

BEHIND OPEN DOORS

**A Construct of Nursing Practice
in an
Australian Residential Aged Care Facility**

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GLOSSARY

ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
BP	Blood Pressure
CAM	Care Aggregated Module (Obsolete Funding Regulation)
CofA	Commonwealth of Australia
CEO	Chief Executive Officer
CN	Clinical Nurse
CNC	Clinical Nurse Consultant
CRS	Complaints Resolution Scheme (Aged Care Act 1997)
CW	Careworker (also known as personal carer, nursing home aid, personal care assistant, assistant in nursing, nursing assistant, personal care worker, unlicensed healthcare worker, and 'non-nurse')
DOC	Documentation
DON	Director of Nursing
DVT	Deep Vein Thrombosis
EN	Enrolled Nurse
GP	General Practitioner
Int	Interviewer
NPO	Non-Participant Observation
Non-nurse	Careworker (CW) doing nursing work
Nursing Staff	RNs, ENs, and CWs
Nurses	RNs and ENs
MN	Medical Notes
OH&S	Occupational Health & Safety
PCAI	Personal Care Assistance Instrument
PN	Progress Notes
RACF	Residential Aged Care Facility
RCI	Resident Classification Instrument
RCS	Resident Classification Scale
Rel	Relative
RN	Registered Nurse
ROM	Range of Movement (exercises)
Staff	Nursing staff including RNs, ENs and CWs
TV	Television
UTI	Urinary Tract Infection

ABSTRACT

This thesis explored the relationship between the discourses of nursing care, the nursing care provision, and the perceived nursing care needs of three highly dependent residents in a residential aged care facility in Australia. Residential aged care in this country has undergone major reforms since 1987 and the nursing profession has struggled with these changes because of the documentation, validation, and accreditation requirements; the inadequate determination of dependency on nursing care for funding; the Registered Nurse (RN) being removed from the bedside to a role of scribe and delegator; the increasing acuity and complexity of the residents' needs; an increase in the turnover of residents; a rise in the nursing staff attrition rate; the delivery of care by untrained and unqualified persons; the RN being accountable and responsible for the care given by 'non-nurses' from a distance; and, the inadequate skill mix and staff to resident ratios provided in these institutions. The interest of this thesis was to research gerontological nursing practice in the context of residential aged care.

Residential Aged Care Facilities (RACFs) in Australia that care for the highly dependent elderly were identified in the thesis as disciplinary institutions that used 'subjectivation' as a means to control the efficiency and effectiveness of the labour force and the 'docile' bodies of the residents, whilst at the same time the government rhetoric is that of the quality of life standards and the rights of residents in these institutions. As well as the discourse analysis, an historical overview of the aged care reforms in Australia was undertaken for the period from 1975 to 2006 that demonstrated the effects the reforms have had on the voice of nurses and nursing care in these institutions. This analysis highlighted where nurses have been silenced and found the federal government determining what is nursing care and what is not nursing care, and also who is providing this nursing care.

Using a case study approach and discourse analysis each of the three residents was studied using data from five sources namely the resident or relative, a RN, a careworker (CW), the current documentation pertaining to the resident's nursing care, and the non-participant observation of the nursing care provided. These discourses on the nursing care and perceived residents' nursing care needs were analysed using the theoretical base developed from the philosophy and research interest of Michel Foucault (1926-1984), who questioned the apparatus and institutions of Western cultures and searched for discontinuities in the practices of what he termed 'disciplines'.

The results of the discourse analysis found nursing care practices that were alarming around the residents' perceived nursing care needs, the documentation of the nursing care provision, and the observed 'actual' nursing care provided. A questionable standard of nursing care was evidenced even though this facility had recently been accredited. A custodial level of mechanistic care was provided to residents in an extremely noisy and public environment within a culture of haste and bustle by unknowledgeable CWs, under the distant gaze of a RN, and the direction of the government documentation requirements. This resulted in unsafe,

unethical, unprofessional, and negligent practices, as well as fraudulent, illegal, and dangerously out of date documentation practices. This was ultimately affecting each resident's quality of life, nursing care, and wellbeing and was an added burden on the residents' relatives. Many discontinuities, dissonances, conflicts, and contradictions in nursing practice were uncovered for these three highly dependent residents that may be transferable and similar to other highly dependent residents in this and other institutions. Indeed it may mirror other disciplines that provide care services, such as mental health care, acute care, and disability care provision.

The concerns for the nursing profession have epistemological, ethical, and political ramifications for the residents and their relatives, the nurses, the non-nurses doing nursing work, the government, and the industry. Epistemologically new nursing 'knowledges' were being developed that were not resident focussed or based on evidence. Ethically, the legislated rights of residents were not being supported, despite the accreditation, funding, and complaint mechanisms in place - and this has the potential to have punitive ramifications for the industry. Professionally and politically, CWs were identified as non-nurses doing nursing work of a poor standard. This care was not based on accepted nursing practice, but developed through the documentation requirements of the federal government department, the applied constraints, and the CWs themselves. Furthermore, the documentation requirements were found to be a pretence in regard to funding through validation and accreditation, as well as a charade in nursing practice.

There is presently a substantial third level of nurses who are identified legally and political as non-nurses doing non-nursing work (known as 'personal' care); but these non-nurses *are* doing nursing work and are identified by the nursing profession and the public as 'nurses' doing nursing work. These non-nurses who provided nursing care are not educated, licensed, or regulated, and are not accountable professionally to nurses or legally to the public. It is proposed that CWs are in need of licensing under nurses' boards requiring at the very least a minimum of training and education. It is further proposed that documentation requirements resort back to professional nursing documentation; funding be dependent on an predetermined minimum skill mix and staff/resident ratio; and the funding of residents be based on a minimum data set and untied from nursing practice. The professional nursing practice of assessment, planning, implementation, and evaluation of nursing care needs resorting to a nursing domain of knowledge, practice, accountability, responsibility, and documentation.

If an acceptable quality of life is to be realised for residents in the residential aged care system, given that highly dependent residents are reliant on quality nursing care that is fundamentally imperative to their very quantity and quality of life, then changes in the residential aged care system and the nursing profession will be necessary. This thesis will contribute to opening up such dialogue between the government, the industry, and the nursing profession in Australia, and it also highlights areas of aged care nursing practice in need of further research.

DECLARATION

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

A.M. De Bellis

Date

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This thesis is dedicated to my father and mother, my husband, and my children because of their support. It is also dedicated to nursing and nurses.

PREFACE

I am an RN of 31 years experience in nursing practice, education, research, and health services. As such, I care about my profession and the quality of nursing care provided by nurses. My research interest was founded on a strong belief that nursing, at its essence, is needs based and through my practice and research my interest focussed on gerontological and palliative nursing care. My master's research studied nursing theory and epistemology as it related to the nursing care needs of patients. It was a natural progression to research the perceived nursing care needs and nursing practices for aged care recipients, as well as the knowledge underpinning the nursing care.

The Aged Care Reform Strategy of 1987 and Aged Care Structural Reform of 1997 were implemented as economically rationalised policies as part of the regulation, standardisation, and commodification of aged care provision. The industry was repeatedly thrown into chaos whilst reforms were implemented. The protestations, research, and anecdotal evidence suggested the system was unfair. It became extremely frustrating for nurses who were being silenced and under extreme pressure, and as a result, were leaving the industry. I was disappointed that with the implementation of the reforms 'nurses' and 'nursing' were taken out of the dominant discourse of aged care provision. The 'discipline' of residential aged care was based on the accommodation of elderly persons and quality of life indicators, rather than the residents' need for nursing care and the quality of that nursing care.

From a nursing perspective the fiscal tools used did not match the dependency of the individuals receiving nursing care and the punitive nature of the system was evident. Added to this was the enforcement of documentation supporting the funding that was at odds with what was expected in professional nursing documentation, was excessive, and had become demeaning to residents. The aged care system and the documentation requirements had also removed the RN from the bedside and rendered them essentially scribes and medication administrators. The nursing profession believed nursing and personal care needs were not being met at the bedside, but government rhetoric was embedded in the legislated right of each and every resident to 'quality care' based on their needs. According to the government, quality was assured through the legislation, the funding mechanism, the accreditation process, and the complaint agency established from 1987 to the present. This rhetoric silenced the nursing profession and the problems being experienced in providing nursing care.

A fundamental point of difference between the nursing profession and the federal government was the dependency and nursing care needs of residents. I wanted to study the 'mismatch' of resident nursing care needs from a number of different perspectives or discourses, with comparisons to the tool and the documentation that determined the funding, and hence the nursing care provision and the quality of that nursing care provision. All CWs do nursing work but this was not recognised and there was no requirement that CWs be trained, licensed, or regulated. The supervision by an RN had become distant and problematic being one of indirect supervision, as well as delegation and then eventually

credentialing; but the RN was accountable and responsible for the nursing care provided by the CWs (non-nurses). My aim was to identify and compare the 'perceived' nursing care needs in the discourses, the actual nursing practices, and the rationales for nursing around highly dependent residents. The direction of the thesis was to make comparisons between the different discourses of those who received the nursing care, those who provided the nursing care, those who directed the nursing care, myself who observed the nursing care, and the documentation of that nursing care.

The nursing home that allowed me access was a 'good' nursing home on the surface, and it was well meaning in its philosophy and management. The nursing management believed the nursing care the residents received to be of a satisfactory to high standard. It was a totally random circumstance that this nursing home consented and it was not targeted for any particular reason, other than the willingness of management to participate. The nursing staff and management were confident in the nursing care provision and the organisation was recently accredited. The nursing staff appeared to be 'good' people and they were friendly, welcoming, and caring in their attitude.

This thesis did not aim to discover poor or dangerous practices and discourses, but because of what was revealed, I began to question the construct of nursing practice. My aim became one of opening up dialogue about the ethos set up by an aged care system that has many problems for residents residing in and nurses working in the aged care sector. I did not set out to uncover what I found and my purpose was not to criticise nursing care, but this is what I have been compelled to do. I make no apology for the nursing care discourses and observations I heard, read, saw, and consequently analysed that were truly represented objectively and subjectively from the data.

The federal government, however, has much to answer for in what was essentially the demise of aged care nursing and competent nursing practice in this facility. Although the findings cannot be generalised, they may be recognisable and transferable to other facilities and other highly dependent residents. The problem of this standard of nursing care happening *at all* in the residential aged care system in Australia is of concern given the government rhetoric. What was revealed has many serious implications for the nursing profession, the residents and their relatives, the industry, and the federal government. I commend the nursing staff of many organisations for the quality of care they provide under the constraints, but nursing has become complicit in allowing the system to dictate the nursing care for residents - to the detriment of the residents themselves and the quality of nursing care able to be provided.

Chapter 1

INTRODUCTION

One does not have to search far to find what the main media discourses are on residential aged care or the public's perceptions of what used to be called 'nursing' homes in Australia. The media inevitably feature stories and narratives when a person or a facility has been exposed by a whistleblower or a government agency of poor practices or abuse - with some homes having to be closed in the past. The vision of nursing home or high care facilities conjures up images of persons in vegetative states, questionable nursing care, abuse of residents, and a poor quality of life. A nursing home is not the place any person wants to 'end up' and most persons contemplate with dread possible admission to such an institution along with any loss of their independence. These institutions are set up by a civil society to provide care to those persons who need, in the main, nursing care. Residents include the dependent frail elderly, young persons with disabilities, people with degenerative conditions, and those who are dying.

Residential aged care in Australia has become highly regulated and this has impacted on the nursing care in these facilities that have become 'disciplinary' in their organisational structure and operation. This has been achieved through rhetoric and instrumentation that is ultimately defining the nature of nursing and who can provide nursing care in these settings. Many problems have been experienced by nursing staff (RNs, ENs, and CWs) in residential aged care, and these issues have been clearly identified in the past and they would appear to be ongoing. The documentation requirements, the nursing labour force issues, and the quality of nursing care able to be provided are all areas that are constantly playing out on the ground in practice. These problems have been highlighted consistently and although the rhetoric is one of them being addressed through various reports and reviews, this is not the case as far as nursing is concerned. Nursing practices and discourses in these institutions are important areas of research if nurses are to ensure a level of quality in the provision of nursing care based on knowledge and evidence.

In order to undertake a study on nursing practice in residential aged care the system at the macro level and the practices at the micro level can be questioned to provide a construct of the nursing care practices. The focus for this thesis includes: an analysis of the residential aged care system in Australia in an historical sense as it relates to nursing in this sector; and an analysis of the nursing care for three highly dependent residents who were accommodated in a residential care facility. The purpose was to analyse discourses and practices about nursing care provision in aged care facilities for highly dependent residents and how nursing has been constructed by the system.

Admission to a residential aged care facility requires a person to be dependent on 24 hour nursing care in 'high care' institutions, however, these persons can also be accommodated in 'low care' hostel type residency with no requirement of the presence of a RN or EN. The care provided in high care facilities is quintessentially nursing care – it is extensive, intensive, complex, and often palliative in nature. The very quality and wellbeing of a resident's life (or death) is totally dependent on the quality of nursing care they receive as the residents are dependent on nurses for most or all of their activities of daily living (and dying) and, therefore, their very existence and quality of life. This nursing care is provided, in the main, by unlicensed healthcare workers (CWs) and these 'non-nurses' are identified by the government as not doing 'nursing work'; even though their core business of providing personal care to residents is firmly and historically in the nursing profession's domain of clinical practice, knowledge, and research.

The federal government's terminology for the provision of care for residents splits nursing care into 'personal care' and 'nursing care' where the former means not requiring nursing care and, therefore, not requiring nurses to provide the care. The fundamentals of nursing care, which are identified as personal care by the government, are taken to a complex and holistic level in well established nursing theories and texts (Henderson 1966; Orem 1971; Stevens 1984; Belcher & Brittain Fish 1985; Abdellah 1986; Carper 1986; Johnson 1986; Peplau 1986; Lawler 1991; Ballantyne, Cheek, Geoghegan, Hill, & Pardoe 1993; Gadow 1995;

Benner 1999; Holmes & Warelw 2000; Taylor, Geden, Isaramalai, & Wongvatunyu 2000; Potter & Perry 2001; Roper 2001).

All nursing texts make reference and provide evidence for competent nursing practice, however, the government has termed anything other than technological nursing procedures as 'personal' care. The change in language and scope of nursing practice has cut the fundamentals of nursing practice from the nursing paradigm. This has been an unspoken deconstruction and restructuring of nursing. The majority of people who require 24 hour nursing care are elderly and their nursing care needs are complex because they are inevitably the most dependent in all or most activities of living and dying - otherwise they would not be in residential aged care. The provision of quality nursing care is necessary in residential high care facilities, however, for the past 30 years the nursing profession has been constantly struggling with the aged care system and slowly relinquishing control of nursing care in these institutions. It will be proposed that this is to the detriment of the nursing profession and the residents' quality of life.

The overview of the aged care reforms in this thesis highlights the progressive and consistent silencing of the nursing profession in regard to the structuring of nursing care provision in aged care facilities. The name of 'nursing homes', which made their purpose very clear, are now 'residential aged care facilities'. This was only one of the subtle shifts that have occurred in the transformation of the industry since 1987. Another juncture is where 'accommodation' rather than 'nursing care' became the focus of providing the services. This was despite residents in nursing home type facilities requiring higher levels of complex, intensive, and extensive nursing care because the resident profiles had become ones of increasing in number, dependence, debility, acuity, and deterioration - usually until the resident's death. It will be demonstrated that nursing and nurses are not valued or recognised by the federal government, and it is the government department that is determining the very nature of nursing practice in residential aged care and nursing as a whole with negative outcomes for those who require nursing care. 'Non-nurses' are doing nursing work and 'practicing' at nursing and it will be argued that this construct is impacting on the quality of the nursing care able to be provided for residents of residential aged care facilities.

Aims of the Thesis

The aims of this thesis were to analyse nursing practice in residential aged care using the philosophical and research perspective of Michel Foucault (1926-1984). This directed the research firstly to an historical analysis of the aged care system and the reforms from the perspective of nursing, and secondly to a discourse analysis of nursing practice for residents in the field. The discourses about nursing in the system and at the practice level are compared for incongruence between the aged care system, the perceived nursing care needs, the actual nursing care provision, and the documentation of nursing practice.

The Research Questions

The research questions guiding this study related to the domain of nursing practice in residential aged care and included:

How is nursing practice situated in the Australian government's rhetoric, reviews, and reforms? (Chapters 2 and 3)

What are the discourses around the perceived nursing care needs of highly dependent residents in a residential aged care facility from the perceptions of the registered nurses (RNs), the careworkers (CWs), the residents and relatives, the researcher, and the documentation; and, do these discourses conflict and why? (Chapters 8, 9, and 10)

How do these discourses constitute, construct, and influence nursing care practices for highly dependent residents in a residential aged care facility? (Chapter 11)

The theoretical and philosophical underpinning for the thesis uses the works of Michel Foucault who was born in France in 1926 and died in 1984. His studies and comment on psychiatry, medicine, sexuality, penal practices, pedagogy, and

indeed any institutionalised Western entity he termed a ‘discipline’ (Foucault 1977) - such as aged care - form the basis for this study as an exploration for a ‘truth’ in regard to nursing practice in residential aged care. This thesis explores the historicity of residential aged care in Australia as the system or discipline that has impacted on gerontological nursing practice. A discourse analysis is undertaken using highly dependent residents as the case studies in order to question the perceived nursing care needs, practices, and provision at the ground level.

The construct of nursing care through the various discourses about nursing is significant when it impacts on nursing epistemology and practice standards, as well as ethical and political concerns. The system of control inevitably has an effect at the practice level of any discipline such as nursing in institutionalised care. Through analyses of the discourses at the practice level the system can be exposed for the effects the system is having on the ground. The focus of this thesis is nursing practice in residential aged care, through a study of the minutiae of nursing practice and how this is related to the macro level of control. In other words, the complex level of the aged care discipline is revealed by the historicity of the system, and also by focussing on the nursing practices through the study of the dominant discourses for those practices at the micro level.

Shaping the Thesis

An introduction to Foucauldian philosophy that underpins this thesis is provided in this chapter after the following overview of all the chapters that constitute the study. The theoretical underpinning is necessary before chapters 2 and 3 that analyse the Australian government’s aged care reforms since 1975, and the impact the reforms have had upon nursing in residential aged care facilities. The discourse in the government reviews and reports is analysed historically from the perspective of the nursing profession and nursing practice in aged care. The first period to 1996 determined policies that were instrumental in a radical transformation of the aged care industry. Further reforms with a change of government consolidated these into the Aged Care Act of 1997. The aim of the

government continues to be high regulation and scrutiny, whilst also opening up to a managerial, corporate, and market design approach having implemented a user pays system and rhetoric of choice for persons. Nursing practice is situated in the discourses of the government, and it is established that nursing has been and continues to be silenced, fragmented, and undervalued. Furthermore, nurses, non-nurses, and the nursing profession have become docile bodies complicit to the situation of a bureaucratic determination of nursing practice in residential aged care.

In order to explain what Foucault terms a discipline, chapter 4 uses his work on the penal system to demonstrate residential aged care has all the ingredients of a discipline for the control and provision of services by the federal government. Although nursing practice can be termed as a discipline in Foucauldian terms in its own right, it is a profession that is weak, powerless, and eroded under the dominant discourses in aged care. As such, gerontological nursing practice is controlled inside the discipline of aged care. It is demonstrated that nursing care is dominated by external discourses inherent in the aged care discipline and not provided according to nursing discourses, evidence, and knowledge. The disciplinary mechanisms used, by their very nature, have had a profound effect on nursing practice at the bedside for highly dependent residents in an aged care facility.

Residential aged care uses disciplinary means such as classification, documentation, punitive measures, and standards for the function and control of the system. The discipline of aged care is controlled through the means of regulation, standards, legislation, and surveillance within a punitive system whereby facilities are penalised financially or by closure if regulations and standards are not met. This is termed 'panopticism' and chapter 4 discusses the concepts of a discipline, panopticism, and the carceral society (Foucault 1977) as related to the aged care system and nursing practice in these types of facilities.

In order to simplify a study into something that can be explained when the questions of power and knowledge arise and the relations and discourses are within an economically focused discipline that is complex, a question will be

much easier to resolve if the focus is at the micro form of knowledge. A study becomes simplified by analysis of the minutiae of a practice in a discipline that is difficult to explain because of its complexity. This also complements the case study design and discourse analysis methodology chosen to conduct the research.

