standards, related to such things as residents bedroom size.

In this chapter, the structure of the argument is further developed beginning with the importance of the physical context of the nursing home building and in particular the aspects related to space and lifestyle for residents. This discussion is followed by an exploration of organisation culture that is preceded by my contention that nursing home culture is best described as a routine-task oriented culture. These two aspects form the platforms of the argument. Joined with this discussion of organisation culture are psycho-dynamic theories that are applied to develop the argument further, alongside the research findings and discussion that follow in Chapters 5 and 6. These psycho-dynamic theories deepen the understanding of the dominance of the culture, as well as the meanings ascribed by various groups to the physical context of the building; these groups being the architects, the community, the residents and the staff.

Prior to a discussion of the Conceptual Framework, it seems important to define why I set out to explore a research question in which 'the building' is pivotal. It is probably best said by Livesey (1997, p.25) in an article which explores Ricoeur's theories of metaphor and narrative, as they pertain to architecture. Livesey makes the point that
architecture can be understood as works of human making, which are designed, constructed, inhabited and interpreted; architecture shapes spaces in which human actions unfold'. A nursing home is the work of human making, for habitation by individuals (who are collectively referred to as residents) who along with the staff and relatives are affected by the shaping of space where their human actions unfold – their interpretation and re-interpretation of the spaces. In which case, a life lived in such a building, or more precisely a life ending in such a work of human making, warrants attention and illumination of factors involved. In this thesis this will be the extent of the incorporation of Ricoeur's theories, as the research is constrained by the original design as well as overall length requirements.

2.2 The Conceptual Framework

The Conceptual Framework was formed from a synthesis of areas, these were:
(1) observations in the field of aged care by myself as a researcher, practitioner and consultant;
(2) contributions from the literature related to architecture and aged care provision;
(3) questions associated with each of these areas.

The purpose of the framework is manifold. Initially, its design was an attempt to visually represent the spheres or domains I wished to explore in the research and which form the core of the thesis. It also served as a method for managing information and ideas related to these spheres. This led to its use as a technique for coding of the data obtained from interviews with architects and data gathered in the case-study of a nursing home.

The Conceptual Framework comprises three elements: the first element is the building, the actual physical structure that forms the nursing home. The second element is the spaces created by the building. These spaces may have been created intentionally, e.g., as in the formal placement of a sitting area in the building design or unintentionally, e.g., where residents or staff take a space and create an informal sitting area in it. The third element is the one element that is intangible in this framework. It is the concept of 'the sense of place'. This is best described as a perception or feeling held by residents
and others about the nursing home and themselves in relation to it. This sense of place may form a reciprocal relationship, generated by the environment, between the resident and an aspect of the environment.

![Diagram of the Three Elements of the Conceptual Framework]

**Figure 2  The Three Elements of the Conceptual Framework**

The elements of the Conceptual Framework are overlapped deliberately because not only does one element give rise to another beginning first with the building, the elements often times appear inseparable in terms of one's influence upon another. In interviews conducted for this research, this first element was simple enough for people to relate to, however, it seemed the case that the other two elements were at times indistinguishable but none the less important to them.

Livesey (1997, p.25) depicts the importance of the inter-connectedness amongst the three elements portrayed in the Conceptual Framework when he states 'the work of architects tends to concentrate on the formal and constructed, often neglecting the intangible and the elusive, or the way in which people inhabit and use buildings and the spaces they encompass'. Clearly Livesey is bringing to our attention the perspective an architect may take in the design of buildings, whilst also focusing on the elements arising from the physical structure.

This inter-connectedness amongst the elements is demonstrated in the following passage taken from the autobiographical work White Cargo, written by the actress Felicity
Kendal (1999, pp.311-312) where she is writing about visiting her father who has experienced a stroke and now lives in a nursing home.

Collecting my paper, I ring the bell. The door is buzzed open. After a quick 'hello' at the reception, I'm on my way, up the four flights of stairs. Past the tiny lady with the tiny dog, past the sad one in the chair. Up and up again. It's lunchtime and saintly nurses are delivering trays of 'school' food: stews and cottage pie, rice pudding and custard. Comfort food, all easy to chew. The doors to the rooms are always open, and the televisions' relentless activity flickers over the old bent heads.

At the top floor, pushing through the fire door on to the far landing, I pass the lovely lady with the cat asleep on her bed. The lady sits in a chair staring at the door. I wave a greeting and go on past the bathroom of amazing contraptions: handles to hold on to, chairs in the shower cubicles, lavatory seats to fix on – the trappings of the infirm, making the spacious room resemble an eccentric gym filled with pulleys and alarm cords. And at last I am at your open door.

The pictures on your walls: your favourite watercolour, a sketch from your first job, an oil painting I gave you years ago – all futile, pathetic attempts to make this room your home. The pinboard is looking a bit sad. The photograph of you on your seventy-fifth birthday is curled at the edges, and the snap of holding your great-grandson in your arms with such tenderness reminds me of how vibrant you were and how you nearly always wore a smile in the years before... Birthday cards from a couple of years ago are still pinned up, and framed photos of Jennifer's children and mine are balanced on the shelf.

It's a cosy room, a kind room, but I am filled with a quiet panic when I think it will be the room you die in. After all the marble palaces, the gilded monuments, the hotels and dak [sic] bungalows, that it should come to this – to die in an old people's home, however wonderful, is so very sad.

But for the moment you are still with me: still staring, still silent, but still here. And once again I start my banal prattle: 'I'm here, darling, how are you? It's Foo, Daddy...’

In this passage aspects of the physical characteristics of the building are conveyed so that an understanding of the physical lay-out of rooms, corridors and service areas is established. The actual room occupied by the resident is presented as a space that is a
little pathetic and in stark contrast to the life led. The sense of place one takes from the passage is sad and desolate.

2.2.1 The Building

Figure 3 The Building – the first element

Although they are inanimate, buildings are none-the-less as influential as people. A relationship is formed between a building and its immediate 'external' environment, that is, the local community, the natural environment and other buildings and between its 'internal' environment, its occupants. Buildings can be welcoming or alienating. They can elicit a range of emotions in relation to their appearance and in association with their specified use. These emotions can range from triumph to derision. Their internal spaces can be used to delineate activity to mirror the primary task of the occupants. They become inextricable from the purpose for which they have been designed. I contend they are powerful role shapers of their occupants.

From the themes discussed in Chapter 1 'Introduction and Rationale for the Research', it is evident that the actual physical structure of the building itself has meaning for several groups: the in-coming resident; the family of the resident; the staff; the architect of the building and the wider community. The meaning conveyed by the building to each of these groups may vary. When these meanings are transformed into expectations of the nursing home's role, each group may hold different and possibly conflicting interpretations of the primary task of the physical environment of the nursing home. The building is a manifestation of meaning imbued by the architect and each of the groups mentioned above.
In the aged care literature on 'physical environment' and 'built fabric' discussions are often limited to design specifications, building regulations and the adequacy or otherwise of these. The primary issues of concern are the functional aspects of care giving and safety for residents, staff and visitors. Hence issues such as room size, ratio of residents to toilets and showers, non-slip surfaces, placement of door-handles and hand-rails receive great attention (Commonwealth Department of Health and Aged Care 1999 (a); Wells and Evans 1996). These are rightly critical issues in the operation of the nursing home business, however physical environment or physical structure is only one dimension of the 'built environment'.

Buildings have two faces: their external face to the external world, the one viewed by passers-by and the general community, while their internal face forms an internal world. The building creates a relationship with its surrounding environment, which may include other structures, adjacent buildings, the community and the natural environment. The extent to which this relationship influences any of the aspects of the Conceptual Framework is not clear, however it is well known that many built environments do not live in harmony with their neighbours, from a design point or the aesthetics. An unhappy marriage with the surrounding environment may influence the perception of the environment by residents and staff. In terms of the general public there seems to be a strong opinion that a building should be smart in appearance with well tended grounds. Refer Plates A, B, C and D pp. 29-30, for examples of 'The Building'.

2.2.2 The Spaces Created

THE SPACES CREATED

Formally or informally created/
Intentionally or unintentionally used

Figure 4 The Spaces Created – the second element
The second element is the spaces created by the physical structure. These spaces can be both formally created by the architect in the design of the physical structure and informally by those who live and work there, and those who visit. They may both be used intentionally or unintentionally. These spaces may be inside or outside the structure and are often designated (although not always consciously) as private spaces and public spaces. There are numerous examples of how people shape spaces to suit themselves. Take for example the re-arrangement of chairs and tables to get the best view, or to sit in the sun. Often in a work setting staff will re-designate storage space for equipment where it concides more appropriately with the work flow, leaving the intended space unused. And people will be innovative, see the following photographs for examples of this in residential aged care environments. Refer Plates E,F,G and H, pp. 31-32, for examples of 'The Spaces Created'.

2.2.3 A Sense of Place

![A Sense of Place](image)

Figure 5 A Sense of Place - The Third Element
The third element is that of a 'sense of place'. The physical structure of the building is tangible as are many of the spaces created by it. 'A sense of place' whilst emergent from the elements of physical structure and spaces, is an internally designated concept in the psyche of an individual, owned by them and having a private meaning understood in its entirety only by them. It is akin to what Willcocks et al. (1987, p.4) refer to as 'the metaphysical, the meaning and significance ascribed by individuals and communities to home'. Refer Plates I,J,K and L, pp. 33-34, for examples of 'A Sense of Place'.

These three elements, the building or physical structure; the spaces created; and the sense of place form the Conceptual Framework. The Conceptual Framework was incorporated into the interview framework for interviewing architects and re-configured for use in interviews conducted in the case-study of a nursing home. Its use in this
research is described in Chapter 3, Method, and it is applied to the analysis and discussion of findings in Chapter 6.

Refer Figure 6 page 35, which depicts the Conceptual Framework Schema in full.
Plate A - Example of 'The Building'

Plate B - Example of 'The Building' with adjacent housing
Plate D - Example of The Building - covered walkway for residents, staff and

Plate C - Example of The Building with adjacent open area
Plate E – Example of 'The Spaces Created' – formally created space, intentional and unintentional use

Plate F – Example of 'The Spaces Created' – corridor with recreational area, formally created space with intentional and unintentional use
Plate G - Example of "The Spaces Created" - Secure Resident Unit, formally created space, intentional use

Plate H - Example of "The Spaces Created" - a staff area, informally created
Plate I - Example of 'A Sense of Place' - resident's room

Plate J - Example of 'A Sense of Place' - available bench space in room
Plate K – Example of 'A Sense of Place' – shared living

Plate L – Example of 'A Sense of Place' – symbols of the setting
What Role does the Building Play in the Organisation Culture of Nursing Homes?

The Built Environment (Physical Context)

The Architect/Designer
- The Resident
- The Staff
- The Family/friends

The Building
- The nursing home building/physical structure

The Spaces Created
- Formal and informally created spaces/intentionally or unintentionally created

A Sense of Place
- A perception or feeling held by residents and others

**Figure 6 - The Conceptual Framework Schema**

**The Building** - The architect in initial design phase. Residents, staff, family and friends.

**The Spaces Created—formal and informal** - The residents, staff, family and friends. Architect in initial design phase.

**A Sense of Place** - The residents and others

**Description**
This figure of the Conceptual Framework provides a schema which links the research question with the four groups who have a two way relationship with the built environment of the nursing home. These groups are the architects, the resident who lives in the nursing home, the staff who work in the nursing home and the family and friends who visit the nursing home. The three elements which form the Conceptual Framework are depicted in the centre, while the list below the elements highlights which groups are most closely linked with each element.
2.3 Theoretical Perspectives

This thesis explores the dynamic amongst staff and residents, generated by and within the physical context of the nursing home environment. As a way of describing and analysing this milieu, I shall draw on literature from the field of organisation culture and psycho-dynamics. The purpose in drawing from the field of organisation culture is to facilitate mapping of the key factors in the culture of both the social and physical environments of the nursing home setting. Organisation culture is about the social enterprise of the organisation, which extends to and incorporates aspects of the physical setting. Discussing the organisation culture of the nursing home environment is a central component of this research and acts as a platform, without which it would be difficult to analyse the findings with regard to the relationship and importance of the physical environment.

However organisation culture alone is inadequate to fully address the findings of this research. Most contributors to the field of organisation culture and even organisation behaviour, do not venture into the deeper dynamic of organisation functioning, that is, the unconscious and hidden aspects which can permeate all operations: the psycho-dynamics. In order to deepen the cultural analysis and discussion which appears in Chapters 5 and 6, I draw on relevant theory from the field of psycho-dynamics.

2.3.1 Organisation Culture

A single, universally accepted definition of organisation culture is hard to find. Rather, the literature reveals that organisation culture is constituted by many factors, which include documents, stories, buildings and spaces, mutually understood behaviour and practices amongst staff groups.

2.3.1.1 Nursing Home Culture

I contend that the nursing home culture is best described as a routine-task oriented culture. In brief, I mean by this that the focus is on the completion of tasks rather than on the relationships occurring between people i.e., staff-residents, staff-staff, staff-visitors. I will explore this further in Chapters 5 and 6. The purpose in examining the
specific culture in the nursing home environment in this research, is to explore the manner in which the building plays a part in contributing to this culture. In turn this exploration helps lead toward what is missing in the culture and how the building supports this. The term, 'routine task', refers to the scheduling of repetitive day-to-day activities associated with maintaining optimum hygiene and nutritional status of residents. In association with this are the activities which focus on contributing to the residents lifestyle and well-being, which are generally scheduled for week-days fitting in around meal and shower times. Staff groups are organised along functional lines with nursing and personal care staff attending to the Activities of Daily Living - the nutritional and hygiene needs, lifestyle and activities staff attending to the psycho-social aspects of care and therapeutic interventions and domestic staff undertaking meal preparation and cleaning and laundry. All staff are in uniform, however the different staff groups are often indistinguishable to residents. Apart from outings, activities take place in physical settings designed in favour of the completion of routine tasks, generally those related to personal hygiene, nursing and personal care needs. Ritual plays a strong part in the routine task oriented culture.

2.3.1.2 Working definition of organisation culture for use in this research

For the purposes of this study I will examine culture as those interactions occurring between people (i.e., the social enterprise) that are mediated by organisational task, organisational boundaries, organisational defenses against anxiety and the interaction between these and the organisational holding environment. The terms used in this working definition will be examined below and the theories examined will form a basis for the working definition. Refer to Figure 7 page 68, 'Conceptual Framework Schema with Culture Dimension Included'. This figure incorporates the Conceptual Framework discussed earlier in this chapter with the working definition of 'Culture' described here.

The writings on organisational culture have canvassed such aspects of organisational life as rituals, folklore, symbols and artefacts in an attempt to describe and map organisational life. Much of the purpose for doing this has centred on identifying ways to measure the health and appropriateness of a culture in order to influence it. Schein (1997), amongst others suggests that the importance of culture lay in the need for
managers (and others) to understand their organisation's culture, in order to implement change processes. These change processes range from the small scale re-structuring of departments to major re-definition of organisational primary task.

2.3.1.3 Contributions on Organisation Culture from the Literature

Schein (1997) developed a model for determining organisation culture. The model entitled, 'Levels of Culture', comprises three parts, (i) artefacts, (ii) espoused values, and (iii) basic assumptions. There is a degree of correlation between the levels of Schein’s model and the Conceptual Framework I have designed, particularly in relation to the level of artefact. Schein writes that at this level artefacts include

all the phenomena that one sees, hears, and feels when one encounters a new group with an unfamiliar culture. Artefacts would include the visible products of the group such as the architecture of its physical environment, its language, its technology and products, its artistic creations, and its style as embodied in clothing, manners of address, emotional displays, myths and stories told about the organisation, published lists of values, observable rituals and ceremonies, and so on.

It also includes the visible behaviour of the group and the organisational processes into which such behaviour is made routine (p.17).

The espoused values are constituted by 'strategies, goals, philosophies' (Schein 1997, p.17). They are the articulated, publicly announced principles and values that the group claims to be trying to achieve, such as 'product quality' or 'price leadership' (p.9), as would be the case in sales or manufacturing industries. In a nursing home setting it would be expected the espoused values would aim at providing the highest level of care for residents and treatment of all residents as individuals. The basic assumptions level of the model represents those beliefs, which are held by all members of a group and act to provide cohesion in the thinking. Schein states that 'basic assumptions defines for us what to pay attention to, what things mean, how to react emotionally to what is going on, and what actions to take in various kinds of situations' (p.22). We are in turn 'comfortable with others who share the same set of assumptions and very uncomfortable and vulnerable in situations where different assumptions operate either because we will
not understand what is going on, or, worse misperceive and misinterpret the actions of others' (Douglas 1986 in Schein 1997, p.23).

During the 1980's contributions to the management literature on the topic of organisational culture peaked. During the 1990's fewer specific references to the importance of organisational culture are to be found, replaced with so-called new management topics espousing new techniques for improving organisational effectiveness. Even in 1985, Kilman, Saxton and Serpa in an article where they defend corporate culture studies from being considered as faddish, then go onto suggest that corporate culture having been the rage for years, may well give way to some new 'hot' management topic. They trace a connection across the human side of organisations from the initial human relations movement in the 1940's and 50's, suggesting a slow evolution and relationship with organisational culture. The relevance of organisational culture seems to have been embraced by theorists and managers and more recent articles incorporate culture as one amongst many themes, attending to it now on an implicit, rather than explicit basis.

Stapley (1996, p.9) writes that 'organisational' culture is seen by many writers to be a unifying force which is tangible and can be viewed by management as a controllable variable for manipulation in achieving organisational effectiveness. Stapley himself (1996, ix) writes that 'organisation culture is a complicated phenomenon that cannot be reduced to a simple definition of some or all of the symptoms'. He considers it is important to examine both the conscious and unconscious processes in organisations and that to date definitions of organisation culture have failed to include both. This view is consistent with the approach taken by Czander (1993) who considers the culture of an organisation to be an ambiguous concept, one which is largely concerned with the employee's feeling state. He sees a strong relationship between the task of an employee and a supportive environment, which give rise to an effective sentient life. Czander suggests that this is where the importance of the organisation's culture rests, on its ability to either support or destroy the sentient life that supports the task (of employees).

In gathering the data for this research, the cultural domain of the nursing home environment is described and the meanings of certain acts, activities and the role of
artefacts are brought to the foreground for consideration. This coverage is consistent with the work of Smircich who in summarising five dominant themes in organisation culture research suggests those of cognition, symbolism and unconscious processes, treat organisations as cultures. This deviates from the contingency framework of comparative management and corporate culture, which treat culture as a variable. Smircich suggests this represents a shift where 'culture is no longer what an organisation has, rather, it represents what an organisation is' (Smircich 1983a in Smircich & Calas 1987, p.233 in Jablin et al. 1987). This notion of what an organisation is aligns with Kilmann et al. (p.422) description of culture as the social energy that drives - or fails to drive- the organisation. It is this social energy which I am trying to delineate.

In a contribution to the sphere of economics and nursing homes, Bond and Fiedler (1999) argue that major changes will be required in traditional nursing home culture in order to meet the growing pressure for the dual needs of cost effective and resident focused care provision. In their study they examine the importance of a social versus a physical intervention in promoting the well-being of residents in a long-term care institution (p. 38). To measure the effect of the interventions part of the study required the creation of an organisation culture scale. In summary, this consisted of measuring staff satisfaction, quality of care and the organisation's mission in terms of how well it interfaces with its environment. Amongst their findings they suggest that spending money on architectural renovations in long-term care settings must be matched with resourcing of leadership development and consensus building for administrators or staff (p.42). Bond and Fiedler (1999, p.43) state this attention to leadership is required to effect changes desired by the organisation. Without effective leadership at the first-level leader position, 'even very drastic and expensive changes in the physical environment appear to have little benefit on the unit's organisational culture'

This article demonstrates not only the interest in providing physical environments which are more suitable to the requirements of long-term care residents and less hospital like in design, but also highlights the inter-relationship between organisation change, culture and leadership.
2.4 Psycho-dynamics in Organisations: Selected Theories

Most theories associated with the psycho-dynamics of organisations originated from studies which focused on the individual and were later applied at the organisational level, to gain greater understanding of organisation functioning, which is the objective in conducting this research. Schein (1997, p.23) notes that it is when basic assumptions (as in his model) are challenged that anxiety and defensiveness are released. This is what I am trying to elucidate. Schneider and Shrivastava (1988) in an attempt to identify links between the individual level of analysis and the organisational level of analysis in relation to organisation culture, provide a detailed analysis of basic assumption themes. They incorporate the work of Schein (and others) and extend it by discussing individual, group and organisational dynamics, suggesting that ‘the sources of basic assumptions are the psychodynamics created by the interaction of conscious and unconscious forces at each of these levels’ (Schneider and Shrivastava 1988, p.494). They incorporate Bion’s basic assumptions behaviours (p.496) within their discussion and ultimately develop a schema of organisational basic assumptions. Their objective was to uncover basic assumption themes in order to interpret strategic behaviour in organisations.

The specific psycho-dynamic theories which are applied to discussion and interpretation of findings in this research are, the theory of Social Defenses which develop in order to mediate role anxiety (Menzies-Lyth 1988; Hirschhorn 1995), the concept of the Organisation Holding Environment (Bridger 1990; Stapley 1996), which supports development of individuals, the organisation's definition of its Primary Task (Rice 1963), that which the organisation must perform to survive and Boundaries around task systems inclusive of social as well as physical aspects of the organisation (Miller 1993). Each of these is discussed in greater detail below.

2.4.1 Defensive Techniques

Organisations, groups and individuals within the organisation can each develop defenses in response to the anxiety generated by the work required of them (Hirschhorn 1988). According to the psychoanalytically oriented cultural anthropologists, at the level of the organisation, organisational structure is established to defend against the primitive
anxieties associated with libidinal and aggressive wishes that are aroused within the context of work. Further, the organisation structure itself is established to function as a defence. Thus structure is established first to reduce the anxiety associated with the primitive wishes that are aroused and then to defend against the greatest dread – conditions of anarchy and the absence of structure (Czander 1993, p.106). Czander (1993, p.110) agrees with Menzies position that social defenses are necessary, because they allow employees to work on their respective tasks and to make this work tolerable. When social defenses are excessively relied upon they may contribute to dysfunctional forms of ego functioning and even to pathological conditions (Czander, 1993 p.111).

Social defense theory refers to a socially structured defense mechanism for defending the individual or group from anxiety related to the task. Hence the term social defense against anxiety. Jaques (1955 in De Board 1995, p. 117)) suggested that within an organisation the defense against anxiety is one of the primary elements that bind the individuals together.

Social defenses can be many, however the whole purpose is to reduce or eliminate the anxiety of an individual, group or whole organisation. Stapley (1996, p.63) writes that 'the characteristic feature of the social defence system is its orientation to helping the individual avoid the experience of anxiety, guilt, doubt and uncertainty'. Menzies (in Czander 1993, p.109) and Stapley suggest social defenses develop overtime, often as the result of collusive interaction and agreement at an unconscious level amongst the members. These social defenses then became taken for granted by the older members of the institution and new members must come to terms with them.

The key point about social defenses is that the defenses are unconscious. Czander (1993, p.110) writes that the precondition for the development of a social defense is the collective experience of anxiety, given that social defenses are considered to be nothing more than a collectively agreed upon process, similar to shared beliefs and values. This latter point resonates with Schein’s model of Levels of Culture at the third level, that of unconscious, taken for granted beliefs.
According to Czander, a social defense originates in response to the collective experience of anxiety, when one member of a group articulates a way or a process that can be used by everyone to reduce the experience of anxiety (p. 110). Czander states that employees defend against the anxiety associated with the unconscious libidinal and aggressive wishes by utilising defenses such as denial, projective identification, splitting and projection (1993, p.106).

Two major contributions to the literature on social defenses came from work conducted in health care settings and hence both are relevant to this research. The first is the (frequently cited) study by Menzies in 1959 of nurses in a large metropolitan teaching hospital in London (1988). The second is the work by Miller and Gwynne (1973) in residential settings for people with disabilities. Menzies identified that nurses consciously agreed to engage in the behaviours associated with the defense of depersonalisation, this becoming part of their behavioural repertoire. Czander (1993, p.110) states that 'Menzies claims that this defense is used to reduce the anxiety associated with libidinal and aggressive wishes which are evoked when the nurses are required to perform tasks in a certain manner'.

Miller and Gwynne set out to analyse the culture and practice of residential environments that care for the physically handicapped and young chronic sick, in terms of social defense mechanisms (De Board, 1995 p.125). In their view, intense anxiety and stress must be created which affects the staff and the inmates. This anxiety they attributed to the task assigned by society to an institution of this type. 'The task that society assigns – behaviourally though never verbally – to these institutions is to cater for the socially dead during the interval between social death and physical death' (Miller and Gwynne in De Board 1995, p.125).

Czander (1993, p.111) notes that Travelbee (1974) and Menzies both conclude that irrevocable and profound change occurs when a (generally) young woman enters nursing and is confronted with her own sense of vulnerability. Nurses are exposed to illness, suffering, and death, which precipitate a number of behavioural responses to anxiety and they may become indifferent, detached, or facetious.
Whilst Menzie's work took place in an acute care facility, essentially it still contained the elements of staff providing nursing care on a twenty four hour basis as did Miller and Gwynne's work. Their work was located in residential environments, i.e., that which forms a permanent home. The latter point is particularly relevant to this research, because nursing homes become the permanent and last home for those who live there. They also offer nursing care on a twenty four hour basis, often to populations which include residents who are young but permanently disabled (author's consultancy experience of conducting Residents' Satisfaction Surveys, 2000). In nursing homes, as in both Menzies and Miller and Gwynne's settings, distasteful tasks must be performed. These include cleaning up urine and faeces and doing dressings on wounds that may show no signs of healing, and the handling of people as they die and after death. Menzies Lyth (1988) in referring to an article of 1970, states these external realities, stimulate powerful anxieties in all nurses to do with unconscious phantasies of ill, injured, dying and dead people. Additionally staff may work with residents whose level of dementia means they behave not only erratically but also dangerously. Lastly, nursing homes may offer specialised palliative care, which requires high level clinical skills coupled with an ability to tolerate residents' need for a high level of pain control and often spiritual support and engagement. The social defenses which staff groups develop in the nursing home setting in order to conduct their work, are discussed in Chapter 5.

### 2.4.2 Holding Environment

As stated earlier, psycho-dynamic concepts and theories in this research are applied at the organisational rather than the individual level, from whence many were first established. Another psycho-dynamic concept is that of the 'holding environment'. This concept developed from the work of D.W. Winnicott (1971) with infants and mothers. Winnicott described the holding of the infant and the provision of a facilitating environment as central to development. The concept illustrates how the 'holding environment' between the developing infant and its mother is fundamental for successful adult maturation. This initial 'holding environment' expands to include the family and later, the many environments one enters in adult life. The notion of holding is more than the physical as in the holding of the infant, it also includes the boundaries created initially by the mother, to facilitate appropriate development of the individual.
This development, described as the ability to integrate and differentiate in order to both develop and protect the self, are continued throughout adult life, but it is at the infant-mother relationship level that the importance of a holding environment is first made evident.

Stapley (1996, p.157) writes of this holding environment as being made possible by the mother doing the right thing at the right time: that is when the baby is ready for it. She provides the context in which development takes place. Therefore, where the infant and later growing adult experiences the holding environment as 'good enough', that is, not perfect but able to sustain appropriate development by the individual and where basic trust exists, the individual will achieve mature dependence.

Stapley (1996) writes extensively on organisation culture from a psycho-dynamic perspective. He is of the opinion that any organisation wishing to develop a task culture (and presumably anyone analyzing a task culture) should pay particular attention to the holding environment and to how members perceive it. Anyone wishing to positively influence the culture should aim to ensure a mature situation (p.160). It would appear that leaders, strategies and structure, and numerous other elements of organisation specific artefacts and activities, must be considered in an analysis of the holding environment of an organisation.

Czander (1993, p.67) draws on the object relations theorists 'good enough', environment and posits the view that the organisation and its authority structure can be viewed as nothing more than a symbolic recreation, or representation of aspects of the early-parent child relation. 'As a symbolic parent it must be good enough to buffer its employees from the dangers associated with power, authority, termination, loss, deprivation and the employees' own internal conflicts' (p.67). In Czander's view this is difficult for any organisation to achieve, for a variety of reasons. Whilst Stapley (1996) is not in disagreement with Czander he expounds on the existence of the organisational holding environment more extensively, suggesting that members of an organisation relate to an organisational holding environment in the same way that the infant relates to the maternal holding environment. If the holding environment is 'good enough' that is if the primary task is clear enough and achievable, the culture that develops will be task
supportive. 'However, where, for any one of a variety of reasons, the holding environment is not good enough there may be regression or an anti-task culture' (Stapley 1996, p.148). Where organisational holding environments are perceived to be good enough for group members to have basic trust, then progression occurs (Stapley 1996, p.148). Organisation members will have a basic trust and a state of mature dependence will exist, making it possible for co-operative relationships to exist between organisation members and the organisation holding environment (Long, Newton and Dalgleish, 2000).

2.4.3 Primary Task and Boundaries

In the discussion of the holding environment reference was made to both primary task and boundaries. All organisations are designed to perform tasks and these tasks are represented in the formally depicted organisation structure. These organising principles are embedded in open systems theory, which Miller & Rice (1967) describe as importing of raw materials across the boundary of the organisation, conversion of the raw products and then export of these. Here the individual work units can be identified and the inter-relationship they have with each other is reflected in a series of interconnected lines. The tasks of each of the work units ultimately serve the overall primary task of the organisation, which is the quintessential reason for the organisation's being.

In order for each work unit to undertake its task, the system each unit comprises is delineated by boundaries. According to Czander (1993, p.233) 'Dysfunctions within any given task system (the place where the task is performed) which make it impossible to perform the task optimally, are a function of the ambiguity found in these boundaries. Trying to locate and define boundaries around a task is difficult and complex'.

Rice (1963, in Czander 1993, p.234) views the organisation as having two major subsystems: the operating subsystem where the actual conversion of work takes place - inputs to outputs - and the managing subsystem, which is external to the operating subsystem but has the responsibility of managing and regulating the boundaries of the organisation. The managing subsystem co-ordinates the work of individual sub-systems and their relationships to other systems and how these other systems support and
constrain the tasks. It is the constraining of the task amongst subsystems which is critical when looking at the organisation as a whole, as these efforts constantly detract from achievement of the primary task.

Task and boundary are closely aligned. Czander (1993, p.212) states that each boundary between every system offers opportunities for either collaboration or conflict. Ferguson (1968, in Czander 1993, p.212) considers that the interface between systems and subsystems (i.e., between its parts), is either welded and linked or stressed and broken. Czander provides four types of boundary management within the organisation and its subsystems, which should be assessed. In brief these are, regulation of the task system boundary (inputs, conversion and outputs); regulation of the sentient group boundary (including role and division of labour); regulation of the organisation's boundaries (presumably internal and external) and regulation of the relationships between task, sentient and organisational boundaries (p.212). Czander is very clear about the connection between the emotional life of the members of the system, noting that group members' emotions and feelings will affect their perception and response to work and organisation activity.

In Chapter 5 the primary task of the nursing home as perceived by the staff and a relative of a resident, is discussed. Boundaries around tasks and between staff groups are examined. In Chapter 6 the physical boundaries presented by the building are assessed in relation to the primary task and the routine-task oriented culture of the environment.

Bearing the above points about open systems theory in mind and applying the concept (at a simplistic level) to nursing homes, the inputs, conversion and output model has very different connotations in practice than, to say, that of a manufacturing industry. Outputs are not returned to the community as exports or products, the outputs are deaths. This is recognised by Miller and Gwynne (1973, p.75) who write that there is a ‘fundamental difference between the institutions we are describing and most other enterprises with a human throughput’. As they state modal outputs from hospitals are cured patients (though some die), of a college, graduates (though some fail and drop out on the way) and of an airline, passengers who reach their destination (though a few miscarry). However in residential institutions for incurables the modal output is dead
inmates. When considering the outputs from nursing homes, which are deaths, perhaps the notion of outputs should be broadened toward a wider embrace of the actual experience of the death for the residents and others, one which is least painful and stressful to all concerned. This perspective enables death to be seen in a more positive light.

With their focus on the output end of the system, Miller and Gwynne (1973, p.75) state 'the inexorableness of this boundary at the output of the system [of dead inmates] gives rise to many of the problems encountered both in running institutions of this kind and in living in them. In particular it leads to difficulty in agreeing upon the primary task'. They note that because defining the primary task in terms of exporting rehabilitated inmates to the external world cannot be, then the attention must be turned to the task of the institution in providing an appropriate setting for inmates. Miller and Gwynne's adjunct model of institutional management that defines the three systems of support within the transformation component of the standard systems model, provides some optimism for assessing the organisation culture of the nursing home.

There are many similarities between the residential environments for physically handicapped and chronically sick discussed by Miller and Gwynne and nursing homes. Both provide twenty four hour residential care on a permanent basis to people who require physical and psycho-social support. As with Miller and Gwynne's setting, explicating the primary task of the nursing home is difficult – is it a setting for 'living' in or 'dying' in?

2.4.4 Application of Theories to the Nursing Home Environment

The focus of 'the basic organisational model' (Miller and Gwynne 1973, p.76) in which the dependence, independence and support system are balanced can articulate with the physical aspects of the building which is the resident's home. In a nursing home setting, where attention should be paid to providing an appropriate setting, as in the case of Miller and Gwynne's residential environments, the physical context becomes an important component of the organisational model and the organisation culture. The provision of a physical setting where the built environment reflects community houses
and dwellings and is as non-institutional as practicable, is a necessary first step. This must be followed by residents making the spaces created by the building, into whatever form of representation of themselves and their life they wish. Fostering a 'sense of place' in residential environments is challenging, but not perhaps impossible. Three nursing home environments provide illustrations of this goal.

In 1999, in Alice Springs in central Australia, a purpose built residential aged care facility for Aboriginal people was completed. Some of the residents are local to Alice Springs but many are from hundreds of kilometres away from places such as the Pitjitianjarra Home-lands. The building is designed as a cluster model, with each cluster housing fifteen people. At the end of each of the buildings facing towards the desert are large open areas with open fires. This has been done because it is well known that members of the Aboriginal communities from these regions prefer to sit outside, on the land. Kinship ties and ties with the land are indivisible from Aboriginal culture. Large groups of visitors may arrive at any time to visit a family member, often expecting to find shelter at the chosen location. The previous residential facility was totally inconsistent with the needs of Aboriginal people. It was located in the centre of the town, surrounded by a high wall with gates. The staff had used the open central area between two buildings as the 'outside' space and strung up shade-cloth to extend the concept of a verandah. This provided residents and others with a space where they could gather and sit.

The second residential facility 'Corumbene' (which is an Aboriginal word meaning a peaceful place by the water) is in New Norfolk in the Derwent Valley in Tasmania. Corumbene was re-developed in the late 1990’s, to reflect aspects of the local region. The aim was to 'honestly engage with the social and spiritual reality of a particular place, and use that as the creative basis of producing a building design' (Crane 1997, p.4). The architect fashioned the building in such a way that it relates to the past lives of the residents. The whole of the building, its external form and the interiors within, are symbolic of the images naturally associated to by the people living in the Derwent Valley. The Derwent Valley is a Hops growing region and an abiding symbol for those who have lived there is the oast house. The oast house shape has been incorporated into the overall form of Corumbene. The concept has been extended to the interior with
small hops pickers huts, an outside water tank and other symbols of the region. 'The building creates 'traditional’ values because it is redolent everywhere with associations and memories, even though it is in fact a radical departure from tradition as exists in standard nursing homes at the present' (Crane 1997 p.4).

'Corumbene's architect, Robert Morris-Nunn, has endeavoured to extract symbols which are easily understood by the people who will inhabit the building and that belong to their traditions, giving their lives a little extra richness through making all the spaces very personal. Old dummies, crazy weather board lean to's, sheds that look like they are half pissed and need another drink before they either straighten up or fall over altogether, ramshackled kitchens full of love, these are the things whose significance goes way beyond the narrow sterility of good taste to deeply touch peoples hearts' (Crane 1997, p.6).

The last example is of a building in the outer eastern suburbs of Melbourne. This example was provided Mark, one of the architects interviewed for this research. Mark described this particular nursing home design as being post-modern. In this instance the architects who designed the facility, opted for a ship-like feel, installing port-holes in areas of the building occupied by residents and using a variety of floor levels, which required residents and staff to navigate stairs. My interviewee believes that residents are uncomfortable with post-modern designs, as they did not grow up with them, they grew up in the 1930's and 40's. Of this particular building he had heard reports that residents were disconcerted by the port-holes and that staff did not think the design worked (as it was not functional).

None of these building designs in and of themselves can generate a 'sense of place'. Moreover the variety of building styles might read like a list of theme parks, designed more for novelty and attractiveness to the community and others than for the residents welfare. As stated previously in the Conceptual Framework discussion, 'a sense of place' is an internally designated concept, owned by the person. However both the building and the spaces created formally and informally are important in facilitating the development of 'a sense of place' for an individual.
In Figure 7 p.52 the Conceptual Framework Schema is married with the aspects of culture as defined in this thesis. The diagram represents a relationship of influence between the three elements of the built environment and the organisation culture of the nursing home.

2.5 Conclusion

In this chapter I have introduced and discussed the Conceptual Framework and theoretical perspectives by which the research findings of this thesis are discussed and analysed. The three elements that comprise the Conceptual Framework, namely the building, the spaces created by it, and the sense of place associated with it, have each been described. I have drawn on literature from the field of organisation culture that I apply in Chapter 5 to facilitate description and analysis. In Chapter 6 the Conceptual Framework is applied to analysis and discussions of findings. Finally I provided discussion on selected theories and concepts from the field of psycho-dynamics as they apply to the organisation setting. These theoretical perspectives will be used to analyse and interpret the findings of the research, in concert with the Conceptual Framework and analysis of the organisation culture of a nursing home environment.
The Building
The nursing home building/physical structure

The Spaces Created
Formal and informally created spaces/intentionally or unintentionally created

A Sense of Place
A perception or feeling held by residents and others

What Role does the Building Play in the Organisation Culture of Nursing Homes?

The Built Environment (Physical Context)

The Architect/Designer
The Resident
The Staff
The Family/friends

Figure 7 - The Conceptual Framework Schema with 'Culture' Dimension Included

The Building - The architect in initial design phase. Residents, staff, family and friends.
The Spaces Created - formal and informal - The residents, staff, family and friends. Architect in initial design phase.
A Sense of Place - The residents and others

Description
This figure of the Conceptual Framework provides a schema which links the research question with the four groups who have a two way relationship with the built environment of the nursing home, i.e., the architects, the resident who lives in the nursing home, the staff who work in the nursing home and the family and friends who visit the nursing home. The three elements which form the Conceptual Framework are depicted in the centre, whilst the list below the elements highlights which of the four groups are most closely linked with each element. In this figure the psycho-dynamic concepts applied in the analysis of findings in Chapters 5 and 6 are depicted on the right, indicating a relationship between the three elements and the dimensions which form the working definition of culture for use in this thesis.
Chapter 3  Method

3.1  Introduction

The Preface to this thesis provided a perspective for the discussions that follow through an introduction to my experience of health settings and in particular aged care. Chapter 1 built upon the preface by developing the personal aspects into a cogent series of issues affecting residential aged care, which in turn act as a rationale for the research. In Chapter 2 the Conceptual Framework was described in detail. The Conceptual Framework forms an integrated model for analysis of data and discussions related to the building's role in the culture of nursing homes. Psycho-dynamic and organisational theories applied to the findings of this thesis were also discussed in Chapter 2. The working definition of culture and how this definition was formed from an amalgam of theory was also presented in Chapter 2.

In this Chapter, the selection of a qualitative research approach that provided the foundation for the research design is discussed in full together with the various data collection methods of semi-structured interviews, participant-observation and a drawing technique used during the research process. A detailed step-by-step approach to the research design is provided which includes discussion on the sources that resulted in the various interview guides used during the research. A significant element of the research approach was the application of case-study method using a single case, Beechwood Nursing Home. The selection of this single case and the case-study approach are discussed in detail.

3.2  A Qualitative Research Approach

At the outset of the work for this thesis it was clear that the methods for eliciting data would be drawn from a qualitative research approach and that this extensive field would inform the overall design. As Lee (1999, p.64) states 'qualitative research may be well suited to the pursuit of questions of description, interpretation and explanation'. From the outset of the research process I had intended to explore the relationship the building
had to the culture of nursing homes, therefore Lee's statement resonated with the aim of the research question. Lee also highlights that most qualitative studies routinely apply multiple techniques such as interviews and observations within a single study (1999). The research question which I set out to answer, was 'what role does the building play in the culture of nursing homes?' The research approach therefore had to facilitate answering this question. The principal method I selected through which to conduct the research was a case-study of a single nursing home. The case-study method appeared to be the most suitable in this instance as it lends itself to studies which Yin (1994, p.4) describes as 'exploratory' and 'descriptive'. This position was consistent with my goal to understand the role of the building in the culture of nursing homes and the case-study method enabled me to explore and describe phenomena that I considered would elicit this understanding. Within the case-study method I employed the data collection techniques of semi-structured interviews, participant-observation and a drawing technique. In addition two interviews were conducted with architects prior to the case-study. The data collection techniques are considered as methods within the qualitative research approach and their application is discussed in relevant sections of this chapter.

### 3.2.1 A Qualitative over a Quantitative Approach

There is wide debate over what constitutes qualitative research and in particular whether qualitative research is simply research without numbers (Lee 1999; Symon and Cassell 1998). As part of this distinction, Lee summarises Creswell's five fundamental differences in the realities of the designs of the two kinds of research - ontology, epistemology, axioms, rhetoric, and methodology - that go far beyond the simplistic notion of numbers versus no numbers (Lee 1999, p. 6). Without labouring the philosophical origins of each, I have provided only the position of qualitative researches described by Creswell. The ontological assumption is that qualitative researchers typically assume that multiple subjectively derived realities can co-exist. The epistemological assumption is that qualitative researchers commonly assume that they must interact with their studied phenomena. The axiological assumption is that qualitative researchers overtly act in a value-laden and biased fashion. The rhetorical assumption is that qualitative researchers most often use personalised, informal and context-based language. The methodological assumption is that qualitative researchers
tend to apply induction, multivariate and multiprocess interactions, and context-specific methods. For the most part, these five assumptions did underpin the current research process.

In addition to considering Creswell's description of different realities between quantitative and qualitative research groups, I also took my lead from Lee's identification of the four underlying themes, which he claims are generic to the domains of qualitative research design. These are:-

1. Qualitative research occurs in natural settings - my research was to take place in a nursing home;
2. Qualitative data derive from the participants' perspective - whilst I did undertake participant-observation, the interview data was provided from the perspective of participants;
3. Qualitative research designs are flexible (i.e., reflexive) - it was not possible to fully comprehend the issues, problems and opportunities that the research process would yield and therefore necessary to remain flexible;
4. Instrumentation, observation methods, and modes of analysis are not standard.

The decision to use a qualitative research approach over a quantitative approach was facilitated by Cassell and Symon (1994 in Lee 1999, p.6) who offer six defining differences between quantitative and qualitative research approaches. Their six reasons are summarised below in relation to my research question - 'what role does the building play in the culture of nursing homes?'

1) Numbers versus no numbers – or quantification versus interpretation. Qualitative researchers endeavour to describe organisational phenomena. This was what I wanted to do, describe what I was observing and hearing about the culture of the environment and how the building played a part in this and to interpret this. There was no clear need to count or measure these aspects, however, quantitative data could have been incorporated.
2) Qualitative researchers explicitly and overtly apply their own subjective interpretations to the understanding of organisational phenomena. Quantitative researchers seek objective and finely calibrated descriptions. The use of a variety of data sources including my own experience could be legitimately included in a qualitative research approach.

3) Substantial flexibility is acceptable which allows for unpredictable research problems. Research designs can be adjusted to overcome unforeseen difficulties. Quantitative research is often more rule drive with researchers having a clear mental model about designs. Flexibility was key in the research design as some limitations in the work-place were anticipated, others were unanticipated.

4) Qualitative researchers focus more on understanding organisational processes and less on predicting outcomes. Quantitative researchers focus more on predicting outcomes and less on process variables. I considered organisational processes were far more important than predicting an outcome, which was not a major aim of the work.

5) Qualitative research is usually grounded within the local context in which the phenomena of interest occur. This can make generalising empirical results to a larger population or other setting problematic. Quantitative research tends to be context-free and is therefore more generalisable. At the outset I considered it more important to gain as much insight as possible in one nursing home venue. I recognised that generalising from the findings would be limited through this decision, although it did not exclude drawing inferences that were applicable to other nursing home environments when appropriate.

3.2.2 Qualitative Research and the Interpretive Paradigm

As Lee states, researchers must ask themselves not whether a qualitative or quantitative design should be tried, but whether the best method has been applied (1999, p.11). This is echoed by Symon and Cassell (1998) who note that it is often the practical
requirement of the research problem that decides the techniques to be used, rather than a paradigmatic preference on the researcher's part. This reference to paradigm relates to the generally accepted notion of how research is organised around one of three major research paradigms known as, positivist, interpretive and critical. Each paradigm differs with regard to its historical, epistemological and methodological framework. Of the three research paradigms, it is the interpretive approach that provides the foundation for this study. The interpretive paradigm focuses on social research where symbols, symbolic interactionism their meanings and the subjective experiences of individuals are central to the understanding of the problem at hand. Connole (1990, p. 8) identifies the principal focus of the interpretive method being on identifying and portraying human actions, their motives and the social contexts in which they occur. Morgan, summarising Denzin (1983, p.25), narrows this reference to human actions noting that humans construct and organise their everyday life through intertwined streams of consciousness. Humans are seen as reflexive, intentional actors, constructing and reconstructing a world rich in meaning, motive, emotion and feeling through interaction with others. Morgan (1983, p.25) notes that Denzin recommends that this attention to understanding the social life of individuals requires the interpretive researcher to participate in and use concepts that belong to the situation being studied, in order to reveal its nature, as it cannot be understood through observation at a distance. Hence the need to adopt data collection techniques which require immersion in the setting of a nursing home.

This research falls within the category of organisation studies. Lee (1999) notes that in recent times organisation scientists and managers have begun to adopt qualitative methods to explore ever complex problems within organisations, however many of these organisational scientists and managers have come from a training of quantitative analysis and positivism and do not fully understand qualitative methods. This research forms a complex real-world issue, which is not easy to address and which Lee describes as confronting organisation scientists and managers as a research problem (1999, p.2)
3.2.3 Summary of Overall Research Design

a) Literature review, development of theoretical model integrating physical and non-physical aspects of residential aged care (the Conceptual Framework), Refinement of research question

b) Development of interview framework for architects interviews (Appendix B)

c) Interview two architects experienced in nursing home design and building

d) Selection of single-case to form case-study/application/permission granted – anticipate attendance over 2 month period, various times and days of week (Appendix C)

e) Design phases of case-study beginning with observation phase follow with interviews (See Appendix D&E)

f) Commence observation phase, first 3 weeks attendance at nursing home but extends over entire period of attendance

g) Conduct interviews including those where interviewee completes a drawing. Interview 10 staff, 2 residents and 1 relative of a resident. Attend 3 meetings during case-study

h) Conclusion of case-study

3.3 The Purpose of Interviewing Architects

The decision was taken to precede the case-study with interviews with two architects. Through my consultancy work I had become aware of the enormous role architects play in the establishment of a residential aged care facility and how wide can be the architects sphere of influence in design. Given the large contribution by architects to the living and working environment formed by a nursing home, I considered it important to conduct interviews that developed my appreciation of their critical role, in relation to nursing homes. This seemed even more important when considering that upon completion of a nursing home building, of all the groups involved with its operation, the architect will have the least to do with it.
Architects must marry the practical with the creative in their designs, whilst remaining cognisant of state and local government building requirements and the regulatory requirements established by the Federal Government for Certification of residential aged care facilities. Architects must also incorporate in the design the stated needs expressed by their client, be they for-profit or not-for-profit providers. Often, architects will use a consultative process with nursing home staff, residents and the wider community to elicit a deeper understanding of needs, however the architects interviewed during the course of this research stated this was not a routine practise.

Ultimately, the nursing home building is the product of the architect's interpretation of the requirements of others, together with his or her own creative process. Gutman (1997) writing about architectural practice from a psycho-dynamic stand-point, notes that the creative accomplishment of architects is always fragile. He states that 'this is because it rests on the imaginative leap rather than a scientific formula, and because the conflict that stimulates it can be re-lived innumerable times. This fragility in turn sustains a climate of chaos and abuse as the artist relates defensively to critics, and also to admirers (1997, p.7)'. Although Gutman is focusing on the 'design architect', no doubt the designer of the controversial building or space - Gutman’s summation of the experience of the creative endeavour of architectural practice applies to all architects. His point that the process of becoming creative is an injurious one as it involves experiences of submission and humiliation (p.7), appears to be no less true in Australian practice to that of the United States. One assumes it is experienced by the architect whether they are involved in the creation of a glamorous icon or an institution such as a nursing home or prison. Given this, what role does the architect bring to the experience of designing a nursing home? This question is explored in Chapter 6.

3.3.1 Aim of the Interview

The aim of the interview was to determine what the architect sees the primary task of the nursing home as being and to explore how this is translated into the design of the physical context and the functions and operations of the organisation.
3.3.2 The Interview Framework

Three sources informed the interview framework for both the interviews with the architects and the interviews conducted at the case-study venue. The sources were pertinent information arising from the literature: the work of Peace, Kellaher and Willcocks (1997); and the field of psycho-dynamics, drawing on the concepts of task, role and boundary. The information from the literature has been grouped under the themes of 'The Resident', 'The Family' and 'The Staff' as depicted below in Table 2. I have grouped the salient points from the literature under each of these of themes. Close reading of the points under each theme demonstrates the importance of the building and overall physical context, particularly for residents and families.

<table>
<thead>
<tr>
<th>The Resident</th>
<th>The Family</th>
<th>The Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in a nursing home</td>
<td>Family Crisis</td>
<td>Difficulties in dealing with own ageing</td>
</tr>
<tr>
<td>Home-like/institutionality</td>
<td>Loss &amp; Grief</td>
<td>Difficulties in dealing with ageing parents &amp; relatives</td>
</tr>
<tr>
<td>Spatial organisation</td>
<td>Family Relationship</td>
<td>Medical Model of Care versus alternative models</td>
</tr>
<tr>
<td>- orientation and way finding</td>
<td>Distribution</td>
<td>Quality of Life Issues for residents</td>
</tr>
<tr>
<td>Privacy</td>
<td>- quality of care</td>
<td>Social distance between staff and residents</td>
</tr>
<tr>
<td>Security (from outsiders)</td>
<td>- appearance</td>
<td>Low status work</td>
</tr>
<tr>
<td>Social interaction opportunities</td>
<td>- atmosphere</td>
<td>Female dominated, part-time work-force</td>
</tr>
<tr>
<td>Ambulation</td>
<td>- location</td>
<td>High numbers of unqualified staff</td>
</tr>
<tr>
<td>Involvement in common activities</td>
<td>- reputation</td>
<td>Feeling not valued for contribution</td>
</tr>
<tr>
<td>Transportation</td>
<td>- building safety</td>
<td>'primitive anxieties and primitive fantasies about death &amp; decay add to the strains of looking after the elderly' (Zagier Roberts 1995, p83).</td>
</tr>
<tr>
<td>Communal Dining</td>
<td>- quality of food</td>
<td></td>
</tr>
<tr>
<td>Voluntary Associations</td>
<td>- cost</td>
<td></td>
</tr>
<tr>
<td>Change in Physical Environment (feeling/sense of) institutionalisation</td>
<td>- activities</td>
<td></td>
</tr>
<tr>
<td>Role take-up (as new members of an organisation)</td>
<td>(Prawitz et al.1994)</td>
<td></td>
</tr>
<tr>
<td>- new support base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- establish new role definition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- re-define previous roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Numerof 1983)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance of competency (in Activities of Daily Living and engagement in social interaction)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy &amp; Regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Home Selection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 Themes from the Literature
Peace, Kellaher and Willcocks (1997) re-visited their extensive research in residential aged care environments undertaken in the 1980’s, to generate a values framework as depicted in Table 3. Their framework takes into consideration Goffman's characteristics of total institutions (1961). It is of interest that Peace et al. considered these characteristics as still applicable to life in nursing homes some forty years after their appearance. Peace et al. (1997, p.45) summarise Goffman's characteristics of total institutions as being:

- batch living - daily *en masse*;
- binary management - two groups (the managed and the managers);
- inmate role - losing roles, disculturation.

| **Autonomy** | Depersonalisation, infantilisation |
| **Choices** | Rigidity of routine, structured living, resource-rich/resource-sparse environment |
| **Dignity** | Block treatment of people |
| **Individuality** | Residents seen as homogenous |
| **Self-determination** | Levels of staff-determined as opposed to resident-determined behaviour |
| **Integration** | Social distance between staff and residents |
| **Privacy** | Balance of public and private living |
| **Citizenship** | Participation both within and outside the home; the degree of isolation or integration with community |

Table 3  **Values underpinning an engaged existence and the threats from institutional life** (Peace, Kellaher and Willcocks 1997, p.45)

This values framework encapsulates many of the concerns that are prominent in the literature related to residential aged care. The framework is a form of institutional measure, one which provides an insight into the tension between the type of organised care often referred to as a medical-model approach and that of a social or collaborative approach to care. It also points to one of the paradoxes which appear to be associated with the provision of residential aged care - the existence of institutional buildings and organisation practices in settings which claim to offer home-like services and care. For
example, choices versus rigidity of routine: in some residential aged care settings residents are forced to abide by the organisationally determined meal-times, rather than choosing their preferred meal-times on a daily basis. Another example is that of citizenship and participation outside the home by residents. Promoting the involvement of residents in activities outside the aged care setting varies from setting to setting. Transportation to activities can be sporadic, with the result that residents do not continue in outside community affairs in their role of citizen.

3.3.3 Selection of Architects for Interview

Two architects were interviewed. In order to maintain confidentiality of the interviewee their names have been changed. Mark and Lorin are both engaged in busy practices in which the greater part of their work is designing facilities for residential aged care. Mark was known to me through the consultancy work in re-structuring of residential aged care. I identified Lorin through her company's web-site address. I contacted both architects initially by telephone, explained my research and followed the telephone contact with a letter of introduction and confirmation of the interview date and time (see Appendix A). Architecture is primarily a male-dominated profession and I particularly wanted the balance of one male and one female as I wanted to explore whether significant differences existed in the interpretation of a nursing home building, a physical environment where people live and work. It should be noted that neither Mark nor Lorin were the architects for the case-study venue, nor was it discussed with either of them.

The decision to interview two architects was based on the intention of the study to focus on the organisation culture of the nursing home and the role the building played in this, rather than a study solely of the architects' role in the creation of nursing home buildings. I wanted to gain an insight into the architects' perception of the purpose of nursing homes and of their role in creating the physical context of a nursing home. Interviewing more than two architects would have generated more data but it was not considered that this would have directly added more to the understanding of the role played in relation to the impact of the building on the culture. Also, the literature canvassed regarding architecture and nursing home buildings supported this decision.
Invariably the literature focused on good building design from either an aesthetic or practical orientation together with awards won for successful designs. While this is a valuable and important functional part of architecture in relation to nursing homes, the literature did not illuminate the research question in which the nexus between the building and the organisation culture were to be explored. Hence the research set out to integrate the knowledge and experience of various disciplines associated with nursing homes and to undertake an analysis of organisation culture, which was not embraced within the literature, canvassed for this study.

3.3.4 Location of the Interviews

I met with Mark and Lorin at their respective offices. In both instances the interviews were conducted in 'meeting rooms' within the offices. Also in both instances the interviews were interrupted. In Mark's case, by his business partner and in Lorin's case by an interstate 'phone call from builders involved with the construction of a nursing home in northern Australia.

As Mark and I already knew one another very little time was invested in an introductory period to the interview and we moved swiftly into a question-answer format, lasting one hour. In the interview with Lorin the beginning of the interview was spent familiarising Lorin with the objective of the research and informal conversation about her background. The interview lasted one and a half hours.

3.3.5 The Interview Technique

Field and Morse (1985, p.67) use the term 'guided interview', whilst Lee (1999, p.62) uses the term 'semi-structured interview' to describe a process where the interviewer is seeking information about a topic, which has general themes, targeted issues and specific questions, with a pre-determined sequence for their occurrence. The sequence does not prevent the interviewer from pursuing matters which arise during the course of the interview, whilst allowing the informant freedom of responses and description to illustrate concepts. The interviews with the architects can be described as semi-structured or guided interviews.
As Field and Morse (1985) note, the interviewer must have strong skills to manage the interview and to keep the informant on track. This is in order to minimise the dross rate, that is, the amount of irrelevant information obtained (p.66). The interview with Mark was straight-forward with the order of the questions being closely adhered to by myself as the interviewer and Mark as the respondent, with Mark elaborating on points during the course of the interview, corresponding with the question being asked. The interview with Lorin was quite different in that I did not manage to ‘guide’ the interview as closely as I should have. The more conversational style interview with Lorin resulted in a small dross rate.

The interviews with the architects were intentionally focused on the physical aspects of the building and the contexts arising from it.

3.3.6 Recording of Data

The interviews were not tape-recorded. In both cases I took extensive notes during the course of the interview, using short-hand codes corresponding with a question to represent responses from the interviewee. In Mark's interview the majority of note-taking was a verbatim report of his comments. Whilst the same order of questions was followed with Lorin, the note-taking was broader with fewer verbatim recordings. This was an outcome of the interview being more discussion like, with Lorin cycling back to previous questions in order to expand on points as noted in section 3.3.5.

3.3.7 Data Coding and Analysis

The notes from the interviews were transferred into computer word-files, which formed hard-copy transcripts of the interviews. The process of coding then followed what Lee (1999) refers to as meaning condensation. The interview data forming the transcripts were then read with a view to extracting the most important themes, looking for 'natural meaning units'. These units are portions of the text - whole or part sentences or paragraphs that are judged to relate to an identifiable theme (or issue) and which can be re-assembled against that theme (Lee 1999, p.90). This is akin to what Fleet and Cambourne (1989) describe as chopping up the raw data into meaningful bits and then
pushing these meaningful size bits through a specially designed grid. This grid resembles the researcher's original ideas and mini-theories (p.40).

I also followed what Lee (1999, p.93) calls hermeneutic meaning interpretation, where as the researcher I imposed meaning on the interview data based on the perspective's of a pre-existing paradigm. In this instance this pre-existing paradigm is psychoanalysis, or more accurately psycho-dynamics. I should state that I also experienced what Fleet and Cambourne (1989) refer to as feeling 'swamped' by the sheer complexity and amount of what had been collected. This was particularly the case with Lorin’s interview and the interviews conducted during the case-study, which are described below.

3.4 Case-Study Method

A single case constitutes the case-study. The decision to choose a single case rested on the purpose of the research, that of answering the research question through the exploration and detailed description of the role the building plays in the organisation culture of nursing homes. This required an exploration and description of social phenomena related to the nursing home building. By focusing on a single case - one nursing home, carefully selecting the units of analysis for study and using multiple data collection methods it was anticipated that a rich data source would be obtained.

The single case for the case-study was a seventy-five bed nursing home owned and operated by a large church and charitable group. It is located in the eastern suburbs of the capital city of Melbourne. The building was only recently completed, having been re-developed from a thirty bed facility where rooms had multiple bed occupancy (up to six per room) to a facility three times the size, in which the majority of rooms are single occupancy. Throughout this thesis the nursing home forming the case-study is referred to as Beechwood Nursing Home.

The case-study method embraces multiple data collection techniques as well as the incorporation of quantitative analysis as appropriate. Within the case-study of the nursing home the methods used to elicit data were participant-observation, interviewing and drawing technique. As noted earlier these methods are considered to fall within the
qualitative research approach as does case-study method itself, within the views expressed by Lee (1999); Symon and Cassell (1998). And yet, Yin (1994, p.14) who has made substantial contribution to the understanding and application of case-study method makes the point that case-study strategy should not be confused with 'qualitative research.' Presumably this is because it can stand alone as a research method and because case-studies can be any mix of quantitative and qualitative evidence. This debate to one side, the case-study method lends itself to field work which mirrored two of the points Berg and Smith (1988, p.25) make about 'clinical' research. These points being (i) that the researcher has first hand experience with the social system being studied - in this instance a nursing home and (ii) the researcher in role is required to examine his/her emotional and intellectual reactions while inside the role.

As the aim of the research was to understand the relationship the building has to the organisational culture of nursing homes, a method which provided for questions of "how" this happened and one which facilitated exploration and description was vital to the successful conduct of the research. The case-study method meets these criteria. Specific reasons for using a case-study approach included –

1)  the appropriateness of the method given the research question, over other methods;
2)  the legitimacy afforded by the method to incorporate multiple data collection techniques i.e., participant observation data, interview data, drawing representation data;
3)  the opportunity to focus (in an intense manner) on one facility i.e., a single venue for the purpose of participant observation.

3.4.1 Selecting the Case-Study Venue – The Political Realities

At the time of writing this thesis the aged care industry was under considerable pressure preparing for the mandatory requirements of Accreditation. Accreditation requirements are described in Chapter 1, Introduction and Rationale for the Research. As a result I determined that few facilities would welcome a researcher in their midst, as there would be no immediate gain in terms of the current pressures they were confronting. Having worked with the major industry body representing the for-profit sector of residential
aged care, I had witnessed this body being defensive and openly hostile to any form of enquiry about its conduct and practices. I did not therefore consider it would be an easy job to gain access to a for-profit facility. Moreover many of the owner/operators of these facilities are uneducated with regard to research and its objectives and potentially could have made undue demands about the nature of the research that would influence the outcomes. I believed I could not approach those for-profit operators who may have accommodated me, because I had worked closely with them on implementing continuous improvement programs in preparation for Accreditation. There was too great a risk that I would not be able to stay in the role of researcher and would be pulled into that of consultant.

Given the difficulty in negotiating access to a private for-profit operator, I decided to seek out a church and charitable operator who I knew had accommodated students at both under-graduate and post-graduate levels. Here again balance was at issue. I had been engaged to conduct a Residents' Satisfaction Survey throughout their facilities. The organisation knew me and trusted me, which facilitated the process of securing access to Beechwood Nursing Home, a facility where I had not conducted the survey and none of the staff were known to me.