The art of governing or the ‘governmentality’ of the aged care discipline is explained in chapter 5. This theory is used to explore the governmentality of residential aged care; how it has come to be constituted as an institution; and how it is presently being governed. Governance does not have the same meaning to this concept, as far from being altruistic governance that has a pastoral connotation and implication, governmentality is more a means to achieve an economic rationalist end through the use of strategic power relations of control through dominant discourses. As such, it will be argued that nursing practice within the discipline of aged care is being controlled by external means that are strategically constituted through the governmentality of the aged care system.

The disciplinary nature and governmentality of residential aged care has relevance to nursing practices and the nursing care needs of residents in residential aged care facilities. Governmentality is the means by which organisations, individuals, and nursing practices are constructed. In essence, this thesis aims to analyse the construct of aged care nursing practice according to how the governed (the residents and the nursing labour force) relate to the system of the state that governs them, and how this affects nursing care practices. Residential aged care in Australia is a state controlled bureaucracy that is determining aged care and the nature of nursing practice in these institutions and, as such, is recognised strongly in the governmentality of contemporary Western institutions described by Foucault.

Chapter 6 describes discourse analysis from a Foucauldian perspective. It is the discontinuities, silences, what is said and not said, the contradictions, the conflicts, and the agonisms of any practice that requires analysis in order to reveal the effects of external controls and dominant discourses that are constitutive of that practice. This thesis uses a total of fifteen discourses concerning the nursing care of three residents as the case studies. All these discourses were focussed on

the nursing care and nursing care needs of the residents as case studies. The data analysis revealed nursing care the residents received or did not receive, as well as the standard of the nursing practice.

The justification for using a case study design is given. The use of case studies and discourse analysis centres around the varying perceptions and interpretations of nursing practices and nursing care needs for the three highly dependent residents of a residential aged care facility. These differing discourses are analysed according to the disparities, contradictions, and conflicts contained in them. The residents as the sample units, as well as their relatives, the nursing staff, the documentation, and myself were the informants for the research data. Data collection methods of audio taped interviews, non-participant observations, and document analyses formed the five data subsets analysed. The discontinuities in the discourses concerning the same nursing practices and differing perceived nursing care needs for these residents direct the analysis. The three residents were observed and their nursing care needs and nursing practices interpreted through the discourses that were questioned and critiqued utilising a qualitative analysis.

Chapter 7 discusses the ethical considerations for the research and introduces the setting, the recruitment of participants, and the methods used for data collection. The residents as the case studies are described as to their individual situations and the relatives of the residents are also portrayed. An analysis framework is then presented that tracks the analysis process through a number of levels for each of the residents under themes. Chapters 8, 9, and 10 present the findings of the discourse analysis and these chapters are collectively entitled 'A Discourse of Neglect'. The differing sources of discourse around the same subject (the resident) and the same subject matter (the nursing care) are interpreted and analysed using processes of case analysis, pattern matching, coding, clustering, cross case analysis, and synthesis under themes common to the residents where there were similarities and contradictions in the discourses about the same thing (nursing).

The discourse analysis questions and comparatively analyses the data for differences, contradictions, and problems concerning the nursing care needs of the residents. Analysis of the perceptions by the different persons either providing

nursing care or receiving nursing care, the observations made, and the written text are all related to the nursing care provision for each resident. These results are both a description and an exposure of the day to day nursing practices for these three individual residents. The data chapters are lengthy and detailed because of the depth necessary to expose the miniscule and hidden discontinuities that expose the effects the system is having on quality nursing care. Appendices are utilised in these data chapters as the raw data is extensive about the nursing care for the residents. As a result of a compliance with the aged care system chapters 8, 9, and 10 demonstrate residents are in a dangerous space where they are continually placed at risk. This is ultimately also placing the nurses and non-nurses, the nursing profession, the industry, the public, and the government in a situation where the integrity of the system is in peril.

The discussion of the findings in chapter 11 frames the problems identified into issues recognisable under the seven themes. As such, nursing practice in this facility is problematised into several main issues in order to highlight the salient points revealed in the data analysis. These are discussed integrating the relevant literature and recommendations are also made for further focussed nursing research. According to Foucauldian thought, in order for a truth to be discussed openly, this problematisation is necessary for the possibility of change or transformation to occur.

Finally in chapter 12, following acknowledgement of the limitations of the research, the concluding remarks are directed to the meanings of the findings for the residents and relatives, the nursing profession, the industry, and the government. The three questions guiding the research are answered and whilst solutions are not attempted, the major finding and recommendation is one of need for further reform in the system through open dialogue. The ethical, epistemological, and political ramifications are covered in this concluding chapter because these areas of nursing practice are represented strongly throughout the data and analysis.

Because changes are determined to be necessary, the final chapter concludes with thoughts on reform and transformation from a Foucauldian perspective and a case

for change is made. Transformation will be necessary to have a positive impact on the nursing practices occurring in residential aged care. This work opens up the possibilities of dialogue between the nursing profession and all others involved in the provision of residential aged care for highly dependent residents. As the care provided is essentially nursing care, the nursing profession must awaken to the determinations occurring at the political, epistemological, and ethical levels that are having a profound effect on nursing practice in residential aged care institutions in Australia.

An Introduction to the Philosophy of Foucault

In order for the historical analysis of the aged care reforms to be understood from the philosophical underpinning of the thesis, an introduction is necessary to the work of Foucault. The aim is one of getting at a truth of nursing practice in residential aged care according to the reforms, discourses, and practices concerning nursing. Foucault (1994v) states that any truth in terms of its constitution is constructed by the discourses about the practice bound up in strategic plays or power relations. Truth and power are related in that it is the power relations that determine what truth will survive and, therefore, which discourses will become dominant to support that truth. The ‘power of truth’ is a political question in that one truth will dominate for any practice brought about by the power relations in play. The truth of nursing practice and the power relations determining the care are both the subject and object of this thesis. The hegemony created by the aged care system in place is further discussed in chapter 11 as it is linked to the quality of life for residents.

“Truth” is linked in a circular relation with systems of power that produce and sustain it, and to effects of power which it induces and which extend it – a “regime” of truth... “Truth” is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements...It’s not a matter of emancipating truth from every system of power (which would be a chimera, for truth is already power) but of detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates at the present time. (Foucault 1994v, pp132-133)

Foucault (1994f) states that questions about practices in Western societies, such as nursing, have interconnecting constructions between the subject, power, and knowledge as all actions and discourses have ethical, epistemological and political power relationships that produce a truth for that practice at a certain juncture. In residential aged care nursing, this thesis proposes that the truth of nursing practice is being influenced by mechanisms of domination by the residential aged care system and this is having a negative impact on nursing care for residents. Through research into the discourses on nursing practice some of these external mechanisms functioning through power relations can be exposed to reveal a truth of nursing practice in the field as well as the control mechanisms involved that are determined by the system.

Inside state apparatus such as the police, medicine, justice, education, and aged care the mechanics of power and the discourses that support them and how these mechanisms are exercised within a sociopolitical framework are based on a reciprocal relationship between knowledge and power determined through discourse (Foucault 1994v). He maintains that the central question and subsequent questions for philosophy and critical thought are the following: *'What is this Reason that we use? What are its historical effects? What are its limits, and what are its dangers?'* (Foucault 1984a, p249). The focus of this thesis is on the reason and rationality behind what is nursing practice in aged care by researching the nursing care needs, practices, and discourses. The historical aspect of the aged care reforms are studied from the perspective of nursing and the dangers inherent in the present situation become central this thesis of aged care where the system is directly affecting the residents, relatives, and nursing staff.

If intellectuals in general are to have a function, if critical thought itself has a function, and, even more specifically, if philosophy has a function within critical thought, it is precisely to accept this sort of spiral, this sort of revolving door of rationality that refers us to its necessity, to its indispensability, and at the same time, to its intrinsic dangers. (Foucault 1984a, p249)

In most civilised Western societies the securities, dependency, choices in health, and rights to health have become the dominant discourses. Foucault (1994i) cautions against what might become the 'normality' in matters of health, whereby social security and social cost may have a negative balance in that the cost to the

individual or society may outweigh the security of the individual or society, and he calls for investigations to be directed to the rationality that determines our choices in the matter of health and security. What interests Foucault is the ‘*techne*’ (tekhne). This is meant not as technology, but the ‘practical rationality governed by a conscious goal’; and not the study of government or an institution but rather what rationalities are used by those who govern and those who are governed. (Foucault 1984a) These questions are relevant in that nursing at the practice level in aged care is governed and rationalised by the government, the organisations, agents, relatives, and nursing staff. The majority of residents are governed by others and their bodies are given over for ‘care’.

Whereas government is also a function of technology: the government of individuals, the government of souls, the government of the self by the self, the government of families, the government of children, and so on. I believe that if one placed the history of architecture (*or aged care*) back in this general history of *techne*, in this wide sense of the word, one would have a more interesting guiding concept than by considering opposition between the exact sciences and the inexact ones. (Foucault 1984a, p256)

Power has a major part to play in truth production as what is stated and what is silenced or unspoken are determined by power relations and moral choices. Each society or discipline within a society, such as aged care in Australia, has its own regime of truth brought about by constraints through dominant discourses that produce compliance or dispute and this is termed as ‘the political economy of truth’. (Foucault 1994v)

...truth isn’t outside power or lacking in power ... truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its “general politics” of truth – that is, the types of discourse it accepts and makes function as true; the mechanisms and instances that enable one to distinguish true and false statements; the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (Foucault 1994v, p131)

The way power is exercised in its specificity or detail, the mechanics or workings of power, and the meaning of the relations of power and their mechanisms in the production of truths, are important in any analysis (Foucault 1994v). Furthermore, social security services, such as residential aged care, also have ‘perverse effects’

in that by giving people a greater security, we also increase their dependency on the state with an ensuing cost (Foucault 1994i). Foucault does not suggest posing problems in terms of the 'state' or the government because he views this as limiting and repressive, and would rather propose a problem be studied at its roots where any metapower may have an effect (Foucault 1994v). In this thesis, nursing is related to the aged care system as it is dominating nursing care, and the research is undertaken in the field of care at the bedside of highly dependent residents as case studies.

In describing a discipline, Foucault (1994v) proposes that by the individualisation of subjects who are examined, under surveillance, and individually observed, such as residents in an aged care facility, a totalisation of power that is effective, efficient, and controlled is structured. The means by which this occurs are through many sub or micro power relations and discourses that further constitute and reinforce the overriding power. This can be positive for security or negative in the form of repression and domination. The incorporation of power is able to render the individual and collective bodies under control through a process of making them docile, asleep, silenced, and disciplined to the dominant discourse - thereby governing their acts, attitudes, and modes of everyday behaviour and practice. The subject as such, '*becomes the object of highly complex systems of manipulation and conditioning*' and the concept is postulated of '*the discipline of the body and the control of the population*' for the benefit of civilization as a whole (Foucault 1994v, p125).

By rendering the body docile through the individualisation of each individual and all individuals, the population or service can be controlled effectively because of the increased knowledge mechanisms used by the governing body through social, political, and economic means. In effect, the population ends up controlling itself with an omnipresent gaze from the government or state. The means of control by which any apparatus functions becomes necessarily more refined and automated, and thus increasingly more cost effective. Foucault (1994a) discusses the control of populations necessary for any industrial society to take shape including an individual's time being transformed into labour time and attached to the production apparatus. This leads to the maximum extraction of people's time in

the management of any institution and this is particularly relevant in residential aged care organisations. Subjectivation describes the manner in which power is exercised through surveillance and examination along with the giving of rights that permeate any rhetoric in a discipline. Foucault terms this as an epistemological power that is '*...a power to extract a knowledge from individuals and to extract a knowledge about those individuals who are subjected to observation and already controlled by those different powers*' (Foucault 1994a, p83). He describes the 'infrapower' or '*the whole set of little powers of little institutions*' that makes possible the political and economic power that is exerted on persons through the dominating discourses.

When describing the historical nature of how health care has become what it is today Foucault (1994b) states the problems of illness, hygiene, sanitation, poverty, and aged care became attached to the apparatus of production causing a relationship between labour and the needs of production. Health and wellbeing become a central objective of political power within an economic and rationalist framework that takes charge of bodies and contains them for their own good and for their health (or because of illness).

Noso-politics is a term developed by the placement of health problems relative to the problems of assistance or service. Illness, debility, old age, and poverty become 'useful' by attaching them to an apparatus of production. Economic management of health, work, and labour necessitates the subjectivation and ever increasing utility of the labour force and labour time, which necessarily entails the 'correct management' of the discipline. This medicalisation and correct management of individuals are evident in residential aged care where residents, the labour force and the industry are scrutinised in numerous ways as a means of controlling the industry in providing a service. (Foucault 1994b)

The following quote provides an overview of the historical nature of health and the formation of hospitals from the eighteenth century. If 'hospital' is replaced by 'residential aged care facility' and moving on from a curative model, it becomes apparent why Foucault's work fits well with residential aged care institutions. It is also the only time Foucault mentions nursing.

...the hospital is intended to become a functional element in an urban space where its effects must be subject to measurement and control. It is also necessary to organize the internal space of the hospital so as to make it medically efficacious, a place no longer of assistance but of therapeutic action. The hospital must function as a “curing machine.” First, in a negative way: all the factors that make the hospital dangerous for its occupants must be suppressed... Second, in a positive way, the space of the hospital must be organized according to a concerted therapeutic strategy, through the uninterrupted presence and hierarchical prerogatives of doctors, through systems of observation, notation, and record-taking. These make it possible to fix the knowledge of different cases, to follow their particular evolution, and also to globalize the data that bear on the long-term life of a whole population, and finally, the substitution of better adapted medical and pharmaceutical cures for the somewhat indiscriminate curative regimes that formed the essential part of traditional nursing. (Foucault 1994b, pp103-104)

Aged care institutions have developed in Australia and their constitution and means of control can be traced historically as to the power relations, truths, and knowledge used or not used by the governing bodies through the dominant discourses and subtle changes or shifts in the language used. Residential aged care control is maintained through the means of the government’s prevailing rhetoric that utilises the means of care through examination, surveillance, and classification.

In order to describe the aged care reforms that have had such an impact on nursing practice in residential aged care, the following two chapters focus on the changes historically. These are presented in chronological order over the past 30 years and this historicity has been necessary to explain the junctures and discontinuities that have given rise to the dominant discourses, which have impacted and constructed present day nursing practice in aged care. This analysis is limited and does not study the aged care system prior to 1975 and the quality of the nursing care provided during this period.

The next chapter discusses the early reforms prior to 1997 that the present system is essentially based upon. Chapter 3 focuses on the situation that has culminated as the aged care system and the nursing care able to be provided in residential aged care facilities at present. The government is implementing further reforms in

2007 with a 'new' funding model to address some of the problems being experienced by nurses. These reforms, however, will do little toward providing solutions to what is revealed in this thesis, as the changes proposed will actually add to the burdens already being experienced by nurses and non-nurses.

Chapter 2

THE REFORM OF RESIDENTIAL AGED CARE AND THE SILENCING OF NURSING – 1975 to 1996

The following two chapters locate nursing practice in the discipline of residential aged care in Australia. The structure of aged care is discussed from an historical perspective of the reforms that had their beginnings in 1975 with recommendations for the planned and sustainable care of the ageing population in Australia (Coleman 1975). The Aged Care Reform Strategy of 1987 and the subsequent Aged Care Structural Reform and Aged Care Act of 1997 have had a profound effect on the industry, nursing, and the care of residents in aged care facilities. Nursing, as the core business of aged care facilities, includes what the government department has termed ‘personal care’ in these facilities and a major assumption of this thesis is one of nursing praxis and the holistic provision of person centred nursing care by nurses.

Foucault’s description of the birthing of social medicine establishes a biohistory resulting in the medicalisation of bodies enshrined within an economy of health. With the advent of capitalism from the eighteenth century on in Western industrialised countries, social medicine developed into three co-existing systems of welfare medicine, administrative (population) medicine, and private medicine. (Foucault 1994c) Residential aged care in Australia can be historically traced to determine junctures, whereby these institutions have been constituted by a civil society to nurse and care for the elderly who are unable to be cared for elsewhere or cannot remain in their homes.

Rapley (2003) discusses the concept of the ‘production of the present’ being dependent on contingencies and discourse that make the present possible and aged care is not alone in this phenomenon. Services such as the penal, education, health, mental health, and disability systems have also become corporatised giving rise to commodification, individualisation, choice, the enterprising self, quality, and the rhetoric of rights. Rapley (2003) discusses rhetoric and the normalisation

that occurs because of the possibilities that become either dominant or docile. Some discourses are discarded, and others are emphasised. Some options are made possible, and others are made impossible and essentially silenced.

The policy of government determines the social realities of services and the individual becomes the discursive object for service provision through the use of the official discourses and documentation. This regulation by the government of the individual and the quality of service provision uses terms that have their roots in the corporate managerial language. The construction or constitution of persons is invoked by policy using the discourse of commercialisation and corporatisation. The managerialist discourse becomes the organising principle in service provision with a particular emphasis placed on 'quality' of service or care. (Rapley 2003)

...the explicit invocation of the notion of 'quality of life' as an organizing construct within the corporatist/managerialist framework of service provision which the text constructs... The theme of 'quality' is routinely invoked, and equally routinely linked to the notions of 'care', 'responsiveness' to 'individuals' and fiscal rectitude. (Rapley 2003, pp133-4)

Rapley (2003) argues that through the consumerist approach to service provision, the people who receive the service become 'partners' of the government, along with the regulators, institutions, and evaluators with monitoring employed to accredit and validate services. This managerialist approach is easily recognised in residential aged care and how it has been constructed through the reforms.

The remainder of this chapter and the next chapter provides an overview of the aged care reforms over the past 30 years as the governing discipline that has affected gerontological nursing. This historical constitution of aged care nursing has developed from an economically driven system that includes complex legislation, regulations, and standards. These chapters aim to highlight the reforms and reports where these have had a direct effect on nursing practice in aged care institutions. The presentation of the junctures and crossroads are achieved through the chronological construction of the residential aged care reforms and nursing through the ongoing reviews, committees, consultations, and reports commissioned by the federal government. The importance of finding junctures establishes a silencing of nursing and nurses that has had an effect on nursing

practices, administration, research, and education in aged care provision. The following highlights the nursing home era prior to 1997 and the shift to residential care (rather than nursing care) that the subsequent reformations have been based upon. This enables the contextualisation of the present situation of aged care and nursing as to how the system and nursing care has been constituted through the dominant discourse of the government.

The Nursing Home Era - 1975 to 1986

Pre-Reform

The federal government reports from 1975 to 1986 determined the structure of the initial major reform known as the Aged Care Reform Strategy of 1987. In one of the earliest reports on aged care provision in Australia it was recommended that nursing home care belonged to the health services and was considered to be a hospital or clinical situation requiring professional care and management (Coleman 1975). This discourse did not influence the subsequent reforms in regard to nursing practice, which resulted in the need for professional nursing care and management being overlooked as a fundamental underpinning of all the subsequent reforms. Nursing practice in aged care instead became hidden, silenced, and devalued by removing nursing and medical care from the base and core business of the service provision. Prior to the 1987 reforms, nursing homes were deficit funded, had no admission assessment, were viewed as lucrative businesses, and were questionable in regard to fraudulent practices. The quality of nursing care was not examined until 1984 when the government commissioned labour force studies.

An inquiry found that despite the rising expenditure for the aged and their care, there was a gross dissatisfaction with aged care programs (Holmes 1977). Problems identified included lack of co-ordinated programs, concentration on institutionalisation, and the failure to match services to needs. Some of the recommendations have been realised and some still have not. Included in the recommendations were cost-sharing between the federal and state governments;

community care programs to discourage institutionalisation; the planning of independent, hostel, and nursing home accommodation; and the setting up of assessment and rehabilitation teams. It was established that nursing home costs were unsustainable with the predicted ageing population, as well as there being an uncontrolled growth of nursing home beds because it was viewed as a lucrative business.

Nursing home care was established to be the most costly form of care and reform was necessary. It was estimated that 25% of patients in nursing homes could be treated satisfactorily in their own homes if services were made available and that there was a considerable overlap in care between independent living, hostel accommodation, and nursing homes. (Doobov 1980) This essentially stated that nursing and nursing homes were providing nursing care to persons whom did not actually need this nursing care. Thus, a firm direction for deinstitutionalisation was established and only those who needed nursing care were to be admitted to nursing homes. The accommodation focus for the elderly had its beginning at this point and the shift became one of a residential need rather than an individual's need for long term 24 hour nursing care.