Permission by the church-and-charitable operator to undertake the research was granted quite swiftly, as was access to the venue (Refer Appendix C). However a conundrum developed during the conduct of the case-study. The church-and-charitable operator being under pressure from the Accreditation Agency, brought forward the dead-line for the completion of the Residents' Satisfaction Survey. Undertaking the Survey would not only have confused me as to my role at Beechwood, it had the potential to severely damage each of the data collection methods I had planned to utilise.

It was agreed that resident interviews for the Survey would be conducted by a staff member from another site and that at the conclusion of the case-study I would undertake the data analysis and report preparation for Beechwood Nursing Home. Further, during the period of the case-study no reference was made to me as the person with responsibility for the Survey. I found this difficult at times, as staff would ask about its progress during my presence. This did concern me, as I knew I would be returning to the
venue to provide a report to the very staff I had interviewed for the research and yet it had not been revealed to them that the Survey was my product. For the purpose of conducting the case-study research, I decided to leave this matter to one side and not to cloud the case-study.

3.4.2 Design of the Case-Study

In Yin's extensive discussion on case-study research (1994, p.49) he promotes a three phase structure to the case-study method. These are 'define and design', 'prepare, collect and analyse' and 'analyse and conclude'. An aspect of the 'define and design' stage includes (at least) preliminary theory development at the outset of the case-study. This is one of the areas where Yin suggests case-study method departs from methods such as 'ethnography' or 'grounded theory' because these methods deliberately avoid specifying any theoretical propositions at the outset of an inquiry (1994). In this particular case-study at the 'define and design' stage a theoretical model was proposed. This model is referred to as the 'Conceptual Framework', which is comprised of three separate but inter-related elements: those of the building, the spaces created by it and a sense of place. The Conceptual Framework is fully described in Chapter 2 'Conceptual Framework and Theoretical Perspectives'.

In case-study research it is critical to identify the unit/s of analysis and embedded units of analysis prior to beginning the research. As mentioned earlier the case-study is constituted by a single nursing home in which the primary unit of analysis is formed by the organisation as a whole. As Yin (1994) notes, to prevent collecting data on everything study propositions need to be generated in order to direct attention to something that should be examined within the scope of the study. The central proposition of this study was that the building did play a role in the culture of the nursing home. This led to the development of embedded units of analysis for study at the nursing home venue. These units of analysis are presented in Table 4 together with the data collection technique applied during the case-study.
### Table 4 Units of Analysis

<table>
<thead>
<tr>
<th>Unit of Analysis</th>
<th>Data Collection Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Unit of Analysis</td>
<td>Participant Observation</td>
</tr>
<tr>
<td>- Beechwood Nursing Home</td>
<td></td>
</tr>
<tr>
<td>Embedded Units of Analysis</td>
<td>Participant Observation</td>
</tr>
<tr>
<td>- The Building</td>
<td></td>
</tr>
<tr>
<td>- Staff (registered nurses, nurse</td>
<td>Interviews</td>
</tr>
<tr>
<td>assistants, lifestyle and activities</td>
<td>Drawing technique followed by</td>
</tr>
<tr>
<td>staff, catering and hospitality staff)</td>
<td>Interview</td>
</tr>
<tr>
<td>- Residents</td>
<td></td>
</tr>
<tr>
<td>- Families</td>
<td></td>
</tr>
</tbody>
</table>

Beechwood Nursing Home constituted a social situation with three primary elements that Spradley (1980) refers to as a place, actors and activities. The place being the physical setting - Beechwood Nursing Home, the actors being the people at the place and the activities being all those activities which occur in the place, sets of which form 'events'. An example of this is a large-group activity session.

### 3.4.3 Phases of the Case-Study Plan

Following the granting of permission to undertake the research at Beechwood Nursing Home, I created a plan for the conduct of the case-study. The total period of the case-study was planned over a six week period. Phase 1 was to last around two weeks and would focus on observation/participant observation of the building and the physical context of Beechwood Nursing Home. Phase 2 was to last around four weeks and the focus in this phase would be on interviews with staff, residents and relatives. Phase 1 actually extended over the total period of the case-study.

By structuring the research plan into two phases, it allowed me time to ‘wander’ the building, paying attention to its features and how various occupants used it. I was at liberty to conduct informal conversations and familiarise myself with the organisation. Many of these informal conversations constituted data, which I later drew upon in the analysis of findings.
As the first day of the case-study approached I was experiencing an increasing level of
anxiety related to my entry process into Beechwood Nursing Home. I was worried about
how I would manage my role as researcher, the case-study itself and began to doubt that
I could make sense of my research question. It was identified that I was probably
experiencing 'parallel process', where the key dynamics driving the system being
researched, are being played through in parallel form in the researcher (Berg and Smith
1988, p.31). I was then in a position to be able to make use of my experience as data. I
was particularly interested in the notion that my anxiety about entry and role may
resemble the anxiety experienced by new residents about entry into the nursing home
and the role they would take up.

My attendance at Beechwood Nursing Home began in January, 2000 and finished mid-
February, 2000, with one further day's attendance in March 2000. Records of the
proposed days and times of attendance were provided to the Director of Nursing/Manager
of Beechwood Nursing Home. I asked to be notified of any day or event which it was considered unsuitable that I attend. No instance transpired and I was
allowed free access to the building with the proviso that any photographs I took did not
include residents. I was also required to have permission from each of the three Unit
Managers to access their 'house'. I attended the venue for approximately five hours per
day, for three or four days per week, which included weekend days. No resident refused
permission for me to be present at any activity (excluding personal and intimate activity,
which I did not observe), however I could not establish whether the residents had been
asked permission for me to attend and undertake the case-study.

3.4.3.1 Participant-Observation Phase

The participant-observation phase of the case-study was planned for the first two weeks
of attendance at Beechwood Nursing Home, although it extended throughout the whole
period of the case-study. Using Spradley's (1980) scale of involvement my role as
participant-observer moved from low involvement where I was passive to that of
moderate. I never fully joined the organisation in that I did not take up a role as an actor
(e.g., a registered nurse) which would have made my participant-observation
involvement complete in Spradley's view (p.58). In the participant-observation phase I
was conscious of having to ground myself regularly to pay attention to the building and the physical context and to develop what Spradley calls an explicit awareness achieved by overcoming years of selective inattention of not seeing and not hearing (1980, p.55). This was a challenge as I found myself having to look beyond the culture of the nursing home and nursing practice with which I was familiar, to that with which I was not - the building. This phase then moved into observing the interactions of the actors, the staff, residents and others with the building and physical context.

3.4.3.2 Guide for Participation-Observation, Phase 1

The focus of the participant-observation phase was on the physical structure and the interaction with the physical structure by staff and residents. To facilitate this I created a list of questions in order to focus my attention. The sources used to generate the questions were the same as those used to guide the interview with the architects. These have been discussed in Section 3.3.2 The Interview Framework.

3.5 Selection and Limitations in Choosing Interviewees

Prior to commencing the case-study I envisaged interviews would be conducted with staff representing the different staff groupings, residents and relatives. Consistent with the case-study method I had no pre-conceived idea of how many interviews would be conducted. The study was not endeavouring to compare one groups experience of the building and physical context with another, rather how they experienced the building and how it influenced their role. As my presence at Beechwood Nursing Home became more familiar to staff and residents and as my awareness of the building and the culture of the facility grew, I began to approach staff to secure a time for interview. During the participant-observation phase I had made it clear that I planned to conduct interviews and a number of staff had registered their interest in being interviewed.

Securing both people and times for interviews proved to be quite difficult. Although it appears that no consistency was applied to the reasons for selecting interviewees, this was more a result of the consequences of leaving the floor in order to attend an interview with me. I quickly learned to make a time with an interviewee which was the
quietest time on their shift, however a good deal of flexibility was also required. In the case of the Unit Manager of Elm House at Beechwood Nursing Home it took three attempts to conduct the interview as she was called away on each occasion. Conversely, there were those staff who had indicated they would be happy to be interviewed, remembered this and asked me if I still wanted to see them. These situations were managed on an individual basis, sometimes their informal discussions provided much useful information and I asked their permission to use this material, which substituted for a formal interview.

Although access to residents and their family members was easier than access to staff for an interview there were a number of issues which prevented easy conduct of an interview. Of the seventy-five residents of Beechwood Nursing Home there were few who were able to fully engage in an interview. Of those who were able, they were also engaged in activities or outings that restricted the time I could conduct an interview. Also, the relatives who did visit on a regular basis came to assist with activities or feeding of the resident and were restricted in the time available for interview. This did not restrict informal conversation nor periods of observation and both these sources provided valid data.

Interviewee details and data collection techniques used with interviewees are provided in Table 5. Interviewees gave written permission for the interview to be conducted, information to be recorded and for copies of drawings to be retained. The names of interviewees have been changed to maintain confidentiality.
### Table 5 Interviewee Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Location in Building or Span of Role</th>
<th>Interview Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heather*</td>
<td>Lifestyle Co-ordinator</td>
<td>All 3 houses of Beechwood</td>
<td>Drawing &amp; Interview</td>
</tr>
<tr>
<td>Margo</td>
<td>Hospitality Services Co-ordinator</td>
<td>All 3 houses of Beechwood</td>
<td>Interview</td>
</tr>
<tr>
<td>Frederick</td>
<td>Nursing Supervisor</td>
<td>Primarily Birch and Pine House</td>
<td>Drawing &amp; Interview</td>
</tr>
<tr>
<td>Olivia</td>
<td>Unit Manager</td>
<td>Pine House</td>
<td>Drawing &amp; Interview</td>
</tr>
<tr>
<td></td>
<td>Quality Manager</td>
<td>Whole of Site</td>
<td>Drawing &amp; Interview</td>
</tr>
<tr>
<td>Kaye</td>
<td>Resident</td>
<td>Pine House</td>
<td>Interview</td>
</tr>
<tr>
<td>Olya*</td>
<td>Resident</td>
<td>Pine House</td>
<td>Interview</td>
</tr>
<tr>
<td>Francine</td>
<td>Unit Manager</td>
<td>Birch House</td>
<td>Drawing &amp; Interview</td>
</tr>
<tr>
<td>Morris</td>
<td>Chef</td>
<td>All 3 houses of Beechwood</td>
<td>Interview</td>
</tr>
<tr>
<td>Beatrice</td>
<td>Director of Nursing &amp; Manager</td>
<td>Whole of Beechwood Nursing Home</td>
<td>Interview</td>
</tr>
<tr>
<td>Hilary</td>
<td>Unit Manager</td>
<td>Elm House</td>
<td>Drawing &amp; Interview</td>
</tr>
<tr>
<td>Kerry</td>
<td>Nurse Assistant</td>
<td>Pine House</td>
<td>Interview</td>
</tr>
<tr>
<td>Wilma</td>
<td>Nurse Assistant</td>
<td>Birch House</td>
<td>Interview</td>
</tr>
<tr>
<td>Delia</td>
<td>Relative</td>
<td>Birch House</td>
<td>Interview</td>
</tr>
</tbody>
</table>

* Interview conducted in two parts

### 3.5.1 Interview Environment

All but the two interviews with the residents, Kaye and Olya, took place in a room designated as the 'quiet room'. This room was allocated for my use, provided there was no clash with the needs of families or any pre-booked attendance such as medical students. The 'quiet room' was attractively furnished with a round table and chairs and was a comfortable room in which to conduct interviews. Its outlook was over the courtyard area and its location meant that it was away from the congested areas of the
building. The interviews with the two residents, Kaye and Olya, were conducted alone in their rooms.

3.5.2 Length of Time of Interviews

Interviews lasted around forty minutes. This varied, however, and some interviews lasted as long as an hour and a quarter. Two-thirds of the people interviewed became distressed and often cried, which required sensitive handling of the interview on my part. Two interviews were conducted in two parts, the first with Heather who requested a second interview and the other with Olya, a resident. Olya's interview was broken in order to allow her to have her lunch.

3.5.3 Guide for Interviews, Phase 2

Central to the interview guide were questions related to the building. These questions were aimed at defining what interviewees considered to be the primary role of the nursing home, how the building did or did not support staff, residents and others and how the building influenced the role of staff and the culture of the organisation. No two interviews were the same. Several factors had a bearing on this and influenced both what questions were asked of each interviewee and the sequence in which they were asked. The most significant of these factors being: the extent to which I had engaged in informal conversations with interviewees; specific comments provided by interviewees which offered new depth related to the influence of the building; the span of role of the interviewee.

The interview process can be described as semi-structured and not dissimilar to the interviews with the architects described in Section 3.3.5. The need to guide the interview was critical to reduce the dross rate. The most powerful challenge to the guiding of the interview came with accommodating the time-pressure on some interviewees who had limited time available and in the instances where staff were visibly upset.
The interviews with the residents differed from those with the staff or the relative or a resident. The interviews were more conversational in style and began with each of the residents telling me how they came to be living at Beechwood Nursing Home. From this point I focused on questions relating to living in their room and in the building. Again, sensitive handling of questions was crucial.

During the interviews with staff it became clear that certain questions needed to be re-framed to clarify their meaning. The most notable of these being questions related to the primary task and role of the nursing home building. This was altered to ‘do you think this is a building for living in or dying in?’ Questions that focused on death, were not asked of residents.

3.6 Using Drawing Technique

Drawing technique is a method used by many analysts in their work with clients. More recently it has been taken up in organisational research using a synthesis of elements of social and psychological sciences and organisational disciplines and where it is often used to stimulate creative thinking and problem solving in organisations (Stiles 1998). Stiles, considers pictorial data can assist in the quest for a richer understanding of organisations, by exploring the subjective experience of individuals from an interpretivist research approach. This he suggests will greatly add to our knowledge of how organisations work because they help explain more fully what underlies people's perceptions and actions. However, it is this subjective experience of individuals, which is at odds to the traditional perception of organisation functioning. Stiles (1998, p.191) attributes the purpose behind much of the gathering and using of pictorial data as limited by the dominant orthodoxy in sociological approaches to research which is governed by realist ontologies and positivist epistemologies (Stiles 1998, p.191). This position holds that there are hard, tangible, reasonably unchanging structures in the social world which can be identified and measured because such knowledge is verifiable and testable by using hypotheses and other positivist scientific approaches.
Stiles adopts a 'social constructionist' view derived from Berger and Luckman (1965) and Weick (1979) who contributed to the interpretivist research through their identification that individuals and groups can experience the same reality in different ways. Stiles notion is that these 'constructs' form the basic building-blocks of meaning, which he states can be articulated mentally as verbal images and also as visual images. His objective is to locate meaning in these constructs which provide an understanding of the 'deeper' level of latent, embedded phenomena such as human assumptions, values and perceptions.

Cooper Marcus (1997) is just as interested in the use of pictorial data to convey deeper meanings but this time they are about home (rather than organisations) and in particular the inside of home and the emotional content of this for individuals. Cooper Marcus orientation to drawing and their analyses is influenced by Jungian philosophy. In her longitudinal study, her technique involved visiting people in their homes, having them draw a picture of what their house meant to them, leaving them alone to draw their picture, returning and having them actively dialogue with their picture. This process proved insightful for many of her interviewees, revealing great love, personal growth, dislike and repetitive behaviour in house choice amongst many other aspects.

Combining Stiles argument for using pictorial data within organisation studies to examine deeper meanings, with Cooper Marcus's application to derive the meaning of home with individuals plus the experience of drawing technique in my doctoral class, I introduced the technique in my research. The purpose of using drawing technique was to gain insight into the deeper meaning for individuals about the culture of Beechwood Nursing Home and how the building played a role in this.

### 3.6.1 Drawing Technique - The Process

As noted in Table 5 there were five interviewees who completed a drawing. These five were all staff members with whom I had developed a high level of informal relationship. The process for undertaking the drawing technique involved asking the interviewee at the commencement of the interview to begin by doing a drawing in response to a
question which asked them to represent how they felt about being at Beechwood Nursing Home; what it meant to them.

I supplied large sheets of paper and brightly coloured Crayola pens and textas. I left the person alone for about 10 - 15 minutes and upon return I asked them to describe their drawing to me. The majority of interviewees made a comment about their drawing skills and how long it was since they had done something like this, but most took to the idea quickly. Some prompting was provided to those concerned about what to draw. I explained succinctly that the picture could be anything they wanted, a symbol such as a flower. I was mindful that too much explanation from me could influence their pictorial expression to the question.

When I returned to the room the drawing was placed between us on the table and I asked the interviewee to explain it to me. From this process I was then able to probe further and on occasion I would offer a hypothesis. This allowed the interviewee to agree with the hypothesis, refute it or offer an alternative. This process is consistent with the advice by Stiles (1998, p.195) that it is important that the drawer explain their drawing rather than the researcher relying on their own judgement of what the drawer was trying to convey.

3.6.2 Data Analysis of the Drawing Technique

Insightful analysis through using this technique could not be guaranteed by myself as the researcher, anymore than analysis of the verbal data from interviewees. As a researcher I felt anxious about using the technique, but I also believed that I would be afforded deeper insight into both the individual and collective meaning of the building and the organisation culture of the nursing home. I anticipated an articulation between the verbal and pictorial images provided by interviewees, that in turn would provide data related to elements of the Conceptual Framework. Often in organisational settings, the drawing technique analysis is used to reveal organisational constructs and collectively held perceptions about these constructs and the organisation. Whilst the objective of using the drawing technique was not as purposefully targeted as that described, I was
interested that all five drawings contained the same symbol – the sun. An analysis of the content of three interviewees’ drawings are discussed in Chapters 5 and 6.

3.6.3 Data Recording of the Drawing Technique

I took extensive notes during the interview or, on occasion where this was not practical - in such instances where interviewees became distressed - I wrote notes about the interview as close to its finish as possible. I kept all original drawings and made photo-copies for interviewees. The articulation of the notes with the drawings is extremely important as the notes were my vehicle to aspects of the interviewee not available to me by studying the drawing alone.

3.7 Data Recording of the Interviews at Beechwood Nursing Home

During Phase 1 of the case-study copious notes of observations were made in hard-copy. These observations included what I was hearing as well as seeing and what I was feeling and experiencing. As with the process described with the interviews with the architects, no taping of interviews took place. Notes were written during the course of the interview, using a short-hand form to indicate particular questions and responses. Immediately following each interview and certainly on the same day, the notes were studied for comprehension and detail and corrected and expanded as necessary. In the data recording process, a margin was used to indicate my feelings and observations during the interview. The hand-written notes were maintained in this form, they were ordered on the basis of Phase 1 and Phase 2 data, but they were not entered into computer file or transcribed into another form. I considered the hand-written notes, which constituted raw data was the most effective form of recording as it triggered recollections and feelings in me when I revisited it for analysis.

3.7.1 Data Coding and Analysis

The raw data was coded under the four categories as detailed below. To distinguish amongst the categories four different highlighter pens were used. The decision to use these categories was the first step in ordering the data. In these broad categories I could then identify key themes. Isolating words or sentences was not as advantageous a
technique in this research as it is to other methods. The key themes were the entry to understanding relationships amongst actors and amongst actors in relation to the building. Rather than allow the data to give rise to codes and meanings, I made the decision to apply the categories developed for the theoretical model as part of the theory development. Once the raw data was assigned to a category or in some cases two categories, the weighting of data amongst the categories could be explored. Themes then began to emerge which were the entry to understanding relationships amongst actors and the actors and the building and interpreting their meanings.

1) Physical structure = green. In this category all observations and interviewees' comments which related to an aspect of the actual physical structure of the building were included.

2) Spaces created formally & informally = bright pink. In this category all observations and interviewees' comments which related to staff, residents or others attempts to create or use a space that had been intended for use in a particular way or had been taken over for use in an unintended manner, were included.

3) Sense of place = orange. In this category all observations and interviewees' comments which related to expressed feelings about the environment including comments related to activities and lifestyle.

4) Culture = mustard. In this category all observations, interviewees' comments, my feelings and experiences and management and operational issues were included.

These first three categories are identical to the three elements of the Conceptual Framework described in Chapter 2: Conceptual Framework and Theoretical Perspective's. The Conceptual Framework is also the theoretical model developed at the outset of the research referred to in Section 3.2.3 above. The analysis of the data is to be found in Chapters 5 & 6.
Chapter Review

This chapter describes the qualitative research method and data collection techniques that were applied in the course of this study, the focus of which was the exploration of the role the building plays in the organisation culture of nursing homes.

The decision to use a qualitative research approach was argued and a step-by-step plan of the research process was provided. This was followed by elaboration of each of these steps. In particular the sources that guided the development of the theoretical model, referred to as the Conceptual Framework throughout the thesis, are discussed. These same sources also informed the interview guide for interviews with two architects and thirteen people interviewed at Beechwood Nursing Home. Beechwood Nursing Home formed the single case in the case-study method used in this research. The data collection techniques selected for use in this research included participant-observation, semi-structured interviews and drawing technique. Each of these methods and their application was described in this chapter. Overall the qualitative research approach and the methods used for data collection were considered the most appropriate for research being conducted within a social setting and paying close attention to human actions.

This study could have been restricted to an exploration of the organisation culture of nursing homes, which would have yielded rich information. However, I was interested in a much broader study, that of the building's role in nursing home culture. It would have been difficult to research aspects of the building without observing how it influenced the culture of the nursing home. Likewise, I could have undertaken a study where the analysis and interpretation of the findings was drawn from management and organisation theory literature and not from psycho-dynamics. Apart from making the study inappropriate to the objectives of the doctoral program, the research would not have taken the understanding of nursing homes and their culture to new depths. Symon and Cassell (1998, p.6) state 'insightful analysis is really at the heart of successful investigations' and through my research design and analysis of findings I hope this is what I have achieved.
Chapter 4 'The Case-Study Venue', which follows, details the physical characteristics of Beechwood Nursing Home. The findings discussed in Chapter 5, and more particularly Chapter 6, are contingent upon an understanding of the physical characteristics described in Chapter 4.
Please note

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CHAPTER 4 The Case-Study Venue

4.1 Introduction

In Chapter 1, I provided an introduction to the sphere of residential aged care. As part of the discussion I highlighted the powerful emotional forces which exist within the community toward nursing homes and their role. I discussed the regulatory and legislative changes to residential aged care provision now expected as a result of the Commonwealth of Australia's Aged Care Act 1997. There are two key aspects of these changes that have a direct bearing on this thesis. The first is the change required with respect to the nursing home building, referred to as 'Certification'. The other is the requirement for residential aged care facilities to meet the five planks forming 'Accreditation', by the end of 2000. 'Certification' forms one of these planks whilst the meeting of Standards of Residential Care is another. Both are related to discussions in this thesis and both were addressed in Chapter 1. The introduction to residential aged care, the issues confronting it, the expectations by the community, the regulators and the nursing home industry itself, were provided as a rationale for the pursuit of the thesis topic.

In Chapter 2, The Conceptual Framework was introduced. This framework focuses on the physical context of the nursing home building. It is comprised of three separate but inter-related elements and through this thesis I seek to explore how each of these elements is manifest in the culture of the nursing home environment. Chapter 2 also discussed the theoretical perspectives used for data analysis and discussion of findings that appear in Chapters 5 and 6. Importantly, it is the amalgam of theory from the field of organisational culture with selected theories from psycho-dynamics, which provide a working definition for organisation culture for use throughout the thesis. This working definition was married with the Conceptual Framework in Chapter 2 and in Chapter 5 and 6 this marriage is explored at length.

In Chapter 3, the Method chapter, the background on how my thinking developed toward a research question, namely 'what role does the building play in the culture of nursing homes?' is provided. The sequential and sometimes accidental steps in the
research design and process are discussed. The qualitatively oriented research method employed for this thesis is introduced pointing out the benefits of the method for this particular research. The importance of exploring and examining the physical context of the nursing home building was stressed. The physical setting for the case-study research is taken up below.

This chapter provides a detailed introduction to the case-study venue, Beechwood Nursing Home. This detail includes the location of the venue, basic management and operating arrangements, staffing, physical characteristics including floor-plans of the building and a profile of the residents. The issue of Accreditation faced by the organisation is also discussed as it highlights both the expectations of regulators about nursing homes and the pressure confronting staff to achieve it. The information in this chapter is important to the discussions which follow in Chapter 5, which focus on the culture of the nursing home and to Chapter 6, which focus on the relationship of the building to the nursing home culture. The physical context of the nursing home environment experienced by staff in their work-role, residents and others as observed by me and interpreted from the data are taken up in Chapters 5 and 6.

4.2 Beechwood Nursing Home - Background and Location

The Beechwood Nursing Home is one of several residential aged care facilities owned and operated by a large not for profit member of the church and charitable sector of the aged care industry. The Beechwood facility was acquired from private operators, late in 1997 after a significant period of renovation and development. With the change of ownership, about twenty-four residents chose to continue living at the renovated site, under the new ownership arrangement. A large majority of staff also chose to stay working at the venue and transferred to the employ of the new owners. Interestingly over 90% of the staff group employed at the 'inner-city' location of the church and charitable operator, chose to move to the Beechwood facility.

The purchase of the Beechwood facility represented a significant break with tradition for this large church and charitable group because Beechwood was the first of their facilities to incorporate 'Extra Service Places'. Extra Service Places must be approved by the
Commonwealth Government through a process designed to cap the number of Extra Service Places in the community and to ensure current beds are not lost in the system as a result of a 'for-profit motive'. An Extra Service Place bed license enables a facility to charge a higher rate (often significantly higher) although Commonwealth reimbursement is reduced. To do this a facility must be able to demonstrate that they offer significantly higher standards of service with respect to accommodation, food and services, than would be offered to non-recipients of Extra Services (Commonwealth Department of Health and Aged Care 1999 (b), p.48). Nursing care is excluded from this equation.

The granting of a license to provide Extra Service Places made Beechwood Nursing Home unique amongst its organisational counter-parts. Moreover, for a church and charitable provider to enter into a segment of the market governed by for-profit forces, was a landmark initiative. Beechwood Nursing Home was granted twenty-four Extra Service Places. At the time of the case-study there were only seven residents designated as Extra Service. These were located in Birch House on the same general site as the nursing home. The co-location of Extra Service residents with non-Extra Service residents proved difficult for staff to balance in terms of the culture of the nursing home. This is taken up in Chapter 5.

There are seventy five residents at Beechwood, all classified as being in need of high care level services, as per the Resident Classification Scale (RCS) (Commonwealth Department of Health and Family Services 1997). This scale determines the receipt of Commonwealth subsidy payments to the venue. Like many other residential aged care facilities, the validators (as they are known) may arrive at any time to review the RCS claims being made by a facility. This means determining whether the level of care being claimed is both what is actually provided and what residents’ need. Payment is made for residents who are in need of care, the higher the level of care: the higher the payment. However, at one and the same time, facilities must demonstrate that every effort is made to maintain a level of function of residents appropriate to their daily life. Senior staff made reference on several occasions, to a sense of an impending visit by the validators.

The purchase of the Beechwood facility required residents to transfer from the inner city location (which was sold) to Beechwood Nursing Home. This meant a move from the
inner city of a major capital city to a location, some thirty-five kilometres away. The inner city location was closely located within walking distance for staff and other residents from 'head office' where the hostel facilities were located. The two hostels being low care environments, acted as a feeder base for residents, who over time, came to need a higher level of care and assistance. This new location was in an established suburb of around 25 – 30 years, with a lower to middle-income level and in a green and leafy area.

The move of services from the inner city to the out-skirts resulted in both geographic and emotional dislocation for residents. Husbands and wives were now separated, with one partner located at the 'in-city hostel' facility and the other at the Beechwood location. This aspect was not over-looked by staff. The Unit Manager of Pine House thought it quite distressing that this had occurred. She described residents of the hostels at the inner city site as 'the losers' in this arrangement as it forced changes to the daily practice of a number of residents. One gentleman now located at Beechwood Nursing Home used to walk up from the 'head office' hostel site, to the inner city facility just up the road to have his lunch, 'but he can't do that now'. The Unit Manager considered these issues resulted from not being able to provide staged care from independent living to high level care, at the Beechwood facility.

Another outcome of the move was the reduction in access to amenities such as shopping precincts. At the inner city location, those able residents and small groups - often in wheel-chairs, could make their way to the old familiar shopping districts, located nearby. With the move this practice had been replaced with a bus trip to the shopping centre, which is a large satellite development several kilometres away. Olya, a resident of both the inner city location and later the Beechwood site, drew this to my attention during my interview with her. 'I didn't mind it down there on five floors – you got wheeled down to Chapel Street for a bit of shopping whereas you need to go in the car to Knox City or Chadstone [satellite shopping centres] or anywhere'.

According to a middle manager at the city site of the charitable operator, it was a business decision which resulted in the transfer of residents from the inner-city location to the Beechwood Nursing. The inner-city location required extensive renovation in
order to meet Certification requirements, but its sale net some $14 million dollars. These funds were used for capital development and re-furbishment of other facilities owned by the church-and-charitable group. The purchase of the Beechwood Nursing Home was undertaken because the church-and-charitable group wanted representation in the region as well as closer links with its constituents in the region. It is not known whether the Board of Management factored into their decision any consideration of the effect on residents of re-location. For residents, such major change is experienced as a fracturing of their social world, which often drives them into dependent behaviour by the simple removal of options and amenity. It affects their 'sense of place'.

Part of the communication amongst the sites and with head office occurs via 'the bus' that travels from venue to venue once a day, taking documentation and equipment from place to place as needed. The bus is used for outings and is shared amongst the venues depicted below in Figure 8 as well as for outreach service residents, attending on a day basis.

Of the five nursing home facilities, the Beechwood site is the most recently built and has only been fully occupied for approximately fifteen months. The equipment, furniture and soft furnishings are of a higher standard than those of its counter-parts. It was built on the site of a former thirty-bed nursing home, however little was retained of the original building in the overall structural re-development.
Head Office
Location of CEO, Director of Care Services, Facilities Administrators, Therapy Staff, Human Resource services.

Beechwood Nursing Home, 35km from head office. Seventy five residents in three houses – Birch, Pine and Elm, seven ESP's. Secure dementia unit. Majority of residents female, Anglo-Saxon. Age span less than 60 years to

Figure 8 Diagram of Head Office and Suburban Sites

Community home care services, independent living units and day care activities are also provided by this operator but are not represented on this diagram.
4.3 Management

Head office is responsible for major operational decisions including the choice of quality system, the selection of senior staff, the major policy and practice protocols which govern the 'work practices' at sites and decisions about large maintenance and infra-structure projects. The Director of Nursing/Manager on site at Beechwood Nursing Home has responsibility for management of the site budget, human resources and overall administration, in concert with 'head office'.

Figure 9 Organisation Structure of services and 'Houses' at Beechwood Nursing Home

Birch House, Pine House and Elm House each have a Unit Manager. The site Manager has the dual title of Director of Nursing/Manager. The Unit Manager for Pine House had recently changed positions and was balancing the Unit Manager position with that of Quality Manager for the whole facility. To reduce the perceived overall burden of this new role, a re-distribution of the number of beds per 'house' took place, establishing Pine House as a 21-bed unit. The major groups of staff at Beechwood Nursing Home are
nursing and care staff, lifestyle and activities, catering and hospitality staff. The largest of these groups is the nursing and care group, who provide twenty-four-hour, seven-day-a-week cover. Catering and hospitality staff also work seven days a week, but not on a twenty-four-hour roster.

Unit Managers plus the overall site manager are all registered nurses. Whilst this practice is consistent with residential aged care facilities providing high level care, it mirrors an expectation by the community and the industry that care in the nursing home environment equates more closely with clinical management and care of residents, than of lifestyle factors related to well-being. The registered nurse is responsible for overall Unit management and co-ordination of care, with some input to rosters. The role involves dispensing medications, attending to dressings of wounds (where required), social interaction with residents, monitoring resident behaviour, ensuring residents are eating and drinking and attending to the needs of family members and friends of residents. Ensuring staffing is appropriate on each unit for every shift, seven-days-a-week was managed by Frederick. On numerous occasions I arrived to find Frederick huddled over the roster. He is talking to himself about who couldn't come in for a shift and how difficult it would be to get an agency person.

4.4 Staffing

The nursing and care group of staff are allocated to work on one of the three houses. Whereas, the work of the lifestyle, activity and therapy staff group, and the hospitality and catering staff group takes places across the whole environment. This is a commonplace situation in most residential aged care facilities. The numbers of nursing and care staff are well above those of activity and therapy staff, with nursing and direct care considered the area of most need in the majority of health care facilities. The reasons for this are embedded in the evolution of the discipline of nursing and the allied health disciplines. Historically, nursing roles included direct care, some therapy roles such as physiotherapy and a major part of the cooking and cleaning duties. Professional development of nursing saw it shedding what are called 'non-nursing duties' and transferring most therapy and activity responsibilities out of the discipline's parameters.
From Monday to Friday there are three Unit Managers, one per house and five nurse assistants or Enrolled Nurses on duty. The ratio of direct care staff to resident is 1:5 during weekday morning shifts, increasing to 1:7 on weekends. There are less staff on duty for the evening shift, with one staff member to two houses during busy periods. Night shift staff totalled five qualified staff, two registered nurses and three Enrolled nurses. There are two full-time life-style and activity staff, working Monday to Friday. One Occupational Therapist, half-time, a visiting Physiotherapist part-time (both these positions are shared with 'head office' sites). There is a head-chef and eight staff in Catering, a Hospitality Services Co-ordinator and eight staff. Some staff work in both catering and hospitality. Maintenance is a shared position with other sites and head office.

The core staffing group of Beechwood Nursing Home is relatively stable, with many staff being long-term employees of the church and charitable group operating Beechwood Nursing Home. However, thirty per cent of staff working on each of the three houses may be from an Agency, that is they are not permanent members of the team. Staff of Elm House inform me, that many Agency staff return frequently to work there, as they know the Unit and its work requirements. This situation also applied in Birch and Pine Houses.

During the case-study period, several advertisements were placed to recruit registered nurses, but there was not even one telephone enquiry received. The senior nursing staff of Beechwood Nursing Home attributed this to a lack of interest by registered nurses in aged care practice, particularly amongst new graduands whose preference is for acute sector practice. The staff stated that registered nurses have a negative perception of aged care and do not equate it with career advancement. This view accords with those in general in the aged care industry and in the discipline of nursing. Further, the shortage of registered nurses in aged care has been acknowledged as a national and international problem. In Australia it has been placed on the agenda as an issue for discussion at the level of the Australian Health Ministers’ Advisory Committee (AHMAC).
4.5 Accreditation

During the case-study period, as with 3,000 residential aged care facilities around Australia, Beechwood Nursing Home was deeply involved in the process of preparing for Accreditation. By the end of 2000 all facilities in receipt of Commonwealth funds for aged care must achieve Accreditation or their funds will be in jeopardy. Accreditation is awarded for either one or three years. There are five planks to achieving Accreditation -

1) Certification of the Building
2) Meeting Standards of Residential Care
3) Recognising User Rights,
4) Meeting Concessional Resident Ratios
5) Prudential arrangements

Of the five planks of Accreditation it is no 2) 'Meeting Standards of Residential Care' which directly involves Beechwood Nursing Home to the greatest extent. The other planks of Accreditation requirements are co-ordinated by 'head office' in association with site management.

This preparation for Accreditation was being orchestrated through the head office of the organisation, with one staff member, Olivia, co-ordinating and overseeing progress through the new dual position she now occupied of Quality Co-ordinator and Unit Manager of Pine House. The work took up much of the constructive thinking time of staff and everyone was aware of the necessity to prepare for and pass Accreditation. The consequence of failing the Accreditation requirements meant jeopardising Commonwealth funding (without which the facility could not operate). During the case-study period, I observed that failure would be interpreted as personal failure, by management and all staff groups of Beechwood Nursing Home. Even residents were engaged in the process of preparation for Accreditation with responsibility for passing or failing being projected by staff and management into residents. Residents (and significant others) were informed of the various requirements and several were 'briefed' in anticipation of interview by the Accreditation assessors.
Preparation for Accreditation involved the assimilation of a quality management system. Essentially the quality management system revolved around the implementation of an over-arching system that connected the written policies and procedures with the observable and demonstrable practices in the work-setting. These policies and procedures were developed against all forty-four Standards of Residential Care, which cover Management Systems, Staffing and Organisational Development, Health and Personal Care, Resident Lifestyle and Physical Environment and Safe systems (Commonwealth Department of Health and Family Services 1998). The integrity of the overall system relied upon the sub-systems effective performance and compliance. These sub-systems included, for instance, catering and laundry, where, for example, thorough infection control practices are essential.

The development and implementation of the quality management system created tension between the 'head office' site and the Beechwood facility. Head Office had expectations related to time-frames for implementation of the quality system that could not be easily matched with those at Beechwood Nursing Home. This tension between the 'head office' and the Beechwood site surfaced on several occasions during my case-study period. Such issues as promotion and management of 'Extra Service Places' were controlled by 'head office' not by Beechwood Nursing Home, as were the management and resolution of information technology system issues. The state of information technology is not uniform throughout the sites. The head office is equipped with and uses e-mail for communication and is moving to on-line documentation use. This means providing accessibility to residents medication records on-line from a range of sites. Beechwood Nursing Home has provision for this, but it is not working effectively. During my attendance at Beechwood Nursing Home, requests to rectify the computing hardware and software problems were voiced at meetings but seemed not be taken up by 'head office' management. I attributed the tension I experienced to unclear role boundaries at the middle and senior manager levels between Beechwood Nursing Home and 'head office', coupled with an inability to exercise authority on the part of Beechwood Nursing Home.

Beechwood Nursing Home did meet the requirements of Accreditation. On the day the interim report was verbally presented to the facility there were thirty-two staff (this
represented more than 50% of staff) and several residents in attendance. Several staff who were off-duty came to hear the report. The Chief Executive Officer of the whole enterprise was present as was the 'head office' Director of Care Services. Champagne was handed round. Following the initial success, in the presence of the 'head office' CEO and Director of Care Services I became aware of an overwhelming sense of deflation on the part of the DoNJ/Manager, the Quality Co-ordinator and the Nursing Supervisor of Beechwood Nursing Home. It seemed they felt robbed of the triumph of having passed and were forced to share the moment of glory with managers whom they felt were not deserving of this reward. The Accreditation process served to bring to the fore-ground elements of the dominant culture of the nursing home, which are discussed in the following chapter.

4.6 Beechwood Nursing Home - Physical Characteristics and Resident Profiles

By current industry standards, the Beechwood facility is extremely smart in its presentation. The furnishings and decor are elegant and modern and compared to many nursing homes the feeling conveyed on entry is of an attractive, clean, well-appointed facility. The decor is perfectly matched with bed-spreads and curtains being of a very high standard, paint colours are up to the minute, prints and tapestries adorn corridors and communal areas and are of hotel standard. In keeping with industry trends the re-development of Beechwood Nursing Home saw the establishment of 63 single rooms and 6 double rooms, all with shared en-suite access – one bathroom between two residents for single room occupancy and one between four for double rooms. The previous facility on the current Beechwood site operated four and six bed rooms – no longer acceptable. The building conforms to the current Certification requirements, these were discussed in Chapter 1 'Introduction and Rationale for the Research'.
4.6.1 Floor-plan of Beechwood Nursing Home and Features of the Building

In order to provide greater depth to discussions which follow in Chapter 6 and to help locate aspects of the building which are taken up in the discussion, the floor-plan of the building has been provided at the end of this chapter. It provides the lay-out of each of the three houses, Birch, Pine and Elm; their respective nurses stations; dining areas and lounge; the kitchen and laundry service areas; the staff room; reception area; and activity and therapy room. The image had not been up-dated to reflect the changes in room use associated with the therapy and activity areas and the staff-room, which are indicated on the diagram. These changes in room use are taken up in Chapter 6.

The main entrance to the building is at the rear of the car park. The entrance is formed by a spacious reception area with two staff offices adjacent and toilets on either side of reception, opposite the front door. To enter the residents’ area, visitors must walk into Pine House past the glassed-in nurses’ station and the staff-room. At the juncture of three corridors they can turn left to head toward Elm House at the rear of the building, passing the kitchen and laundry en route. Or, they can turn right to head toward Birch House.

Refer to Figure 10 Beechwood Nursing Home Floor-plan on p. 99.

4.6.2 Birch House

Birch House is located at the front of the building. It faces the road-way and is adjacent to the drive-way access to the main entrance. Pine House forms the middle unit and Elm House is located at the rear of the building.

Birch House houses the main day room, located at the front of the building. It overlooks the street. This room is not only the lounge area for Birch House and the use of Extra Service Place residents, it is also the main activities room for the whole of Beechwood Nursing Home. There are two court-yards in Birch House one coming off the main lounge. There are fountains in the court-yards (which were not working during the period of the case-study). The dining room for Birch House overlooks one of these
court-yards. The nurses station for Birch House is located just prior to the entrance to Pine House. It is separated from the corridor by a high timber counter. A set of entrance/exit doors is located adjacent to the nurses station desk, which provides daytime visitor access and is the only access to the building after 5p.m. at night. Residents designated as Extra Services are located in Birch House. At the time of the case-study there were seven Extra Service Places out of 24 beds. Extra Service residents receive superior services in the form of hospitality services. At Beechwood Nursing Home this included larger rooms, silver service meals and teas, a visiting library service, morning papers, à la carte menus, large-screen television, separate sound and video system, a large arm-chair in each room and a cabinet affixed to the wall of the room for personal effects. Drapes and furnishings were of a higher standard that those found in Pine or Elm House. The plan is for Birch House to become totally Extra Service Places.

4.6.2.1 Resident Profile

There are 24 residents in Birch House - seven of who are Extra Service Places. Residents cognitive abilities range from dementia and confusion through to those who have no cognitive impairment whatsoever. All residents have some physical limitation. This limitation ranges from residents who require assistance to undertake all physical activity through to those who require minor assistance to dress or care for themselves. All Extra Service Place residents are physically dependent but mentally alert. The age-range is sixty years and above.

Refer to Figure 11 Birch House Floor-plan on p. 100.

4.6.3 Pine House

Pine House accommodates both the kitchen and laundry services, which makes them centrally located in the building. The office areas and reception are located at the entrance to Pine House. Therefore, during weekdays, all visitors must pass through Pine House en route to Birch House or Elm House, unless they use the after hours entrance in Birch House. Pine House nurses station is located at the juncture between the reception area and office area and Pine House. The dining and lounge rooms in Pine House open out into a very large-courtyard area.
4.6.3.1 Resident Profile

There are 21 residents in Pine House. The ratio of dementia residents requiring major assistance is higher than Birch House although there are a number of residents who have a high level of cognitive functioning but require help with physical aspects of care. A number of Pine House residents cannot move without assistance and require feeding.

Refer to Figure 12 Pine House Floor-plan on p. 101.

4.6.4 Elm House

Elm House is in two halves, one of which cannot be accessed without knowing the key-code to enter and gain access. Behind the locked doors is a mirror image of the other half of the House. This closed off section is referred to as the secure unit. There are court-yards opening off the dining rooms in this house. The main activity and therapy room is located at the rear of the building in Elm House. The nurses' station is located at the entrance to Elm House, immediately outside Pine House. Like that of Birch House, it is separated from the open corridor by a timber desk with a high ledge. Located opposite is an office used by the Hospitality and Catering staff. The dining area doubles as a lounge area in both halves of Elm House. All meals and many activity sessions are held in these rooms.

In Elm House, there is a room known as 'the quiet room', which looks out on to the main court-yard. It is furnished with a round table and chairs, with matching drapes. There is also a white-board stored in the room. It is designated as the space where relatives can go should they need the privacy. It was allocated for my use as a student and is regularly used by medical and other health care students.

There is a narrow path-way at the rear of the building and along the southern perimeter, where residents can walk. It is secure from road way access, ensuring the safety of residents with dementia who 'wander'.
4.6.4.1 Resident Profile

There are thirty residents on Elm House, fifteen of who are in the secure unit. The residents in the secure unit experience dementia and whilst they are not all physically dependent on staff there are multiple problems associated with confusion. For example, eating meals starting with dessert, dressing and undressing repeatedly, continence problems, wandering and disorientation. Associated with these are periods of aggressive behaviour by some residents. The other fifteen residents are similar in profile to those of Pine House although there are fewer residents who are as mentally alert.

Refer to Figure 13 Elm House floor-plan on p. 102.

4.7 Business as Usual

Over the case-study period the business of the nursing home continued, with two deaths occurring, new admissions arriving and tours of the building taking place weekly. The head office site informed Beechwood Nursing Home that an advertising promotion was to take place in the Beechwood region promoting the Extra Service Places, because little interest had been demonstrated by the market in the region for this calibre of care. Staff told me it would have been far more successful at the 'inner-city' location.

My case-study work took place over the summer months and some-days the temperature reached over 30 degrees celsius. Keeping the building, and hence residents cool was a challenge, as although only recently constructed, ducted air-conditioning was only located in Birch House (site of Extra Service Places). Several pedestal fans were purchased and staff developed methods for keeping rooms shaded as the sun moved around during the day. The outdoor areas of the building were of no benefit as they had no suitable shading or appropriate ventilation to allow cooling of the building, which forced residents to stay indoors.
4.8 Conclusion

This chapter has concentrated on providing information about the case-study venue. This information relates to the location of Beechwood Nursing Home, its management arrangements, staffing, Accreditation, physical characteristics and floor-plan of the building as well as detail about the three houses comprising Beechwood Nursing Home. This information is considered to be important to the discussions that follow in Chapter 5 about nursing home culture and those in Chapter 6 about the relationship of the building to nursing home culture. The basic management and operating arrangements discussed in this Chapter provide an insight into the relationship between head office of the church-and-charitable operator and the Beechwood Nursing Home site. Data obtained through observation by me as well as participation in meetings revealed tension existed between the head office site and Beechwood Nursing Home. This tension was discussed and attributed to differing expectations between the two sites and a lack of authority at the Beechwood Nursing Home site. One of these sources of tension, the preparation for Accreditation and implementation of a quality system was discussed in detail. Further reference to management arrangements, authority and the quality system are to be found in Chapter 5.

The floor-plans accompanying this chapter and discussed at length provides the reader with a visual reference to accompany discussions in both Chapters 5 and 6. As part of the description of Birch, Pine and Elm House, a profile of residents on each house was provided. This profile provides information regarding the physical status of residents and their needs as well as the variation in mental status amongst residents. It was identified that Birch House is home to seven residents categorised as Extra Service Places, that Pine House is also home to the kitchen and laundry services and Elm House provides a secure unit for fifteen residents with dementia. Various features and aspects of each of the houses are incorporated within the discussions that follow in Chapter 6.
Figure 11 Birch House Floor-plan
PINE HOUSE

Figure 12 Pine House Floor-plan
17 NURSES' STATION
18 THE QUIET ROOM
19 ELM HOUSE LIVING & DINING ROOMS
20 INTERNAL COURTYARDS
21 RE-LOCATED ACTIVITY ROOM
22 SECURE UNIT ENTRANCE

ELM HOUSE

Figure 13 Elm House Floor-plan
Please note

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CHAPTER 5 An Analysis of the Nursing Home Culture

5.1 Introduction

In this chapter the findings from the case-study research, undertaken at a seventy-five-bed nursing home are discussed. This is augmented by data obtained from the architects' interviews, conducted prior to the case-study. Both the case-study and the interviews with the architects were discussed in Chapter 3. In Chapter 4 details related to the case-study venue were presented. These details included organisation arrangements, floor-plans of the case-study venue and profiles of Birch, Pine and Elm House. These details are important to the findings discussed in this chapter, which focus on the culture of the nursing home environment.

In Chapter 2 ‘Conceptual Framework and Theoretical Perspectives, I introduced the contention that the organisation culture of a nursing home is essentially a routine-task oriented culture, where the emphasis on routine minimises opportunities to meet psycho-social needs of residents. In the discussion in this chapter, I analyse data gathered from the nursing home case-study that supports this contention. The central argument in this thesis pivots on the establishment of a relationship between the culture of the nursing home and the physical context of the setting. Apropos of this objective, this chapter begins by providing detail related to daily life in the nursing home, the perception of the primary task of the nursing home and the work practices of staff. In Chapter 6 which follows, the relationship between the organisation culture and the physical context of the setting are discussed.

A working definition of culture for use in this thesis was also established in Chapter 2. This working definition is expressed as the examination of those interactions occurring between people (i.e., the social enterprise) that are mediated by organisational task, organisational boundaries, organisational defenses against anxiety and the interaction between these and the organisational holding environment. Applying this definition I explore why the routine task culture dominates in the nursing home environment and why certain psycho-socially oriented needs of residents are not attended to. Particular attention is paid to the social defenses that operate in the nursing home culture.
5.2 Nursing Home Task Culture

As stated in the introduction to this chapter, it is my contention that nursing home culture is at best a routine task oriented culture and that adherence to routine by staff serves their needs, more than those of residents. Given that the objective of organisations is to achieve a task-oriented culture as argued by Miller and Rice (1967) and Hirschhorn (1995) why should one which is defined by 'routine' matter? A culture dominated by routine as in a nursing home setting may have benefits for residents, such as those which are associated with the security and comfort of order and routine, but it would appear that many of the benefits are for staff rather than residents.

There are several important issues emergent from the combination of a routine task culture of the nursing home and a physical environment that favours this culture. These issues are central to the residential lifestyle of the people who live in the building on a twenty-four hour basis and who often require assistance with their activities of daily living. These issues centre on maintaining the locus of control with the resident; ensuring privacy; fostering a balance between privacy needs and social needs; and maintaining self-identity in a communal living space. The routine task environment and the emergent issues are discussed in depth below.

5.2.1 The Routine of the Routine Task Oriented Culture

To provide a deeper understanding of the routine that suffuses the culture of the nursing home, what follows is the time-table of activities that take place on week-days at Beechwood Nursing Home. This time-table is typical of daily life in Elm House, one of the three units of the nursing home. There are 30 residents in Elm House, many of whom experience dementia. The time-table covers the hours between 7am and mid-afternoon, which coincides with the first shift of nursing and care staff for the day. Upon looking through the day’s activities it is not difficult to appreciate that activities are time dependent and that daily life is characterised by repetition. In order to execute the timetable effectively, a high degree of organisational skill is required on the part of both the nursing and care group and the hospitality staff.
**A Day in Elm House**

0700 - Residents made ready for breakfast, sitting up or sitting out of bed, depending on Care Plan requirements. Residents who need feeding, are assisted – more feeds are required in the Secure Unit of Elm House, as there are fewer independent residents.

Medication Round and Dressings*

0800 - Showering and dressing as per Resident's Care Plan.

0945 - Residents seated in lounge areas of Elm House or in their own rooms – as requested by some.

1000 - Morning tea served.

1000 – Several residents taken to Birch House for activities or activity undertaken in lounge area of Elm House. Music Therapist may visit.

1145 – Residents sat up for lunch, in chairs or at the table as per ability.

1200 - Lunch trolley arrives and staff take lunches to residents. Residents fed as needed. Other residents remain in room and eat lunch alone.

Medication Round.

1300 - Several residents attend afternoon activities in Birch Lounge or in small lounge area. Music may be played. Toileting takes place.

Staff retreat to Nurses Station to complete 'documentation'. This means updating charts related to the residents in their care, such as fluid balance chart, bowel chart, out of the ordinary events, e.g., falls, skin tears, declining interest in food. Staff on 0700 to 1300 hrs shift, finish.

1415 - Hand-over takes place in each house. Early shift finishes for Nurse Assistants and Enrolled Nurses at 1430hrs.

1500 - Unit Manager/Registered Nurse in charge leaves.

"Medication rounds take place at each meal-time. In addition there are medications to be distributed at other times during the day and in the evening. Dressing of wounds will be done following showers and as per requirements, e.g., twice a day, once a week. The severity of dressings will vary from simple skin tears to major ulceration – many of which are considered to be totally avoidable. Doctors and other visiting health care providers will call at will. Medical practitioners will generally expect the registered nurse in charge of each 'house' to be available.
The pattern to the days described above is universal in the three houses that comprise Beechwood Nursing Home. It centres on feeding; getting residents out of bed; washing; toileting; dressing; social activities; and putting residents to bed at night. The work resembles that which is expected of a parent in western society. A margin note made during my case-study indicates that I see the nurses and carers role as limited to cleaning and feeding of residents, in order to send them off to be entertained by the life-style and activity staff. One significant difference with this pattern between the care of the aged and the care of children, is that residents are passive not active in this process, which is the reverse case for children who generally take up activities with relish. Notwithstanding the developmental aspects of activity for children and the different stages of the life-cycle between the young and the old, it is still significant that passivity is experienced amongst the residents.

5.2.2 Lifestyle and Activity Sessions

Large group activity sessions take place in the lounge area of Birch House. These include carpet bowls, religious services and the celebration of days of special significance such as Australia Day, St Patrick's Day, Easter and Melbourne Cup Day (a major horse race). The life-style and activities staff create a theme for the day, which is reflected in the meals served, the clothing worn and the music played. For the Irish Catholic celebration of St Patrick's Day on March 17, residents and relatives were served green cordial and green ice-cream. Staff wore green t-shirts and residents wore the colour green. A group singing event of familiar Irish songs took place and residents' were provided with large-print lyric books. Throughout the afternoon event for St Patrick's Day, only the activity and lifestyle staff were in attendance, no nursing and care staff or hospitality staff participated. I found this to be typical during the period of the case-study. Below is a representative time-table of weekly activities for Beechwood Nursing Home. Some activities were held in Pine or Elm House.
Throughout the day individual 'therapy' activities such as physiotherapy are undertaken with residents – although this occurs to a lesser extent with residents on Pine House and Birch House. Residents will have their hair done, on site. Visitors may also be present and birthday celebrations for residents take place. There are bus-trips organised for residents which include visits to gardens, having fish and chips by the sea (an evening outing), travelling the newly opened freeways and visiting shopping centres. Relatives visit throughout the day and spend time with residents or take them out for lunch or an outing. Many relatives attend at meal-times to feed their family member (if required), often being present for both the midday and evening meal. Visitors bring in flowers. A few residents in Birch House have pot-plants outside their windows on the balconies. These are organised and usually cared for by family and friends, although lifestyle and activity staff also pay attention to the plants. No provision for plants is made in other areas of the building, except the perimeter of the outdoor court-yard.

There are no organised activities on weekends. (The fact that no activities are provided on week-ends is frequently expressed by residents in response to the Residents' Satisfaction Survey. This was also the outcome at this case-study venue. Author's work, 2000). Although the nursing home residents are there seven days a week, the emphasis on activities and the overall operation of the facility is concentrated into the Monday to Friday period. Appointments with specialists, both inside and outside the nursing home as well as seeing other visiting services including 'music' and 'pet' therapy can only be achieved during week-days. This emphasis on week-days, resembles commercial businesses which have their main activity during week-days and offer no services on weekend days. From a business perspective one major reason for this arrangement, according to facilities, is the cost involved in paying staff weekend and penalty rates, which makes weekend services and activities prohibitive.
5.2.3 Days in Pine House and Birch House

For Pine and Birch House residents the daily pattern is similar to that described above, however the dependency levels of residents is much less in each of these houses to that of Elm House. As a result more residents are able to feed themselves and assist to a greater extent in their own personal hygiene. A larger number are also able to ambulate (walk) unassisted. The ability of residents to interact at a meaningful social level is also greater. Many residents in these two houses and a few on Elm House, prefer to eat alone in their rooms. Olya, a resident of Pine House has expressed her preference to eat alone, in her room. Whilst Olya shares her room, her companion is transferred each day to Pine House lounge and is dependent on staff feeding her.

There are two resident-initiated activities at Beechwood Nursing Home. Heather, the Life-style Co-ordinator, fosters these activities. These are the Friendship Group, which is run by a resident and his wife, and the other is Music Appreciation, run by another resident, Kaye. Kaye was formerly a music teacher. Both take place on a weekly basis and are advertised throughout the facility encouraging all residents to participate. Friendship Group is held in the Pine House dining room and centres around a special morning tea. All the best china is brought out for the occasion and just prior to lunch, sherry is served to those who desire it. Kaye has a vast collection of music as well as being able to draw on resources at Beechwood. It is rare to see resident-initiated activities and I was able to participate in both during the period of the case-study.

Two Illustrations of the Routine Task Culture

An excerpt from my interview with Margo, Hospitality Service Co-ordinator at Wantirna, provides an apt representation of the emphasis on routine and the drivers behind it.

Me: Do you think residents have authority at Wantirna?

Margo: 'No, not really they're showered when the nurses are ready, they're fed when the kitchen is ready, they're put to bed when nurses are ready'.
Me: Is it the building that encourages this?

Margo: 'No, not really'.

Me: Is it the culture? (acting as a reinforcer)

Margo: 'Yes, if there is no routine then things won't get done. Meals have to be out for shifts to change*, but we should be able to accommodate residents if they say, I don't want lunch until such and such a time, nursing and kitchen staff should accommodate this, should be open to changes in routine. If you want to lay in bed, should be able to and eat what you want. You can do it at home'.

*One group of staff finishes their shift at 1p.m. and others must go to first or second lunch within a defined space of time, however the practice is that residents who need feeding take priority.

In addition to demonstrating the emphasis placed on routine within the nursing home environment, this excerpt reveals another dimension, that of a conflicted position between routine on the one hand and residents preferences on the other. As Margo went on to tell me, one of the residents designated as Extra Services had requested a change to their meal-times, which was seen as quite unusual in the setting.

Many residents and their families introject this routine task-orientation of the environment, which becomes a supportive and reassuring aspect of day-to-day life. At Beechwood the permanent members of the nursing and care staff are reasonably static, only moving between 'houses' in cases of staff shortages. According to staff at Beechwood, residents found it reassuring to be cared for consistently by the same staff members, suggesting that it helped the resident feel secure when staff were familiar with their individual requirements.

Residents can become anxious if meals are late, their bed is not made or they have not been showered. It seems the routine task-oriented culture is a strong thing to fight
against, and may act like a vortex willing the new resident to adopt the culture or be alienated by it. This alienation is an undesirable state in which residents are labelled as 'difficult' and 'unco-operative', because they would like to exercise control over their lives. Residents therefore become complicit in the domination and maintenance of routine. This is reflected in the comments about meals and general access in the building during the interview with Olya, a resident of Beechwood Nursing Home, living in Pine House.

Olya: 'I don't eat much at all here. At home I liked my own cooking. Couldn't tell you where the kitchen is'.'

'The kitchen is located in the same 'house' as Olya, approximately 50 feet away.

'I've only been into the courtyard three times. I don't like to worry the girls when they ask me, they have enough to do wheeling people around, I like to give them a break – I wish some others would'.

During the writing of this thesis, my own experience of acculturation took place. My partner's mother moved from an independent living unit to a low care facility on the same site. She had been used to preparing her own meals and ate at whatever time she wished. I remember her clearly saying, I won't be having my meals at 5 o'clock in the evening. Within a few weeks she had adopted the meal-time routine of the facility and now her outings and telephone conversations have to be timed around this evening meal. And yet, she often comments on how long the evenings are for her, quickly adding that staff have to get off by 6 p.m.

5.3 Defining the Primary Task of Beechwood Nursing Home

In this section I provide a cross-section of views about the primary task of Beechwood Nursing home. The primary task of an organisation has been described elsewhere as the reason for the organisation's survival (Rice 1963). It has also been suggested that different groups within an organisation may have different definitions of the primary
task (Zagier Roberts 1995, p.29). Whilst the primary task is considered to be vital to an organisation’s survival, I am less concerned with survival of the nursing home (notwithstanding the expectations of Accreditation), given that market forces indicate that there are not enough beds to meet requirements in the current climate. What is important to establish is the interpretation of the primary task of the organisation by staff and others, within the nursing home environment. This has implications for the management of boundaries and the conduct of work within the environment.

To elicit the interpretation of the primary task most (but not all) interviewees were asked whether they saw the nursing home as providing a place for living in, for dying in or both? On occasion this question was phrased as 'do you see the building as providing a place for living in or dying in or both' or 'what is the role of the nursing home'. Whilst I recognise that these are different questions, the phrasing of the question was dependent on what ground had been covered during the interview and whether a question that focused the interviewees' response was warranted. The nature of restraints on the interview influenced the point at which this question was put. For example, very often staff were available only for short periods of time, or they were called away during the interview, or sometimes we were interrupted. Less formal discussions with staff in corridors and the staff-room also contributed to the interpretation of the primary task of the organisation. Below are the responses from interviewees to the questions oriented towards determining their perception of the primary task of Beechwood Nursing Home.

**Nursing and Care Group**

Olivia, the Unit Manager of Pine House and Quality Co-ordinator considered Beechwood Nursing Home was there, 'To provide accommodation for those who can't manage at home, or there's no carer, or where the carer can't manage. Or, an individual's needs can't be met and they get transferred'.

Wilma, a Nurse Assistant on Birch House responded by saying 'Yes – everyone knows it’s the last step – not getting out and it's there last days. Madge [a resident in her 60s with a chronic condition] could be here for the next 30 – 40 years. What I find sad is Madge, the 80 – 90 year olds have had a long life – still come to nursing home for care.'
When it gets to time, for example with Mrs B. it’s a blessing to go, not suffering – she was full nursing care, had to be turned’ [recently deceased lady who constantly nursed and fed a teddy-bear].

Kerry, a Nursing Assistant on Pine House stated that ‘you can have a place for living and dying in, it’s not like an institution, treated as their home. Perfect place. Big rooms for family to sleep over; roller beds in rooms; tea/coffee; sandwiches for family’.

‘I don’t like to see people die by themselves. Don’t like seeing agency staff with them. I know they come here to die. ‘You make them comfortable and provide a home environment, make them happy. It’s a place to live out their days. We make them comfortable. ‘For Ray we had soft music – rain forest music. It was an environment to die in. We had oil burners’. I ask, Did you cry? ‘Yes I did. We bring relatives to the quiet room and bring Olivia down to them’.

Beatrice, DoN/Manager stated ‘Yes I do [both living and dying in] it can be achieved. A single room is very lonely, many residents have no-one, it’s the saddest thing. Some die in isolation. ‘We make them very comfortable and do the best we can and acknowledge them as human beings’. Beatrice is quite tearful and says she is quite upset by the residents’ loneliness - that it’s hard for her.

Other Staff

Heather, Lifestyle and Activities Co-ordinator - ‘Building encourages "living" environment, yes it does. There is a percentage of people who keep to themselves, but there are opportunities to get involved. The atmosphere is important. It’s generated by nursing staff and staff in general. Friendly feeling’.

‘Building can do both, you can live and die in it. ‘I’ve sat with residents as they’re dying and gone to a lot of funerals. ‘It’s sadder when you lose an active resident. There was one in their absolute element, then he was no longer here not much later’.
Margo, Hospitality Services Co-ordinator responded by saying, ‘we have palliative care, it’s not great when we have to move out someone when they die – shut all the doors including kitchen and laundry for someone whose dying. Nursing staff are great – all staff good and caring with relatives. We have no room for relatives, maybe get a bed (fold-up). You come and see them in the morning sleeping in a chair’.