A further report on efficiency implied a continuing lack of an integrated approach that was leading to increasing costs to institutional nursing care; a mismatch between care requirements and the type of care provided; a lack of control for benefits, admission, and classification of individuals requiring extensive care; a lack of economy in staffing, planning, and designing of homes; and a 'looseness' in the departmental control of expenditure (Steele Craik 1981). In another report commissioned by the government on expenditure it was found that the same problems were still occurring, but now there was an emphasis on the fact that people wanted to stay in their own homes with the 'appropriate' support (McLeay 1982). This switched the rhetoric from one of persons being in nursing homes who did not need nursing care to one of persons preferring to remain accommodated in their home with 'support'.

The McLeay Report (1982) was significant as it changed the rationalisation for reform from economically driven cost containment to the preference of people to

stay in their own homes (at the expense of professional nursing care provision). The recommendations from this report can be recognised in the reforms of the present day. It was recommended that all nursing homes be subsidised on a uniform basis; nursing hours per patient be set to a uniform standard; controls be imposed to limit nursing home growth; assessment for admission to a nursing home be determined by the setting up of assessment teams; and aged care tribunals be established where complaints could be taken (McLeay 1982). This report had considerable bearing on how the present system began in its structural form and most of the recommendations were taken up and exist today. The most significant reform and underlying problem for the nursing profession became the funding of nursing hours for each resident. This was a crucial turning point where the policy conflicted with the nursing care delivery, and the nurses working in nursing homes shifted their focus from the persons they were caring for to the management of the facility determined by the departmental control necessary for fiscal management and government funding.

Another report undertaken before the 1987 reform had as part of its terms of reference the aim to provide guidelines for assessing the appropriate costs of nursing homes; the setting of fees; the determination of operational profitability; the development of indicators of management performance and adequate quality of care (standards and efficiency); and incentives for proprietors to admit extensive care patients (McKinnon 1982). One of the recommendations of the study was that all aspects of nursing home administration and care be converted to measurable criteria, and indeed this has been attempted to the present through the use of instruments developed by the federal government department.

The recommendations from the McKinnon Report (1982) on nursing home care included the use of contracts, licensing, regulations, and standards. These were to be achieved by using monitoring, accounting, verification, scoring systems of 'personal' care requirements, quantification of care requirements prior to and during admission, reporting, and the implementation of control systems that would incur penalty for not meeting standards or for any non-compliance. A punitive system was implemented that would see the abolition of the two level system of ordinary care and extended care in nursing homes and deficit funding.

The sole authority and control of the system Australia wide moved to the federal government and the responsible department and out of the control of the industry and the nursing profession. (McKinnon 1982)

Some further important recommendations from the McKinnon Report (1982) can be found in the present day system as related to aged care nursing practice namely: a comprehensive program to ensure that patients' needs were determined and satisfied '*with the government only paying for an effective service*'; nursing staff levels were to be a factor of the total patient care requirements; and there was to be a strict quality control. There was a subtle shift whereby one recommendation was to admit only those in need of or 'deserving' of nursing home institutionalisation. Another shift was where nursing care became fragmented into 'personal and nursing care' and only technical nursing care was recognised as nursing care requiring nurses.

This dissection of nursing practice was important and has had the effect of eroding 'what is nursing', as well as the authority and direction of the nursing care by nurses. Nursing was determined through the department's assessment of relative dependency despite the care required being in the nursing domain and requiring their expertise. This was a lasting and persistent shift to the assessment of nursing and personal care needs being directed by a bureaucratic instrument to empirically measure the 'relative dependency' of residents on nursing and personal care and the industry was funded accordingly. The nursing assessment of dependency was not a consideration in the economic rationalisation of the reforms.

The focus of the McKinnon Report (1982) was one of cost. In order to determine the cost of care it was reported that the quality of nursing care was the most difficult aspect for the department to assess. Nursing staffing levels were considered to be a factor in total patient care requirements, however, minimum nursing staff ratios were not implemented despite the early recognition of the serious skill mix issues that were raised. The quality control aspect of the recommendations found the assessment for the quality of nursing care dependent on documented evidence and not the actual quality of the nursing care provided.

As long as the nursing care could be validated through the documentation and verified, then appropriate evidence of nursing delivery was justified for funding of the resident.

There was a change in government in 1983 and further reports were commissioned. A senate committee found variations between the states in relation to the costs for providers. In addition, the planning of nursing home beds needed adjustment and control as it was considered there were too many nursing home beds. Essentially this meant a reduction in nursing home beds per 1000 of aged population over 70 years of age (Giles 1984). This is the basis on which the present aged care planning of residential and community care places rests and it has been the basis of policy and a contentious issue ever since (Clare, De Bellis, & Jarrett 1997; AIHW 2005).

In 1984 the focus of aged nursing care became 'residential' rather than a person needing 24 hour nursing care. This placed the emphasis on appropriate accommodation and personal care as the basis of service provision, and not appropriate nursing care for highly dependent residents in a clinical environment. The nursing profession embraced the policy of residential care, but once again nursing was being subsumed, eroded, and devalued in a global sense. Whilst nurses were focussed on the local issues affecting them and those they care for in the field, they were at the same time being silenced and made compliant. Registered nurses were still accountable and responsible for the nursing and personal care provided in nursing homes as there was still a requirement for 24 hour RN cover.

The Giles Report (1984) was instrumental in the formation of the reforms of 1987 through its recommendations that included a grant system for: the funding of nursing homes (the most significant being grant payments to nursing homes based on a set number of categories in terms of the care required); the services provided; the structural attributes; and the costs incurred. The focus was now on individualising each person admitted to the nursing home and tying the funding to this categorisation. Standard nursing hours for each category were provided but were insufficient. Staffing levels and nursing and personal care hours were

determined by the total hours of the relative dependency categorisations through a fiscal instrumentation. This assessment of dependency and the attachment of nursing and personal care hours to it were in conflict with the nurses' perceptions of dependency. What the department determined to be relative dependency contradicted nursing assessment of dependency, and thus contradicted the actual need and practice of nursing care and/or rehabilitation. Nursing assessment and documentation did not match the categorisation and documentation necessary for the government instrumentation. As well as this, the staffing and skill mix needed to provide an appropriate level of professional nursing care was not funded to a sustainable level. Despite the call for minimum staffing levels by the Giles Report (1984) this was not implemented. Many other recommendations were made and some of these were adopted in the subsequent reforms, but there was yet another important report from a steering committee that paved the way for 'aged residential care' (Rees 1986).

In reforming the whole system, the basic dependency of persons living in nursing homes and hostels was researched. It was concluded that there was considerable overlap in the dependencies of residents between hostels and nursing homes and again it was reported that at least 20% of nursing home residents were inappropriately placed in nursing homes (Rees 1986). Residents of nursing homes were now viewed as dependent on care, but not necessarily 'nursing' care. It was also proposed that staffing levels should be of the level and mix to provide holistic and positive quality care - not simply basic custodial care.

Furthermore, nursing care (meaning technical nursing care in government terms) was only to be provided by qualified nurses. As such, the remainder of nursing care termed by the government as 'personal' care could be provided by 'anyone'. The term 'nurse assistant' was to be replaced by the term 'care attendant' and appropriate training, in-service education, and graduate education was recommended to be instituted (Rees 1986). Rather than having the effect of increasing the qualified nursing staffing levels this was turned to an effort of increasing the 'other' care staff (the non-nurses) who were no longer viewed as providing nursing care. This role was no longer 'nurse' assistant but care attendant. This naming of what is nursing care as personal care has been

extremely damaging to nursing as a profession with a unique knowledge base in holistic and somological nursing practice.

No report has been more detrimental to professional nursing practice in aged care than those commissioned by the federal government to investigate the substantial variations in staffing levels, resident dependencies, quality of care, and quantity of care in Australian nursing homes (Rhys Hearn 1986). This was based on a prior study of Western Australian nursing homes by the same investigator (Rhys Hearn 1982). It was suggested that any system of subsidy or grants that failed to take account of the patients' dependency and the standard of care deemed acceptable, would not provide a viable and equitable distribution of resources nationwide, and the benefits provided barely sufficed to maintain a 'custodial' level of care (McKinnon 1982). It would appear from the evidence presented in this thesis that a custodial level of care is still the case some 24 years on.

The Rhys Hearn Report (1986) determined empirically that there was a separation of nursing care into direct care (40.3%), technical care (6.2%), indirect care (37.3%), and staff breaks (16.2%). This implied that nearly 60% of staff time was non-nursing or non-direct care and the notion of bedside nursing care was again diminished. It was further determined that total staff hours per resident was 3.43 hours per day or 25.01 hours per week, and the direct care hours per resident was 2.51 hours per day or 17.57 hours per week. It was these figures that focussed on the supposed dependency on care of residents in nursing homes upon which the government based the categorisation of individuals for the funding of nursing homes.

Although the activities analysed the percentage utilisation of direct care and indirect care, an actual time factor was not built into the instrument or the statistical analyses. A frequency of care factor from the data that was converted into a time factor of care was a major flaw of the study. There was no factoring in the research of the actual time taken for nursing care whether direct or indirect care; the number of staff required for the nursing care intervention; or the skill mix necessary for an appropriate level of nursing care. A division was created in nursing care provision between direct care and indirect care and who provided

that care. The hours allocated for nursing care related to one frequency of care variable and no others. (Rhys Hearn 1986) This report led to the end of the nursing home era where nursing care was previously controlled by RNs working for organisations providing ongoing 24 hour nursing care to the elderly, as well as young persons. Gradually the control of nursing practice in these institutions has slipped from nursing control and the following reforms implemented from 1987 to 1996 by a Labour government were further building blocks for the present system under a Liberal government.

The End of the 'Nursing' Home Era

The aims of the first reform were integration, standardisation, regulation, legislation, planning, and control of aged care on a national basis. However, the options or recommendations taken up by the federal government had their roots in the political or ideological bias of the government of the day. Why some recommendations were accepted and others rejected can be determined at a number of junctures, and yet still others cannot. For example, a prominent focus from 1987 onwards under a Labour government was social justice, but this was shifted to one of an 'ethical responsibility' or a moral choice to provide a minimum standard of nursing care under a Liberal government from 1996 to the present. The interest here, however, was not one of political alignment, but one of nursing practice in aged care where the nomenclature was no longer identifying 'nursing care' as the primary purpose of the institutions and services.

The commissioned studies had a significant impact on the regulation, financing, and outcomes of aged residential care in Australia. The foci became the perceived dependency of residents and the provision of finance for staffing according to this dependency, together with outcome standards to be met. Aged care in Australia was now centred on the maintenance and custody of the dependent aged and meeting basic standards of 'care'. This caused the foci to be ones of accommodation rather than nursing care, dependence rather than independence, maintenance care rather than therapeutic care, and cost containment rather than quality of nursing care. The notion became one of the more dependent the

resident the more funding that would be attracted, but this did not eventuate. The nursing profession accepted the principles behind the initial reforms until their implementation. The implementation found RNs forced to use an instrument of dependency at odds with nursing assessment; nursing hours were reduced; quality nursing care provision was becoming problematic; and the documentation requirements were viewed to be irrelevant to nursing care and demeaning for individuals. The following describes the reforms that are in place to the present day that constitute the system that has, and is, controlling and transforming nursing in aged care.

The Aged Care Reform Strategy - 1987 to 1996

The following section focuses on the effects on the profession of nursing and nursing practice in hostel and nursing home institutions during the period of 1987-1996 where the initial reforms were implemented across aged care services on a national basis. The main aim of the reform was one of a continuum of care whereby community services, hostels, and nursing homes for the aged became an integrated service. However, the planning of nursing home beds and hostel places remained a ratio driven formula with the aim of reducing nursing home beds and moving persons into the community with only those who 'needed it' being admitted to a nursing home or hostel. Aged care was fragmented with state governments in the main providing acute and community services and the federal government providing hostel and nursing home services that began to extend out into community services.

The Aged Care Reform Strategy of 1987, as the precursor to the 1997 reform, had the following as its main aims.

1. Development of a co-ordinated system of planning for residential and community care services for the aged.
2. Closer integration of community and residential care programs to maximise the aged person's real choice in regard to care.
3. Development of integrated assessment mechanisms for all forms of aged care.

4. Enactment of new legislation to underpin and consolidate the reform.
(Gregory 1991c, pp36-37)

Aged Care Assessment Teams

Geriatric assessment teams were set up to assess the physical, medical, psychological, and social needs of all aged people who required ongoing services in order to choose the most appropriate accommodation for their needs (DCS 1987). These gatekeepers of nursing home and hostel beds became Aged Care Assessment Teams (ACATs) that still exist today. It was established these were effective in assessing all persons entering hostels or nursing homes from a multidisciplinary perspective, and they were also able to refer persons to the appropriate service with an emphasis on 'choice'; and a person could not then get hostel or nursing home accommodation without this referral (Gregory 1991a). The change of name from geriatric assessment to one of aged care assessment shifted the notion of care required by these persons. Geriatric suggests the need for medical and nursing care, but aged care has the connotation of accommodation and care, which is not necessarily identified as nursing and medical care. Inherent in the reform was a lack of acknowledgement of the complexity of nursing required for a professional level of nursing care from the fundamental level to an advanced or specialised level.

There was a further problem from a nursing perspective as the system did not allow or entrust RNs to assess or change categories of dependency for residents when their condition improved or deteriorated. If a resident was admitted under a low category of care and deteriorated acutely or to a palliative stage of life, there was no additional funding for the nursing and personal care hours required. It appeared only ACATs were able to conduct assessments of relative dependency that was fixed for one year. The language used in the review of the reform in regard to the assessment teams stated that they were effective gatekeepers in preventing the less frail aged from inappropriate and expensive nursing home care. This change in the discourse found nursing homes to be the least desirable option and that nurses were more costly for the system. (Gregory 1991a) An

emphasis was determined at this point, whereby nurses were not needed to provide ‘personal’ care.

Residents’ Rights

The Charter of Residents’ Rights and Responsibilities was implemented during the 1987 reform as part of the outcome standards (McDonald & Bates 1989; Ronalds 1989; CofA 1997, 2002b). The duty of care on the part of service providers owed to residents or clients under a social justice policy stand to the present day, however, the residents’ rights have become somewhat hidden in the legislation. Most notable from a nursing perspective in the pre 1997 era was the absence of any reference to accessing rehabilitation, palliative care, or therapeutic services to promote independence for the residents or clients.

The first right of the resident was one of *‘quality care which is appropriate to his or her needs’* (DCSH 1987; CofA 2002b). However, the funding allowed for the maintenance of a basic level of care according to the instrumentation. The documentation required to support the funding was, in essence, a distraction for RNs from the supervision and provision of quality nursing care at the bedside. This is evidenced in this thesis, whereby the government rhetoric has been about rights and ethical practice, but the human resources are in deficit to be able to provide an appropriate level of care according to the residents’ need for nursing care. The capacity to provide a quality nursing care is thus challenged. The rhetoric of ‘choice’ during the 1987 reforms implied persons actually had a choice as to where they resided if they needed nursing care in old age. However, choice is relative to what is allowed, and also what is available. Aged Care Assessment Teams (ACATs) were set up to gate keep the admission to hostels and nursing homes but ‘choice’ was limited. Outcome standards and the residents’ dependencies became the focus for the funding of nursing homes, and this was a crucial juncture that laid the foundations for the system presently in place.

Outcome Standards

The Outcome Standards for Australian Nursing Homes were implemented in 1987 (Lindenmayer 1987a; CofA 1987b; Lindenmayer 1987b, 1988b) and the nursing profession agreed with the principles behind these as they were viewed to effectively raise the standard of some facilities. There were concerns, however, with the process of the standards monitoring by the government department, as well as the documentation necessary as evidence for funding that covered broad areas. The judgement or consequence of not meeting the standards attracted the withholding of funding to the institution and other possible punitive measures including closure. (CofA 1987a; Gregory 1991a) The criticism directed at the standards monitoring process and the standards themselves from the industry and the nursing profession in particular, were contrary to the official government evaluations of the program that stated the standards comprehensively covered the quality of life for residents of nursing homes and that the standards were reliable and valid (Braithwaite, Braithwaite, Gibson, Landau, & Makkai 1991).

Some of the standards were questioned in the government review as to their rating, inconsistency, quality, clarity, reliability, and validity. The questionable standards related to nursing practices in the nursing domain and included the areas of pain management, continence, sensory losses, noise levels, and the resident's right to die with dignity (Braithwaite et al. 1991). In the final review of the outcome standards it was recommended that the questionable standards be incorporated into other objectives focussing on quality of life indicators. This was essentially a rearrangement that would see nursing practices subsumed under other objectives that were not nursing focussed and did not assess the quality of care (Braithwaite, Makkai, Braithwaite, & Gibson 1993). This resulted in a further demise of important fundamental nursing areas including pain management, continence, and palliative care that were moved into a social determination subsumed in quality of life standards.

The standards monitoring program was implemented in the expectation that nursing and personal care funding would be acquitted and separate. It was not designed to give emphasis to quality of nursing practice nor the adequacy of nursing coverage. The standards gave emphasis to the areas in which nursing homes were most deficient at the time and focussed economics, systems, and

quality of life indicators rather than the auditing of the quality of nursing care. It was recommended that standards monitoring would need to place greater emphasis on the adequacy of nursing practice if care expenditure was no longer tied to the standards (Gregory 1993). This same report stated that at the beginning of the reform the outcome standards were implemented to address quality of life indicators and that nursing practices did not have an impact on these outcomes because essentially nursing care was proving difficult to verify and validate. It was recommended an accreditation system be set up and this has been realised. The justification given for this was the emotional commitment that was necessary for any program of monitoring required the participation in the decision making process by those concerned. (Gregory 1993) This implied there was a lack of input by the industry and the nursing profession into the development of the outcome standards imposed by the government, and to reduce the resistance by nursing home staff it was recommended a self-auditing process should be implemented.

A consultative committee (Keys 1994) recommended a number of changes be made to the outcome standards system but argued for the retention of the standards, as well as the standards monitoring process despite this being extremely problematic for nurses. The emphasis of this report was to increase training of government staff, as well as staff in the industry, in order to comply with the standards. This placed emphasis not on the standards themselves and their monitoring, but the persons who used them. Further training, therefore, was the proposed solution. It was recommended that any accreditation system was to be additional to the outcome standards and monitoring already in place. (Keys 1994) The government responded by retaining the outcome standards system and putting in more resources for the education and training of the industry to comply with the standards within a new framework of quality assurance through audits (DHS 1994a, 1994b), which did not eventuate until the 1997 reforms.

A number of consultancies recommended the system have the input of the industry and practitioners carrying out quality assurance programs through their participation, choice of instruments, self auditing, and control of decision making (Doyle & Phillips 1992; Ballantyne et al. 1993). This has not been realised with

an accreditation system being imposed on the industry in the following era of reforms. Far from the profession of nursing participating in the development of the new program, nursing was again silenced. Rather than participation and collaboration, an accreditation system was implemented that the nursing staff in aged care compliantly followed without input into its development. The quality of the nursing care provided was henceforth subsumed in the quality of life principles and indicators.

Dependency and Funding

In this era, the dependency of residents was assessed via the Resident Classification Instrument (RCI). This fiscal tool was developed by the government to categorise the relative dependency of each and every nursing home resident (Lindenmayer 1988a). The nursing profession had very little input into the formation of this instrument, despite the dominant government discourse that they did. The RNs were entrusted with completing the RCI and undertaking numerous documentation requirements to support the instrument and the outcome standards. This determined the nursing and personal care hours that Directors of Nursing (DONs) were able to manage.

The separation of nursing into ‘nursing and personal’ care was another example of how the presence and importance of nursing was again being eroded. The documentation was not developed to support and communicate the nursing care of residents, but was developed to support the monitoring, examination, and categorisation of residents. For the nursing profession the documentation requirements were found to be excessive and caused dissatisfaction, an increase in staff attrition, the removal of the RN from the bedside, a deviation from professional nursing documentation, and a risk to both staff and residents (Macri 1994; Emerson 1996; Zuch & De Bellis 1996).

One component of this reform, the Care Aggregate Module (CAM) of the funding temporarily had a positive effect on nursing care in nursing homes. The nursing and personal care funds had to be used for nursing and personal care staff hours

and could not be channelled into profits or other costs (DCSH 1990). Nursing and personal care hours became the focus of nursing management rather than the proprietors who previously had control of the human resources. Ironically, this positive aspect for the nursing profession of the early reform was consequently dropped by the government in the 1997 reform because of some problems being experienced - to the detriment of nursing care. The problem was a lack of nursing and personal care hours according to the residents' dependencies and not the management of the hours. However, the one avenue that allowed control of nursing by nurses was not retained in the second wave of reforms.

The RCI categories (1 to 5) had to be substantiated by documentation relating to the planning and implementation of nursing and personal care as determined by the instrument (Macri 1993). The rhetoric from the department of 'if it is not documented - it has not been done' was a common discourse in this era of reform and funding was reduced if the documentation could not substantiate the service category. One would have to ask the converse, in that if the care was documented, this did not necessarily mean the care was done. The quandary for the RNs and nursing profession regarding the instrument and the documentation was not a difficulty for the government since the perspective was one of examination, categorisation, monitoring, inspecting, and verifying. The departmental governance focussed on cost containment, rather than appropriate nursing care according to residents' nursing care needs or dependency.

In working out the categories of residents it was determined that no more than 10% of the nursing home population should 'fit' into Category 1, the highest dependency (Lindenmayer 1987a, 1988b). Residents were 'fitted' into a category based on a relative dependency to all other residents regardless of their actual dependency. A number of studies and consultations were critical of the RCI (Lindenmayer 1988b; DCSH 1990; Macri 1994) and it was recommended by a steering committee that the RCI be replaced by a new instrument to be developed (DCSH 1990). This has not occurred to the present day where the subsequent instruments have been based on the original RCI. A new model, as repeatedly recommended, has not yet been introduced and documentation remains a serious problem to this day.

Research has suggested the highest dependency residents were not able to be assessed as such by the RCI and major changes to the instrument and weightings were called for, as well as the recognition of dementia care and palliative care (Gregory 1993; Maddocks et al. 1996; Zuch & De Bellis 1996; Clare & De Bellis 1997). Problems were identified in documentation requirements, however, the outcome of the review into the documentation for the RCI and standards determined more training and education for the industry was required. The solution to the problems being experienced focussed on the inadequacies of nursing home staff, rather than any problem with the instrument itself in assessing nursing care dependency. (Macri 1994; Onley 1995) The RCI was criticised by the nursing profession and adaptations were implemented over the next 10 years, however, it remained and continues to the present in subsequent formats.

The working party that decided on the RCI additive model consisted of representatives from the department and the states, but only one nursing advisor. It was determined that the funding system was to allocate residents to a relative 'service need' category and notionally allocate a given number of hours to each category. (Lindenmayer 1988b) There was limited consultation with the medical or nursing profession and the department determined the broad groupings of service needs on which categorisation was based. A nationwide trial was undertaken and the RCI was then implemented on the resulting data. Because of this trial, the department stated the DONs who participated in the collection of the data had verified the RCI as being valid. The rhetoric of the government then stated the DONs had 'developed' the instrument, even though this was only based on their participation in data collection for the government. (Lindenmayer 1987b, 1988a)

Although the nursing profession was invited to submit comments to a review there was no representation from either the medical or the nursing profession on the committee itself (DCSH 1990). All the submissions to the steering committee stated the RCI was not a good predictor of service need and the weightings did not reflect the nursing care need. The RCI failed to take into account residents with dementia, sensory deficits, rehabilitation, incontinent residents, and dying residents. The RCI encouraged dependence and penalised improvements in self

care, as well as therapy hours and nursing and personal care hours were grossly underestimated by the instrument. The RCI was revised slightly in 1992, but the problems clearly identified and articulated continued to occur. (Campbell & Howe 1990; DCSH 1990; Gregory 1993; Macri 1993; Rickwood 1994; Emerson 1996; Zuch & De Bellis 1996; De Bellis & Parker 1998; Parker & De Bellis 1999)

Highly dependent residents in nursing homes were unable to be categorised as such and, therefore, the tool did not succeed in assessing dependency according to their need of nursing care. As well as this underlying flaw, the documentation required was enormous, largely irrelevant, and unnecessary. Nursing and personal care hours had been reduced, the RNs were further distanced from the bedside, and residents considered highly dependent could not attract the highest funding level despite any evidence provided. The RCI was retained for the next 3 years, along with the documentation requirements. (Macri 1993; Keys 1994; Macri 1994) It was recommended the number of categories be reduced but this was not undertaken at this time (Gregory 1993, 1994).

A review of the documentation for the RCI was commissioned and emphatically stated that the documentation was not relevant, was 'overkill', and essentially implied that directors and proprietors were dishonest or careless. (Gregory 1993; Macri 1993) In general, the problems were attributed not to the RCI and the documentation requirements, but to a lack of appropriate knowledge, skills, and expertise and the keeping of poor clinical records. In other words, it was not the problem of the instrument itself and the documentation requirements, but the problem was with the RNs understanding and doing the documentation. Guidelines were distributed, but the complaints and acrimony continued between the validation teams, outcome standards monitors, and nursing staff. The documentation requirements for standards and validation were at odds with the nursing profession's standard documentation requirements, but the department ignored this and RNs continued to work with the instrument and documentation guidelines imposed upon them. (Macri 1993; Snell 1993; Macri 1994; Emerson 1996)

Other funding arrangements existed under this reform including SAM (Standard Aggregated Module), OCRE (Other Cost Reimbursement Expenditure), and the resident contribution. These also indirectly impacted on nursing care provision because equipment such as oxygenation and feeding tubes were not covered and occupational health and safety costs had increased. (DHHCS 1993; DSHS 1994) Capital funding arrangements were non-existent during this era and the ensuing 1997 reforms dealt with this using accommodation bonds. It was recommended that community aged care packages from nursing homes be piloted for persons requiring nursing home type care and wanting to stay in their home (Gregory 1991a). These packages have since been implemented and continue to expand in line with the deinstitutionalisation policy of the era (Howe 1997; AIHW 2005; CofA 2005c).

The End of One Reform and the Beginning of Another

Nursing homes who admitted residents of the highest dependency were still required to have 24 hour RN cover, but RNs found themselves accountable and responsible for higher numbers of residents. In the review of the 1987 reform it was decided hostels did not have to formally employ RNs, even though the dependency of hostel residents had also increased. The reason or rationale given was because ‘generally’ there was access to RN services if they were needed (Gregory 1994). This term ‘generally’ silenced the value of professional nursing in that no regulation was put forward to maintain RN practice and roles in both types of institution. This was to have a dramatic effect in the next era of reform, whereby because it was not necessary to formally require RN supervision in hostels, it was not necessary to employ RNs. This has had the effect of Enrolled Nurses (ENs) taking on the RN role, and subsequently CWs managing the nursing care of highly dependent residents accommodated in both hostels and nursing home type facilities.

It was perceived by the government that the co-ordinated system of aged care broke down because of the separation between community services, hostels, and nursing homes and the new aim became one of a continuum of care. The

development of integrated assessment mechanisms did not eventuate across the sectors, however, and those that were developed and judged to be effective - remained fragmented. Legislation was enacted in the following era after a change in federal government. Overall, the initial reforms were judged to be providing a more equitable, efficient, and balanced service than prior to the reforms of 1987 (Gregory 1991a; Howe 1997), despite the enormous problems being experienced by the nursing profession in aged care.

In summary, the reforms directed the nursing home and hostel industry to account for funding; have assessment for admission; tie funding of nursing and personal care to the dependency of residents; meet outcome standards; and provide advocacy services. In the Aged Care Structural Reforms of 1997 and the Aged Care Act 1997, nursing homes and hostels came under the one funding mechanism based on the residents' categorisation under the Resident Classification Scale (RCS) and named this ageing in place. Nursing home residents continued to be classified according to their relative dependency based on the RCI fiscal instrument. A user pay system was introduced and accommodation bonds were required. Certification followed by accreditation replaced the outcome standards monitoring system. The nursing profession was emphatic in its opposition to the dependency assessment tools being tied to funding, which also required excessive, inappropriate, and irrelevant documentation of nursing care that was taking nurses away from the bedside and 'knowing' their residents. Despite this opposition, categorisation remained tied to nursing care provision and the documentation requirements subsequently increased, were largely irrelevant, and became more complex.

The following chapter focuses on the constitution of the reforms in place to the present (1997-2006) and demonstrates that the problems identified in the initial reforms of 1987 have still not been addressed. The staffing levels, skill mix, workforce issues, image of aged care, documentation problems, quality of nursing practice, recruitment and retention of nurses, as well as education and training continued to be in contradiction and conflict with the system and rhetoric in place. There were also new problems developing, such as, the determination of 'what is nursing care' and 'what is not nursing care'. The discord created is still apparent

and will continue to be so with the 'new' instrumentation due for implementation in 2007, which has been based on the 'old' RCI under an additive model with additional documented nursing assessment requirements now being necessary.

Chapter 3

THE REFORM OF RESIDENTIAL AGED CARE AND THE SILENCING OF NURSING – 1997 to 2006

The Aged Care Structural Reform

Following the election of a Liberal government in 1996 major changes were implemented as The Aged Care Structural Reform 1997 and legislation was enacted under The Aged Care Act of 1997 (the Act). This determined the control of residential aged care in Australia as a federal act with hostels and nursing homes under the one umbrella called Residential Aged Care Services, and the facilities providing the services, Residential Aged Care Facilities (RACFs). (CofA 1997) Theoretically, hostel type accommodation had residents with low care needs and nursing home type facilities had residents with high care needs as assessed by assessment teams (ACATs), however, there could be a mixture of both high and low care residents in the facility with no requirement of direct or indirect RN supervision. Community care packages continued to be funded in line with deinstitutionalisation. A user pays system was adopted and residents were now required to pay accommodation bonds, as well as the daily charge. (CofA 2001d, 2002h)

The user pays system put in place had a safety net for those who did not have the means to pay an accommodation bond (concessional residents). The RACFs were also allowed to charge extra fees for extra services. (CofA 1997, 2002h) The funding component (CAM) that in the past ten years was managed by RNs and provided for nursing and personal care hours was scrapped. Nursing and personal care hours again were under threat with the funds based on the categorisation of the resident's 'relative' dependency on nursing care being managed by the proprietors. The government dismissed any guaranteed assurance of adequate staffing, skill mix, and resident to staff ratios through this change. The Act gave legislative power to the government department to withhold funding to a facility if

the requirements of validation, accountability, certification, and accreditation were not met using documentation as the evidence.

The accreditation system was introduced under four overriding standards that aimed to benchmark management systems, staffing, and organisational development; health and personal care; resident lifestyle; and the physical environment and safety systems. Aged care homes had to be certified and accredited in order to receive funding and the punitive system was retained. The Aged Care Standards and Accreditation Agency Ltd (the Agency) was appointed under the Act to manage the accreditation process; promote high quality care; and supervise RACFs ongoing compliance with the standards. This would be achieved by conducting spot checks; reviewing audits and support contacts; and liaising with the Department of Health and Ageing about homes that did not meet the standards based on quality of life indicators, managerial systems, and personal care. (CofA 2003a) This was viewed as the solution to the problems with the previous standards monitoring system that was created by insufficient hours being funded. As such, only the documentation of nursing care was taken into account in the accreditation and validation system as a minor domain under health and personal care standards.

The National Palliative Care Strategy was launched and as a direct result guidelines were released for a palliative care approach in RACFs, which had been called for previously for over a number of years (Maddocks et al. 1996; Maddocks et al. 1997; De Bellis & Parker 1998; CofA 2000a, 2004a). This was a valuable program for aged care because it recognised the intensive, extensive, and complex nursing care in a palliative care approach, as well as the education and training inherent in this specialty in nursing. However, because of the categorisation of residents for funding, palliative care was not and has still not been resourced adequately in RACFs (Australian Government 2005d). The palliative care approach requires time on the part of nursing staff and as this thesis demonstrates, appropriate human resources are not available in these facilities to provide palliative care. It is to be noted that some organisations do provide quality palliative care to their residents, but this service requires human resourcing and education that is deliberately targeted at the discretion of management and, to a

lesser extent, the nursing staff who may not have the time or the knowledge necessary for a quality service.

The legislated Charter of Residents' Rights and Responsibilities in aged care facilities was further supported, however, changed slightly. The rights of residents become one of an ethical responsibility on the part of the institution and staff. The original charter remains part of the legislation but a code of ethics and a guide to providers on ethical conduct was introduced (CofA 2001c). Each resident had the right to quality care which was appropriate to his or her needs in the original legislation (CofA 2002b, Section 10.13). In the new guide it was changed slightly to read upholding the resident's right to an appropriate 'standard' of care to meet individual needs (CofA 2001c). This juncture in nomenclature from one of *quality* care appropriate to need to one of a *standard* level of care was a shift. The obligations and duties of the government were summarised and included '*... promoting a high quality of care and accommodation that meets the needs of individuals*' (CofA 2001c, p6). The government continually reiterated that the complaint system, accreditation process, and funding provided to RACFs ensured that a high standard of 'care' was being provided in these facilities. This further diluted nursing with it being subsumed under a quality of care and an accommodation focus.

High Care and Low Care, but Not Nursing Care

The strategy of ageing in place was implemented so residents would not have to move between hostel and nursing home type accommodation when their dependency increased or condition deteriorated. This allowed residents to remain in hostel type accommodation; however, funding was available regardless of whether there was RN supervision, presence, or care. (CofA 1997, 2002b) Also the need factor for residents who required 24 hour care was once called 24 hour 'nursing' care and the following was a description where nursing care was subsumed in 'care', and both ENs and RNs became 'nurses' and, therefore, interchangeable.

High level care usually involves 24 hour care. Nursing care is combined with accommodation, support services (cleaning,

laundry and meals), personal care services (help with dressing, eating, toileting, bathing and moving around) and allied health services (physiotherapy, occupational therapy, recreational therapy and podiatry). Low level care focuses on personal care services (help with dressing, eating, toileting, bathing and moving around). Low level care services also provide accommodation, support services (cleaning, laundry and meals) and some allied health services (physiotherapy, occupational therapy, recreational therapy and podiatry). They provide nursing care when required. Most low level aged care homes have nurses on staff, or at least have easy access to them. (CofA 2003a, p7)

This description can be challenged on a number of levels, but it is the domain of nursing and the association of the language used that should be of concern to the nursing profession in reference to the fundamentals of nursing (Potter & Perry 2001). The government has relegated nursing to personal care and has only recognised technical nursing, and then a further association has been made of personal care being a low level care – in contradiction to nursing texts. The name ‘nursing’ was taken out of the discourses and residents were no longer identified as needing nursing care, therefore, it was no longer a requirement that there be 24 hour RN availability unless there were seven high care residents in a low care facility (CofA 2002b). It is proposed this has contributed to a demise of nursing practice in RACFs that has realised the situation of ‘anybody’ being able to provide personal care that is essentially nursing care. This compounded the problem of the funding mechanisms being based on the categorisation of the residents’ relative dependence on nursing care.

The Resident Classification Scale

The introduction of one instrument the Resident Classification Scale (RCS) across low care and high care (hostels and nursing homes) for the purpose of funding was based on the previous Resident Classification Instrument (RCI) that measured the relative dependency of residents. Although the nursing profession again had to grapple with a new instrument, essentially nothing had changed and the problems previously experienced with the RCI continued and do so to the present with the RCS. This ‘new’ RCS was again based on an additive model using the frequency of interventions and weightings to provide a total score and the documentation

requirements remained the same and in effect, increased. (CofA 1997, 2002b) Although there was a chance to make real reform in the area of dependency and needs based provision of care, as well as the opportunity of untying funding from the nursing care documentation, the government instead introduced the RCS based on the RCI to assess relative dependency across both nursing homes and hostels and the documentation required to substantiate the categorisation was retained. The mismatch of the nursing assessment of dependency and the government assessment of dependency continued to be in conflict.

Two reviews of the RCS were undertaken in 2002 and 2003, which recommended a totally new model of classification for funding purposes be developed, and failing this the RCS be modified because of the problems being experienced, such as: excessive documentation that was burdensome and inefficient; an inequitable distribution of funds; and the RCS not reflecting actual nursing care. (ACEMA 2002; CofA 2003c) In one review the only problem identified with the RCS was the excessive burden of documentation to the detriment of direct care (ACEMA 2002), but this has been only one argument used by nurses as far back as 1987. This now became the government's rationale used in order to avoid the implementation of a new model because a new model would mean a major reform and would be more costly. The recommendation of the funding mechanism being untied from the documentation of nursing care was, unfortunately, not taken up (Australian Government 2005b). The criteria for an acceptable RCS funding model was instead focussed on fiscal and management issues only (ACEMA 2002), and not the dependency and needs of residents or their nursing care requirements.

The Resident Classification Scale (RCS), introduced in 1997, is a resource allocation instrument for the residential aged care system. The RCS has eight care categories, with categories 1 to 4 representing the higher care levels and categories 5 to 8 the lower care levels. Although this 'casemix' classification instrument is designed to measure dependency or 'need for care' in the residential care setting, its direct link to funding may in some cases affect measurement outcomes, making comparison of RCS data with other programs unreliable. (AIHW 2004, p11)

It was stated the principles underpinning the RCS model were consistent with quality of care and encouraging of good practice; accurate, timely, complete, and

reflective of current and relevant care practice; could account for variations in costs of care; able to ensure equitable access; efficient, effective, and of quality; not excessively burdensome in administrative effort; and encouraged the maximisation of outcomes. (CofA 2003c)

From a nursing perspective, the review suggested a very positive conceptual framework to address the problems being experienced by nursing, whereby the care planning and delivery is separated from the funding. It was recommended that a minimum data set for funding purposes be developed, rather than relating funding to the nursing and personal care. (CofA 2003c) The government responded that a new model would not be implemented and a modified RCS with reduced categories across high and low care settings would instead be developed based on nursing assessment. The documentation requirements continued and guidelines were implemented. The alternative to the first recommendation was subsequently taken up. This was a modification to the RCS with additional documentation being required, but it was named the 'new' model (Australian Government 2005a, 2005c, 2005d). The government in 2006 has not taken up the recommendation to separate nursing from funding to address the problems experienced in residential aged care that impact on nurses, non-nurses, and nursing.

A number of reviews, evaluations, consultations, and reports were produced during the post 1997 era, with the most significant being the Hogan Report (CofA 2004d) because it was reviewing the pricing arrangements and the National Aged Care Workforce Strategy (CofA 2005a). Also significant because it identified or determined the strategies that will continue to impact directly on nursing practice in aged care and has set the trend for the next few years to 2010. The response of the government to the last RCS review consistently stated that the pricing review would determine the outcome of what course the government would take (CofA 2003d; Australian Government 2004). In the pricing review it was recommended that the RCS be reduced to three categories across RACFs both low care (hostel type accommodation) and high care (nursing home type accommodation) and this recommendation has subsequently been adopted for 2006 along with the new ACFI and NATFRAME (Australian Government 2004, 2005a; CofA 2005b; Australian Government 2005d).

The following sections focus on the reviews and reports commissioned by the government that have determined the dominant discourses up to the present day, which continue to impact on nursing in aged care. These focus on the funding model, the documentation framework, workforce issues, and nursing matters. The Hogan Report had four underpinning principles guiding the inquiry namely quality, equity, efficiency, and sustainability. The main thrust of this report was to propose opening the industry up to a market model as the regulatory mechanisms restricted the economic model of management and competition and that these constraints affected the economic outcomes. The priority in this report was economic and not quality of care or equity. (CofA 2004d) In summary the report stated the 1997 Aged Care Structural Reform had:

... implemented a revised funding and quality assurance structure, as well as putting more responsibility on providers to raise capital funding and on residents with higher income and assets to contribute to the costs of their care and accommodation. With the changing demographic situation, it is now time to assess whether the 1997 changes are adequate for meeting current and future demand for aged care services, while maintaining and enhancing the quality standards and equity of access. (CofA 2004d, pp3-4)

It was at this juncture, with an emphasis on opening up market forces, that the commodification of aged care services were identified in a system where the residents' nursing care needs, the residents themselves, and the nursing labour force become commodities attached to the production apparatus. The aged care labour force (the most costly) becomes the only cost line able to be modified, exploited, and manipulated and the majority of the labour is provided by nursing staff comprising of nurses and non-nurses.