Relative of a Resident

Delia, the daughter of a resident in Birch House had the view ’yes – in a nursing home you don’t come out the other end, it’s out the back door in a box. Old people know what’s happening. They’re now living so long, they’re looked after well and there are more drugs. In their day there was no power, no cars readily available. I have girl-friends who say ”who wants to end up in a nursing home!” You can’t do much, the day is long. It’s the last bit of life. They get basic care/ food/washing. Years ago they would have died, got pneumonia. They need nursing homes for younger people. Madge (the 60 year old woman) needs different things. People used to get sick at home and they died. The Primary Task – to keep them comfortable during the day, look after cleaning’.

From interviewees’ comments, the common theme is one of making residents comfortable up to and when they are dying and providing an environment which is suitable to this purpose, i.e., home-like/friendly/encourages involvement and staff who are caring and sensitive. What is absent from these comments and from my observations during the case-study, was a clearly articulated perception of the role of activities and their relationship to the social well-being of residents in the environment. Care equated with the activities of daily living. These are discussed in section 5.4.2.

Understanding the primary task of the organisation enables it to be translated by the organisation for the purpose of prioritising amongst its different activities and determining the allocation of resources within the multi task-systems which comprise it (Rice 1963). Given this, I was interested to be told by Heather the Life-style Co-ordinator during our interview that her role was made much easier by having access to a fund which ’...means special rewards for residents for activities and special functions, such as afternoon tea on Australia Day. It’s outside the nursing and kitchen budget. You
feel like you're worthwhile – that what you do is worthwhile'. At other work-places, Heather had experienced feeling like a trouble-maker, when she repeatedly asked for support for activities and resources to enhance the residential lifestyle. There was no tension over this at Beechwood Nursing Home as she could draw from a foundation, established through the benevolence of a long serving member of the organising group of the charitable operator. Heather found the atmosphere of the Beechwood operator to be more caring, more of a family.

This financial arrangement speaks volumes about the assurance of core budget funding for nursing and care staff, ahead of funding for lifestyle and activities and therapy for residents. During the case-study, Beatrice the Director of Nursing/Manager of Beechwood advised senior staff that 'head office' were 'falling off their perches' about the amount of money being consumed on agency staff. This funding short-fall reflects the emphasis on the difficulty in recruiting and retaining registered nursing staff, as well as the emphasis on meeting the clinically driven aspects of care over lifestyle activities and therapy.

5.4 Routine Task Culture and Work Practices as Social Defences against Anxiety

In the sections above I have provided detail about the routine daily life of Beechwood Nursing Home. Following this I have described the main theme of the primary task of the nursing home as being to provide care to residents up to and at the point of death. The emphasis being on the physical aspects of care, supported by the environment and accompanied by caring and sensitive staff. In the sections that follow I discuss the work practices of staff groups, in particular that of the nursing and carer group. This is followed by a summary of the social defenses I consider to be operating in the culture of Beechwood Nursing Home. These social defenses are then analysed within the context of aspects of the organisation culture of Beechwood Nursing Home. Prior to this, there is a brief re-visiting of the purpose of a nursing home which is intended to convey a snap-shot of both the staffs and resident's environment, which is relevant to following discussions.
5.4.1 The Purpose of Nursing Homes

The role of nursing homes is generally considered as being to provide care to those who cannot care for themselves at home, or who have no-one to provide the care. Many residents are transferred from other health care facilities. All residents require nursing care and most have a medical diagnosis. In Australia admission is via approval from an Aged Care Assessment Team together with a medical certificate. Some admissions are provided for reasons of housing need ahead of care needs. Nursing homes provide care to residents who are generally classified as being in need of high level care. They are also the main residential environment for people who experience dementia (Mitchell and Koch 1997; Snowdon and Donnelly 1986).

5.4.2 Work Practices in Aged Care

Task achievement forms a strong part of the nursing home task culture. For nurses and carers this is often the achievement of physical tasks with residents. The work of the nursing and care staff is principally in the provision of Activities of Daily Living (ADL's). This means the provision of basic hygiene, nutrition and care needs required by individuals to maintain their health. Where a deficit is identified, planning takes place to meet these needs and evaluating that ADL's are being met, takes place at regular intervals. Ideally the nurse and resident create a 'Care Plan' to meet these needs with the resident encouraged to participate in their own health care. 'Care Plans' are also contributed to by others in the health care team, such as the activity and therapy staff (Garratt & Hamilton-Smith 1997). In most nursing roles and particularly those that are twenty-four hour in nature, ADL's are inseparable from nursing's identity.

The objective behind ADL's is to ensure the patient is achieving or maintaining an optimal level of health. If this is not/cannot be achieved it places the benefits of other therapeutic activities, clinical interventions and health promotion programs in jeopardy. Understanding the biological and physiological principles behind ADL's, is key to the recognition by qualified nurses of any pathology which may be present, or may develop over time. This forms part of the scientific approach to care known as the 'nursing process' (Mitchell & Koch 1997, p.455). As such, the level of knowledge and
competence required by qualified registered nurses compared to nurse assistants, is significantly greater.

A factor in the aged care industry is the increasingly difficult area of staffing. Most nursing homes operate with fewer and fewer qualified to unqualified staff ratios (an outcome of the legislative changes introduced in 1997) and on any one shift there will be a percentage of 'agency' staff. These staff are not employees of the facility, do not know the residents or the building and may never work there again. As noted earlier, Beechwood Nursing Home also used 'agency' staff, particularly at the Enrolled Nurse level. However there was a greater degree of consistency at this venue with 'agency' nurses working there on a frequent return visit basis.

The term 'patient' is used liberally throughout health care literature, irrespective of the actual health care setting, to describe those people who are dependent on the care provided by others. Attempts to break the nexus of dependency inherent in the term 'patient' and to engender a more balanced relationship between expert/provider and person receiving services have taken place. This is reflected in terms now in use in some health care settings, for example, community health services. In nursing homes and residential aged care facilities, the term used is 'resident'. However, visiting specialists, doctors and some staff continue to refer to residents as patients. Residents will refer to themselves as patients. This entrenched pattern may play itself out in the orientation toward illness rather than health and moreover fosters a culture in which this is inadvertently emphasised. Perhaps the following quote by the secretary of the Queensland Nurses Union expresses the difficulty associated both with terminology and interpretation in practice.

Nursing homes should not be confused with retirement villages. While people in nursing homes are usually referred to as residents, for reasons of dignity, they are really patients requiring specialised geriatric health services. A nursing home is a health facility that provides these services. Most people go into a nursing home as a last resort – when they are too sick to look after themselves or be cared for by relatives. Most go from hospital and all require nursing and medical care (Hawkesworth 1999, p.13).
The importance of the physical care of residents is evident in a recent study by Courtney and Spencer (2000) involving registered nurses in residential aged care facilities. In this study it was identified that registered nurses in bedside care roles considered the most important indicator of quality clinical care to be pressure ulcer rates, followed by incontinence rates, hydration management, rates of infection from all sources, skin integrity and poly pharmacy. The authors link their work to Standard 2.4 'clinical care' under the recent Standards of Residential Aged Care which are assessed via the Accreditation process. This standard does not nominate any indicators for assessing the quality of clinical care.

5.4.3 Work Practices and Staff Groups

The routine which is evident in the time-table of daily life provided above in section 5.2.1, appears to be driven primarily by the nursing and care staff whose work centres on Activities of Daily Living. In turn, this dictates the routine task-oriented practices of the hospitality staff, who must prepare meals, serve and clean-up around the time-tabling and routines constructed by the nursing and care group. Further, whilst the staff providing lifestyle and therapy to individual residents or groups of residents have a routine of activity which is time-tabled, (represented in Table 6 above) they are constrained in their schedule by the time-tabling and routines set by the nursing and care staff.

Of the nursing and care group and the lifestyle and activity group, one is heavily oriented towards the physical dependence needs of residents, whilst the other is heavily oriented towards the psycho-social needs. Nursing and care staff align themselves professionally with the provision of care which supports the physical dependence needs of residents and aims to maintain physical independence. The life-style and activity group align themselves professionally with the provision of care which meets the psycho-social needs of residents, with the aim of promoting a positive social existence in which residents can engage.

During the period of my case-study I made the observation that it was easier to communicate with the lifestyle and activity staff, than with the nursing and care staff
group. I felt more at ease with them. The nurses and carers were always scurrying off to undertake an intimate care role in private with a resident. They were not 'available' in the same way as the lifestyle and activity staff. The lifestyle and activity staff did assist with feeds of residents – sometimes for assessment purposes, sometimes where a 'house' was very short-staffed. It is more likely that it was to speed the pace of the feeding routine, in order to have residents ready for afternoon activity sessions. The situation of being short-staffed often happened and one Sunday I arrived to find Beatrice the Director of Nursing/Manager, working a late shift as no replacement Agency nurse was available.

5.4.4 Clinically-Driven Hand-Overs

Every day between the change of shifts, hand-over takes place. Hand-over enables staff to pass on information about residents from one shift to the next, which is considered important for the conduct of the next shift. At Beechwood, hand-over takes place at 2.15 p.m. in the nurses stations of Birch, Pine and Elm House. It lasts for fifteen minutes. The Unit Manager or Registered Nurse in charge attends, as well as several staff on duty. The keys for the medication trolley and dangerous drugs and stores cupboards are handed from one registered nurse to the other (it is a legal requirement that only qualified Registered Nurses carry the keys). The information that is passed to the next shift varies according to what is happening in the unit, for example, conveying the status of a dying resident. I attended hand-over at Birch House, which consisted of a run through of clinical issues and needs of various residents, as follows:-

Specific drugs and ointments in use, the presence of urinary tract infection and changed doctor's orders for medications for several residents. General improvements in several residents are noted, whilst the management of eye-drops for one resident is raised. Staff are reminded to use prompting charts to maintain continence in residents where needed. MSSU’s (Mid-stream Specimen of Urine) are being sent off for laboratory examination. A change in dietary needs of one resident is raised. Another resident is identified as needing Normal Saline eye toilets.
As an observer to this hand-over procedure, I was struck as to how clinically oriented it was. There was no mention of activities undertaken by residents and no comments on the general welfare of residents. It seemed as if two entirely different and un-related work groups existed within the same work-place; one being the nursing and care group and the other being the lifestyle and activities group. Even though both staff groups worked with the same residents, often together, it was as if each group had no capacity for the other's information. Where the resident could have acted as the unifying feature for the sharing and contribution of each group's knowledge with the other, this did not take place. I was struck several times by this apparent 'professional distance' between these two work groups.

5.4.5 Summary of the Social Defenses of Beechwood Nursing Home

Drawing upon the information presented to date and consideration of the data, I have formulated 4 principle social defenses that I consider to be operating at Beechwood Nursing Home (and most other nursing homes). These social defenses and the reasons for their existence are summarised below. They are presented from the perspective of the staff.

1) Maintaining routine is paramount to the welfare of our residents. Having a routine which involves time-tabling of one activity leading into the next, avoids long unstructured hours on a one-to-one basis with a resident.

2) The more committed to a routine we are – the less likelihood there is that issues about death and dying can surface – for both the residents and us.

3) Having a demonstrable routine task oriented culture means we can measure what we do and how much of it we do – if it can be measured it can be equated with the emphasis we put on caring for residents. These are what we consider to be our transactions of worth occurring within the boundary between the external and internal environments.

4) A routine task oriented culture enables us to emulate the culture and practice found in rehabilitative and curative health settings – where the emphasis is on clinical activities rather than lifestyle.
5.4.6 An Analysis of the Social Defenses

According to Menzies (1988, p.63) the social defense system is oriented towards helping the individual avoid the experience of anxiety. This is achieved through the elimination of situations, events, tasks, activities and relationships that cause anxiety or, more correctly, evoke anxieties connected with primitive psychological remnants in the personality. In the social defenses listed above, it appears that staff are acting to reduce the anxiety of the situation whilst being convinced of the value of their work.

5.4.6.1 Confronting Unpleasant Tasks, Death and Dying

When Menzies first coined the term Social Defenses she was engaged as a consultant in a hospital, working with nurses (1959). There are several parallels between this original work and the case-study experience in the nursing home. According to Menzies in a hospital the nursing service bears the full, immediate and concentrated impact of stresses arising from patient care (1988, p.46). This is also true of nursing home settings. Menzies states that nurses are confronted with suffering and death as few lay people are and that their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening. In nursing homes these tasks include managing urinary and faecal incontinence, ulcerated sores, feeding residents, performing mouth toilets and handling dying and dead people. On several occasions I made a note of the strong smell of faeces which greeted me in different parts of the building. Menzies (p.46) notes that in many instances patients in hospitals will not achieve a full recovery and that one of the most distressing tasks for nurses is nursing those with an incurable disease. In the nursing home setting nurses care for residents who will never recover their full abilities, as they are ageing. Chronic conditions are common and terminal illnesses are managed under a philosophy and practice of palliative care.

What is quite different in the nursing home setting to that of a hospital, is the certain knowledge that residents will die there. They will not return home. Many staff I talked with had worked with a resident right through to the time they had died, often sitting with them. Staff often attended funerals of residents. Heather, the Life-style Co-ordinator, in discussing the difficulty in recruiting staff to Beechwood Nursing Home
and whether this related to the nature of the work (apart from the pay being less) commented, 'for those people who want to work in aged care – living/dying not an issue. Some don't like working with people who they know it is the end of their life'.

Menzies (1988 p.46) identified in her hospital study that intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurses: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient. Whilst I am uncomfortable with the notion of erotic wishes emerging in an aged care venue (it somehow seems unpalatable) I accept the phantasy situations which Menzies describes (p.47) which draw on the experiences of earliest infancy, where the opposing sets of feelings and impulses are experienced, libidinal and aggressive. I suspect the feelings aroused in nurses working with old people are similar to those described above by Menzies (there are people as young as 30 years old in nursing homes, but these are few and far between).

In Zagier Roberts consultancy work at Shady Glen, a specialised hospital for severely impaired elderly people who required long-term nursing care, she noted that caring for elderly people stirs up many anxieties about future physical and mental decay, and loss of independence. It may also stir up memories and fears about our relationships with older generations, especially parents, but also grandparents, teachers and others, towards whom we have felt and shown a mixture of caring and uncaring (Zagier Roberts 1995, p.75). Residents are also confronted with able-bodied carers, who leave the premises and go home at night, unlike themselves.

Zagier Roberts (1995) witnessed various defenses against the anxiety associated with caring for the elderly in the 'Shady Glen' establishment. These included depersonalising relations with patients by treating them as objects and by sticking to rigid routines; avoiding seeing common elements between themselves and the patients; illness, absenteeism and exhausting themselves to avoid feeling guilty.
The Ritual of the Clinically-Driven Hand-over

Many of the work practices that take place in the nursing home setting which serve as social defenses, Hirschhorn (1995, p.67) prefers to call organisational rituals, reserving the term social defenses to describe the 'gamut of defenses against anxiety'. These organisational rituals help all members depersonalise their relationship to their work. The 'clinically-oriented' hand-over I observed on Birch House, described in section 5.4.4 is an example of an organisational ritual. It conforms to Hirschhorn’s definition as being '...a procedure or practice that takes on a life of its own and is seemingly unconnected to a rational understanding of experience' (p.67). This is accurate from the point of view that the hand-over unquestioningly excluded a 'whole of person' consideration. However, I am certain nursing and care staff would rationalise its value in terms of the importance of continuity in the clinical aspects of nursing home care provision.

In effect, the clinically-driven hand-over is a ritual that cannot be lost, even though much of what transpires fragments residents into bodily functions. In some way the nursing staff (and here I am referring to those qualified staff prepared for practice either in a training hospital or tertiary education setting) would perceive this hand-over process as the legitimate venue for exercising their clinical knowledge and expertise in care provision. My hypothesis here is that the routine oriented practice of a clinically driven hand-over gives the illusion that the nursing home environment equates with a rehabilitative or curative health care setting – as would be found in the hospital. After all, what are nurses there for? The emphasis here is on the clinically driven aspects of hand-over, which I suggest in the nursing home environment, is a social defense. The nomenclature of clinical practice in nursing and the technologies utilised provide mechanisms for defending oneself against anxiety. Like a uniform (so often worn proudly) they serve as flag-bearers of the culture, while acting as boundaries deflecting the anxieties associated with the close nurse-resident relationship and its attendant performance of intimate tasks.

At hand-over other information about residents is conveyed, for example, who has gone on an outing, which relatives have questions that need answering. However, this is often interpreted by successive shifts as extra tasks to be attended to within the time-frame of
the shift. They represent markers about what could go wrong, for example, the person who is on an outing is late back to the building (or worse still, missing or returned by the police – this does happen). These points illustrate how nursing staff interpret the nursing home environment in which they work. It concurs with Goffman's (1968, p.18) characteristic of binary management – that is, two groups in the institution: one the managed and the other the managers.

5.5 Social Defenses and Basic Assumptions in the Nursing Home Culture

In Schein's three tier model for analysing the culture of organisations (1997) he proposes that the most difficult aspect of any organisation to decipher is the third tier, that of basic underlying assumptions (c.f. Bion’s contribution of ‘Basic Assumption Behaviour’ to psycho-analytic theory). Schein states that basic assumptions represent those beliefs, which are held by all members of a group and act to provide cohesion in the thinking. They define what to pay attention to, what things mean, how to react emotionally to what is going on and what actions to take in various kinds of situations. It is when basic assumptions are challenged that anxiety and defensiveness are released (Schein 1997, pp.22-23). Schein's work on basic assumptions resonates with psycho-dynamically oriented concepts of organisational analysis, in particular the existence of social defenses and how they come about within organisations. They are manifest at the group level but originate at the level of the unconscious.

The social defenses described above are akin to Schein's description of basic assumptions, in that they are jointly held assumptions by all groups, which have the effect of binding the groups together in a mutually understood objective. Further, the values are espoused by those who work there, they are reflected in the artefacts, such as written material and in the manner in which the building supports them. These basic assumptions act to regulate the behaviour of groups within the nursing home and fuel the perception of the working environment as a good place to be. However these perceptions are not necessarily the most accurate version of what transpires in the workplace setting.
5.6 Institution-in-the-Mind

The discussion about 'clinically-driven hand-overs' and how they act as a social defense may reflect 'the-institution-in-the-mind' of the nurses. This concept also known as 'organisation-in-the-mind' is defined by Hutton, Bazalgette and Reed (1997, p.114) as 'what the individual perceives in his or her head of how activities and relations are organised, structured and connected internally'. In the case of Hutton et al., the concept of the 'institution-in-the-mind' is articulated with 'organisation role analysis' with individuals. What I am suggesting here is that a collectively held 'institution-in-the-mind' may exist amongst nurses in practice in the nursing home environment. My evidence lay in the routine-oriented task culture, which leaves very little room for either varying the schedule of routine tasks, or in the interpretation of performing the tasks. They are implicitly understood, from one nurse to the next, across each of the levels of nursing staff. Further, agency nurses who may work in a facility only once, while not familiar with residents by sight or name, can take up the technical elements of the routine oriented task culture immediately. Their role is completely unambiguous to themselves and those with whom they are working.

I am interested in the perception of the nursing and care group and the lifestyle and activity group at Beechwood Nursing Home with regard to the 'institution-in-the-mind' of each group. Hutton et al. (1997) suggests that individuals trying to communicate in the same system may not understand each other because of their different and unique experiences of organisational life. To illustrate this (literally) Hutton et al. depict two people - one person carries the picture of the organisation in his head as a square, whilst the other carries it as a triangle (1997, p.116). Extrapolating this illustration of 'organisation-in-the-mind' to the nursing home environment I am suggesting that the nursing and care group see the organisation in their mind as a square, while the lifestyle and therapy group see it as a triangle. Each group's conception of the organisation in their mind, differs from that of the other. This difference of 'institution-in-the-mind' extends beyond the approach to care in the nursing home environment, to the physical context and how it is used. This is taken up in Chapter 7.

I am mindful that the concept of the 'institution-in-the-mind' is considered to be a 'set of experiences held in the mind' of individuals (Hutton et al. 1997, p.115), rather than
groups. Therefore in the idea set out above I may be extrapolating the concept beyond that for which it is intended. However, it seems consistent to me to argue that a relationship exists between the previous cultural experiences of belonging to a staff group and the individual's experiences. These experiences are brought to the current work setting, hence the notion of finding parity with staff from the same discipline, producing a jointly held 'institution-in-the-mind', albeit unconscious.

Having written these descriptions of both the clinically-driven hand-over and ‘the-institution-in-the-mind', I am conscious of the exposure of my own understanding of being in the role of registered nurse. It may be about my need for organisation role analysis to understand my 'institution-in-the-mind'. I am compelled to highlight the legislative and other regulatory parameters on registered nurse practice in health care environments. The onus of responsibility falls to them in terms of clinical status of residents, their safety and whereabouts for which nurses are held accountable. This was demonstrated in Chapter 1, in relation to the Riverside Nursing Home.

5.7 The Subcultures of Birch and Pine House

Interviews were conducted with each of the Unit Managers. The interviews with Francine, Unit Manager for Birch House and Hilary, Unit Manager for Elm House are discussed here. The interview with Olivia, Unit Manager for Pine House is discussed in Chapter 6.

5.7.1 The Interview with Francine - Unit Manager of Birch House

Francine felt pressured and stressed in her position as unit manager of Birch House. Prior to interview she had talked with me about leaving Beechwood Nursing Home and nursing and doing something different. Although Francine felt supported by Beatrice the Director of Nursing/Manager and considered she had a very good group of staff, she felt challenged by her position. The plan for Birch House was to become entirely Extra Service Places. This would be achieved through a marketing promotion. Current non Extra Service Place residents would transfer to Pine and Elm House, when beds became vacant on these units.
The stresses for Francine revolved around the management and care of a residential environment designed to offer Extra Service Places. This was reflected in the quality of furnishings and overall provisions of Birch House with its spacious lounge and dining areas. Birch House was superior in its furnishings and different in its clientele. Francine found it difficult to be heard (by peers) when she talked of the particular stresses on Birch House, the others seeing her as 'better off' and 'better resourced'. She felt they didn't understand the needs of the complex environment, which juggled seven Extra Service Places with non Extra Service Place residents.

All nursing care was to be the same on all units, the distinction between Birch House and the other houses related to hospitality services. But this issue was creating tension amongst staff and residents, with residents expecting more. One of the issues related to the abilities of residents in Birch House. Many of the nurses and carers expressed frustration at having their time manipulated and controlled as a result of (Extra Service) residents making requests which entailed hours of extra work from the carer, putting them under duress to meet the needs of the other residents allocated to them. Staff and unit managers of the other houses saw their residents as more dependent and in need of greater care than those of Birch House, who were more able.

The consistency in staff:resident allocation of Pine House had a negative side. Residents classified as Extra Service, were found by staff to be overly demanding, requiring inordinate amounts of attention. Meeting the demands of these Extra Service residents resulted in staff paying little attention to the needs of the other residents in their allocation. Staff were unable to balance the demands of these residents whom they thought of as being 'more with it' than others. They also felt pressure from residents who said they were paying for a service and they expected it. During the period of the case-study, Frederick, the Evening Supervisor, rushed by me several times saying 'heaven help us when we've got twenty-four of them and not seven' The issues were leading to feelings of frustration and resentment towards the residents classified as Extra Service. Staff felt unable to manage the demands of these residents. As a consequence a negative image was forming about Extra Service residents within Beechwood Nursing Home.
Francine completed a drawing at the outset of our interview, refer Figure 14 on p.132. In her drawing she depicted a sailing boat on calm water. Francine wanted to experience this sense of calmness in her work environment. Her house had a sun over it depicting optimism about the work-place. Some of the trees in her drawing represented a strong tree that could withstand pressure and support others.

5.7.2 The Interview with Hilary - Unit Manager of Elm House

In contrast to the stately finish of Birch House which is shown off at the front of the building, Elm House is located at the rear of the building and is home to thirty residents, fifteen of who live in a secure dementia unit. Some of these residents are physically frail and disoriented in terms of time and space. Visitors to Beechwood Nursing Home may never know the unit is there. It is as if the madness is secreted away at the back of the building, whilst the sanity is promoted at the entrance and the front of the building. Prior to our interview Hilary told me about one woman who comes to visit her mother in the secure unit and can't get beyond the locked doors to the Secure Unit. 'She just can't handle it that her mother is in the locked unit.' Clearly there were deep emotional and psychological issues for this daughter. The physical boundary presented by the doors to the secure unit and the requirement to enter a code for access were barriers that were too hard to cross. I could relate in part to this reaction. On several occasions I found I had to force myself to visit and stay in Elm House. A margin note made by me states, I do not want to go to Elm House and I do not feel welcome in the locked unit. It seems to be a little mad enclave all of its own, at the back of the building, such as might be portrayed in a Dickensian setting.

It took three attempts to secure a time for interview with Hilary and even when she had begun the interview she hopped up and left the room to attend to something. I felt she did not want to be present at the interview, not unlike the difficulties she experienced with residents with dementia who were often difficult to engage for any length of time. Hilary’s experience of being unit manager was not unlike Francine's in that she also felt mis-understood with regard to the needs of residents on Elm House. She felt under-resourced and believed her argument for extra staff was valid, given the demands that
could be made by disoriented residents. However, she was in praise of her staff group and would not want anyone working on Elm House who did not have a capacity for working with these particular residents.

In my informal discussions with Hilary she had struck me as being world-weary. My interview with her took place after her three-week break and this had seemed to make a difference to her. This sense of tiredness and being worn down is reflected in her drawing, refer Figure 15 on page 133, which was made at interview. It is self-evident in the words she had chosen to describe her role, which appear on the drawing.

Francine's and Hilary’s drawings provide an insight into the experience of their roles within the organisation culture of Beechwood Nursing Home. Not only are the parts of the building occupied by their respective units at polar opposites to one another, they are also disparate in relation to physical context, resident mix and staff. Neither drawing is as explicit as Olivia's (which is discussed in Chapter 6) in terms of the building's relationship to their work roles, however the symbols each has used reflects the stresses of their immediate environments.

5.8 An Emotional Experience from the Cultural Exploration

From my observations and comments made by interviewees during the period of the case-study at Beechwood Nursing Home, I made the following note in my records –

What I experienced on several occasions was what I can only refer to here as a reverence towards the nursing staff. The nurses are too busy! Too busy for what? To listen to others, to listen to the residents, to listen to the other staff! This was particularly in relation to the nursing and care staff but not always. Often the comments were meant overall. It was as if the nurses were to be prayed to, as if they together represented a god, a superior being, doing very hard work which could not possibly be interrupted or added to. The role of the nurses defined the interactions with others, the understanding by others and the others formed the impression that their work was lesser. The nurses must be worked around. Somehow they seem to be more important than the residents.
Clearly I am expressing annoyance at the nursing and care staff, who I perceive as not making themselves available to anyone and behaving in a way where they see themselves as put upon. Such situations and feelings as that described in the extract are nearly always multiply determined. If this is an accurate observation and not a transference on my part, then the behaviour of the nursing staff would seem consistent with the four social defenses summarised in Section 5.4.5, in particular the first of these, i.e., Maintaining routine is paramount to the welfare of our residents. Having a routine which involves time-tabling of one activity leading into the next, avoids long unstructured hours on a one-to-one basis with a resident. Is this social defense reinforced by the particular building design and aspects of the physical lay-out? This is discussed in Chapter 6.

On the other hand, a plausible and additional interpretation might be that my feelings of annoyance are a displacement from annoyance with dependent residents, felt by nursing staff and introjected by me. Yet again, this extract might be evidence of transference from my earlier experiences of annoyance with the nursing culture that I have been a part of.

5.9 Accreditation, Quality Systems and the Routine Task Oriented Culture

One of the goals of the quality process of all facilities, which the Accreditation Agency is seeking to promote is 'continuous improvement', which an effective quality system should engender through its internal assessment capabilities. I want to provide a bridge here between Accreditation requirements, discussed in Chapter 4 and the routine task-oriented culture that is discussed in sections of this chapter.

A quality system in the nursing home setting, seems to me to reinforce the routine task oriented culture as well as contributing to the enacting of a defense system both at a personal level and within the social structure. I appreciate the value of quality practices, which ensure the standards of residential care are met. For example, medication management to avoid polypharmacy; involvement in lifestyle activities offered to residents; ensuring adequate nutrition and hydration. I am sceptical about the true purpose of quality systems and this aspect of the Accreditation requirements. I see the
quality management system as another set of routinised, time-tabled mechanistically styled requirements, which become institutionalised and cannot be avoided due to the nature of documentation and internal auditing and reporting requirements. The requirements are added to the existing routine-task oriented culture. It is reasonable to hypothesise that quality systems and Accreditation requirements are elaborate social defense systems to avoid the painful association with residential aged care, because this association requires the acceptance of aspects of the self which cannot be confronted. These include ageing, dependence, loss of urinary and faecal continence, dementia and being 'put in a home'. On the surface, the implementation of quality systems and the Accreditation requirements transmute the unpleasant tasks of nursing homes and hostels which are perceived as undesirable (and which engender primitive anxieties) into those which are considered admirable. In the nursing home setting, staff complain constantly about not having enough time to spend with residents, because of all the other requirements upon them. However, I wonder whether they are glad to have these tasks in order to avoid the anxieties provoked by aged care.

There is a strong sense on my part that at the wider regulatory level of the industry there is a large emphasis on pushing staff to complete work and documentation that is simply 'filler' work. The goal of the work is meeting Accreditation requirements and this is promoted as being the ideal to achieve. However, so much of this activity is repetitive and the associated unquestioning behaviour resembles much of what Menzies identified amongst nurses in her study of nurses in a British hospital in 1959.

5.10 Conclusion

It is paradoxical that the values of 'independence' and 'autonomy' are promoted throughout the literature on aged care and residential environments but the environment rarely bears out the practice of these values in full. Despite attempts to the contrary, as espoused in the literature of the Beechwood Nursing Home itself and embedded in the Standards of Residential Care (Commonwealth Department of Health and Family Services 1997), the nursing home culture appears to be one which is structured around the needs of staff rather than the needs of residents. This was borne out through the discussion of practices in the work setting that contribute to the routine task oriented
culture, which is driven by the staff. The interviews conducted at Beechwood Nursing Home gave depth to understanding the culture of the environment and to the perceived primary task of the nursing home. The latter was revealed as being an emphasis on making people comfortable in the environment up to and when they die, which took precedence over the social aspects of well-being and engagement for residents, whilst living in the nursing home environment.

Based on observation and interviews, I determined that four principle social defenses operated at Beechwood Nursing Home. These social defenses, which exist to reduce the anxiety engendered by the work environment, help to explain the strongly 'routine' nature of the task oriented culture.
Figure 14 - Francine's Drawing
Usually bright sun & a little cloud (from pressure put on by self - type of job).

Words to describe very demanding, satisfying, draining, rewarding.

Good staff, relaxed atmosphere, tiring.

Somedays - covered by cloud.

Somedays burnt out.

Figure 15 - Hilary's Drawing
Please note

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CHAPTER 6 An Analysis of the Role of the Building in Organisation Culture

6.1 Introduction

In Chapter 1 an introduction to residential aged care was provided. As part of this introduction a rationale for the conduct of this research was formed through the discussion of issues confronting residential aged care provision. These issues included the major legislative and policy changes enacted in recent years and the negative perception held by the community toward aged care and nursing homes.