All Australian RACFs were asked to provide financial and management records to the review and there was a 31% response rate from the industry. Based on a financial analysis of this information it was concluded that insights into the financial management of residential aged care had been obtained; the relationship between the department and management of RACFs was 'very tight'; labour accounted for the majority of the costs; an operating surplus (or profit) should be the norm; there were striking differences between institutions that were successful and institutions that were weaker performers; and efficiency and productivity

could be secured with effective management. (CofA 2004d) This reinforced that quality nursing care provision was not the primary concern of the government. It was recommended to retain the planning formula of 108 community and residential regional aged care places per 1000 persons aged 70 or greater, but with added flexibility. (CofA 2004d)

The role of ACATs as the gatekeepers to residential aged care was supported in the Hogan Report. Providers could now apply for higher care needs without ACAT approval; however, this could trigger a validation visit and if the higher care category was not warranted then repayment would be necessary. Given that validation teams consistently reduce residents' categories based on documentation, then repayments would become commonplace. If the resident required moving to another higher care facility then ACAT would have to perform the assessment (CofA 2004d). As this intervention would be at the request of a RN or medical officer for higher care or transfer, it implied the professions could not be trusted or they were not capable of assessing a resident's dependency and nursing care needs for transfer from a low care to a high care category.

The Hogan Report recommended funding supplements be made available additional to the oxygen and enteral feeding equipment in the areas of: intravenous therapy, wound management, intensive pain management, tracheostomy care, dementia care of persons with challenging behaviours, palliative care, as well as residents from disadvantaged backgrounds (CofA 2004d). This was welcomed by the industry and nursing profession, however, encouragement of these nursing practices and resources for the provision of the nursing care would ultimately be determined and delivered by non-nurses under the government's realms of personal care (non-nursing) and technical nursing procedures.

The Aged Care Standards and Accreditation Agency was recommended by the Hogan Report to continue its activities and should include consumer input, as well as having a role in informing consumers about choices and information dissemination about facilities and their accreditation status (CofA 2004d). The standards themselves were evaluated to be successful and the accreditation model,

together with the necessary documentation was to continue (CofA 2004d) despite the ongoing articulated problems for nursing. This report foresaw the development of domiciliary services to the dependent aged as having an effect on residents of RACFs becoming 'more' elderly and 'probably a more dependent' type persons and that the demand for residential aged care will increase because of the ageing population (CofA 2004d). In the meantime, the government had turned its attention to funding of residential aged care and the workforce issues in the industry.

The Aged Care Funding Instrument (ACFI)

It has been decided by the government that the assessment of relative dependency will continue using an adaptation of the RCS in a new instrument known as the Aged Care Funding Instrument (ACFI) with implementation in 2006 (Australian Government 2005a, 2005c, 2005d). The government response to the recommendations of the last RCS review stated that detailed consideration would need to be given to a new model for residential aged care funding and that a number of changes to the current RCS should be progressed in the meantime. This second recommendation was adopted, but called a 'new' instrument, which inferred a new model. (CofA 2003d; Australian Government 2005a)

The new model had been adopted to address only one of the problems identified, namely the completion of documentation requirements taking qualified nursing staff away from direct and even indirect nursing care. The ACFI will do little to address this problem and additional documentation requirements through nursing assessments have been provided through the NATFRAME (2005). These nursing assessments can be used by anybody and will only add to the complexity and confusion inherent in the documentation and funding nexus. As well as this, the encouragement for any person who is unqualified and untrained to undertake nursing in residential aged care will contribute to poor practices and outcomes for the residents.

The ACFI was based on the RCS as a reduced question set (Australian Government 2005a, 2005d). This was itself based on an additive model using the RCI (Rees 1986), which was in turn based on the commissioned nursing workforce studies undertaken years previously (Rhys Hearn 1982, 1986). The model has remained an additive mode of funding with different weightings applied to frequencies of nursing interventions added for a total score enabling categorisation. The RCS was viewed as a 'needs-based' model on the 'relative' care needs of residents (ACEMA 2002). The aims were classification and the allocation of resources according to a dependency determined by the government. The ACFI will not address the problems caused by the continued discord of the funding arrangements to professional nursing practice and documentation in residential aged care. The discrepancies between the government and the nursing profession remained in relation to: the definition of nursing care needs and practices; the skill mix and staff resident ratios necessary to provide a satisfactory level of care; the assessment of residents' dependencies; and the nursing documentation necessary for accreditation and validation for funding.

The RCI was developed from questionable quantitative analyses; the RCS was based on this, and now the proposed 'new' instrument (ACFI) will be based on the RCS. In reality, a totally new assessment of funding needs to be produced separate to the nursing care. Although this was called for in the RCS reviews it has not been adopted by the government (ACEMA 2002; CofA 2003c; Australian Government 2004). Any opportunity of a minimum data set for funding purposes and the handing of nursing back to nurses was lost. The conflict in the assessment of dependency for funding and the assessment of dependency by nurses, as well as the questionable quality of nursing care provision will continue.

The development of the ACFI has been overseen by the Resident Classification Scale Reference Group viewed by the government as having good industry participation at the highest level. There was no nursing representation from the nursing clinical area or academe. One representative from two nursing organisations participated namely the Australian Nursing Federation and the Royal College of Nursing Australia (Australian Government 2005b). It is proposed these persons may not necessarily have had any working knowledge of

the RCI, RCS, or the proposed ACFI. The weightings for each domain category have not been given and will be worked out following the trial to 'fit' the residents into the three categories with the monies available, without additional costs being incurred by the government. (Australian Government 2005a; CofA 2005a; Australian Government 2005b, 2005c, 2005d)

Despite consistent problems with weightings in the previous instruments and a minimal reduction in questions, there are still 14 sections in the ACFI together with additional assessment tools (Australian Government 2005d). Many nursing skills such as the assessment and management of incontinence, mobility, hygiene, nutrition, hydration, and challenging behaviours were not recognised as nursing. The ACFI instrument gives recognition to residents who are dying, however, the problem of classifying and changing classification when a person becomes palliative will continue to be a problem, and the weightings for palliative care have not been provided by the government. All of the ACFI determinations of the needs of residents come under the nursing domain. Any 'D' rating indicating high dependence in the ACFI questions would supposedly require professional nursing assessment, planning, implementation, and evaluation – but it is not recognised as nursing.

Nursing texts provide and define the domain of nursing practice, and these include activities of daily living and what the government continues to term 'personal care' or 'non-nursing' namely: eating and drinking, mobility, hygiene, elimination (including toileting and continence), cognition, and abnormal behaviours (Potter & Perry 2001). If a technical nursing procedure is not required for the resident then a RN or EN would not be required. The ACFI will perpetuate the identified and articulated problem of nursing practice being in consistent conflict and discord with the funding requirements, documentation, and instruments enforced through the regulations. The new model will not address the problems being experienced and identified in previous reviews. Further training of nursing staff in documentation was viewed by the government as the solution.

Documentation Requirements

An inquiry into nursing strongly recommended reducing the burden of paperwork required under the RCS funding in aged care nursing (CofA 2002g). Overall, aged care nursing was viewed to be in crisis as far as the nursing workforce was concerned, and this report implied the system was not commensurate with the quality of care that the public expected and the government regulated. As quoted from the senate committee review *'It is time for the voice of nurses to be heard...'* (CofA 2002g, pxvi), but this has still not been realised in any meaningful way.

Through the recognition of the documentation in RACFs being fragmented and voluminous, a trial was implemented with the aim of creating a national uniformity in documentation in residential aged care, despite this having been attempted previously. This report significantly found that the Draft National Framework for Documenting Care in Residential Aged Care Services was not meeting the objectives of the government, the providers, or the staff providing the care, and yet it will be maintained along with the introduction of the ACFI in 2006. (Urbis 2004) This means the documentation volume and direction will continue to support the imperative of the government's fiscal control and will not support professional nursing care that is resident focussed.

Although some individual assessment tools were evaluated to be useful, the overall framework was not useful for the purpose of care provision and care planning on a day to day and practical basis, and not useful for the accreditation process. It was, however, useful for validators in their verification of resident categories (Urbis 2004). The objective of the government, despite the evidence, was for all documentation to become standardised using the ACFI and NATFRAME, which will eventually become computerised (ACEMA 2002; CofA 2003c; Australian Government 2005a; CofA 2005b). The trial of the ACFI determined the documentation framework was too complex for personal carers (CWs) and required skill levels beyond that of many staff. The move to computer based assessment - that was being strategically addressed but not financed by the government - indicated poor computer literacy among 'some' staff, meaning the nursing staff.

The trial found some positive feedback on the framework; however, in the main the responses were negative. Furthermore, the framework for documentation was criticised for not being user-friendly to management, nursing staff, or the accreditation agency. (Urbis 2004) The users of the draft framework (the nursing staff) reported the new framework did not simplify the approach to documenting care in RACFs; was not less time consuming; did not reduce duplication and effort; and did not improve co-ordination of health team members (Urbis 2004). The RNs in the trial also believed the framework was a very 'poor' tool for monitoring and reviewing the care of residents, but validators found the proposed framework adequate 'in all cases' to complete full audits and verify categories. (Urbis 2004)

The most useful part of the framework as judged by the nursing staff of RACFs was the assessment tools addenda to the instrument itself; because these were something practical that could be used by RNs, ENs (nurses) and 'trained' CWs (non-nurses). This evaluation was understandable given these tools were mostly developed by the nursing profession. (Urbis 2004) However, the NATFRAME (CofA 2005b) has encouraged any person working in residential aged care to use these nursing tools regardless of their training or education.

Because the assessment and planning of nursing care has been directly tied into the ACFI and the funding, it will continue to be in conflict with nursing practice. The direction is yet another means for control by the government in regulating, standardising, and categorising residents to provide the minimum of funding for residential aged care. The government's purpose in developing what is now the new model was not based on evidence based nursing or the provision of quality nursing care. Documentation requirements will continue for governmental purposes rather than for the provision of quality nursing in residential aged care. Further government policy directions on nursing workforce issues are summarised in the following section that finds nurses leaving aged care and problems being placed with the image of aged care and the education of nurses and non-nurses.

Workforce and Labour Issues

The government turned its attention to the aged care workforce because the problems identified in previous reviews and reports were determined to be caused by a lack of training of the workforce or in misunderstandings by the industry and staff of the regulations. A number of studies were commissioned to look into workforce issues in residential aged care, which culminated in the National Aged Care Workforce Strategy (CofA 2005a). The recommendations adopted by this strategy from the previous reviews found some that were not implemented. Most notably, the recommendations regarding skill mix and staffing levels of the aged care workforce were not addressed by the government in this strategy. All other recommendations were responded to positively in some way.

The discourse of the government was one of there being enough funding in the system to provide for: RACFs to employ appropriately qualified staff and to pay above award wages (thereby making this an issue between the nursing staff and their employers); an assurance in the accreditation process in determining the quality of care and an appropriate standard of care (not nursing care); and with the vehicle of residents' rights they or their relatives could always make a complaint and were encouraged to do so if required (but they did not). (CofA 2005a) The workforce issues described below demonstrated how nursing was silenced in matters directly relating to nursing workforce issues.

A review of the literature did not paint a very positive picture on what it meant to be an RN or EN in aged care. Some of the highlights included statistics that supported there was a reduction of RNs and ENs working in aged care whilst the number of employed CWs or similar 'nursing assistance' roles had risen significantly, in compensation (CofA 2002c). This then turned the rhetoric to one of qualified nurses not being available and, therefore, there was no choice but to employ persons with no training or qualifications. Employment of CWs rose in direct proportion to a reduction in qualified nursing staff at a time when the acuity and complexity of residents was actually increasing. Qualified nurses were leaving because of industrial issues related directly to the reforms. The strategies proposed by this review were an upward movement of the RN role and an

expansion of the EN and CWs' roles. Further education and professional development of RNs and ENs was proposed as the solution. In addition, resources were to be directed to supportive work environments; collaboration between industry and educational organisations; improving the image of aged care nursing; developing a nursing career path from CW to professorial level; and further development of aged care nursing research. (CofA 2002c)

All strategies were positive suggestions, however, the issues of CWs actually doing the nursing work and the RNs being far removed from the bedside were not addressed. Simply increasing the proportion of RNs and ENs would provide a solution, if they could be attracted back to the industry, but this was not one of the proposed strategies. Skill mix and staffing levels were found to influence recruitment and retention negatively, as well as the standard of care (CofA 2002c), but this was not responded to by the government. The onus fell on the industry being responsible for skill mix and staffing levels as RACFs were in receipt of 'sufficient' funding for appropriate staffing levels and skill mix, and accreditation ensured quality of care was being delivered.

The review of nursing found the most significant workforce issue and the one to be focussed on was the recruitment and retention of nurses (RNs and ENs) in aged care. An implication was that the attrition rate was affecting the quality and standard of care able to be provided. Many nurses had left the aged care sector and in some cases the profession altogether, and because the industry could not then retain and recruit a qualified workforce the government's rhetoric became one of there being a shortage (CofA 2002c), rather than addressing the underlying causes of the shortage. Staff shortages were reported to have compounded the low morale experienced, and overworked nurses expressed their inability to provide quality resident care with this being most profound in the aged care sector. Another common theme in the literature was the lack of acknowledgement within the sector and the general community of the complexity of knowledge and skills needed for effective and appropriate nursing care for older people. (CofA 2002c)

The study on the recruitment and retention of nurses in aged care identified a number of issues relevant to burnout and attrition.

Facets of lack of professional respect ranked highest. These included organisational support—physical and emotional, respect from other health professionals, involvement in decision-making, opportunities for career advancement, ability to take on responsibilities and leadership and the ability to influence the working domain. Chronic and profound nursing shortages compounded the stress experienced as overworked nurses felt guilt and anxiety over their inability to provide quality resident care, thereby reducing their own estimation of personal professional effectiveness, and self-esteem. Nurses are feeling deprived of dignity and autonomy, and perhaps more importantly, deprived of the psychological rewards, once the keystone to nursing as a caring profession. These factors result in endemic low morale and poor image, which appears most profound in the aged care sector. Recruitment therefore becomes problematic as women in general, and nurses in particular, seek employment opportunities that are more rewarding in psychological and financial realms. Other factors influencing nurses' decisions include flexibility of work hours, salaries, benefits and childcare. The composition of aged care workload and staffing-mix impacts on burnout where nursing staff are required to assume additional duties which further restricts their time availability for resident care provision. (CofA 2002e, p14)

The following issues were identified as needing attention by the government in the aged care sector namely the RCS model, the funding, 'nursing' in the sector, accreditation, wage parity and working conditions, segregation of funding for staffing and care hours, staffing levels and the skill mix, and the concessional resident ratios (CofA 2002d). The segregation of funding for nursing and personal care crucial in the delivery of quality care through an appropriate skill mix and minimum staffing levels was not addressed by the government as recommended previously (CofA 2002e).

A further report was commissioned into the quality of working life for nurses in residential aged care including RNs, ENs, and CWs (CofA 2002d). It was common knowledge that the occupational health and safety risk to nurses was high in aged care and there was also a high degree of stress (Gates, Meyer, & Fitzwater 1999; McDonald 2001; CofA 2002d). The commissioned report surveyed 28 persons involved in the provision of aged care including 17 RNs, 2 managers, 2 union officers, and 2 CWs. Factors that contributed to job dissatisfaction were numerous and included: not being valued by the community and nursing profession; a greater proportion of high dependency residents being

admitted; the lack of trained staff; resource allocation issues; the lack of appreciation by proprietors; the lack of understanding of the complexity of the nursing work done by personal care workers; a lack of time to do the work; too much being expected; the imbalance between staff rights and residents rights in the context of work demands on staff; occupational health and safety (OH&S) issues; the accreditation and documentation practices; professional isolation; issues surrounding the administration of medications; the increased accountability and justification through documentation; the wage disparity; the nature of the work; and the division between RNs and CWs - plus many others. (CofA 2002d)

The impact of general work satisfaction and the negative factors of working in aged care included fatigue, frustration, and low self-esteem and these far outweighed the positive factors. In addition there was a decrease in the quality of care, morale, recruitment and retention, as well a lessening of the ability to 'attract' customers. Some strategies were identified and included increasing staff and decreasing workloads, decreasing documentation, additional funding for education, adoption of less hierarchical structures, improvement in wages, better recognition of nurses, and better funding to the industry (CofA 2002d). Another report (CofA 2002e) on the recruitment and retention of nurses in RACFs was commissioned and this comprehensive appraisal focused on recruitment and retention, as well as re-entry training for RNs and ENs who had left the profession or moved to other areas. The strategies were all steps in the right direction to employing more qualified staff and for the re-entry of nurses in aged care; however, no amount of education and training will attract and retain nurses if the environment is such that they cannot nurse. The report again highlighted the problems experienced by nurses (RNs and ENs) and providers in aged care nursing, and some strategies were suggested to address these problems.

The report's main aim was to identify the key reasons for nursing attrition in the residential aged care sector. All findings had common themes driving the strategies or recommendations that included: encouraging supportive work environments (viewed to be lacking); improving OH&S to minimise the level of stress (viewed to be high); improving flexibility in hours of work (viewed to be inflexible to family needs); improving rates of pay (low compared to acute

sector); provision of further training and education (viewed as lacking); improving the image and recognition of aged care nursing (viewed to be poor); improving professional and career development (viewed to be restrictive and unsupported); improving staffing levels (because of staff shortages); employment of more qualified nurses (because of the shortfall and an inappropriate skill mix); improving standards of resident care (viewed to be at a low level); and improving documentation and accreditation processes (viewed to be inappropriate, large in volume, and unnecessary). (CofA 2002e)

The recommendations focussed on further research into workforce issues such as attrition and appropriate staffing levels and skill mix; and strategies to support a better work environment in aged care, improved management in RACFs, education and training for nurses and nurse leaders, movement towards wage parity, an improved image of aged care, development of a recommended documentation format, development of a career structure for aged care nurses, establishment of a national research program in aged care nursing, and the development of a national education and training plan for aged care nurses and ‘direct care staff’ (CofA 2002e). Essentially, these recommendations had all been determined previously, but had not been addressed by the government.

The government responded to this report very quickly (within the month) (CofA 2002f) by deflection of most recommendations to the pricing review of aged care, the Hogan Report, as well as the then pending outcomes of the National Aged Care Workforce Strategy (2005). Where not deflected to these reviews, the government answered the recommendations with a summary of the reviews and reports that had been undertaken, as well as the resources and programs already put in place. The aim of the aged care system was ‘... the provision of an adequate number of aged care workers – nurses and paid care workers – with appropriate skills and qualifications to meet the care needs of consumers of the Commonwealth’s aged care system’ (CofA 2002f, p4). Workplace issues such as staffing and skill mix were dealt with through the use of the standards and the accreditation process together with the Code of Ethics and Guide to Ethical Conduct (2001c). Wage parity was dealt with by rhetoric that stated there was already a committed provision of funds for assistance to providers and this was

determined to be enough for the providers of aged care to address any disparity in wages between the acute and aged sectors, and the federal government had no jurisdiction to set wages for aged care staff (CofA 2002f). This further highlighted the disconnected nexus between federal and state governments in the provision of health care.

The government's response on the recommendation to further examine appropriate staffing levels in the aged care sector was probably the most crucial to the profession of nursing and the quality of nursing care. The government response stated that the review of the 1997 reforms found that funding arrangements allowed providers to pay above award rates to their staff and this would not be addressed further and was left up to the proprietors or management. Furthermore, the legislation allowed providers of aged care services to be flexible in their adopted approach in order to meet their quality of care responsibilities under the Act; and the Agency monitored the standards of care and services to determine the accreditation of homes. Together with this rhetoric, the Complaint Resolution Scheme effectively dealt with problems concerning the health, safety, and wellbeing of residents. (CofA 2002f)

To reinforce this, a government report on the operation of the Aged Care Structural Reform 1997 under 'quality of care' used the number of aged care facilities that had or had not been accredited to justify that there was quality of care in RACFs (CofA 2003b). It will be argued that the actual quality and provision of nursing care is not being resourced or evaluated according to the findings of thesis. In addition, presently an accreditation approval is totally dependent on the documentation of care according to a fiscal tool and not the nursing care provided; and the complaints system has been found to be impotent and not utilised by residents, relatives, or staff for varying reasons.

The response by the government to the recommendation that an appropriate skill mix be examined further found them deflecting the problem to the Aged Care Workforce Committee (in partnership with the sector) in order to '*... to facilitate the identification of the core skills needed to provide the necessary minimum standards of care. This work will assist the sector in identifying desired minimum*

qualifications for working in aged care.' (CofA 2002f, p13) The government in identification of the benchmark of 'minimum' standards of care and 'minimum' qualifications was a contradiction to the provision of 'quality of care' when minimum standards would allow for a custodial, minimal delivery of care. Quality of care and appropriate evidence based nursing care cannot be delivered on a minimum of standards and provided by persons with minimal or no qualifications. The up-skilling of CWs was to be resourced by the government, but there was no recognition of them undertaking nursing work. Further research into aged care issues, and further identification of the skills needed to provide aged care were now prominent. (CofA 2002f) The government again failed to address the needs of residents being one of nursing care requiring nursing skills.

The Hogan Report stated that the workforce in aged care was such because of 'adjustments' in the direct care workforce, meaning RNs and ENs had been leaving or were being distanced. These adjustments had taken RNs and ENs away from direct care and there had been a relative increase in the employment of personal care assistants caused by the shortage of nurses, as well as *'the development of more efficient workforce structures'* (CofA 2004d, p49). The report suggested improvement was required in the skills of CWs as they were the largest group of providers of 'direct' care. The solution was not directed at the employment of more RNs and ENs and it would seem that non-nursing care had now become 'direct' care, which once again reinforced the implication that 'anyone could do it' with improvement in their skills. RN and ENs were not necessary or required for direct care as they provided most of the indirect care. There was no acknowledgement that the system had created this problem in the first place and, therefore, the system would not or could not be changed.

Careworkers as Non-Nurses and Nursing Work

In 2002 a senate inquiry was conducted into nursing and some of the consistently reiterated recommendations concerning aged care nursing have not been adopted by the government, while the areas of education and training, improving the image of nursing, support for an improvement of working conditions, and an

encouragement for re-entry into nursing were viewed as being taken care of on the part of the government. (CofA 2002g) The first recommendation stated that 'standard nomenclature be adopted throughout Australia to describe the level of nurse and their qualifications, and including unregulated nursing and personal care assistants' (CofA 2002g, pxvii).

No person other than an EN or RN can be called 'nurse' under the state and territory nurses boards and this has become problematic when others are undertaking nursing. A juncture has occurred, whereby CWs of any description have been grouped in with nurses at a senate level of inquiry. Discourse of this grouping of CWs with nurses has permeated other areas as well. For example, in the Australian Nursing Federation's discourse on industrial relations (ANF 2005) and also in their recruitment strategies for membership. The discourse on the delegation of care to unlicensed healthcare workers exposes the apparent contradiction in that CWs could not be called nurses and could not perform nursing work contained in one discourse, but on the other hand CWs were being grouped with nurses in other discourses and were undertaking nursing work (Gilmore 2005; NBSA 2005). It has been acknowledged that CWs, however titled, provide nursing care and that they should be regulated by nurses' boards (Gilmore 2005). In further recommendations, regulatory authorities were called upon to develop a framework for the regulation of currently unregulated or unlicensed healthcare workers (CofA 2002g). This was accomplished in South Australia (NBSA 2005) with the production of guidelines for delegation to unlicensed healthcare workers, but not the regulation of these persons. Because of the problem with nomenclature of the aged care workforce a contradiction has been created and nursing has become more fragmented. The CWs doing nursing work are not recognised as performing nursing care. The CWs cannot be called nurses, but are viewed as an unrecognised and unregulated third level of nursing.

The government also commissioned another review that stated the industry and government would find it increasingly difficult to provide the number and the quality of staff required for residents to receive quality care in RACFs. The review used the term workers for RNs, ENs, and CWs viewed as providing the direct care to residents. The major source of data and the results for this review

were biased from a CW perspective as they formed the majority of the participants. Vacancies for direct workers were determined to be generally low, even though the government continued to state there was a shortage. (Richardson & Martin 2004) In reality, there was a shortage of RNs and more vacancies for RNs, but overall the workforce, the CWs, would have liked to work more hours than they actually did. The attrition rate was high in aged care as 1 in 4 CWs and 1 in 5 nurses had to be replaced each year. Nurses (RNs and ENs) were less likely to be content and satisfied with their work than the CWs. (Richardson & Martin 2004) The majority of participants who gave direct care were CWs, and RNs and ENs were grouped in the results under 'direct carer responses', therefore, the overall comments were not representative of RNs and ENs who were the ones least satisfied, the ones leaving, and hence the ones who needed to be attracted back and retained. A convergence was created in this report between nurses and CWs as direct care providers who had now become generic aged care 'workers'.

The review actually questioned the belief that the labour market was in crisis at all in aged care as vacancies were not high; there was little use of agency staff; the staff seemed to be well qualified for their duties; the workforce had a high level of confidence in their skills; they believed they used these skills effectively; there were high levels of job satisfaction (especially CWs); the majority expected to be doing their job in 3 years time; and there was a wish by staff to increase their hours. (Richardson & Martin 2004) This study contradicted all previous issues identified by nursing as to the problems being experienced because it was skewed to CWs' perspectives. Despite 'workers' being happy with their work and conditions and there being no crisis, the government wanted to attract more CWs; as there was not a long training period for these workers; and if there was only a 'modest change to pay and conditions' more CWs could be attracted into aged care (Richardson & Martin 2004). This identified the need for more CWs rather than more qualified nurses.

When it came to the educational level of the aged 'direct care' workforce, termed the workers, the statistics provided by this study were not conveniently divided into nurses and CWs, but an overall response to the highest level of education was given. Of course this skewed the results towards the educational levels of CWs,

and as such the review stated that the majority of workers had not completed Year 12 level. It was further established that nurses got paid more than CWs and the highest earners were nurses. (Richardson & Martin 2004) This raised doubts as to whether the nurses were deserving of this higher earning given that they spend the least amount of time on direct care for residents. The responses from the nurses and CWs to the work itself was interesting in that 60.3% disagreed with the statement 'I am able to spend enough time with each resident' and in qualifying this, that there was a 'sense of being too rushed to do a good job' (Richardson & Martin 2004, p33).

It is reasonable to assume that direct care staff think that their main role at work is to take care of the needs of residents in quite a hands-on way. When many of them feel that they cannot do this to the extent and in the manner that they judge to appropriate, it is not surprising that they feel under pressure to work harder. Nurses in particular are likely to feel that they cannot do all that is expected of them in the time that is available. (Richardson & Martin 2004, p34)

The review was interested in the employment of CWs and their attrition and retention as the key group of the labour force, however, the study focused on all nursing staff as workers. The review found between 2.5% and 3.5% of all shifts were staffed by agency staff and this seemed to be acceptable. The results from the survey of facilities found that it appeared RACFs were not facing large difficulties in recruitment with the majority (62.6%) having had no vacancies at the time of the study. There was no problem in the recruitment and retention of 'direct carers' and, therefore, from their point of view there was no problem or any difficulty in the recruitment and retention of RNs and ENs in aged care. (Richardson & Martin 2004)

There has been recognition of an increasing dependency and acuity of residents in RACFs (CofA 2001b, 2004d), however, there were less RNs and ENs to provide the nursing care and more CWs were employed (CofA 2001b). The CWs were providing the majority of nursing care, but there was no formal requirement that they have any qualifications or training. If the ENs scope of practice was increased this would allow providers to employ CWs rather than ENs, and ENs rather than RNs. The providers' responsibilities in relation to nursing services in

high residential care and staffing were broadly in the provision of appropriate skills to the level of need. There was provision in high care for a RN or 'other' health professional appropriate to the need and also 'for all high care residents, initial and on-going assessment, planning and management of care for residents are carried out by a registered nurse' (CofA 2001b, p16; 2002b, Section 11.12) but there was no requirement RNs be employed.

Aged Care Nursing Education

During this era there were a number of reports commissioned concerning nursing education. The most notable includes the review of nursing education and the requirement for a specific aged care component to be included in undergraduate nursing curricula nationwide. (CofA 2001a; Nay et al. 2002; CofA 2002a, 2002c, 2003b) Aged care scholarships and aged care places have been provided for undergraduate students and there is also 'encouragement' of the industry to embrace a minimum qualification for the non-nursing or personal care workforce of Certificate III or equivalent before 2008 - but this is voluntary (CofA 2001b, 2003b). There was no acknowledgement of the work CWs did as nursing work or a requirement for RN cover. The government became committed to better preparing the 'non-nursing' workforce to Certificate III level (CofA 2001b, 2003b).

The government's response to the lack of a nursing career structure in aged care nursing stated that \$47.5 million dollars would be given over four years to the education and training of 'workers' in the aged care sector (CofA 2002f), which would include assistance for nurses to undertake postgraduate work, as well as aged care 'nurses' to undertake undergraduate studies via specific aged care places in programs that had a gerontic focus. The majority of the resources were going to the CWs' training and certification. The government also supported 'industry developed careers' and the provision of education and training structures, mainly for CWs. (CofA 2002f) In 2006 the government announced \$7.5 million over four years to train ENs in medication administration in the aged care sector (ANF 2006a) essentially making it unnecessary to employ RNs.

The undergraduate curricula for nursing students were described in one government report on nursing education as being orientated to acute care, promoting ageism, and allowing students to have poor experiences in aged care clinical experiences. This placed part of the problem with the higher education sector and the implication was that university programs were not providing positive experiences for students, nor including a specific aged care focus in curricula, and that this in turn was affecting the recruitment and retention of RNs in the industry. (CofA 2002c) On the surface, this did not seem to be a fair appraisal of the situation in that problems in the aged care sector cannot be placed with the nursing academe alone and the main problems inherent in the system are silenced. On the other hand, any strategies in this direction would not harm the provision of nursing in the aged care sector. It was viewed that the current structure of the nursing team in aged care was an inappropriate structure in terms of employing staff to provide adequate levels of personal and nursing care. (CofA 2002c)

In regard to university nursing graduates a principles paper was presented as to what was needed to be included in undergraduate nursing curricula specific to aged care (Edwards 2004). The content for undergraduate nursing curricula included: indigenous and non English speaking aged care issues; assessments, differential diagnosis and management of challenging behaviours in the older person; comprehensive assessment of the older person; medications and issues of polypharmacy in the older person; pain assessment and management in the older person and in particular the person with a cognitive impairment; wound management in the older person; continence issues in the older person; nutrition and hydration in the older person; communication with older people; residential care - the positives; the transitional care continuum; palliative care in the person with end-stage dementia; loss, grief, death and dying; quality, safety and risk management (Edwards 2004). All of the above were included in the new funding model, but mostly under the 'personal care' module of the ACFI. What is necessary in an undergraduate nursing curriculum is actually what the government determines to be personal care. This has again caused a contradiction in 'what is

nursing’ and ‘what is not nursing’ according to the discourses of government’s instrumentation and the definition of nursing.

The initiatives by the various reviews about nursing education in the tertiary sector deserve commendation, however, the contradictions and problems experienced by nurses and non-nurses and the quality of nursing do not lie solely with the tertiary education of RNs. The problems also exist because of a system in place that is controlled by the federal government, whereby nurses find they can no longer nurse and non-nurses are providing non-recognised nursing care. Until this underlying problem is addressed, the issues with nursing in RACFs will continue. Further to the education of nurses and non-nurses in aged care, nursing research also had mention in two government responses to reports of this era.

Nursing Research

It was recommended that the government establish and fund a national research program specifically directed to aged care nursing (CofA 2002e). The government response stated that financial assistance to undertake postgraduate studies or research was already available and would provide practical applications to the outcomes of improved care. The government cited the establishment of the Productive Ageing Centre at the University of the Sunshine Coast (a corporate entity in partnership with the National Seniors Associated Limited). Although it was a positive development it was not specific to nursing research. The government also established the Ageing Research Capacity Building Project to network all researchers on ageing issues including ‘matters of concern to the nursing profession’ (CofA 2002f).

On examination, a nursing research program could not be found in these two initiatives. The recommendation although not totally ignored was in fact not addressed, and there were no funds made available specifically to nursing research. All the funds were directed to research about ‘ageing’ in general and neurodegenerative research specifically. Aged care nursing research would not be resourced other than within other programs of aged care research in conjunction

with other disciplines. The government recognised the need for nursing research and having made recommendations on this, have now been perceived as having addressed it. In reality nothing has actually been targeted to fund research into nursing in aged care. As such, nursing has again been muted and subsumed into medically or socially directed research programs.

In summary, the National Aged Care Workforce Strategy (2005) released recommendations about the aged care workforce (CofA 2005a), but it contained nothing new. This strategy was developed by the Aged Care Workforce Committee to identify the workforce profile of the residential aged care sector and its future needs until 2010. The continuing issues of skill mix and staffing levels have essentially been silenced by the government's response to the report on recruitment and retention, whereby present funding levels are determined to be at a level commensurate with an appropriate mix and staffing levels in RACFs, and that this could be assured through the accreditation procedures and complaint mechanisms (CofA 2002f). The senate inquiry into nursing also specifically recommended that benchmarks for resources and skill mix in aged care nursing were needed for improved care for residents and best practice (CofA 2002g, pxxiii and Ch7). This implied that it was required. This juncture, where the government responded to the recruitment and retention issues, essentially silenced the skill mix and staffing issues so important to professional nursing practice and the quality of nursing care able to be provided in residential aged care.

The strategy developed by a committee was implemented by the Strategy Implementation Group that was well represented at the executive level of some nursing organisations and heads of nursing schools (CofA 2005a). According to the strategy the issues identified in the senate inquiry into nursing were the same as those experienced by nurses in aged care (including attrition, recruitment, and retention), but aged care was singled out as being in an acute crisis. (CofA 2002g) As such, the focus for the strategy became attrition, recruitment, and retention of nurses in aged care thereby ignoring the specific workforce issues related to the quality of nursing care, documentation, funding, staffing, and skill mix in order to retain and recruit nurses. Among the language and directions that were introduced in the strategy were the multi skilling of the workforce (CWs) under workplace

practice models (CofA 2005a). This essentially meant that CWs could be multi skilled to do everything and anything from cleaning the toilet to preparing food, giving food, practising hygiene, and administering medications.

Another term, governance, emerged as what was essentially the art of governing through controlling by regulatory means. The desired outcome of the strategy under a 'responsive workforce' had a very diluted description of what quality of nursing care and the provision of quality nursing care meant, in the following statement.

The residential aged care industry has the staffing numbers and skills mix to develop and maintain a positive workforce which responds to changing client profiles and can focus on resident outcomes. (CofA 2002f, Figure A, Objective 5)

Furthermore, the government recommended a staff modeling tool be developed by the Peak Aged Care Organisations and the Aged Care Sector that would enable RACFs to place staff with the 'right' skill mix in the 'right' job to achieve the best outcomes for the residents. The government firmly relinquished responsibility for staffing levels and skill mix and handed this over to service providers. RACFs were called 'homes' in this document and all levels of nursing staff were called 'workers' (CofA 2005a). These shifts in responsibility, concepts, language, and nomenclature that referred to nursing work, nurses, non-nurses, and the nursing domain were gaining further momentum and, therefore, acceptance. Extra funding was to be provided to RACFs as an adjusted payment package as a strategy to enable the provider to have the ability (not viewed as lacking previously) to pay competitive wages to attract and retain staff. However, this was actually conditional on the service provider producing financial statements and would involve compulsory participation in workforce surveys. The financial encouragement for staff to undertake training was dependent on further audits and surveillance. (CofA 2005a)

Nine years on from the 1997 reform, further reforms are to be implemented with the 'adapted' ACFI, as well as the documentation necessary to categorise residents into now three categories across all low and high care RACFs. Accreditation and certification will continue; workforce issues will be viewed to

have been addressed by the Aged Care Reform Strategy skill mix and staffing levels are off the agenda as far as the government is concerned. Despite a senate inquiry, the nursing profession continues to be silenced and nursing itself is being changed; and RNs are still to be utilised as agents for the government system through the documentation requirements. Nursing has moved away from direct care in a hierarchical structure that is inherent in residential aged care.

The RN is accountable and responsible to the public through legislation for the nursing care and the non-nursing care in residential settings over which they have no direct control. As well as this, the RN has become an agent for the government in the documentation necessary for the validation of funding and accreditation. RNs employed in the aged care industry have been forced to embrace a whole new system of assessment through to evaluation that does not fit with what is considered normal practice or documentation in the nursing profession. The scrutiny and examination practices are evident in residential aged care, whereby the resident and the labour force have become objectified, commodified, standardised, and controlled through various means of examination and scrutiny.

The previous two chapters have discussed the reforms in residential aged care from their beginnings 30 years ago. Nursing care has been influenced and controlled by the system in place, and nurses and nursing have progressively been silenced by the various government reviews and reforms. The problems being experienced will continue in the residential aged care sector where nursing is not valued or identified in the provision of care through subtle shifts and junctures in the rhetoric from the dominant discourse emanating out of the federal government. Having established this context of residential aged care in Australia and how it relates to a domination of nursing, the next two chapters provide an overview of the work of Foucault (1926-1984) and its relation as the philosophical underpinning of residential aged care and nursing. In chapter 4, the framework provided by Foucault finds residential aged care in Australia to be a state organisation that uses disciplinary means to control the industry and its workforce in providing services. The conduct of the government as a discipline is further analysed in chapter 5 under what is termed the 'governmentality' of organisations in Western societies and its application to residential aged care.

Chapter 4

THE DISCIPLINE OF RESIDENTIAL AGED CARE

Although a capitalist system can be viewed as driving the apparatus of aged care from an economical perspective on which political decisions are made, the concept of the subjugation of individuals within a system together with the power relations formed and the knowledge or 'truths' formed, in turn constitute and strengthen the structure and mechanisms by which control is exerted - as a discipline that becomes self governing. Nursing practice in residential aged care, as the object under study in this thesis, is determined to be subsumed in a disciplinary system that is affecting aged care nursing practice. Foucault (1977) uses the historical formation of the penal system as it has been constituted to demonstrate how Western society has been influenced, institutions affected, and practices impacted on and that these can be mapped historically. He concludes that any institution can be studied through the mechanisms of control on the practices within the institution that allow it to exist and be maintained.

The following three chapters focus on the philosophy and research of Michel Foucault and the theoretical application to residential aged care in Australia. This chapter discusses the term 'discipline' as defined by Foucault (1977) and the disciplinary nature of Western organisations and governments that drive services for the benefit of a civil society. It is proposed that residential aged care is one such service or clinic that uses disciplinary means for administration of the system that is comparable to the penal, medical, or school services as other disciplines. It is contended that there are commonalities in all disciplines from an historical, societal, economical, and political position. Chapter 5 describes the role of the government or the state and how services and organisations are governed in industrialised societies. Chapter 6 describes the meaning of discourses and discourse analysis and the power relations inherent in all discourse about any practice in any discipline. The aim of the three chapters is to globally relate the concepts of discipline, governmentality, and discourse analysis to nursing practice in residential aged care according to Foucauldian thought.

Disciplines

Foucault (1977) describes disciplines as general formulae and prescriptions of domination, in that a human or corporate body becomes the object of investments and strict powers that impose constraints, prohibitions, or obligations on that body. Extending this, an economy of power develops, whereby a body is treated collectively, whilst at the same time worked on and studied individually. As such, the discipline becomes a unified, productive, totalitarian state or institution through disciplinary methods, as is the case in residential aged care.

These methods, which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, might be called 'disciplines'... the disciplines became general formulas of domination... Discipline is a political anatomy of detail... (Foucault 1977, p139)

This utilisation of the body or bodies through detailed study renders them docile and complicit whilst at the same time productive. Residential aged care can be identified as having this economy of power whereby, each individual resident is classified and validated with staff enforced into being agents for the government. It is through the bodies of individuals by their resistance and compliance that a totalitarian state is produced and a form of hegemony exists. The government, agents, proprietors, and staff are agents and actors in the apparatus that is the system of residential aged care. Foucault (1977) states that methods give rise to a discipline through a scale of power, an object of control, and a modality by which power is exercised. The residential aged care system has a power structure that is controlled by the federal government through instrumental means and, as such, is recognised as a discipline.

Disciplines, such as residential aged care, aim for the control of the time, space, and movement of docile bodies as part of the system. Persons are utilised through their activities whilst at the same time undergoing subjection, manipulation, and increasing domination.