In Chapter 2 the theoretical model entitled The Conceptual Framework was discussed as were the theoretical foundations used in this thesis. A working definition of organisation culture was established in Chapter 2. This working definition incorporates aspects of organisation theory and psycho-dynamics. In Chapter 3 the methods employed for the conduct of this research are extensively discussed including the use of case-study method of a single venue, Beechwood Nursing Home. In Chapter 4 the organisation arrangements and physical characteristics of Beechwood Nursing Home were provided. Accompanying the discussions in Chapter 4 are floor-plan details of Beechwood Nursing Home and its three houses, Birch, Pine and Elm House as well as service and reception areas. These floor-plans and details are integral to the discussions taken up in this chapter.

Chapter 5 is the first of the two chapters that focus on analysis and discussion of findings. Its focus is the culture of nursing home environments, using Beechwood Nursing Home as a case in point. In this chapter, I described the culture as a routine task oriented culture, which dominates day to day functioning. I argued that a number of social defenses were in place which both reflect and reinforce the routine task oriented culture and associated work practices of staff. An example of these socially structured defenses is evident in the clinically oriented role of nursing staff which serves the physical needs of residents whilst overlooking their psycho-social needs. This practice was reflected in such arrangements as the restrictive time-tabling of activities, the emphasis on activities of daily living and highly visible 'clinical' practices and exchanges amongst staff.
In Chapter 6 findings related to the building and its role in the organisation culture are discussed, again using Beechwood Nursing Home as the example. The theoretical model formed by The Conceptual Framework is used in the analysis to illuminate the relationship between the physical context and the organisation culture, as defined in Chapter 2. This physical context is constituted by the physical structure of the building; the spaces created by it; and the experience of a sense of place. In this chapter I extend the findings related to the organisation culture by exploring the links between these findings and the physical structure created by the building. My hypothesis is that the physical context does influence the organisation culture of the nursing home environment.

The chapter begins with a recount of my initial experiences of the Beechwood Nursing Home building and those of visitors and staff. This is followed by a major section that applies the three elements of The Conceptual Framework to findings from Beechwood Nursing Home. The three elements which are discussed are the physical structure, the spaces created by it and the experience of a sense of place. The next section concentrates on issues of privacy within the nursing home environment. The focus of discussions then moves to organisational boundaries and task culture. This chapter culminates in a discussion of the quality of the holding environment of Beechwood Nursing Home.

The findings that are discussed in this chapter are primarily drawn from my participant-observation conducted at Beechwood Nursing Home and the interviews with staff, residents and a relative of a resident at the venue. The drawings made by several interviewees also form a data source and in this chapter I introduce the data from the interviews conducted with the two architects prior to the case-study. Whilst Beechwood Nursing Home was pivotal to this study, my experiences of other nursing home buildings are reflected in this chapter.

6.2 First Experiences of the Beechwood Nursing Home Building

It was difficult not to be seduced by aspects of the building on first impressions. It is superior to many facilities with regard to the level of furnishings and standard of fittings. This first impression seemed also to apply to visitors, seeking a nursing home
bed for a partner or parent. Many commented on how lovely they found the presenting environment to be. Some made mention, on tours of the facility, about the lack of odour (from urine or faeces), although this was not my first experience.

Beechwood nursing home, unlike many nursing homes, provides ample off-street parking. This was located adjacent to the main entrance that served as the residents' pick up and drop off point. I was initially struck by how much area had been dedicated to the large car park and the drive-through entrance with its two stately palm trees. From the outside the building resembled what I considered to be a low key rehabilitation unit - although I had never worked in one.

During business hours visitors enter a foyer area, where a receptionist is available to answer queries and direct visitors to locations in the building. The receptionist is located behind a glassed in area as might be found in a bank. This divides her from the open foyer area. This point is taken up in section 6.7.1. Throughout the building staff wore the corporate uniform of the charitable operator and displayed a name badge. Staff from agencies working on a casual basis, also wore uniform and name-badge.

Smart tapestries and dozens of grouped prints along the walls greet visitors. Large silk floral arrangements are located at the entrance and strategic points throughout the building. Each of the houses is colour co-ordinated with paint colours considered to be up to the minute. However, it took me some time to realise that each 'house' has its own colour theme. On my first tour of the building I felt challenged and disoriented by it. I did not appreciate that the colour theme changes between each house. When I notice that the carpet colour changes from green to blue between Birch House and Pine House, I feel like I've found an anchor, a key to understanding the arrangement of the building. I thought if it is this difficult for me to 'get a fix' on the lay-out what must it be like for much older people.

Birch House, which faced the street and was home to Extra Service residents, was furnished at an even higher level than Pine and Elm House. Here there were large pieces of reproduction furniture in the hallways and lounge. Windows were finished with fabric covered pelmets upholstered to match the bedspreads and curtains. It was also home to
the only bookcase in the facility. Books were regularly changed by a visiting library service. Staff were aware of this superior finish of Birch House, as demonstrated on the weekly tour for visitors, led by Frederick the evening supervisor. It was his practice to avoid Birch House unless any visitor intended making an application for an Extra Service Place, because 'they just get to see how nice it is with the furnishings and they won't be there'. These new residents would be allocated a place in Pine or Elm House.

Walking from reception through the building visitors were required to pass through Pine House with its glassed in nurses station on the right, followed by Beechwood's staff-room. Visitors not bound for Pine House would make their way through Pine House to either Elm House at the rear of the building or Birch House at the front. Invariably they would have to make their way past trolleys in the corridors of Pine House, en route to one of the houses or the service areas of the kitchen or laundry.

Depending on the time of day visitors would find residents engaged in one of the tasks or activities described in Chapter 5. There may be singing or music drifting through corridors of the building, coming from the Birch House lounge or the music therapist's guitar as she worked with residents in the lounge of Pine House or elsewhere. The lunch trolley may be on its round, which acts as a reminder of how early the meals are served in this environment; lunch at midday; dinner at 5p.m. As I go about the building I am conscious of televisions being on in most rooms. Together they set up a wave of noise that dominates the corridors. I wonder whether the televisions are on for the resident's benefit, or to create social distance between the staff and the resident. Intermittently a sharp beeping sound is heard coming from the corridor or the staff-room. The call-bells of residents are diverted to this beeper, carried by a nurse, who acknowledges the call but leaves the beeper on. It continues to go off every few minutes.

By the second week of the case-study at Beechwood Nursing Home it became apparent that it was one nursing home comprised of three distinctive houses, Birch, Pine and Elm. In effect there was one organisation culture with manifest differences amongst each of the houses. Much of the culture of each house was directly influenced by its physical context. There were obvious distinctions related to the 'type' of residents of each house and the staff group/mix assigned to each. The less obvious were those
disparities revealed through an analysis of staff comments and interviews, in particular those with Unit Managers. A number of these disparities related to the organisation culture were addressed in Chapter 5. The disparities related to the building are addressed in this chapter.

6.2.1 First Responses from Staff

My interest in the building provided a bridge for discussion with staff. The building was perceived as neutral territory about which they could pass comment without compromising themselves in anyway. Everyone, including residents and their visitors had an opinion on the building, from the size and fitting out of residents rooms to the location of service areas and the overall decor. There was a rush by staff to tell me how the shortcomings of the building impacted on their work practices and immediate work areas. For example, in Birch House there were small cabinets for residents’ use, affixed to the wall opposite the end of the bed. The position of the cabinet resulted in staff being pinned against its sharp corners as they manoeuvred residents in wheel-chairs in and out of the room, pushing the bed to one side to enable them to do so.

Although Birch, Pine and Elm house were designated as 'houses', staff referred to them as corridors. The reaction by staff to the building indicated they felt over-whelmed both by the size of it and the lay-out of areas. I wondered how older people coped with the dimensions and lay-out of the building. Often staff commented on how they perceived the building appeared to disadvantage residents. Comments related to spatial arrangements and distances, size and manoeuvrability of furniture and location of fixed furniture.

Over the weeks I was at Beechwood, staff became used to my presence and would identify an aspect of the building, which in their view was dysfunctional. Given the building was only completed within the previous twelve months it was of interest how the limitations of the design and overall finishing affected staff, residents and visitors. Many of these limitations are taken up in the discussion below which addresses the articulation of these aspects within the organisational culture of Beechwood.
6.3 Applying the Conceptual Framework

In the following sections the three elements of The Conceptual Framework are applied to findings and discussions with the objective of establishing a clear link between each element and the daily life at Beechwood Nursing Home. The three elements that form the Conceptual Framework, were discussed at length in Chapter 2. They are the physical structure, the spaces created by it: formally and informally and a sense of place. As stated previously these elements are to be considered as separate but inter-related.

6.3.1 The Influence of the Physical Structure of Beechwood Nursing Home

![Diagram: THE BUILDING - The nursing home building/physical structure]

**Figure 16 The Building – the first element**

The physical structure of Beechwood Nursing Home plays a role of influence in both the work of staff and the lives of residents. Although it is a fixed (and inanimate) form the physical structure's influence on residential life can be determined through an assessment of how it supports or limits work practices and activities. From this perspective the physical structure's ability to direct and control events becomes evident. It is my hypothesis that the physical structure abets direction that is less supportive with regard to work practices and activities, than is desirable. This is attributable to a design which is inflexible; a floor-plan arrangement that marginalises key activity areas; and large physical distances between significant meeting and activity points. The floor-plans for the building and each of the houses, Birch, Pine and Elm were provided in Chapter 4 and should be viewed in conjunction with this chapter.

While the building conforms to current Certification specifications as discussed in Chapter 1, short-comings related to it were expressed both by staff at the venue and from head-office. The Facilities Manager for the charitable group that owns Beechwood, had strong views on the design of the building. He noted how often institutional or
hospital plans are used as the benchmark when designing a nursing home. To him, Beechwood had not been described around a concept. The shortcomings in his view included, the hotel lobby style impression of some of the open areas of the building; the small size and location of the waiting rooms outside the entrance to the secure dementia unit located in Elm House; the lack of privacy in the residents' lounges in the nursing home where staff and visitors walked through whilst residents' were eating. The Facilities Manager also considered the large outdoor courtyard as being of no use, as there was no shade and the concrete was slippery. Like many staff members, he also commented that you become lost in the building and that it was a long walk from location to location within it. These points are taken up below.

6.3.2 Physical Distances - An Issue for Staff and Residents

The overall design of Beechwood Nursing Home is based on long corridors with residents' rooms running off these. The service areas of the kitchen and laundry are located in Pine House, adjacent to residents' bed-rooms. The staff-room is also located in Pine House as are several storage areas, the main cleaning store-room and staff locker room.

Staff expressed dissatisfaction with the overall building with regard to distances and corridor arrangements. This dissatisfaction also applied to arrangements within Birch, Pine and Elm houses. Distances added extra walking time, which irritated and tired staff. It added to the length of time involved in back-tracking for a meal or to collect and transfer a resident from one area to another. This was reflected in staff comments such as 'you need roller-skates to get around', 'it's a long way to walk' and in reference to distances between points as being 'right down the end'. The distances between points within Birch, Pine and Elm House were an issue for staff but the distances between the main meeting and activity points within the building was an issue for both staff and residents. These main meeting and activity points were the -

- main lounge in Birch House
- dining areas of each of the houses
- quiet room located in Elm House
- reception area
- nurses stations in each house
- staff room
- lifestyle and therapy room.

Refer Chapter 4, for details on the location of each of these points.

The main lounge of Birch House is the major meeting and activity point of the building. It is the focal point for large group activities for residents, which take place from Monday to Friday. These activities range from carpet bowls and church services to themed activities as described in Chapter 5. The room is spacious with doors opening onto a court-yard. It has an open fireplace, large television, sound system and piano. It overlooks the road and has a view out across trees. The level of soft furnishings is of a high quality. Staff and residents alike expressed admiration for this room and I noted how serene I found it. However, there are two significant issues associated with this main lounge. The first is its physical location and the second is the design of the room. This latter point is taken up in Section 6.3.3. As the main room for large group activity, residents from each of the houses must find their way to it. The majority are taken by wheel-chair or large padded arm-chairs on wheels, some residents are assisted to walk and some come unaided. The location of Birch House lounge at the farthest end of the building directly impacted on staff’s decision to transport a number of residents, who could walk with assistance, by wheel-chair. For the staff it was a decision based on expediency, for the resident it reduces their independence and reinforces their lack of ability.

It was interesting that several long-term employees of the charitable operator, had never ventured to the therapy room. In one instance Wilma, a nurse assistant, transported a gentleman via wheel-chair from Birch House to the therapy room, in order for him to undertake some weight work. This required her to stay with the resident. As stated earlier, the therapy room is in Elm House, at opposite ends of the building to Birch House. As a consequence Wilma became anxious, as she could not meet the needs of other residents assigned to her care in Birch House while she was so far away and her work-load was referred onto her colleagues.
The most striking example of physical distances between significant points in the building is the location of the room designated as the therapy room. On the original floor-plan arrangement the lifestyle and therapy room was designated as being where the staff-room is now. The decision was taken to increase the size of the staff-room, convert the original staff-room into the nurses' station for Pine House and to locate the lifestyle and therapy room to the farthest end of the building, being the rear of Elm House. In effect the two principal areas of the building suitable for multiple uses as activity areas are positioned at opposite ends of the building from each other. The lifestyle and therapy room is used infrequently for therapeutic physical activity with residents. Although spacious by comparison to the lounge areas, it is nonetheless difficult for residents to access than is Birch House lounge. The room is used to store equipment for activities and lifestyle and therapy staff use it for preparation as well as for meetings. Occasionally small groups of residents gather for activity.

6.3.3 Consequences of Design

As a consequence of the design of the building, several issues arose. In the case of Birch House lounge the design was inflexible and limited the manner in which it could be used to effect with residents. There were six entrances to the room, four of these were double doors opening either onto the court-yard or front balcony. In all cases no chairs could be placed in front of the doors, particularly those that were fire exit doors. Also nothing could be placed in front of the fire equipment. The physical aspects limited the amount of useable space in the room. This presented challenges for the lifestyle and activity staff.

A consequence of the dual use of Birch House was the requirement to organise the furniture for each large group use. For example, a session of carpet bowls required both re-arrangement of furniture and protection of furniture that could not be moved. At the end of each session staff were required to re-set the furniture for general use by Birch House residents and visitors. This procedure took up a great deal of time as it occurred as often as twice a day, five days a week.
A further issue related to the dual claims on Birch House main lounge. It is at one and the same time the Birch House residents' lounge and the only room large enough to accommodate residents large group activities. There were several occasions where room usage was prioritised for Birch House residents, in particular those classified as Extra Service Residents. The lifestyle Co-ordinator and activity staff were required to generate alternative activities in the smaller lounge and dining areas of Pine and Elm House, which double as activity rooms. These staff found this situation distressing because they had to deal with the result of a two-tier resident structure, based on privilege and access within the living environment.

The lounge areas of Pine and Elm House, both double as dining areas. Pine House provides accommodation for residents who can ambulate independently, to those with dementia who are bed-ridden. The lounge in Pine House is barely able to accommodate a handful of residents in large padded arm-chairs on wheels, who are transferred to this area during the day. There are chairs and lounges for the use of other residents, but the total resident complement of 24 would never fit into this area. Both nursing and lifestyle staff spent a great deal of time in the smaller lounge and dining areas manoeuvring residents in padded wheel-chairs to allow residents into or out of the room. If lifestyle staff did not assist nursing staff with the transfer of residents and on occasion their feed, residents missed out on activity sessions.

The dining room of Pine House is located opposite the kitchen. Residents who eat at the dining table do not require assistance with their meals, although some may be in wheel-chairs. None of the dining tables throughout Beechwood Nursing Home are suitable for residents in wheel-chairs, as they cannot get close enough to the table to eat with ease, a point noted by several staff. As a consequence they eat more slowly, their meals go cold and are inadvertently removed before the resident has finished eating.

While it was a management decision that decided the allocation of rooms and their uses, it is evident that the physical structure through an inflexible design with long corridors, contributes to the manner in which staff are able to optimise its use. Moreover the design limits, rather than encourages residents fully in their day to day life.
6.4 Whose Space Is It Anyway - Staff or Residents?

Figure 17 The Spaces Created – the second element

In Chapter 5 as part of the discussion of the findings about the organisation culture of Beechwood Nursing Home I highlighted data which indicated that the residents had little authority within the environment. The schedule for activities being developed and organised by staff, albeit with varying degrees of consultation with residents. Staff indicated that time-tableing and routine was at their behest, rather than residents. During my participant-observation phase when I was perhaps most acutely tuned to the environment, I began to record my feelings in response to what I considered were transgressions of residents' spaces by staff. I have described elsewhere the second element of the Conceptual Framework as 'the spaces created formally or informally' within the nursing home building. The concept being that spaces are designed intentionally for particular uses, *e.g.*, the kitchen, and that spaces may be actively taken for use in an unintended manner. Beechwood Nursing Home provided numerous examples of both intentional and unintentional use of spaces created formally or informally.

6.4.1 Transgressing Residents' Space

Heather in her capacity as Lifestyle Co-ordinator, had expressed discomfort with the number of thoroughfares in the building. She closed off the lounges in Both Pine and Elm House in order to deter people from just walking through when activities were on. It was most disruptive during the 'Reminiscence' activity as it caused the group to stop and it was difficult to gain momentum again once this happened.
The dining room of Pine House is opposite the kitchen. It is also close to the staff-room that is centrally located in Pine House. The main outside court-yard area is accessed from Pine House dining room. Staff breaks coincide with residents' meal-times and most staff venture out to the court-yard either to eat or to have a cigarette. To do this they pass through Pine House dining room, while residents are eating. Some staff acknowledge the residents, some excuse themselves, most just pass through.

There are several other doors by which the court-yard can be accessed, although none are as proximate to the staff-room as the Pine House exit. Sitting with residents during activities and meals, I noticed that I became incensed at this constant passage of foot-traffic, which mostly ignored the residents and generally left the court-yard door ajar, creating a draught. I wanted to point out the inappropriateness of this behaviour, after all it was the residents dining room. In this situation, the physical structure controls the location of the dining room and the space formally designed and intended as a dining room is used in an unintended fashion by staff. That is, as a point of egress.

Studying the feelings of irritation and anger aroused in me by this situation, I began to see that this was an instance of projective identification where feelings were being posited in me as the recipient, to lessen the anxiety of the other. The question for me was which was the other? Logic told me it was the staff with whom I could readily identify who were splitting off their bad part - their self-consciousness about trespassing in a residents area - and locating the feelings in me (Klein 1964). However it is possible that it was the residents and not staff who were splitting off their bad feelings of anger. Residents may have found it intolerable to hold feelings of anger towards the staff, knowing those who trespass are also the same staff upon who they depend for care and who are entitled to a break.

A second instance of space use that illustrates formal space being used informally and in an unintended manner, is that of the large court-yard adjacent to Pine House. The area is attractive with a centrally located outdoor table and chair settings, large umbrella to shade the table and barbecue area, as shown in Plates M and N on page 147. The court-yard area is popular with staff who frequent it for their meal and cigarette breaks, accessing it via Pine House dining room as described above. Throughout the period of
the case-study, I saw only one resident in the court-yard and this was on the balcony level, sharing morning tea with family members. Another resident told me she had only been in the court-yard three times in her eighteen months as a resident. Although quite a large area, it is rarely used for large group activity, the wider and more accessible outdoor car-park area being preferred by such visitors as the travelling zoo.

The courtyard is visible from Pine House dining and lounge rooms, a number of residents' rooms in Pine House and the quiet room in Elm House. It is both the high level of visibility of use by staff, as well as the under-utilisation by residents, which creates problems. Beatrice, the Director of Nursing/Manager didn't mind the staff sitting in the court-yard as long as the cigarette butts were cleared up. The staff have got to have somewhere to go. Beatrice later added that she hated the staff smoking in this area because it was the residents' area.

Margo, the Hospitality Services Co-ordinator commented that the court-yard is used more by staff than residents, 'It's a magnet, it's the only place to come outside. I used to be a smoker and now I look out at the court-yard and think that [the smoking] doesn't look too nice'.

As life-style co-ordinator Heather would have liked to use the outdoor area more often with residents but found that it was inappropriate for their use. The ramp access couldn't be negotiated by wheelchair bound residents and for those walking the ramp was at the wrong degree of slope. It had been improved with the addition of balcony railings after someone fell into the garden. There was also minimal shade available for protection during sunny, hot weather that reduced its suitability for residents' use. Heather stated 'it would be nice to have a covered area'. When residents are outside they are kept on the upper areas. (The fact that minimal shade cover was provided is almost incomprehensible in a country with one of the highest skin cancer rates in the world and where other indoor-outdoor settings such as schools, provide shade and a have a policy of 'no hat - no play').
Plate M - The Outdoor Courtyard Area, Showing Access from Pine House

Plate N - Outdoor Courtyard Area, View from the Quiet Room
The outdoor court-yard was difficult to access. It could not be reached without going through the dining or lounge rooms of Pine House. Whilst it could be accessed through the quiet room in Elm House, this room was located at a distance to the other two houses. These issues of lack of suitability forced the lifestyle activities back into the building. The difficulties in access presented by the location and design of this court-yard area reduced residents’ enjoyment of the facility, as it restricted them from even sitting outside to admire the garden.

6.5 Searching for A Sense of Place

Elsewhere I have described the three elements of The Conceptual Framework as being separate although inter-related. This description is the most accurate in relation to the third element 'a sense of place'. I have stated that a sense of place has an intangible quality, that makes it harder to define than the elements of the physical structure and the spaces created by it. Nevertheless these other elements can contribute to the perception of 'sense of place' held by residents. A sense of place may come about through many avenues. As noted in Chapter 2 a sense of place means different things to different people. For some it is one's life possessions such as books, photo's even plants and flowers; those things which mirror the life of an individual. Alternatively, it may come about through the creative expression of feelings as in craft work or the production of something. Religious or spiritual pursuits may achieve a sense of place for others. Given its unique qualities of felt properties for individuals, how then is a sense of place generated for and by people living in a nursing home?
Writing from a Jungian perspective Cooper Marcus identifies how, throughout our lives we strive for wholeness, and that the places we live in and the places themselves have a powerful effect on our journey towards wholeness. Her work revealed that the personalisation of space with movable objects, rather than the physical fabric itself [of the building] were symbols of the self (1997). These symbols of the self may be synonymous with a sense of place, for some people. Although Cooper Marcus does not use the term 'sense of place' her description of the conscious and unconscious meaning of home resonates with my intended meaning. The juxtaposition of the concept of wholeness and the personalisation of space, raises questions about the understanding and achievement of both in nursing home settings.

To begin with the term 'selection of a nursing home' is a misnomer. There are few beds available at any one time and people are often forced to take what they can get, irrespective of location, standard of care or general appearance. On entry, residents are provided with a bed in a room, which may be single or shared with one or more others. Residents enter having been forced to divest themselves of virtually all possessions or movable objects. Those they do bring with them are small in size and number compared to earlier periods of their lives. If as Cooper Marcus states these movable objects are powerful expressions of the self then they must be invested with emotion. By limiting the number of objects a resident can have with them due to room size and then arranging the room so that it has minimal area available on which to set out possessions or display photographs, how is a resident's sense of place achieved? Moreover, the move to a nursing home is often an emotional one for all involved. Achieving wholeness may be challenged in a nursing home environment and rather than feeling integrated, residents may experience a fracturing of their lives, if the setting can't support them beyond immediate physical needs.

6.5.1 A Sense of Place in the Last Home of Life

All staff interviewed recognised Beechwood Nursing Home as being the last place a resident would live. Heather, the Life-style Co-ordinator stated that it was hard for residents to accept this and even more difficult for those who still owned a house somewhere. Heather said it took a lot of work with the resident for them to accept being
at Beechwood. It was difficult for them to let go. She found it made a big difference if the resident or their family had chosen Beechwood Nursing Home. For those who owned a home, the sale of their house cemented their occupation at Beechwood Nursing Home as permanent. Olya was a case in point. As a resident, she still owned a house in an old established seaside suburb. She wanted to return to her house and commented 'I'm hoping to be well enough to get home'. There was no support for her at home and it seemed unlikely that she would return there.

This role played by Heather in facilitating the entry of a resident into the nursing home environment and the active recognition of it being the last home was the only occasion such a role was mentioned by a staff member. Heather found herself accessed more than the nursing staff to spend time with residents and family members, as she said, 'to work with them about being in a nursing home environment'. Once families realised Heather was not a nurse she found herself sought out more for non-nursing role requests. She attributed this to her more 'casual involvement' with residents and families than the nurses, who are 'being rushed and have a job to do'. This information links directly with the 'busy' routine task culture and social defenses operating in the culture described in Chapter 5.

It is in the room occupied by a resident that their personal possessions can be displayed. This room is a bed-room. At Beechwood Nursing Home the majority of residents have their own rooms and they are encouraged to bring with them personal items of meaning. These items tend to be photographs, books, jewellery, mohair rugs, a special cushion, a radio or some artefact of the person's history such as their husband's war service medals. Depending on which room the resident occupies, small items of furniture such as a bookcase or an electrical item may be brought in. At Beechwood, the longer a resident had lived there the greater the number of personal items they possessed and the greater the level of tolerance displayed by staff towards these items. Kaye, a resident of six and a half years, owned dozens of cassettes and was an active subscriber to a range of magazines and philatelic providers. Her single room was more spacious than others and was able to accommodate two large bookcases. These 'movable objects' may well be emotional anchors for their owners when all that it familiar is no longer there and they are forced into a living environment for reasons of physical rather than social need.
As well as providing emotional anchors, it is possible that some possessions may act as transitional objects for residents. Entry into new organisations is considered to be anxiety provoking for individuals. Entry to a nursing home may be analogous with entry into an organisation, where a person takes up a role as resident, a process Czander (1993) refers to as crossing the boundary. Winnicott (1958) notes that a transitional object is an instrument the entrant uses to cope with the depressive affects invoked during entry. Entry into an organisation evokes separation-individuation issues from childhood. At entry employees' experience a repetition of affects associated with early separation experienced in their relationship with mother. Winnicott developed the theory as a way to explain how the child moves from dependence and symbiotic attachment to individuation and autonomy. A child may have a blanket, or teddy bear, or other object that plays a role in reducing anxiety in situations that are new, strange and different (Czander 1993, p. 71.) Entry to a nursing home may be analogous with entry into the work-place. Objects belonging to the person may form transitional objects, which assist them to reduce the anxiety associated with the new place. Objects 'connecting familiar with new, past with present, subjectivity with objectivity, inside with outside, etc.' (Van Buskirk and McGrath 1999, p.825). Three residents of Beechwood Nursing Home who each experienced dementia, owned teddy bears that they never parted with, except for laundering. They cared for and fed them. The teddy bears may well have been role reinforcers for them, in that they saw themselves as the teddy bear's mother as well as the teddy bear acting as a psychological and emotional anchor.

6.6 The Physical Context and Residents' Privacy

The last aspect to be discussed in this section is that of privacy. This aspect of the nursing home environment provides an opportunity to illustrate how the building, together with the culture of the organisation, shapes the way in which privacy is manifest in the minds and practices of residents and carers. The physical structure of a building and the way it provides for spaces can either support the privacy of residents or result in a public level of exposure which non-residents would find unacceptable. Likewise the culture of the organisation can endeavour to foster behaviour in staff which ensures privacy of residents is maintained, or it can do the opposite. Integral to this is
the way in which the physical context, formed through the elements of The Conceptual Framework, is employed by both staff and residents to support privacy.

Privacy begins with the personal space provided for a resident. Consistent with community expectations and building requirements nursing homes are moving towards a greater number of single rooms with (shared) en-suite facilities. Peace et al. (1997) and Bartlett (1993) have both identified a preference by potential and current residents of aged care facilities for a single rather than a shared room. However, it is not the case that all residents who share would like a single room.

There are only a handful of shared rooms at Beechwood Nursing Home and these are located on Pine and Elm House. Olya, a resident of Pine House who did share a room, expressed a preference to have a room of her own. Olya, who could ambulate with assistance and often moved around Beechwood in a wheel-chair, was co-located with a resident who was high-care, physically incapacitated and required feeding. They were ill matched in terms of physical and cognitive abilities. At night Olya found it inappropriate to have her television on, fearing it would disturb her neighbour - a few feet away. The location of the television meant Olya kept the light off at night to reduce the glare from the screen. Staff had advised her that she would not be disturbing her neighbour, but Olya didn't feel 'it was right'. The area provided for the television at head height, recessed into a space in the built in wardrobe, meant the angle of the television set was difficult for her to see from her bed, without being constantly propped up by staff.

When Olya first came to Beechwood Nursing Home from the inner city location, she was allocated a single room in Birch House. She was required to move to make way for an Extra Service Place applicant. This she didn't mind, as she refused to pay the extra money required for these services, although she appeared to miss the friend she had made there. In her shared room she had used the small amount of open space provided to her to place out her son's photograph and drawings from her grandchildren. She had brought with her a small refrigerator for her personal use. Olya said she found the feel of

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(As discovered by the present Federal Minister of Aged Care who insisted her father be moved to a single-room and was taken aback when he said he'd rather stay with his friends).
the shared room different to the single, stating 'I don't seem to settle down in this room'.

Olya declined the offer of another single room, on the basis of a conversation with a male nurse. He told her there had been two deaths in this particular single room and that they always come in threes⁴. Olya said 'well I didn't want to be the third. Shame, I wish I'd taken it'. She never mentioned this conversation to any of the senior staff or her unit manager. Olya exhibited mixed feelings towards the nursing home and the staff, saying 'it's very nice here, both the residents and staff, I get on with them all', adding later that 'this place is built more for style than comfort'. Olya rarely mixed with other residents and preferred to stay alone in the bed-room watching television or doing cross-words, although she did attend Friendship and Gardening Groups. I asked her if she had a favourite spot in the building. She sneered, then added that she enjoyed Birch House lounge.

The arrangement of the physical structure of Pine House directly affected Olya's privacy. Her shared room was located on a long corridor along which trolleys, staff and visitors travelled constantly. The formally created space she occupied, was not a private space over which she exercised psycho-social control, it was shared. As such, a degree of courtesy and respect toward her co-occupant was required of her on a full-time basis. As a result of these aspects working together, Olya's sense of place seemed impoverished.

Kaye, a resident of six and a half years had different views about living at Beechwood Nursing Home and about the privacy afforded her. Kaye had lived in the old dilapidated building and now the new building. Kaye was able to move about in a wheel-chair but with disabilities resulting from a stroke, she needed assistance with a range of activities of daily living. Kaye commented that all staff respected her privacy and knocked before

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⁴ This cultural myth is extremely powerful amongst nurses and I immediately associate with it. I have participated in many conversations where amongst ourselves we would expect a third death. Invariably it was true! This particular myth is fairly ubiquitous. Another is the idea of a red and white floral arrangement arriving on a ward – this is associated with an impending death. Often different regions have different myths.
they entered. She reinforced this point later in the interview by stating 'I love it here, I really do'.

Kaye considered it easy to get around in the building and loved the colours. Although she says she doesn't go out much, she finds the paths and access are easier. Kaye ran one of the two resident-initiated group activities. This was the Music Appreciation Group for residents in the Birch House lounge, once a week.