The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A 'political anatomy', which was also a 'mechanics of power', was being born; it defines how one may have a hold over others' bodies, not only so that they may

do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, 'docile' bodies. (Foucault 1977, p138)

A discipline focuses on the individual who is embodied, hence the name 'body', and by scrutinising the body to an infinite degree in every minute detail there is an increased potential or capacity (aptitude) to be dominated and controlled in an effective and efficient manner. Foucault uses Napoleon's mechanism of power as an early example, whereby Napoleon established '*a mechanism of power that would enable him to see the smallest event that occurred in the state he governed, his intention being to embrace the whole of this vast machine without the slightest detail escaping his attention (Treilhard, 14)*' (Foucault 1977, p141).

Through focusing on the needs of residents (individual bodies) and also on the body of the nursing staff (the labour force), residential aged care and the nursing care within it are dominated and controlled by the government through disciplinary means. Service providers, residents, relatives, and nursing staff are scrutinised in detail, whilst at the same time acting as agents for the mechanisms through which the domination exists. The world of detail, scrutiny, and meticulousness through surveillance is important in that it is these little things in the power relations present that allow a capacity for further domination, control, and order. (Foucault 1977) Application of Foucault's description of a discipline to residential aged care can be determined, whereby the classification of residents and the documented details are the means by which the government exercises domination and control of the industry along with its labour force, and also nursing.

The Art of Distributions

In describing the art of distributions Foucault states that a discipline requires enclosure whereby it becomes a protected heterogeneous place of disciplinary monotony (Foucault 1977). Residential aged care can be viewed as enclosed when the term has the following as its aim.

The aim is to derive the maximum advantages and to neutralize the inconveniences (thefts, interruptions of work, disturbances and ‘cabals’), as the forces of production become more concentrated; to protect materials and tools and to master the labour force. (Foucault 1977, p142)

A further principle in the art of distributions is that of partitioning or elementary location whereby each individual body has their own place and each place its own individual. The logic is one of locating people or populations through their classification and sectioning thus allowing for the supervision of their conduct. The aims of utility, mastery, and further knowledge of the individual or social body for the purpose of control are paramount. (Foucault 1977) Resulting from this art of distribution was the introduction of ‘functional sites’ or institutions such as schools, prisons, and aged care facilities.

These institutions are designed for utility, containment, and the creation of useful space. This allows for the supervision of bodies and the ongoing surveillance and communication between the bodies both within and without. In Foucault’s view a clinic or a residential aged care facility has things and bodies that are distributed, partitioned, and incorporated into a therapeutic space where they can also be scrutinised.

Gradually, an administrative and political space was articulated upon a therapeutic space; it tended to individualize bodies, diseases, symptoms, lives and deaths; it constituted a real table of juxtaposed and carefully distinct singularities. Out of discipline, a medically useful space was born... distributing individuals in a space in which one might isolate them and map them; but also of articulating this distribution on a production machinery that had its own requirements. (Foucault 1977, p144)

As such there is a link under a discipline between the distribution of bodies and the arrangement of space around the machinery or mechanisms of production. Aged care is one such discipline where the bodies of dependent residents are examined and arranged spatially for utility, surveillance, containment, and control. *‘Discipline is an art of rank, a technique for the transformation of arrangements. It individualizes bodies by a location that does not give them a fixed position, but distributes them and circulates them in a network of relations.’* (Foucault 1977, p146). The disciplines create complex spaces that serve the discipline through the architectural, functional, hierarchical structures, and power

relations. The problem for the state and the agents is to provide an instrument to cover it, master it, and impose order. In residential aged care the instrumentation in use, the documentation requirements, and the accreditation and validation processes are identified as active in the control and conduct of residential aged care. Furthermore, the governing of residential aged care services has been centralised to a federal level and has become highly regulated.

Time and Activities

Foucault (1977) articulates the significance of time and the control of activities whereby rhythms, practices, and repetition are regulated in disciplines such as schools, workshops, hospitals, and in this case aged care facilities. The timetabling of practices and activities permeates the disciplines and has been refined to a condition of measuring hours, minutes, and seconds of activities and practices in the discipline. The attempt to ensure that time is utilised usefully incorporates the introduction of supervision, examining, and surveillance. There is to be no wasting of time by the labour force, which in economic terms is the means of production or the mechanism for the provision of services. (Foucault 1977). The workforce is also something that can be manipulated to reduce costs. The Rhys-Hearn (1986) study of nursing activities in nursing homes in Australia identifies the beginning of this scrutiny of time and practices of nursing staff in the aged care industry. Although the study relates to frequency of activities rather than the time it takes or the number of staff required, it laid the framework for the RCI and consequently, the RCS and ACFI instrumentation. (Rhys Hearn 1982, 1986; Australian Government 2005d)

Foucault's 'temporal elaboration of the act' describes a collective and obligatory rhythm that is imposed as a program in a discipline (Foucault 1977). This programming assures its implementation in its enactment by controlling its development and mechanisms, thereby forcing a compliance or docility brought about by the collection of data. Residential aged care is one such discipline that finds the industry complying with instruments in order to satisfy the system requirements for funding as described in the following quote.

The act is broken down into its elements; the position of the body, limbs, articulations is defined; to each movement are assigned a direction, an aptitude, a duration; their order of succession is prescribed. Time penetrates the body and with it all the meticulous controls of power... In the correct use of the body, which makes possible a correct use of time, nothing must remain idle or useless: everything must be called upon to form the support of the act required. (Foucault 1977, p152)
It constitutes a body-weapon, body-tool, body-machine complex.’
(Foucault 1977, p153)

In his description of the ‘body-object articulation’ Foucault (1977) states that a discipline defines each body and the power relations it has with the object it manipulates, fastens, or glues together. The application to residential aged care finds overt hierarchical power relationships between the management and nursing staff, between the nursing staff themselves, between the residents/relatives and the staff, as well as between the facilities and government.

Another relevant principle of this concept of discipline is the notion of ‘exhaustive use’ in that the timetable is used to make the most efficient use of time. The discipline arranges time in a never ending, exhaustive use of it to attain maximum speed and efficiency. (Foucault 1977) The cost-effective-efficiency conundrum that at the same time produces the rhetoric of individual rights and responsibilities, standards, quality of life or care, and wellbeing can be found in the residential aged care discipline. This is especially valid for proprietors of facilities in that the time of the staff has to be fine tuned to extract the maximum output using the minimum input. The aim is to reach exhaustive use or maximum speed and maximum efficiency, even though this ultimate aim may be impossible because of the organic nature of disciplines. (Foucault 1977)

This control inherently makes the subject an object by defining and categorising activities that are scrutinised to create further efficiencies or knowledge (Foucault 1977). In residential aged care, in an attempt to establish what it is persons do in providing nursing care, the labour force has been studied, activities determined, and the residents classified. This is a way of controlling the activities of nursing and nursing staff through the classification of residents. The government sets the framework and the institution is bound through management practices to attain maximum efficiency and meet outcome standards. *‘The disciplines, which analyze*

space, break up and rearrange activities, must also be understood as machinery for adding up and capitalizing time.' (Foucault 1977, p157). The government has undertaken this scrutiny of time and activities with the use of the RCI, RCS, and ACFI. This is further extended to service providers who impose a second level of scrutiny of the nursing workforce in time and activity in order for maximum cost effectiveness.

Tactics

Foucault states this demand for an ever more efficient machine results in a number of forces being integral parts of a discipline namely: the individualisation of bodies in relation to other bodies (RCI, RCS, and ACFI), the maximum extraction of time (nursing staff), a precise system of command (evident in the aged care structure), and 'tactics' (strategies and rhetoric as discourse).

Tactics, the art of constructing, with located bodies, coded activities and trained aptitudes, mechanisms in which the product of the various forces is increased by their calculated combination are no doubt the highest form of disciplinary practice. (Foucault 1977, pp164-7)

This concoction is clearly evident in residential aged care, whereby the government has used these forces of individualisation, the exhaustive use of time, and a system of command. As Foucault (1997) states, the chief function of a disciplinary power is to train and correct for further efficiency and effectiveness and this is occurring in residential aged care as described in chapters 2 and 3. The tactic can then be used for more efficiency and effectiveness by producing single units through examination that act to unify in their relation to each other, such as the residents' relative dependencies. This in turn increases the control of the bodies and the institutions.

The success of disciplinary power derives no doubt from the use of simple instruments; hierarchical observation, normalizing judgement and their combination in a procedure that is specific to it, the examination. (Foucault 1977, p170)

The history of the aged care system supports this disciplinary system and the tactics used in residential aged care. The introduction of the instrumentation that classifies residents according to their 'relative' dependency impacts on nursing

practice from an efficacious angle, meaning economic rationalism overrides the quality of life the residents have, and the nursing care that can be provided. Because the instrument remains attached to the nursing care provision and documentation, nursing and nursing practice is being changed for economic reasons rather than the quality of nursing care for residents and the improvement of nursing practices.

Surveillance

In a discipline, coercion and rationale can be implemented and made visible through mechanisms of control by means of observation and examination. According to Foucault, in a perfect or ideal discipline, power would be exercised through all possible means and the observations would produce an all powerful control on all that occurred including the actions of all the bodies within the discipline. *'The perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly.'* (Foucault 1977, p173) The concept of hierarchical surveillance is one of embedding, whereby a constructed architecture renders individuals visible and this hierarchical surveillance operates in order to transform or train those individuals, whether referring to residents or the labour force of an aged care facility. With supervisors or agents themselves being supervised, the surveillance in turn governs their conduct and makes it possible to know them; and it also provides the opportunity to transform them. (Foucault 1977)

Hierarchical surveillance involves intense and continuous supervision of bodies in their activities and the quality of the product or service. It also requires a structure of supervisors or agents; a system of supervision with a number of instruments and observers known as 'agents'. Foucault takes this further to a reciprocal relationship, whereby the hierarchical surveillance is increased in efficiency through the active and complicit participation and distribution of those individuals who are in the integrated disciplinary system. The observers are also observed. (Foucault 1977) If this holds true, by exploration, surveillance, observation, and participation in the hierarchical surveillance within a disciplinary apparatus, such

as aged care, the activities and knowledges of the labour force is influenced or transformed according to the data collected about them using both tactics and strategies for compliance. The power relations that permeate human existence constitute relations between knowledge and power that are polemic in nature in that there are always alternative views, gazes, and dominations that can be termed knowledge.

The term 'gaze' by a witness, an observer, and the documentation form various knowledge/power relations between subjects and objects and become pertinent to a discipline. In aged care the differing gazes of the government, the proprietor, the agents for validation and accreditation, management, levels of nursing staff, the residents and relatives, and the documentation are very apparent. The same event, phenomenon or activity of nursing practice can have different subjective gazes upon it as an object. These gazes, examinations, observations, positionings, or perspectives are at the same time forms of knowledge and power. Power cannot be maintained without knowledge and knowledge would not exist without power. It is a 'reciprocal, correlative, and superimposed' relationship in which gazes form an essential function of keeping the system under control through the generation of knowledge about subjects and self-governance. (Foucault 1994a)

Normalising Judgement

Foucault (1977) discusses 'normalizing (sic) judgement' as the means used for the correct training in any discipline. He states 'At the heart of all disciplinary systems functions a small penal mechanism.' (Foucault 1977, p177) and it is the penalty that will enforce a compliance to examination, and thus further control. This disciplinary penalty is necessary when there is change or a non-compliance of some form that departs from the normal or the accepted. This non-conformance or inability to carry out activities is punishable in some form or another in any discipline. Normalising judgement and training for the government and industry can be recognised in residential aged care as a punitive system.

Discipline judges individuals 'in truth' and uses this to indulge or privilege, or to penalize and punish. Discipline uses rewards, awards, attainment of higher ranks and places. By reversing these it

punishes thereby conformity is attained to a certain model or programme. All become subjected, subordinated, docile and end up being like one another. (Foucault 1977, pp180-2)

The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions compares, differentiates, hierarchizes, homogenizes, excludes. In short, it normalizes... (Foucault 1977, pp182-3)

The examination, described previously, combines the techniques of hierarchical surveillance and normalising judgement. *'It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish.'* (Foucault 1977, p184), and *'The examination manifests the subjection of those who are perceived as objects, and the objectification of those who are subjected...'* (Foucault 1977, pp184-5). The examination allows individuals to be classified, differentiated, unified, judged, and transformed giving rise to power and domination over them. Individual bodies, the labour force, or corporate bodies are made subjects and in turn become objectified entities through examination, as each is related to each other resulting in their normalisation and compliance. This subjectivation and individualisation is also a means of control over bodies whether a resident, a nursing staff member, or an aged care organisation.

Judicial Penalty

Judicial penalty opposes normalising judgement in that it specifies acts according to a number of general categories by allowing either the permitted or the forbidden. The operation of the penalty is via a corpus of laws, regulations, and texts (Foucault 1977). In residential aged care the judicial penalty of the withdrawal of funding if standards, documentation, validation, and regulations are not met, is one prime example.

The power of the state to produce an increasingly totalising web of control is intertwined with and dependent on its ability to produce an increasing specification of individuality. (Rabinow 1984, p22)

The judicial aspects of residential aged care services suggests the law operates more and more as 'the norm' and the judicial system is increasingly being incorporated into the continuum of apparatus, the function being regulation and

control. 'A normalizing (sic) society is the historical outcome of a technology of power centered (sic) on life.' (Foucault 1976, p144) The political technology of life is tied to the disciplines of the body in all their forms and also to the regulation of populations. In residential aged care services, the government uses the language of rights and that these serve a political end, however, these rights also offer the means by which a challenge can be made to the judicial system. As will be discussed in chapter 11, the rights of residents are continually under challenge in residential aged care.

It was life more than the law that became the issue of political struggles, even if the latter were formulated through affirmations concerning rights. The "right to life, to one's body, to health, to happiness, to the satisfaction of needs, and beyond all the oppressions or "alienations," the "right"... was the political response to all these new procedures of power... (Foucault 1976, p145)

Foucault contends that analysis can make visible the power relations and structures of truth whether normalised or judicial, that are directly connected to the body or bodies in what is termed 'biopower' or 'biopolitics' (Foucault 1976). This has its origins in early public health and the birth of the clinic for the public good in a civilised society.

The Clinic

When describing the development of the hospital, the clinic, or in this case a residential aged care facility, the patient or resident is under a constant level of surveillance. Along with an internal hierarchy, the facility becomes the place of training and a producer of knowledge through record keeping and surveillance. The examination is able to transform the bodies into visible objects that then enable the exercising of power over those bodies. The visibility and examination of the subject ensures power can be exercised over the subject through the objectification of that subject relative to all other subjects. (Foucault 1977) The aged care system in Australia has undertaken this with the residents, the labour force, and facilities through instrumentation, examination, and documentation that relate one to all and all to one. This has a normalising effect in the avoidance of judicial penalty and the rationales become more difficult to challenge.

As residential aged care facilities provide care to the frail and aged, Foucault's (1976) analysis of the 'right of death and power over life' has bearing in that residents are generally in a terminal stage of their lives and are in need of nursing care. Medicine and aged care in Western society is viewed as having 'power over life' and two parallel and interconnecting elements are acknowledged. Firstly, the body being viewed as a machine to be utilised efficiently and effectively through the discipline described as 'an anatomo-politics of the human body'; and secondly the development of regulatory controls that are imbued on the human body and result in a biopolitics of individuals. This biopower developed from public health and has been constituted through capitalism that administers and manages the lives of individuals using disciplinary means with an aim of the subjugation of bodies and the cost effective control of populations. (Foucault 1976)

Institutions such as aged care that developed from this biopower ensure the maintenance of the labour force and, therefore, the means of production or the service for residents. Techniques of power are present at every level of the social body in Western societies and institutions. The utilisation of biopower in institutions ensures the relations of domination are supported with an outcome of hegemony. (Foucault 1976) In residential aged care, the bodies of residents, the labour force, and the industry are controlled through technical means that are driven by power relations and knowledge production reinforced through discourses that may be verbal, written, or silent depending on the dominant discourse at the time.

Documentation

The examination introduces individuality into the field of documentation, considered to be essential in the keeping of the meticulous and detailed archives to be utilised. The subject is thus positioned and objectified within a field or network of writing and texts. (Foucault 1977) Computer technology will provide a greater ability of scrutiny, individualisation, and examination that will further inform the government for increased efficiency and effectiveness. The

documentation of residential aged care correlates, accumulates, serialises, classifies, categorises, and averages – all for the purpose of fixing norms. This provides a general register with each individual having an effect on the overall calculations. (Foucault 1977) This phenomenon of record keeping and documentation is very evident in residential aged care and the problems associated with the funding documentation requirements have been highlighted in the previous two chapters.

According to Foucault, the examination with all its documentation makes each individual a ‘case’, both as an object for knowledge and as a means of power. The case ‘...is the individual as he (sic) is described, judged, measured, compared with others, in his (sic) very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded, etc.’ (Foucault 1977, p191). Residential aged care has two types of subjects that are objectified and documented about. The residents and the nursing staff who are both subjects who are described, judged, measured, and compared with others, as well as trained, corrected, classified, and normalised. The documentation of the residents’ individuality, classification, and description in residential aged care is the means of control by which the capacity of the dominating discourses to dominate is increased (Foucault 1977), and it is firmly tied to nursing care in the aged care system.

Finally, the examination is at the centre of the procedures that constitute the individual as effect and object of power, as effect and object of knowledge. It is the examination which, by combining hierarchical surveillance and normalizing judgement, assure the great disciplinary functions of distribution and classification, maximum extraction of forces and time, continuous genetic accumulation, optimum combination of aptitudes and, thereby, the fabrication of cellular, organic, genetic and combinatory individuality... a modality of power for which individual difference is relevant. (Foucault 1977, p192)

According to Foucault, anyone who is marginalised, in a lesser position of power, vulnerable, mad, delinquent, aged, or dependent will be more individualised through increasing examination as a descending technology of power that allows a ‘political anatomy of the body’ to be implemented through the production of knowledge (Foucault 1977).

The individual is no doubt the fictitious atom of an 'ideological' representation of society; but he (sic) is also a reality fabricated by this specific technology of power that I have called 'discipline'. We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him (sic) belong to this production. (Foucault 1977, p194)

The knowledge gained by the government of residential aged care through examination of the industry, the residents, and the labour force has been significant and used by the government to argue policy and resource allocation. As described in the previous two chapters, the dominant discourses were determined by the interests of the government and the examination was used to justify decisions made regarding nursing care; and in this process the discourse of quality nursing care provision was and is repressed.

Panopticism

Within a discipline, inspection functions ceaselessly and different gazes are ever present with everything observed and recorded. Enclosure, segmentation, and compartmentalisation occur. A discipline such as residential aged care lays down for each individual his or her place (accommodation), health (dependence on nursing care), and wellbeing (quality of life). It is disciplinary mechanisms and analysis through which power is reinforced. Regulations penetrate into the smallest details of an individual's life through hierarchical disciplines that allow power to function through capillary or diffusion mechanisms. The mechanisms or structures that support the exercising of power of human over human include hierarchy, surveillance, observation, and documentation of the individual bodies within the discipline.

Mechanisms of power are disposed around the 'abnormal' individual who because of their individuality does not fit the mould or the norm, with the aim of labelling and classifying the individual. This alters or transforms the individual to fit into the discipline. It produces automation and 'disindividualises' and the panopticism

(the simultaneous gazes from within and without) are undertaken by any person and individualities are a collection of separated individual bodies. (Foucault 1977) It is apparent the classification of residents in residential aged care is described in the above, but also in relation to who has the capacity to provide and document the nursing care. Any problems experienced are repressed by responses from the governing body for further 'training' to occur in instrumentation or documentation rather than the employment of qualified nurses.

The Panopticon was developed as a model prison by Bentham in the eighteenth century (Foucault 1977). It is used as the architecture of a discipline, whereby the individual is alone, segmented, individualised, and constantly visible and transparent both from the inside and the outside. The major effect of panopticism is to produce a state of 'permanent visibility' that assures the automatic functioning of power for the control of the many. Persons are numbered and supervised and the individuals play a complicit role in their own subjectivation to the dominating power. In other words, there will be a submission and compliance rendering the docility of individuals, or a resistance or struggle against the domination rendering a delinquent in some form of conflict with the system. (Foucault 1977)

Through this subjectivation of the individual through panopticism, as occurs in residential aged care, the individual body or organisation becomes docile and passive to the mechanisms of the discipline and to those exerting power over them. This applies to not only the residents, but also the nursing staff in the organisations. Among staff in disciplines, their performances are observed, their time is mapped, and their aptitudes are assessed and this has occurred in residential aged care. Foucault (1977) also discusses the nature of panopticism as being one whereby it can be used as a 'laboratory' in that it can be used to '*...carry out experiments, to alter behaviour, to train or correct individuals*' (p203). The panopticon has a central control whereby individuals such as residents can be observed and controlled from a central point; but it also functions to observe the employees in order to judge them, alter their behaviour, and impose methods such as classification and documentation. (Foucault 1977)

In aged care, panopticism starts at the government level and extends to the service provider, the executive, the labour force, and the resident - and in the process residential aged care becomes automated. The automation of the panoptic institution becomes one of self-governance and self-observation. The gazes exerted on the subjects occur from a centralised observation from within, but also through the means of transparency from without. Each subject is partitioned from other subjects and gazed upon from within the apparatus at its centre, and also through a public gaze, from without, in order to be 'transparent'. The penetration of this panopticism produces knowledge that is further used to exert more power and control. The gazes and examinations form knowledge about the individuals who are subjectified and this collectively maintains the control, order, and power.