Kaye's room was larger than most of the single bed rooms. By comparison to most of the other rooms Kaye's was alive with expressions of her former work-life as a teacher of music and of her hobbies, one of which is stamp-collecting. There were two book-cases both of which were laden, several pictures on the walls and calendars. Kaye maintains subscriptions to a number of groups such as music groups, philatelic groups and wild-life funds.

I walked with Kaye to admire a rose planted in a court-yard of Birch House. The rose we went to view was planted in memory of her husband. It had been bought on her behalf by one of the activity staff. I remember thinking it was a symbol of hope. As we left her room I noticed Kaye moved to slide close the door to her bathroom and toilet area, making them out of view. This seemed to be an expression of the need to hide private space which represents intimate physical activity, from the eye of the visitor, as people often do in their own home.

Both Olya and Kaye became emotional during the course of my interview with each of them. I chose not to address any question to them that asked about the building as a place to die in. However Kaye did raise with me that she didn't know how long she would be at Beechwood and whether she would die there.

6.6.1 Beds for Residents' or Residents' Rooms?

In the mind of some staff the idea of a single room seems preferable to a shared one. On several occasions I overheard telephone conversations where senior staff were advising someone on their waiting list that a bed was available, 'the only problem being that it
was in a shared room'. This may be a projection on the part of the staff member who would prefer to have a single than a shared room.

Beds are the currency of nursing homes. Bed availability, bed occupancy, high care and low care beds, total numbers of beds. Staff talk of 'beds' rather than residents rooms as if the only thing a resident truly occupied was a bed.

It is interesting that in the Beechwood Nursing home building, as in many others around the country, the only privacy available for a resident is if they remain in their room, with the door closed. This room is a bed-room, not a room where one (generally) entertains visitors over morning or afternoon tea.

6.6.2 Privacy and Isolation

Most staff in nursing homes have a negative attitude toward single rooms, in terms of their work-roles. I have found this to be the case in all nursing homes I have visited. Staff consider single rooms to be unnecessary for residents who are high care; do not ambulate; and are often not aware of their immediate surroundings. They also see en-suite bathrooms as a duplication of services. En-suite bathrooms keep a nurse/carer in a room with one resident, preventing them from attending to a greater number of people at one time. Single rooms also substantially add to the overall floor-size size of a building, which increases the walking between points for staff. It also limits the extent of task coordination and as a consequence adds to the amount of time taken to achieve tasks. Likewise, it also increases the space to be covered by residents between significant points. This may disadvantage residents if it not paid close attention in the planning phase of the building.

Nursing and care staff in particular expressed the desire to have an unhindered view of residents. If residents are located in settings such as single-rooms or lounges and communal areas that are out of view of staff - isolated from the nurses station - this makes the task difficult. Surveillance of residents by staff, is a task they consider should be aided by a clear view of residents. To do this, residents are often forced to congregate
in an open lounge or similar area. Staff will find ways to manage residents to suit their own needs. In her experience as an architect designing nursing homes, Lorin has witnessed staff controlling the location of residents by turning lights off in order to concentrate residents in one location, where they can be seen.

Although there will never be a return to multi-bed rooms along an institutional model of nursing home design, staff lean towards this style because they see it as assisting them in their care role and if they are assisted, they believe it augers well for residents. Conversely, it deprives residents of life-style choices even very small ones such as the volume of a radio or television set and fosters dependency, in an environment often struggling to be home-like rather than hospital-like.

Within the culture of the nursing home, privacy is often times seen as synonymous with isolation. At Beechwood Nursing Home, this view was expressed by Heather, the Lifestyle Co-ordinator and Olivia, Unit Manager of Pine House. Heather encouraged residents to join activities, to have them come out of their rooms. She feared that by staying in their rooms and eating alone, residents were socially isolated. Olivia concurred with Heather's views. Whilst Pine House as a thoroughfare was the most busy and noisy of the three houses, Olivia also considered Pine House residents to be socially isolated.

Beatrice, the Director of Nursing and Manager revealed the paradox associated with providing single rooms for residents. The changed community expectations and those enshrined in the Aged Care Act of 1997, put pressure on the residential aged care industry to provide single rooms. This pressure created a level of tension that was inherent in the following comments by Beatrice the Director of Nursing/Manager,

'With the emphasis placed on the single room concept, you've got to have a lot of activities – the budget is not there for that – I feel residents get lonely, I encourage them to come out [of their rooms]. Singles – have advantages and disadvantages, families want single rooms. Single room is very lonely...many residents have no-one...saddest thing, some die in isolation'. 
During this part of the interview Beatrice is quite teary and says she is quite upset by the residents' loneliness – that it's hard for her. Perhaps Beatrice's emotional state during interview was attributed to projections of her own about loneliness and what the nursing home environment symbolised for her. Beatrice had spent recent years nursing her own parents, who had since died. Beatrice had also commented that she wished she had come to aged care nursing earlier, that she enjoyed it.

6.6.3 Privacy and Staff

Privacy for staff seemed also to be an underlying issue in the culture of Beechwood Nursing Home. A staff member commented there was 'no-where inside for privacy' and perhaps this is why they 'escaped' to the out-door courtyard for all breaks. It was the only space which was resident-free, an unintended by-product of design limitations. Both architects, Lorin and Mark, indicated that in their nursing home designs they provide separate space for staff which is away from residents. This had changed from ten years ago, when designs were more a 'happy family' approach, according to Lorin, with everyone 'all in together'. At Beechwood, there had been recognition that staff needed a place of their own within the residential environment, as indicated by the doubling in size of the staff-room from the original design. However, it was centrally located with little sense of privacy from residents' requirements or the business of the nursing home.

Time-tabling of activities with residents and adherence to routine ensures staff are able to take their breaks. These breaks are entitlements that are specified in the industrial awards for each staff group. The breaks may well act as 'buffers' or short respite from the intensity of the work-load and its associated demands, particularly those of an intimate nature.

The desire to isolate one self from the demands of the role in the nursing home environment surfaced in unusual ways. Coinciding with the end of the early shift at 2.30 p.m., I had noticed a strong desire on my part, to desert my field work and leave with the staff. I felt this as a desire to go outside to freedom. It was a strong need to get away for a while, for respite from the intensity of the environment. I suspect this was a projective
identification. The second instance related to my use of the 'quiet room' for interviews. I pride myself on having a good sense of direction, but clearly this does not run to spatial concepts as several times I had trouble locating the 'quiet room'. I could not accept that it was located at the far end of the building in Elm House, the precinct of the secure lock-up unit for residents with dementia. There are two possible interpretations of the difficulty I had in retaining the location of the 'quiet room' in my head. First, staff were projecting into me their feelings of resentment about not having a private space to escape to and leave behind the demands of responsibility in the caring environment, hence I kept losing the location of the quiet room as a way of denying this projection. Second, I could not accept the location of the 'quiet room' in Elm House, in the middle of a dementia unit – I felt surrounded by madness and I reacted with a degree of alarm. This need to separate from residents was also borne out with informal conversations about partitioning the nurses' station of Elm House, in order to separate staff from the open reception area. It seemed that Elm House staff felt exposed and vulnerable and wanted to be cocooned, perhaps it was to keep away from the madness of residents.

At Beechwood Nursing Home, as with so many other nursing homes, there was no allowance for staff needs, beyond the provision of a staff-room. The two offices adjacent to the reception area were in constant use and often shared by two or three staff in their administrative duties. It was difficult for senior staff to find any private area in which to discuss sensitive issues with staff. Olivia, the Unit Manager for Pine House reported that others often burst in on her, even when she had someone with her who was in tears.

There was no space available for staff meetings larger than a group of eight people. Larger meetings had to be held in residents' spaces. I attended several that were held in the Pine House dining room. On each occasion there were several interruptions by residents and staff.

6.7 Explicating the Nexus Between the Nursing Home Building and Organisation Culture

In the sections above I have explored the manner in which the nursing home building can direct the day to day activity of the environment. In particular I sought to
demonstrate how the physical structure of the building with its floor-plan lay-out and allocation of particular areas can be misguided and impact on both residents and staffs lives in the environment. To this information I added examples of the use and misuse of spaces within and outside the physical structure that are under-utilised by residents, and as a consequence significantly curtails the range of activity available and the quality of life. The third element of The Conceptual Framework, a sense of place was applied to a study of the ways in which space and sense of place with its meta-physical qualities might be engendered for, and by, residents within the nursing home. It is important to re-iterate that these findings are representative of many nursing homes.

In the following sections I proceed to describe and compare aspects of the organisation culture unique to the three houses of Beechwood Nursing Home in which the building plays a direct role. This discussion extends the findings in Chapter 5 on the organisation culture that were summarised at the beginning of this chapter. The working definition of organisation culture as described in Chapter 2 is incorporated with a discussion of the physical context of the nursing home environment. This working definition stands as those interactions between people (the social enterprise) that are mediated by organisational task, organisational boundaries, organisational defenses against anxiety and the interaction between these and the organisational holding environment.

6.7.1 Organisational Boundaries and Task Environment

The design of the physical structure of the Beechwood Nursing Home building enabled employees to invoke barriers that reinforced their routine task orientation. I have already discussed the dominant culture of Beechwood Nursing Home as one that supports physical aspects of care over that of psycho-social aspects. The most pronounced physical barriers were those associated with the location of the main meeting and activity points. These being the Birch House lounge and activity and therapy room in Elm House. From a functional perspective, the location of the activity and therapy room at the rear of the building in Elm House, poses significant inconvenience to the lifestyle and therapy staff. The location makes it difficult to make use of a room that is not within easy access of the majority of residents at Beechwood nursing home. In its previous intended location of Pine House it was central, which meant residents could make their
way to it or be assisted to it with greater ease. At the rear of the building it presented a challenge to reach it, either you had to cut through the residents lounge in Elm House or go the long way via corridors. Taking into account the discussions on culture in earlier sections, the location of the activity and therapy room at the rear of the building suggests the socially structured defenses of the nursing home environment are oriented towards clinical care over socially engaging residents in creative or therapeutic activity. This is reflected in the location of both the specifically designated space for this purpose, which is hidden and out of view, like a secret, and the inability of other spaces within the building to support socially engaging activities in an optimal fashion. It would have been more appropriate for the staff-room to be located at the rear of the building, as staff could more easily negotiate the distance than most of the residents.

I have demonstrated through earlier discussion in this chapter how the physical structure directs activity and limits it. The physical structure is synonymous with physical boundaries. There is a complicity in the way staff make use of these boundaries as a means to control residents whereabouts. These physical boundaries were created by locking of particular areas such as the secure unit in Elm House; and through the division of the building into three units identifiable using different colour themes in the soft furnishings, wall colour and carpets as indicators. At Beechwood Nursing Home I observed many instances where residents would be stopped by staff from moving between houses, with comments such as 'no, not this way dear, you don't belong here, back you go'. With that, the resident was gentle turned in the right direction and the staff member went about their business. The reality of physical boundaries (fences, locked areas and individual houses/units) in nursing homes is a vexed problem. On the one hand they help to reduce the prospect of residents wandering away from a building, which is a responsibility of the nursing home; on the other, they are used to control the activity of residents. The practice of staff to return a resident to their 'house' appears to be one of safe-guarding the resident, however, it also limits the span of control a resident has within the building and raises questions about which part of the building is home for the resident. Is it their bed-room, the lounge and dining areas of their house or the whole of the physical structure and its spaces? Clearly the action of keeping residents within a physically defined area with real or psychological/artificial boundaries is consistent with the need to provide physical safety and the staffs need to provide it.
This action, however, also reduces the span of the world a resident can access and alludes to staff's perception that home is the resident's immediate bed-room and possibly the 'house' where the room is located.

As noted earlier in this chapter, the reception area of the nursing home was divided by means of a glassed-in wall, through which the receptionist was visible. There was a small opening wide enough for items such as documents to be passed through. It was similar to the counters in banks, where staff are separated from the very customers they are there to serve. Margo, the Hospitality Services Co-ordinator who had spent two weeks on a relief role in the reception area, described it as 'the fish-bowl'. Margo suggested it might have been glassed-in to reduce the noise levels for the receptionist. Certainly the transfer and reverberation of noise throughout the physical structure was evident, a consequence of both the design of the building and the decision not to build it as a solid structure. The glassed-in reception area presented a physical boundary. It was a demarcation line between the staff who represented the charitable operator of Beechwood Nursing Home and those in need, the residents and their families. In this it accords in part with Goffman’s description of the split between two groups: one the large managed group and the other the supervisory group or managers (1968, p.18). This is symbolically reflected though the partitioning of the reception area, separating the group who manage from those situations and actions which provoke anxiety - the residents or managed. A further symbolic artefact was the wearing of corporate uniform by staff, which immediately distinguished them from residents. When I first saw this glassed-in reception area I recalled the comments of a lecturer who once said to me you can tell a lot about an organisation from the way it (initially) treats you and its presentation (Newton J 1997, pers. communication).

6.7.2 The Water-Jugs, The Building and The Culture of the Organisation

Quality Systems Meetings were held at Beechwood Nursing Home on a monthly basis. The purpose of the meetings was to review the implementation and operation of the quality system recently introduced at the venue. Staff in attendance included those with direct responsibility for aspects of the quality system, unit managers and department heads. I attended one of these meetings and towards the end of it Margo, the Hospitality
Co-ordinator raised an issue related to residents’ water jugs. She stated they were not being cleaned daily, nor the water replaced on a daily basis and some water was two days old. The stale water and infrequent cleaning of the water-jugs presented a health and safety problem to the organisation. This was of paramount concern in terms of resident welfare.

A discussion ensued around the table as to whose role it was to collect the jugs; when to collect them; who was to clean them; re-fill them and then distribute them. Beatrice, the Director of Nursing/Manager asked the group why this issue came up at every place she had worked at, saying 'I'm right, aren't I?' Demarcation issues amongst the staff groups regarding responsibilities and work practices emerged. Night duty staff were identified (within this room only) as having more time available than on other shifts. Nursing did not see it as their role to remove the jugs and yet the nursing staff relied on jugs being cleaned and filled regularly, in order to help hydrate those residents incapable of providing themselves with a drink. Registered nurses needed the water supply to help with medication distribution to residents.

Solutions were suggested by several staff, each proved unworkable because of the difficulties of the location of the kitchen and laundry areas. There was not enough space to store seventy-five jugs waiting to be washed, six at a time on a three and a half-minute cycle. It would take hours and the process was noisy. The kitchen and laundry are located in such a way that they occupy a major portion of the central area of the building as well as being opposite residents’ rooms. One wall of the laundry abuts residents’ rooms. The location of these service areas restricts their use as the operation of the industrial equipment generates noise and vibration that carries throughout the building and is amplified at night, disturbing residents. The carriage of vibration and noise is a consequence of the building not being of solid construction throughout.

The inability of the meeting to resolve the water-jug problem was striking. The discussion pivoted around whose role it was to undertake the tasks associated with water-jug removal, cleaning, filling and replacement, how this would be done, how it would coincide with another role, such as distributing morning teas, seemed
unresolvable. The decision was taken to form a working party of three. Even when this action was decided, the issue was revisited at the Unit Managers meeting.

Importantly, the work practices entailed in the water-jug problem were exacerbated by the problem presented by the building. The ability of the group to reach a decision on work practices, was hampered by the location of the kitchen in the middle of the residential environment; the limited kitchen space; the small size of the dish-washer; the noise emanating from the machinery; and the capacity for the building to carry noise. Although the meeting considered the night-shift had more time than other shifts to assist with the removal and cleaning of the water-jugs, they could not undertake this work as it could not be done at night. Interestingly, the night-duty staff were all registered nurses. There were no kitchen or domestic staff on duty. The water-jug issue appeared to reinforce the demarcation of roles amongst the staff groups. The nursing staff's role identity seems tied to mediating between the needs of residents and the role of others, to meet these needs. It is of interest that the solution to form a working party was made by Heather, the life-style co-ordinator who is not a member of either the domestic group of staff nor the nursing group.

The issue of the water-jugs illustrates a number of aspects this thesis set out to explore. First it shows how integral the building is in the decision-making processes of the organisation culture. The issue itself brought to light the tension between the boundaries of each group and demonstrated that neither of the two major sub-systems were operating effectively. Rice (1963) defines these subsystems as the operating subsystem, that is the system where conversion of work takes place and the managing subsystem, whose responsibility it is to manage and regulate the boundaries of the organisation. In this instance, the managing subsystem seemed unable to co-ordinate the work of the individual sub-systems. The subsystems appear to be experiencing what Czander (1993) refers to as discontinuity. Each subsystem is trying to define its boundary and establish a control region, which leads to decreased co-operation and intersystem transactions.

At Beechwood, the staff groups appear to be heavily reliant upon a task culture which closely specifies who does what, when it is done and how. In effect a routine oriented culture which requires little in the way of discretion about task order and how the work
is undertaken. This model of organisation and service delivery is at odds with espoused professional values of the nursing discipline in particular, over recent times.

6.7.3 The Manifestation of Physical and Psychological Boundaries

Physical and psychological boundaries are active in the minds of staff. The water-jugs issue demonstrated this in the manner in which staff interpreted task, role and boundary. It was also evident amongst the unit managers of each of the three houses, particularly that of Olivia, the unit manager for Pine House

Early in my case-study I came across Olivia, standing at the juncture of the three corridors which form Pine House. She remarked, 'I've just told Steve (the maintenance man) I'd like to blow everything up'. She was looking at the linen trolley and the food trolley. All food and linen trolleys must pass through Pine House from the kitchen and laundry to Birch and Elm House. This is also the case for trolleys carrying stores, such as continence pads that are bulky. The major chemical store cupboard and cleaning equipment cupboard is located in Pine House as is the staff-room, the staff locker area, the main notice board for residents and visitors and the public phone. Each of these is adjacent to the juncture of the three corridors of Pine House, which is the major access point to the Pine House lounge for residents. In this brief exchange with Olivia she went on to make one other point, this related directly to residents. Olivia said the residents in Pine House were the most socially isolated and this was demonstrated on Christmas Day. The Pine House dining room and lounge were used for the Christmas Party – but it didn't work, a point which Beatrice - the Director of Nursing/Manager reinforced with Olivia. One relative 'attacked' Beatrice, saying there was not enough room and too many chairs. Olivia said she totally agreed with her.

Olivia's drawing was produced in response to the request to draw what it is like to work at Beechwood Nursing Home. This was discussed in Chapter 2, Method. Her drawing is reproduced on page 166, Figure 19. A summary of the drawing and points from her interview appear below. Both provide insight into the salient relationship between the physical environment of Pine House and the organisation culture of Beechwood Nursing Home.
The solid circle has been divided into two hemispheres, the one on the left further divided into three segments with the third segment further sub-divided into two. The one on the right is divided into two segments. Arrows feature in each segment, drawn as to represent opposing forces. Olivia says the right hand side of the diagram is her career side. I am struck by the sense of fractured-ness in the diagram, both in the two hemispheres and in the third segment on the left hand side. I comment on how the diagram seems fractured and she agrees, saying she doesn't know whether to stay at Beechwood Nursing Home or go.

Throughout our discussion of the drawing I began to form an impression that Pine House is not valued by others and I suggest this to Olivia, who agrees. She has just begun telling me how on weekends stock goes missing from Pine House and is used on the other two units, Birch and Elm House. Olivia tries to manage her supplies and the costs, she seems to be inferring that the other units and unit managers don’t do this. Located as it is in the middle of the building, Pine House is a point to go to when looking for things that are needed in the other units.

Olivia says she is in limbo at the moment and she will review her role after Accreditation, which is only six weeks away. Olivia feels she knows what needs to be done overall in her Quality Co-ordinator role, but her Unit Manager role competes ‘absolutely’- adding then you’ve got the residents and that’s what I’m here for. Even when I’m on my management day I’m called away by doctors’. Birch House has agency staff on Monday and they refer to Olivia and so do staff. She feels you have to have time to support the Grade 1 registered nurse. She feels as if it’s an identity crisis. ‘I don’t know if it’s because I’m in a corridor and it’s a thoroughfare’ – I ask, are you more accessible?’ ‘don’t know why they all come to me, sitting in Pine House nurses station everyone can see you, they see you talking and still come in, staff barge in even when you’ve got people in tears – in the other office’.

Towards the end of our interview, Beatrice the Director of Nursing/Manager bursts into the quiet room, without knocking, saying there you are. Olivia says yes, here I am talking to Trish. Our interview is irrelevant to Beatrice. She needs to see Olivia and takes up a discussion with her. At the time I remember thinking how Olivia is not able
to protect herself from intrusions. Everything about Olivia seems to be fractured or there is an element of duality in relation to role, feelings, wanting to be left alone and always being found.

This sense of being ‘in limbo’ I believe reflects the status of Pine House within Beechwood Nursing Home. This is represented in Olivia’s drawing by the divided segment on the left-hand side of the hemisphere, entitled ‘Building’. The ‘in-limbo’ feeling described by Olivia, is about being suspended between two choices – to stay at Beechwood Nursing Home in her dual role in Pine House, or to leave. It is also saying that Pine House is suspended, or in-limbo, between two other residents’ houses, neither of which are confounded by the problems of being home to the kitchen and laundry amongst other utilities, as Pine House through zone.

Figure 19 Olivia’s Drawing
The dual role held by Olivia seems to be a clear theme reflected in her drawing. She is both Unit Manager of Pine House and Quality Co-ordinator for Beechwood, a dual role for which she says she is not paid enough and highlights the responsibility placed on the registered nurse in the environment. Duality and the anxiety it provokes, seems to be a theme of Beechwood Nursing Home. Several staff have positions with dual responsibilities, Beatrice as Director of Nursing/Manager and Olivia as Unit Manager and Quality Co-ordinator for the site. The Birch House main lounge for residents is also the large group room for residents' activities. Pine House is a residents' house and at the same time it is bisected for the purpose of accessing two other houses as well as being home to the service areas of the kitchen and the laundry. Elm House has two sub-units, one a secure unit that must be accessed through a key-pad system and the other a mirror image of the secure unit. There are court-yards in Elm House and Birch House designed for residents use and not useable as is the case with the main court-yard. The lifestyle style work at providing activities and therapy for residents in cramped spaces which have a dual use - lounge and dining areas for residents, whilst the main activity and therapy room is rarely accessed. Lastly there is a schism between the purpose of the physical context provided by the building and the perception of staff as to its purpose which is seen as dual, that is it is a building to live in and to die in. This position seems to have been taken up in the social defenses and routine oriented task culture of the nursing home, where the emphasis is on cleanliness, hygiene and safety of residents over socially engaging and productive quality activities. In Goffman's description of total institutions of which aged care constitutes one example, he uses the term social hybrid to describe an environment, which is part residential community, and part formal organisation (1968, p.22). Again, this reflects a duality borne of different perceptions about purpose - primary task, structure - both physical and organisational, and outcomes - exports across the boundary.

6.8 Holding Environment

The working definition of organisation culture used throughout this thesis considers the social interactions amongst people in the light of organisational task, organisational boundaries, anxieties and defenses in terms of the organisation holding environment. In the discussions in Chapter 2 I identified that I was drawing on these psycho-dynamic
concepts (with their psycho-analytic origins) for application at the level of the organisation, rather than the level of the individual.

The purpose the holding environment serves is enabling individuals to grow and develop (Shapiro and Carr 1991). This encapsulates Winnicott’s envisioning of the holding environment from infancy to adult-hood. As the author of the theory of the holding environment, Winnicott believed that the first holding environment is that created by the mother and this expands to include others and the various groups that individuals come into contact with over a life-time (Stapley 1996; Van Buskirk and McGrath 1999). According to Van Buskirk and McGrath (1999, p. 808) it is the quality of the holding, the sense in which it engenders basic trust in one's surroundings, that determines the extent to which the person can become a genuine, creative individual.

Extrapolating the concept of the holding environment to organisations, Stapley (1996, p.39) notes that just as the holding environment provided by the mother influences the infant, so the holding environment of the organisation influences the culture. In Stapley’s view the holding environment is not equivalent to the culture, rather it is how the members of the organisation interact or their interrelatedness with the holding environment that results in the culture. It is the members perception of the holding environment that results in the unique and distinct culture that is the feature of every organisation (Stapley 1999, p.39). The nexus between the holding environment, organisation culture and development is re-iterated in Van Buskirk and McGrath’s work in a Community Women's Education Project. According to Neumann and Hirschhorn (1999, p.693) Van Buskirk and McGrath seek in this project to identify which aspects of culture most provide and symbolise 'holding to maturation' for participants of the project.

Whilst there is no explicit discussion of the building's relationship within the concept of the holding environment, the term environment is used as a broad expression of place. Rycroft (1995, p.49) notes that psychoanalysis tends to concern itself wholly with human aspects of the environment. He advises that a distinction needs to be made between Umwelt, the total environment as perceptible by the observer - which would be me as the researcher - and the Merkwelt (perceptual environment) of the subject being observed - that of residents, staff and others. The latter consists solely of those aspects
of the total environment that are perceptible and relevant to the subject. Given this, what is the perception by staff, residents and others of the physical context of the environment as a part of the holding environment?

Van Buskirk and McGrath (1999, p.812) note that for an organisational culture to constitute an adequate holding environment, it will have to provide resources for persons in varying stages of growth and regression. In an attempt to provide a definition about the holding environment in organisations, the authors refer to 'those practices and symbols characteristic of a local organisational culture which supports (either well or poorly) the specific identities of organisational members'. Van Buskirk and McGrath recognise that for some members of an organisation, the organisation will be an excellent holding environment providing space for creativity, while for others it may be an area for existential crisis. They suggest that organisation cultures have to support their members in four ways through: the opportunity to merge with others, the enactment of me-not me boundaries, the provision of creative space, and stability for moving on. They incorporate these points into four propositions for the purpose of their own work. Central to these is the notion that organisation cultures that are good holding environments contain symbols, structures and practices to support each of the four points above (1999, p.814). These four aspects are taken up below.

6.8.1 The Holding Environment of Beechwood Nursing Home

It is my view that the physical structure, the spaces created by it and a sense of place to be found in the nursing home, together directly contribute to the quality of the holding environment experienced by residents and staff. These aspects should be considered alongside the psycho-dynamic concepts of task, role and boundary, which are contained within the holding environment definition. The physical context of the building articulates with the perception of staff about their role, it affects the decision making process about basic operations and directly influences the manner in which work practices are undertaken and how the overall routine task oriented culture manifests.

As described above, the four aspects identified by Van Buskirk and McGrath are here considered in relation to staff and residents of Beechwood Nursing Home.
1) the opportunity to merge with others:

for staff - there appears to be opportunity for staff to be reflected in the culture and for a feeling of belonging to be engendered;
for residents - I do not think this holds true, residents have great difficulty coming into and adopting the culture of the nursing home and little relating to the symbols, structures and practices reflects the residents involvement, in the way that it does staff;

2) enactment of me-not me boundaries:

for staff – there is evidence of strong me not-me boundaries around each of the staff groups, however the ability of the environment to develop the me-not me boundaries of these staff groups beyond defensiveness seems limited;
for residents – the absence of suitable physical and psycho-social boundaries challenges the continuity of residents' identities. Me-not-me boundaries become eroded as a result of structures that foster dependence rather than independence.

3) the provision of creative space:

for staff - little provision of creative space as demonstrated by the strong routine task oriented culture;
for residents - some attempt to provide creative space, but this is limited by the routine task oriented culture and the spaces in the building, including private space, which must have a bearing on 'a sense of place';

4) stability for moving on:

for staff - staff are reasonably long term employees of this environment, perhaps it does not provide them with the ability to move on. Staff who leave would not be expected to continue to relate to the culture;
for residents - moving on in this culture, meant to die. There was no obvious support for residents to discuss this aspect of their residential occupancy, although palliative care services were available.

When considering the holding environment and the idea of 'holding to maturation' in relation to residents, there seems to be little opportunity to merge with others, the enactment of me-not me boundaries is constantly challenged, the provision of creative space is minimal and the support for moving on is not a suitable criteria for this setting.
Indeed the four aspects by Van Buskirk and McGrath may all be unsuitable for application here.

Upon reviewing the extensive discussion of the routine task oriented culture in Chapter 5 and the specific relationship of the building to aspects of the culture detailed in this chapter, I am reluctant to describe the holding environment of Beechwood Nursing Home as 'good enough' for either staff or residents.

6.9 Conclusion

This chapter is the culminating chapter of this thesis. In this chapter The Conceptual Framework was applied to the discussion of findings related to the organisation culture, principally from the Beechwood Nursing Home. Each of the three elements of The Conceptual Framework was described in full and related to the organisation culture of the nursing home.

The limitations arising from the physical structure and the spaces created by it, together with the ability of the building to direct work practices in the nursing home environment was explored and discussed. This was followed by a description of how a sense of place is manifest by residents living in a nursing home. It was made evident that the physical context of Beechwood Nursing Home falls short of an optimal physical environment for either residents or staff. Residents are disadvantaged with regard to the significant meeting and activity points in the building as well as the amount of space provided for personalisation of rooms. Staff are challenged by the overall size and lay-out of the building and use the building to reinforce boundaries as well as their routine task oriented work practices. Following the discussion of the physical structure, the spaces created by it and a sense of place the discussions moved to an exploration of the nexus between the building and the organisation culture of the nursing home. As part of this, interview data and one drawing were included to illustrate links between the culture and the building and the influences on work roles.
The final part of this chapter draws together the working definition used throughout the thesis. The quality of the holding environment of the Beechwood Nursing Home is discussed with the ultimate realisation that the holding environment serves neither staff nor residents satisfactorily.
CHAPTER 7 CONCLUSION

7.1 Introduction

We shape our buildings, thereafter they shape us.

This chapter brings the thesis to a conclusion. It draws together the origins of the research; discusses significant findings from the data; places these findings in context; and assesses the potential to apply the findings to other residential aged care facilities.

This study attempted to identify and explore the role the building plays in the organisation culture of nursing homes. To do this a research plan was formulated in which the central plank was a case-study of a seventy-five bed high care nursing home. As part of the case-study, interviews were conducted at the nursing home with ten members of staff, two residents and a daughter of a resident. The study was also informed by interviews with two architects, who specialise in the design of nursing homes and aged care facilities. A theoretical model entitled 'The Conceptual Framework' was developed prior to the case-study. It was tested by applying it to findings related to the physical context and the organisation culture of the case study venue. The hypothesis that the building does influence the culture of the nursing home environment was explored by studying the manner in which the building influenced the lives of those who work in the nursing home and those who live there. This challenge was met with the use of theoretical contributions from organisation theory and psycho-dynamics, which together provided a vehicle for analysis of the culture and the building’s role in it.

In section 7.2 that follows, the origins of the research are discussed. This is followed by discussions related to key findings of the research, including a brief analysis of the negative image of nursing homes; the organisation culture of the nursing and preferred building designs. In section 7.6 the application of the theoretical model - the Conceptual
Framework - and its suitability and veracity as a tool for use in other residential aged care settings is analysed. In section 7.7, I discuss the limitations of the research. This is followed by sections related to my learning as researcher and the potential benefits arising from the research. The benefits arising for various groups involved with residential aged care are summarised. The chapter closes with final comments on future residential aged care and the balance between private and public spaces.

7.2 Origins of the Research

Like many researchers I set out to answer a question. The question was forged from my interest in the relationship between the built form of nursing homes and their organisational culture. I wanted to know how and in what ways the building influenced the culture of the nursing home environment. The research developed from my experience and knowledge of residential aged care environments. It was extended through a literature search of nursing homes and their physical environs. The synthesis of these sources lead to the development of a theoretical model, referred to throughout the thesis as the Conceptual Framework. The model was fully discussed in Chapter 2 together with theoretical perspectives drawn from organisation theory and psycho-dynamics. The importance of the model remained an enduring theme as I moved into the research design phase of this study. Eventually I realised that the model itself was as integral to the study of the nursing home environment, as were the domains of organisation theory and psycho-dynamics. The model was then actively incorporated in the data analysis and discussions of Chapters 5 and 6.

7.3 The Negative Image Associated with Nursing Homes - An Analysis

In Chapter 1, it was established that the community has a negative attitude towards aged care and nursing homes. It was identified that the media treat nursing home issues in a particularly unfavourable light. Residents are portrayed as vulnerable and nursing home operators as predatory. This image quickly fuels the perception held in the mind of the community at large. Reaction to issues is swift and voluble. Notwithstanding the requirement to ensure care and conditions in nursing homes are both satisfactory, it is of
interest that their portrayal is emotive and that the reaction of the community is negative.

It is plausible that the reaction of the community at large, is based on the internalisation (and personalisation) of images, rather than its concern for current residents of nursing homes. These images are associated with ageing, incapacity, dependency and vulnerability. The nursing home symbolically embodies each of these images. The symbolic representation associated with the nursing home is also a challenge to the fundamental belief in the provision of quality care. Nursing homes represent the larger institution of health care. Society is taught to trust in its institutions, which are meant to uphold values associated with caring, no matter your status or background. The community's 'institution-in-the-mind' about nursing homes, wants to see them as a caring environment, provided for people who can no longer live alone and require 'loving' assistance. It appears that the nursing home represents the ideal of a nurturing mother. The community finds it intolerable that the nurturing mother has the capacity to be a demon. This inability by the community to reconcile its 'split-off' bad part about ageing and its unpleasant aspects, leads to a desire to set out and destroy - at a verbal level - the very place which is supposed to provide care. The institution of the nursing home is no longer reliable as a source of continuity to reduce the anxiety held collectively by the community. Its quality as a holding environment, the last holding environment, is placed in question.

7.4 The Organisation Culture of the Nursing Home

The findings of this study reveal that the culture of the nursing home can be accurately described as a routine task oriented culture. In Chapter 5 the tasks of daily life provided by the nursing and care staff group and the lifestyle and activity staff were discussed. In this culture it is apparent that meeting the physical care needs of residents takes precedence over the meeting of psycho-social needs. The drivers of this culture include: the dominance and orientation of the nursing and care group; the legislated requirements for health and personal care; and the design of the building.
A task oriented culture is necessary for an organisation to sustain itself. The principal objective of the nursing home environment is to provide care to the residents of the nursing home. It is the investment in 'routine' in the culture, which is of interest. Routine dominates the staffs working life and the life of the residents. Routine is the occupational glue of the culture, regulating and controlling activities and protecting both staff and residents from the reality of the environment. It also helps to create and keep social distance between staff and residents. The characteristic binding all staff groups across the tension created at the boundary of each, was routine.

In a nursing home, routine is a two way street. Many residents are helped to feel secure in the nursing home environment because of the routine. Changes, no matter how small have the capacity to disturb a resident. Entry into a nursing home behoves a resident to adopt the routine of the immediate environment, a routine set and controlled by others. True, small adjustments for personal preferences are accommodated and residents care plans will reflect this. However, such adjustments do not usually run to the extent of serving a meal upon request.

As a participant-observer, I became aware that physical care of residents was considered paramount in the nursing home environment. This physical care included attention to hygiene and nutrition needs as well as clinical interventions. These activities took (and were given) precedence over psycho-social aspects. At various meetings such as hand-over between shifts, discussions were related to physical care needs and how to meet them, rather than the wider psycho-social needs of the resident population. This was only paid attention if there was some associated pathology.

This emphasis on physical needs and a physical environment that supports this, is reflected in the perception of staff and others about the primary task of the Beechwood Nursing Home. This can be summarised as being to make residents comfortable up to and when they are dying and providing an environment which is suitable to this purpose, one that is home-like, friendly and encourages involvement. The notion of care, equated with the physical aspects of the activities of daily living. There was no clear articulation of the role of activities in the social well-being of residents. There appeared to be a schism associated with the primary task of the nursing home. It was inconclusive as to
whether it was a place to live in or a place to die in - many interviewees argued that it was there to serve both purposes. This duality of the primary task was reflected in the dual operating characteristics of the total environment. These operating characteristics included the emphasis on care, the purpose and use of space in the building and the presentation of the environment. These were discussed in Chapter 6.

The culture is not only a routine task oriented one, it is also founded on strong boundary regulation. In the nursing home setting there appears to be a relationship operating between the organisation structure, the boundaries amongst staff groups and the social defenses of each group and the group as a whole. Structure and role are tightly bound together in the nursing home. The structure exists to defend against both the external environment and internal pressures and associated anxieties these give rise to. The boundaries formed by each staff group are also strong. This became evident at Beechwood Nursing Home, when staff groups found it difficult to negotiate across their boundary to resolve the water-jugs issue, discussed in Chapter 6. This issue was an example of the vigilance of nurses about separating non-nursing duties from their role, while at the same time demonstrating their reliance upon other staff groups to facilitate their role.

In Chapter 5 I delineated the social defenses that I believe operate in the culture of the nursing home. Routine is inherent in these social defenses. Social defense theory holds that the social defenses are a way of structuring external reality, to avoid the anxiety evoked in work. Clearly the social defenses operating at Beechwood Nursing Home enable the staff group to collectively avoid the anxiety associated with ageing and death and the attendant personal care requirements. Highly structured routine work practices act as sanctions, separating the staff from the residents.

The balance between physical care and psycho-social care, is also reflected in the Standards of Residential Care (Commonwealth Department of Health and Family Services 1998). Of these fourty four standards, seventeen are focused on the direct 'health and personal care' needs of residents, whilst ten are focused on 'resident lifestyle'. It is hardly surprising that the greater proportion of standards in these two categories, is on 'health and personal care', after all, the need for physical care is why
people enter a nursing home\(^5\). This need and the requirement to meet these needs is enshrined in legislation and it becomes the raison d'être of nursing homes. The Act also specifies that qualified nursing staff be available for nursing home care. It is less specific about the requirements for, and of, other staff groups. Albeit they are appropriately skilled.

Nurses provide clinical care aimed at maintaining the physical well-being of individuals, this was demonstrated at Beechwood Nursing Home and supported by references to recent literature about the perception of the nursing role. Physical care is most often associated with the 'patient' role. In instances at Beechwood Nursing Home and in many other nursing homes I have heard both staff and residents use the term patient to describe themselves in the environment. This use of the word patient suggests that residents have introjected symbols of the culture and taken up a role as patient. Moreover the clinical orientation of the staff which is reinforced by the building, constrains the culture to one which is related to care and treatment.

The measures which registered nurses use to indicate clinical competence include such things as the prevention of decubitis ulcers; precisely because they are preventable conditions. In other words it is a measure of professional competence and attention to task. It is because registered nurses are prepared for a role focused on clinical care of the physical body that they translate both the needs of residents and the ability of the physical context into constructs which can support their role. A clinical practitioner must practise in a clinical venue where clinical knowledge can be applied to those who have a need. The clinician legitimates the residents need and vice-versa and they mutually engage each other in role. Here is the paradox of the organisation culture and the nursing home building. Clinical care begs certain requirements of the building, but residential life begs different requirements. These differences in requirements are taken up below.

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\(^5\) The 1997 Aged Care Act states that eligibility to receive residential care is based on the person having physical, medical, social or psychological needs that requires the provision of care. Commonwealth of Australia 1997, p.76)
7.5 Preferred Nursing Home Designs

Designing a desirable nursing home seems to be a difficult balance to achieve. This is because the environment must incorporate the functional aspects that support the routine tasks of staff, with those aspects which mirror those we associate with home. While not an architect, Burton (1998, p.54) notes how odd it is that the template for the design of running residential services are in fact institutional models, i.e., schools, businesses, voluntary organisations, government (local and national) and military models. He claims that rarely is home used as the 'model of organisations, of which everyone has strong and deep experience'. The idea of home is at the heart of the concept of any place designed to provide somewhere to live with other people and be given care and support (Burton 1998, p.55). That is what most people might be said to have experienced of a home environment.

In this study the design of the physical structure of Beechwood Nursing Home is at odds on almost all dimensions to those specified by the architects interviewed in the study. It is based on a dormitory rather than a cluster-housing model and its floor-plan lay-out and formally designated use of spaces arising from it, create limitations for residents and staff. Bedrooms run off corridors, communal space is located out of view and is frequently used for more than one purpose. Privacy is difficult to achieve without closing the door to the corridor. Service areas are co-located with residents' rooms. In particular, the juncture formed by the corridors of Pine House is crowded with trolleys on their way to one or other house and the area is noisy.

The 'institution-in-the-mind' of the architects revealed a strong preference for cluster style housing of no more than fifteen residents. Both architects leaned towards functionality for staff from a work practice aspect with proximity to the main areas: these being staff bases, residents' bedrooms and utilities. Minimising travel distances were important, as was discrete management of residents, where staff have vision of communal areas, without making it a prison. The other consideration is to make it a home-like environment reflecting residents needs. Importantly, design impacts on work practices and hence staffing. Long corridors and aspects reminiscent of institutional designs should be avoided because if residents believe they are in an institution they will
behave in kind. Service areas should be out of view, communal areas should be easily accessible by visitors and located so that people do not have to pass residents bedrooms. Moreover, designs should be flexible. This flexibility ensures that rooms can be adjusted to meet increases and decreases in resident numbers and increases in dependency levels. Both architects held the view that a good design will help make staff more productive on the basis that they will enjoy the building. This study found that Beechwood Nursing Home was not an optimal design and as a result it affected both the working lives of staff and the lives of residents.

Consultation and planning were big features of the approach the architects take to nursing home design. Both noted that stakeholders and policy directions must be considered and can often limit ideas. This is reflected in the prescriptive requirements of Certification. Nevertheless they sought out as far as possible the perspective of staff, residents and family members. This process brought with it mixed reactions, some residents not being familiar with a process that invited their comments. Their experiences with staff, particularly staff who had been long term employees of a facility were strongly staff-centred with an emphasis on designs which made their work load easier. Staff were often 'blinkerred' as to new ideas and possibilities until they visited other facilities and had their eyes opened. Rarely did staff see the input of residents, as integral to the process. The outcomes of the architects' consultations with staff of other facilities, echoed comments made by staff at Beechwood Nursing Home.

From the outset of the case-study staff volunteered comments that appeared to be concerned with the welfare of residents in the building, however what they reveal is a staff-centric, functionally oriented view of the building. Such comments included -

- this place is really resident-centre - but not nurse centred'
  - the kitchen shouldn't be in a corridor;
- should have asked an ordinary nurse about the design;
- could have made corridors wider;
- can't see the residents have to rely on bell;
- could have expanded dining area into pretty garden area; and
- the place is a bit of a maze.
Each of these comments reveals the interest on the part of staff to provide a building that supports their practice. No doubt to them this equates with improving their role in caring for residents. Although some staff did comment on how they believed the building disadvantaged residents, there was no indication that residents should be consulted about the environment that forms their last home. The perspective detailed here plus other findings of this thesis indicate that the 'institution-in-the-mind' of staff is of a nursing home building which primarily supports their practice.

7.5.1 The Building Shows How Much We Care

There was a prevailing sense within the culture of Beechwood Nursing Home that the presentation of the building and its internal finishes were a reflection of how much the staff cared about the residents. This was observable in such actions as senior staff instructing junior staff, to ensure curtains were neatly tied back during the day, with the ties at just the right position. Tours of the building focused on room size, features of the building and the range of services available. There appears to be a correlation in the mind of the community and visitors to nursing homes, that an attractive building and superior furnishings equates with a high standard of care.

This study did not set out to establish the level and quality of care services. Rather it set out to study the way in which the building influences the organisation culture of the nursing home. However, it is fair to say that a 'nice' building is no more indicative of the level of care, than it is true to say that poor care correlates with a building which is nothing short of a dump. Moreover it is the wider picture of care services which must be taken into account. A medical model of care, which is not the preferred model of care in a nursing home, may predominate in both environments. What is more important than nice curtains, is finding a technique which assesses the full extent of the physical context and its influence on the nursing home environment.

This can be done through the combination of The Conceptual Framework with an analysis of the organisation culture. This provides a way of gauging the quality of residential lifestyle and the effects on the role of staff. This is discussed in Section 7.6.
At various points throughout this thesis mention has been made of the implications for residential aged care arising from the Aged Care Act 1997; in particular the requirements specified for Certification of buildings providing residential aged care services. The changes came about from a long history of discontent amongst the community, the providers, lobby groups and some residents. The discontent included the variability in the built fabric of nursing homes and other residential aged care facilities, the funding and reimbursement arrangements for care; the inadequacy of residential care standards monitoring; and the need to develop a policy framework which took account of the growing proportion of aged persons within the population. This story is repeated in most western countries.

Extensive changes have been introduced via the Aged Care Act of 1997, including the requirement for all facilities recognised as residential aged care providers to achieve Accreditation by 2001. One plank of this process is Certification, which focuses on the quality of the built fabric. The criteria for Certification are specific in terms of floor area, ratios of beds per room, number of bathrooms whilst keeping uppermost the requirement to maintain buildings against fire and other hazards. However these criteria do not include any discussion about how the building should be planned for optimal functioning. Nor do they suggest what minimum design criteria will ensure that both the physical and psychosocial needs of residents are met. Perhaps there is no design that can do this.

There is a popular trend towards single rooms, which is reinforced under Certification requirements. As identified in this thesis there is a paradox inherent in building facilities with single rooms. Whilst the aim is to provide private environments for residents, they are also perceived as isolating environments. Staff find it difficult to observe and supervise residents, as they simply cannot see them. The functional difficulty associated with the isolation of residents is a direct outcome of the built environment, observable in the work practices of the nursing and care staff. For residents single-rooms fail to provide anything more than a bed in a room with a small wardrobe and side table. The size of the room and available free space governs the number and type of movable
objects' a resident can bring with them. Rooms can be personalised but they do not provide what Peace et al. (1997) have indicated would be preferable, that of an adjacent sitting area, large enough to entertain in. The need for this type of space was evident in the study of Beechwood Nursing Home and reported on several occasions by interviewees.

Conversely additional sitting room space, could add to the overall distances between significant points in buildings, adding to the walking distance for both staff and residents. Additional walking distance may act as a deterrent for some residents. In this study it was demonstrated that the physical structure can direct and limit the ability of residents to take up and use the spaces formally created by it, for example, the inaccessibility of the outdoor courtyard of Beechwood Nursing Home.

### 7.6 The Veracity of the Conceptual Framework

The Conceptual Framework is a simple model. It is based on three dominant aspects of a nursing home environment, they are, the building also referred to as the physical structure; the spaces created formally and informally as a result of the building; and a sense of place evoked by the environment (refer Figure 6). Like most models, neither part works alone, each relates and articulates with the other. It was borne from an interest to provide a way of considering a 'total environment' in residential aged care. The genesis for it was experience, observation and a quest to integrate into a workable form the major domains of a residential setting - the built environment with the organisation culture - and to find a suitable manner of representing these domains which are unbroken and continuous in a residential setting. The Conceptual Framework provides a lens through which to study a nursing home setting. It amplifies the meaning associated with tangible and intangible structures and events through which to analyse organisation functioning.

The work of Peace et al. (1997) which was discussed in Chapter 2, was incorporated into the design of The Conceptual Framework and the study overall. Other work considered in relation to the development of The Conceptual Framework included Moos and Lemke’s (1994, p.45) Physical and Architectural Features checklist of facilities for
older adults, which helps to determine the viability of buildings in relation to programs and activities. Also taken into consideration is the term 'environmental press' that describes the potential demand of the environmental stimulus. Individuals are said to respond to this stimulus through adaptive measures related to their competence level (Lawton 1982).

Whilst measures such as Moos and Lemke's are strong on specificity and detail about aspects of the physical structure, they are weak on integrating aspects of the building with the organisation culture. They favour objective measures of the environment and find it difficult to convey a deeper meaning to the integration of the physical context and the organisation culture. Much of what Moos and Lemke discuss has been incorporated in this country into both the Certification requirements of the built environment and the Standards of Residential Aged Care. Repeating these would be pointless. Instead the Conceptual Framework can embrace both the Certification requirements and the standards of residential care in its application. Most models originate from behavioural psychology that behoves the inclusion of measures that are preferably easy to quantify and objective in nature. Those that emerge from other disciplines such as sociology and environmental perception are strong on the wider public policy implications without grounding this in a form that is immediately of benefit. Occupational Therapy provides numerous measures of environment, parts of which resemble the aims inherent in The Conceptual Framework.

Many health related disciplines appear to be aware of the importance of the building and the importance of the culture of the environment in a nursing home, without actually being able to bring them together in a way which enables a deeper meaning of the residential environment to surface. Models appear to be there to facilitate the staffs welfare and understanding, rather than the residents. Into this I must group nursing whose predominant orientation is firstly clinical care and then social care. At the outset of the thesis my intention was to convey the depth of the three elements of the Conceptual Framework through my findings and discussions, rather than produce a Framework that others could apply. This has been an inadvertent outcome of the study.
The strength of The Conceptual Framework comes when it is married with the psycho-
dynamic aspects of organisation functioning. This provides for a cultural analysis that
enables a deep understanding of the building, the residential provider, their orientation
to care, the staff's behaviour and the residents' welfare. The working definition of
organisation culture used throughout this thesis with its inherent psycho-dynamic
concepts, may be conceptually difficult for residential aged care managers to apply in
practice. However, for a consultant, internal or external with an understanding of both
organisation theory, organisation culture and psycho-dynamics the outcomes could be
rewarding and insightful for both residents and staff.

7.7 Limitations of the Study

The strength of the outcomes of this research rest on the case-study undertaken at one
nursing home. I am in no doubt from my own experience as a nurse and a consultant,
that similar findings in relation to the routine task oriented culture would have been
made at other venues, had they been included in the case-study. What would have varied
is the degree to which the building played a role of influence in these other cultures. The
opportunity to access other nursing homes was restricted by time requirements involved
in conducting case-studies. I am aware that application of the three elements of The
Conceptual Framework in other settings, would have provided more evidence on which
to found any extrapolations. These settings include other high care nursing homes and
low care hostels. In the latter, residents are much more physically active and the level of
dementia is significantly less.

It was not until I reflected on who I had interviewed and why, that I realised I had been
blinkered about this process. Upon reflection it seems the only group of staff I was
definite about interviewing were the three Unit Managers of each of the houses at
Beechwood Nursing Home. There was no balance amongst the staff of the units and
only one staff member of the lifestyle and activity group was formally interviewed. Also
only one relative was interviewed and whilst this provided rich information, interviews
with more relatives would have helped establish a relatives perspective of the
organisation culture and the nursing home building. There were attempts to include
more relatives in interview, however for various reasons including sudden illness, these did not take place.

Two other factors confounded the interview process, the first was the distribution and interview process involved with the Residents' Satisfaction Survey, which I have discussed in Chapter 3. Second, several residents and relatives had been approached and agreed to be available for interview by the Accreditation Agency assessors. Both these events had the capacity to confuse residents and relatives, which did happen and I considered a third interview would further confuse individuals.

7.8 My Learning from the Research

Prior to undertaking this research I had not realised the significant role played by the lifestyle and activities staff in the nursing home environment. Further, I had definitely not appreciated how clinical care dominates the environment. Moreover, I was unaware of the extent to which the building could play such a directing and controlling part in supporting or limiting the activities of the nursing home environment.

It is taxing to care for the same residents, day after day, some of who forget each instruction no matter how simple, who mix their dessert in with their main meal, who repeatedly take off a dressing on a skin tear and go 'walk-about' when you thought they were safe. To add to this, their family members will often need many hours of support in order to reconcile their own anxiety about the situation. Equally taxing is caring for residents at the other end of the spectrum of need, who make extensive demands related to their personal care, require items to be placed in a particular location, and want personalised attention regarding the organisation of their day. Nurses must learn to balance the needs of all residents, to maintain professional decorum and to be attentive and patient. Routine is in many ways a salvation.

As a nurse I am not yet certain how to integrate the findings in terms of my own clinical knowledge and practice. In terms of my nursing peers, the findings must be presented in a manner that can be accommodated by the culture, or they run the risk of being rejected outright. It is a difficult thing to suggest to a committed group of staff, that the very
thing on which they pride themselves - task achievement, is also a dominant and controlling feature of the environment. Nursing staff and other staff groups in the nursing home will have less difficulty accepting the limitations of the physical context. However, it may be a challenge for some to accept that a functionalist perspective is not the only demand on the design of the building.

As a consultant I have broadened my understanding of the multi-disciplinary contribution to the nursing home development and day to day operation. Within this process I have deepened my knowledge of the culture, in particular the holding environment. My work on understanding task, role and boundary is still a work in progress. From ‘The Conceptual Framework’ development I have created a mechanism for assessment of the nursing home environment in terms of its physical context. I believe this tool has the potential to serve as a facilitating tool for educating groups involved with nursing home development.

As a nurse undertaking this research it has brought to light my own bias as a clinical practitioner. As a researcher, it has taken me to new heights of understanding and appreciation of both the role of staff groups and the lives of residents in the nursing home milieu.

7.9 The Potential Benefits of the Research

Earlier in the thesis I had anticipated the outcomes of this thesis as benefiting architects; managers; policy makers and planners; nurses and other staff, involved with residential aged care and in particular, nursing homes. I still hold to that view. The benefits lay in understanding how the physical context of the built environment affects both residents and staff. The community wants the best quality care that can be provided. That care must be provided in a physical setting that is synonymous with supporting it. Moreover the setting must support its residents. Architects and designers are interested in achieving a building that works in the service of all parties involved. Managers/operators are interested in designs that work on functional and cost lines. Staff are interested in buildings which work on functional lines, including those which support residents.
The politics of the balance of public and private ownership of residential aged care facilities and the requirements set down under Certification and Accreditation cannot be ignored. The outcomes of this thesis ask governments in their policy deliberations and owners in their management and financial practices to consider (more closely than previously) the articulation between the building and the organisation culture of residential aged care facilities. Minimum design criteria could be developed based on the beginning findings of this thesis.

An issue that will have to be factored into the future development of residential aged care, is the community expectation, supported by government, of ’ageing-in-place'. This philosophy is already presenting great challenges to facilities as they try to juggle resident mix with inappropriate physical environments, in the light of shortages of qualified staff. Ageing-in-place is an ideal, which is yet to be successfully translated into practice. It will exacerbate the findings related to the physical context and the organisation culture identified in this thesis.

7.9.1 A Summary of the Potential Benefits

- **architects** - deeper understanding of impact and influence of building designs on the lives of residents and workers. Appreciation of organisation culture arising from and linked with the physical context, i.e., the building, the spaces created by it formally and informally and the sense of place arising from it.

- **operators & managers** - as above, plus deeper understanding of factors related to the building which affect care provision and which can be translated into cost savings.

- **policy makers & planners** - as above plus deeper understanding of factors related to the requirements of Certification. Opportunity to develop and incorporate minimum design requirements of the building to optimise residents lifestyle and work setting of staff. Incorporate aspects into ageing-in-place philosophy.
- Staff
  deeper understanding of the organisation culture, their part in it and the building's influence on their role and the lives of residents. Become involved in design and planning, taking a broader perspective.

- Potential residents and their families
  greater input with regard to the private and public areas available for residents and their visitors. Awareness of the building's ability to influence the Lifestyle of the resident, the work of staff and the culture of the environment. More discerning consumers.

7.10 Final Words

Nursing homes form the last home for a small percentage of the population. The majority of residents are female and, in the age category 80 - 90 years of age. A significant proportion of the residents will experience dementia. Entry to a nursing home is based on a health need not a housing need. They require physical care that cannot be adequately provided at home, or at another health facility. Around 12% of residents in nursing homes stay for more than 5 years. Some residents have lived in nursing homes for many years, some as long as eighteen years as was the case at Beechwood Nursing Home. It is not the length of time that is significant, although this will have a bearing on relationships and continuity within the environment, it is the fact that it is the person's last home. As such it must be able to provide them with more than physical care, it must support their social and emotional needs as well.

The fact that the majority of residents in nursing homes are women has a bearing on the findings of this research. The period of history in which these women have lived, which included the two world wars and the Great Depression cannot be ignored. Through this period dependency of women was fostered, their minimal expectations for contribution to public opinion and education was considered a luxury not a right. Some of these residents are inclined to accept conditions as they are, to think of the staff as knowing best and to live a life where they do not challenge anything about the practices of the nursing home. But, this situation will change. Educated women (and men) who are
living longer and have far more sophisticated expectations than those of their parents in residential aged care environments. Peace et al. (1997) have suggested that the gendered nature of domestic space needs to be taken into account in designs and that for women, 'there is significant social distance between living at home in a domestic setting and living in a home that is communal' (1997, p.83). They suggest new models of shared living need to be identified.

The 'institution-in-the-mind' clearly differs amongst architects, nurses and carers, and lifestyle and activity staff. The architects in this study prefer designs which incorporate cluster housing designs which accommodate functional elements which support staff, whilst ensuring the spaces provided for residents are efficient and effective. The nursing and care staff want a design centred on functional lines which supports their roles. One that enables them to have easy access visually and spatially to residents, en masse. Lifestyle and activity staff want a design which provides adequate large and small group space and provides ease of access to spaces. What the residents have as an 'institution-in-the-mind' is unclear.

I am not suggesting as an outcome of this thesis that the routine task oriented culture of Beechwood Nursing Home or any other residential aged care environment would be significantly modified in the light of the Conceptual Framework alone. This culture is quite entrenched and it will take long term broad reaching organisation development which involves a revision of the model of care in the light of learnings related to the physical context and its influence, for this take place. Perhaps then a more authentic physical context, which struggles to be neither a hospital nor a home, will come about. In this more authentic physical context the culture of the environment does not hold as strongly to routine as a form of social defense, and works with the context to optimise the life of residents. This authentic physical context together with the organisation culture will ideally form a 'good enough' holding environment for both staff and residents.

We will continue to have what Willcocks et al. (1987) refer to as 'private lives in public places'. In which case we must honour both the privacy needs of residents and their need to have social relations in public settings. This must be achieved through
appropriate design of the building, the spaces created by it and in the capacity to develop a sense of place.
Please note

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Dear xxxxxx.

Thankyou for agreeing to an interview. As mentioned briefly over the telephone, I am a student at Swinburne University of Technology undertaking a Professional Doctorate in Organisation Dynamics. For the thesis component of my course I am undertaking a study entitled 'A Sense of Place - what role does the building play in the culture of nursing homes'. Professor Susan Long is the supervisor for this study. Should you have any questions, they can be directed to her on xxxx xxxx. In her absence, Dr John Newton can be contacted on xxxx xxxx.

As part of gathering data for the study I plan to interview several architects involved with the residential aged care industry. I will also be undertaking a case study of two residential aged care facilities, which offer high care services to residents as the focus is on nursing homes. The Ethics Committee of the University has approved the proposal for the study, pending some minor changes related to the facilities selected for case study.

Your responses to questions will be recorded in hard copy form. Confidentiality of the information you provide will be maintained by ensuring neither your name or the name of your company are used in the preparation of the thesis. Also, the notes from the interview will ultimately be destroyed in keeping with the requirements of the University.

Thankyou for accepting the invitation to be interviewed. I look forward to our meeting on Tuesday xxx xxxxxxxx at the xxxxxxx office.

Yours Sincerely

Patricia L. Buckley
Doctoral Candidate

Phxxxxxxxxxxxxxxxxxxxxx
APPENDIX B

INTERVIEW SCHEDULE - Architects

Focus of the Interview
The central focus of the interview is the physical structure of the built environment.

Aim of the Interview
The aim of the interview is to determine what the architect sees is the primary task of a nursing home and to explore how this is translated into the design of the building/the built environment and the functions and operation of the organisation.

Questions
1) What is your background and experience in designing nursing homes?
2) What are the features of the nursing homes you design? (How would you characterise your work?)
3) Do you have a preferred model of design?
4) What do you consider is the primary task of a nursing home?
5) How do the buildings you design contribute to meeting the primary task?
6) What do you consider is your role as an architect in designing a nursing home?
7) Who do you think are stakeholders in your design and which are most important to you?
8) Do you consider that the built environment created by a nursing home can influence the role of staff/residents?
9) What boundaries are created by the nursing home building?
10) To what extent do you believe your building designs influence the following items (rate on scale from 1 to 5 where 1 = no influence, 5 = great influence)
    • the autonomy of residents? (autonomy)
    • the privacy of residents? [balance of public and private living]
    • maintenance of dignity? [block treatment of people]
    • self-determination by residents? [levels of staff-determined as opposed to resident-determined behaviour]
    • the individuality of residents? [residents seen as homogenous]
    • the integration of staff and residents
    • relationships with the wider community [integration with the community]
11) Would you live in a nursing home you have designed?
12) How do you think families select a nursing home?
13) I am interested in the relationship between the building, the spaces created through it and the sense of place generated. (Refer to diagram for comment).
Dear xxxxxxx,

Thankyou for your letter which I received this morning, in which you formalise your request for permission to undertake research at .........................

I have discussed your request with the Manager/Director of Nursing of the facility and what it would entail, and in light of her support I am pleased to approve your request.

........................................... has, over recent years, been involved with a number of research projects in a variety of ways and we have a strong commitment to these type of pursuits which ultimately have the potential to benefit the elderly in our care.

We are delighted to have the opportunity to assist your efforts towards the attainment of a Professional Doctorate in Organisation Dynamics at Swinburne University and offer whatever support you may require.

Please contact ........ Manager/Director of Nursing on ........ to make the necessary arrangements.

I trust you will find your time with us valuable and look forward to your feedback.

Yours Sincerely,

....................
Director of Care Services.
APPENDIX  D

OBSERVATION PHASE - Case Study Venue

Focus of Observation Phase
Focus is on the physical structure and the interaction with the physical structure/infrastructure by staff and residents

The Physical Structure
The spaces created formally and informally

A Sense of Place

Does the building contribute to achieving the primary task?

How does the building create a social defense?

How does the built environment appear to influence the role of staff/residents?

What boundaries are created by the nursing home building?

How does the building promote resident autonomy?

How does it maintain residents privacy?

How does it help maintain residents dignity?

What is the balance of resident determined behaviour to staff determined behaviour?

How does the building promote the individuality of residents?

How does the building facilitate integration of staff and residents?

Is the building integrated in the wider community?

Is there a separate area for staff?

Notes:
Staff use of building
Resident use of building
Staff with Residents use of building
Cleaning
Laundry
Food Preparation
APPENDIX E

INTERVIEW GUIDE - Interviews at Case Study Venue

Focus of the Interview

Residents and Families
The focus of the interviews will be on the spaces they use, created by the built environment and taken by them.

Staff
What is this organisation here to do and what is my part in it?

Does the built fabric reinforce 'role' and how (e.g. carers have a power over relationship and residents have an inferior one?)

Who has authority here?

How does the building/spaces/places support giving care?

How does the building/spaces/places support living

What areas are off limits to staff, to residents, to visitors?

Is this a building for living in or dying in (or both?)

Do you have a favourite place in the building?

Would you live here?
Please note

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