It makes control and power possible in a totalitarian way by the individualising and subjectivation of persons in a discipline through power relations, observations, and domination. According to Foucault, individuals in Western societies all participate in the panopticon, whereby power is exerted from within by disciplinary means and from without by societal supervision within the concepts of rights and quality. (Foucault 1977) A central monitor purveys all bodies, such as a RN observing all residents and nursing staff or the government observing and examining all. The monitor (the RN or the government) then becomes unnecessary because all organisations and persons become self governing according to the dominant discourses. Therefore, the organisations, the residents, and the nursing staff govern themselves and the nursing practices (in the absence of RNs who have become the monitors).

Foucault (1977) states the domain of panopticism is firmly in the swampy low ground where it details bodies, movements, activities, forces, and spatial relations – everything about the individuals who are institutionalised and those who work in the institutions. This is described as the political anatomy or structure whose object and end are the relations within the discipline. The panopticon is a representation of one aspect of Western society and it is structured and penetrated through and through with disciplinary mechanisms and surveillance, operated through and generated by power relations. Foucault describes this as a 'network of sequestration' in which individuals form, in a diffusive way, an essential part of

the controlling of any group of individual lives or existences (Foucault 1994a), such as residents of aged care facilities.

With panopticism... there would no longer be inquiry, but supervision (surveillance) and examination. It was no longer a matter of reconstituting an event, but something – or, rather, someone – who needed total, uninterrupted supervision. A constant supervision of individuals by someone who exercised a power over them – schoolteacher, foreman, physician, psychiatrist, prison warden – and who, so long as he (sic) exercised power, had the possibility of both supervising and constituting a knowledge concerning those he (sic) supervised. A knowledge that now was no longer about determining whether or not something had occurred; rather, it was about whether an individual was behaving as he should, in accordance with the rule or not, and whether he was progressing or not. This new knowledge was no longer organized around the questions: “Was this done? Who did it?” It was no longer organized in terms of presence and absence, of existence and non-existence; it was organized around the norm, in terms of what was normal or not, correct or not, in terms of what one must do or not do... a knowledge characterized by supervision and examination, organized around the norm, through the supervisory control of individuals throughout their existence. (Foucault 1994a, p59)

Residential aged care employs panoptic methods for control and power over expenditure. The residents, staff, and administrators are gazed upon by a number of means, and there is a hierarchical nature to the examination. The resident as the docile body is subjected to the nursing staff; who in turn are subjected to the proprietor or executive; the institution is subjected to the government; and, ideally, the government is subjected to the population. In this way the government has a totalising control of what occurs in residential aged care according to the knowledge produced by observations, gazes, records, and surveillance whilst at the same time directing, enforcing, and controlling nursing care in these institutions. Concurrently, the government is being ‘transparent’ under an umbrella of social justice, resident rights, and the availability of complaint mechanisms to ensure quality of care. Foucault (1977) describes deinstitutionalisation as different to enclosed institutional care, but panopticism still applies because of the disciplinary means that constitute such an apparatus of service in community settings.

In order for political power to be exercised it has to utilise an instrument of constant, '*...permanent, exhaustive, omnipresent surveillance, capable of making all visible, as long as it could itself remain invisible. It had to be like a faceless gaze that transformed the whole social body into a field of perception...*' (Foucault 1977, p214); as well as recording all the observations into writing and the keeping of records of the individualised data. The documentation in aged care is analysed and then further utilised to impose additional controls or instruments to make changes that will primarily benefit the government's technological and economical interests.

'Discipline' may be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology. (Foucault 1977, p215)

Aged care in Australia, as one such discipline, uses technological means to achieve the ends of cost effective care for the dependent elderly population. The disciplinary nature of the industry as a panoptic system has become self regulating, self examining, and self governing under the instrumentations that have become normalised through punitive and judicial strategies. Nursing has been complicit in this system constructed by the dominating discourses, however, as will be argued - this has been to the detriment of nursing and nursing care for persons in residential aged care facilities and, therefore, their quality of life.

Disciplinary Societies

Disciplines can be run by state apparatus or non-government organisations and their function is to ensure that the discipline reigns over a society or a group of persons. Foucault (1977, 1994a) discusses the formation of the disciplinary society along broad processes that are economic, juridico-political, and scientific. All these processes apply to residential aged care with the impetus for reform being economic that then moved into the juridical and political arena, and then a scientific process of statistical analysis. This is termed the 'age of social control' that employs panoptic means of supervision and correction that are fundamental

to the power relations existing in the disciplines and disciplinary societies. (Foucault 1994a)

In economic terms the exercise of power is to be established with the lowest possible cost, and then to extend and intensify it, and link the economic growth of power with the output of services. Politically, the exercise of power manages any resistance by discretionary measures and techniques that make possible the ability to control a multiplicity of individuals and a number of production apparatus or services leading to compliance. In this calculated technology of subjectivation, the accumulation of individual persons and the accumulation of capital cannot be separated – each makes the other possible and necessary and residential aged care is the case in point. (Foucault 1977)

The panoptic modality of power is not independent from the juridical and political structures of society. In the formation of disciplines the darker side of processes could unfold and so liberalism or liberties, rights and freedoms, also play a role in the formation of disciplines. (Foucault 1977) *'The Enlightenment, which discovered the liberties, also invented the disciplines.'* (Foucault 1977, p222). The juridical form guarantees a system of rights that are egalitarian in principle and this becomes the rationale for further examination and panopticism. This would apply to the government's response to provide extra funds for wage parity and employing an appropriate skill mix on condition that financial records were surrendered and participation would be required for further data collection by the government. When questions are raised about the quality of nursing care, the government responds with the assurances that the accreditation processes and complaint mechanisms satisfactorily deal with any issues surrounding the quality of care in aged care (CofA 2002f).

In discussing panopticism Foucault (1977) makes the point that the formation of knowledge and power regularly reinforces each other in a circular process. Within apparatus, any mechanism and subject can become the focus of objectification and this in turn can be used as an instrument of subjectivation; and the increase in powers of observation can further produce branches of possible knowledge and transformation. Thus, from the eighteenth century until the present

the techniques of discipline and examination have joined with the juridical investigation. The individual, organisation, or body of individuals who are placed under observation such as residents, facilities, and the nursing staff in aged care, are an extension of justice acting on the body that is imbued with disciplinary methods and examination procedures for control of that body. (Foucault 1977)

Foucault (1977) uses the prison as an exemplar of the formation of what he terms 'complete and austere institutions' in disciplinary societies. An institution is created through the social body using '*... procedures of distributing individuals, fixing them in space, classifying them, extracting from them the maximum in time and forces, training their bodies, coding their continuous behaviour, maintaining them in perfect visibility, forming around them an apparatus of observation, registration and recording, constituting on them a body of knowledge that is accumulated and centralised. The general form of an apparatus intended to render individuals docile and useful, by means of precise work upon their bodies...*' (Foucault 1977, p231) This description applies to residential aged care institutions where all of the disciplinary mechanisms above have been implemented and are flourishing. The aim and its effect cause the docile bodies (the resident, the staff, and the institution) to be deprived of liberties, isolated, and transformed. As for the nursing labour in aged care, it is made distinct through examination and becomes an agent for the cost effective delivery of care that increasingly provides a minimum standard of care with a minimum of human resources.

And, for this operation, the carceral apparatus has recourse to three great schemata: the politico-moral schema of individual isolation and hierarchy; the economic model of force applied to compulsory work; the technico-medical model of cure and normalization. The cell, the workshop, the hospital. (Foucault 1977, p248)

Within residential aged care, as within a prison, the use of inspection, surveillance, and panoptic means is inherently necessary, and becomes so through a system of individualising and documentation. The advent of computer technology has added another dimension to this microscopic mapping, detailing, and observation of individuals in residential aged care.

According to Foucault (1977) the formation of illegalities for governments and other institutions have been constituted to reinforce the system. Illegalities develop out of the environment or context they emanate from and are likened to a reaction to the system in place. In aged care one can view the resident as having delinquent qualities as an institutional product, and also the staff performing illegalities that are produced by the system's control. The more restrictive the legislation, the more illegalities will form and any struggle for justice is thus increased. Delinquency and recidivism are products of the penal system or any punitive system and can be expressed as 'illegalities' that are useful as a reason for further examination and control, and are born out of the system in order to support it. Delinquents or illegalities can be specified and an organisation is an instrument for administering and exploiting illegalities through surveillance and documentation. Foucault (1977) acknowledges the role of class and marginalisation in delinquency and illegalities. The prison fails to eliminate crime but succeeds in producing delinquents or illegalities, which in turn can be useful for society in producing the delinquent as a pathologised examined subject. If the qualities of being a delinquent are transposed into residential aged care one can envisage the residents in some way rebelling or resisting the system, and this could also apply to the relatives, nursing staff, or others and these resistances or illegalities could be manifested in a number of ways.

A good 'penitential condition' is formed from a number of principles or fundamental propositions namely correction, classification, modulation of penalties, work as an obligation and right, education and training, technical supervision, and auxiliary institutions attached for the purposes of surveillance and support. The application of ever more discipline, observation, surveillance, and subjectivation will in turn produce more delinquency, resistance, conflict, and struggle. It is in the struggles, dissonance, conflicts, and resistances that Foucault views research needs to focus. (Foucault 1977) All of these principles are present in residential aged care, as described in the previous two chapters. In the discourse analysis of this thesis it is the contradictions, differences, and illegalities in the nursing care discourses that are examined at the micro level.

The Carceral

The carceral nature of the prison has spread historically into every thread of society through its organisations, institutions, disciplines, corporations, and governments. The disciplinary nature of institutions has permeated far and wide to the extent of a meta-confinement in society termed 'the carceral' or the 'carceral archipelago' in Western societies. The classical form of confinement is homogenisation with disciplining and punitive means creating a 'carceral continuum', which incorporates penal practices and disciplinary techniques into the most innocent of disciplines and practices, along with the society as a whole. (Foucault 1977)

...the carceral texture of society assures both the real capture of the body and is perpetual observation; it is by its very nature, the apparatus of punishment that conforms most completely to the new economy of power and the instrument for the formation of knowledge that this very economy needs. Its panoptic functioning enables it to play this double role. By virtue of its methods of fixing, dividing, recording, it has been one of the simplest, crudest, also most concrete, but perhaps most indispensable conditions for the development of this immense activity of examination that has objectified human behaviour. (Foucault 1977, pp304-5)

Residential aged care is one such discipline enveloped in a carceral society, whereby all the ingredients that make up this phenomenon are apparent in the subjectivation, surveillance, examination, classification, scrutiny, documentation, regulation, and penalty present in society in general, and specifically in the aged care industry.

But, in its function, the power to punish is not essentially different from that of curing or educating... The carceral 'naturalizes' the legal power to punish, as it 'legalizes' the technical power to discipline. ...it becomes natural and acceptable to be punished. (Foucault 1977, p303)

Foucault (1977) views this carceral archipelago as diffusing into all aspects of the social body leading to junctures where there is normalisation, docility, and acceptance.

In summary, from an historical perspective residential aged care is identified as a discipline in a carceral continuum with its effect being one of normalisation of

nursing care of the residents through the subjectivation of the residents, the labour force, and the industry. It is a discipline within a panoptic realm that utilises examination, observation, surveillance, and recording as the means of control over individuals who are objectified through gazes. The information these gazes produce for the government constitute or contribute to knowledge about each individual resident, the workforce, and organisations. Therefore, in the relative totalisation of them all, this knowledge power is exerted and keeps the bodies in the system (residents, nursing staff, and the facility) docile or compliant. The homogenisation and hegemony is constituted by panoptic means by the discipline through the subjectivation of individuals relative to all other individuals in their population. In the case of this thesis the gazes are on the residents, the workforce, and the facility as an analysis.

Within disciplines, the power relations between state and the body are exerted through individualisation that is totalitarian in outcome and interest. Any compliance or submission and any repression or domination is related to the 'truth' production according to the dominant paradigm. Inevitably, individuals and texts have differing gazes and differing positionings that will inevitably produce gaps, discontinuities, and conflicts. There are positive aspects to these from a carceral perspective in that the differences can be productive in leading to transformation and change that can be either negative or positive, or both.

Although residential aged care can be likened to any other discipline in the carceral society that uses panoptic means, Foucault's later works focus on the governmentality and the ethico-epistemologico-political nexus in any discourse about any practice according to the discontinuities in the discourses, and what has been repressed. In the next chapters these concepts are discussed as they relate to residential aged care provision. The next chapter focuses on the 'art of government' in the governing of the conduct of others on behalf of a civil society. The focus of this thesis is the art of governing residential aged care and, therefore, the nursing practices and discourses regarding the nursing care therein. The previous three chapters have discussed the reforms, reviews, and discipline as related to residential aged care. The discourse analysis relates the findings about nursing practice in aged care to the system's governmentality.

Chapter 5

THE GOVERNMENTALITY OF RESIDENTIAL AGED CARE

This chapter discusses the philosophy of Foucault about the ethical, epistemological, and political nexus of individual relations in any society or discipline that is carceral by nature, and is governed. He particularly focuses on government as the state, as well as the individuals who live, work, and are cared for by the state in any given system, such as aged care in Australia. The concept of governmentality is applied to the governing or governance of residential aged care that is controlled and regulated by federal regulation and legislation. A number of concepts in Foucauldian theoretical development are described in the following, as well as the direction for the type of research he believed needs undertaking into any practice - in any discipline. This consequently leads into discourse analysis in determining what needs to be analysed or what research should focus on in the discourses. As discourse analysis is used in this thesis, it is necessary to articulate what this means from the perspective of discontinuity in any practice, such as nursing in residential aged care.

Political Technology of the Self

Foucault (1994m) emphasises that humans are thinking beings who have a 'political technology' and this can be problematic because of the rationales used by government, which he terms the 'reason of state', the techniques and instruments in use, and the policing or examining that occurs. The state has its own rationality, but so too do individuals, however, it is the individuals who make up and reinforce the state. The individual lives, works, produces, consumes, and dies within the state and, as such, individuals are policed and the population is protected and cared for. He views the constant relationship between the individual and the state as necessary to the state itself and terms this the political technology of the individual that is constituted and played out by all individuals with the state. (Foucault 1994m)

Individuals as part of the state are subject to orders with the aim of social order; but the opposite is also possible and necessary in that individuals and the state are also subject to disorders or conflicts, which aims for social disorder. Foucault's philosophical interest lies in these disorders, conflicts, discontinuities, or illegalities that occur between individuals in practice in any state or discipline. This is articulated as the political technology of the self, whereby individuals within are complicit or dissonant and form part of the state and disciplines in carceral societies. (Foucault 1994n)

Any discipline within the state, such as residential aged care, is composed of individuals who comply; but at the same time have the potential to create dissonance. Foucault (1994f) makes a clear distinction between those who are governed and those who govern the governed, which is structurally hierarchical in its nature between the state, the discipline, and the individuals. Foucault's later works explore the relationship one has to oneself from an aesthetic and ethical stance. There are epistemological consequences of these political technologies of the self that are evident in order and 'disorders'. Any question, practice, or discourse will have ethical, epistemological, and political aspects enmeshed in it. (Foucault 1984d)

It is the contention of this thesis that nursing practice has many disorders and disassociations that have a potential ethical, epistemological, and political transformation within them. By studying these 'discontinuities' in the nursing practice discourses, the ethico-empistemo-politico question about nursing practice in residential aged care can be discussed by making the problems relating to nursing practice overt and, therefore, truly transparent. This is relevant to aged care provision in that a residential aged care facility is in institution that must meet standards and comply with regulations held in place by the federal law. The discontinuities between individuals and the state are prominent around nursing care provision and the perceived nursing care needs of residents, which will be described through the data in chapters 8, 9, and 10 of this thesis.

The Art of Government

Foucault's (1994d) notion of governmentality in his work on the government rationality in Western culture, questions the ways governments function, or conversely - dysfunction. This is termed as a 'zone' of research and encompasses studying the practices of government through the power relations and agonistic tactics or strategies that occur in practice. The question of government is also termed to be 'the problematic of government'. (Foucault 1994d) The interest for research is in the techniques used by governments for control and coercion to govern individuals and guide their conduct – whether a school, army, workshop, or as in this thesis, a residential aged care facility (Foucault 1984d). His concern around industrial states is twofold in that there are rationales, technical procedures, and instrumentations for any given state (the policing); but also 'strategic games', which are perilous to the state in that they may give rise to instability. (Foucault 1984d) There is always the possibility of resistance and revolt, or discontinuities, which lead to change, different knowledges, and relations that affect transformation.

Through the term governmentality, the interest becomes the conduct of a person or persons and the activities they undertake - that in turn aim to shape or direct the conduct of individuals in what Foucault terms the art of governing oneself and of governing others. The tendency is for 'a government of all and of each'. The total of individuals as the discipline will use individualisation as a means to a totalising effect - or to totalitarian states at the government level.

Very significantly, political criticism has reproached the state with being simultaneously a factor for individualization and a totalitarian principle. Just to look at nascent state rationality, just to see what is first policing project was, makes it clear that, right from the start, the state is both individualizing and totalitarian. Opposing the individual and his interest to it is just as hazardous as opposing it with the community and its requirements. (Foucault 1994g, p325)

Political rationality has grown and imposed itself all throughout the history of Western societies. It first took its stand on the idea of pastoral power, then on that of reason of state. Its inevitable effects are both individualization and totalization. Liberation can come only from attacking not just one of these two effects but political rationality's very roots. (Foucault 1994g, p325)

... the state's power... is both an individualizing and a totalizing form of power. (Rabinow 1984, p14; Foucault 1994h, p332)

Each and all, and each in relation to all. (Foucault 1994p, p444)

There are different levels of governance being the individual, the family or community, the disciplines, and the state (Foucault 1994d). The aim of government is to establish, as part of the social order, a continuity that is both upward and downward. The art of government is intertwined with political and economic sciences and its development has been increasingly influenced by the introduction of the economy into services – as is the case in aged care. The essence of government is the art of exercising power on the basis of economy - the rationale behind all governments - whilst at the same time maintaining social order, or in this case providing for the dependent elderly. Governments aim for the 'right manner of disposing of things' in the most convenient, efficient, and cost effective way, as do organisations. (Foucault 1994d)

The art of government and empirical knowledge of the state's resources and condition – its statistics – together formed the major components of a new political rationality. A rationality, Foucault assures us, from which we have not yet emerged. (Rabinow 1984, p16)

Given that the federal government in Australia has rhetoric of governance in regard to the management of residential aged care, the notion of Foucault's governmentality becomes relevant. Governmentality is summarised by the convergence of three entities namely the government, the population as the body for interventions, and the political economy. Foucault explains the term governmentality historically in the following in that it is:

1. The ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security.
2. The tendency that, over a long period and throughout the West, has steadily led toward the pre-eminence over all other forms (sovereignty, discipline, and so on) of this type of power – which may be termed "government" – resulting, on the one hand, in the formation of a whole series of specific

governmental apparatuses, and, on the other, in the development of a whole complex of knowledges (savoirs).

3. The process or, rather, the result of the process through which the state of justice of the Middle Ages transformed into the administrative state during the fifteenth and sixteenth centuries and gradually becomes “governmentalized”. (Foucault 1994d, pp219-220)

The concept of ‘governmentality’ is synonymous with the residential aged care system that is regulated by the federal government through instrumental means. The government uses instruments and agents of examination, categorisation, and surveillance within an economic sphere. By describing historical junctures, Foucault recounts the great states, as disciplines, that have permeated contemporary Western society starting with: the ‘state of justice’ leading to laws and a juridical system; which then became an ‘administrative state’ using regulations and disciplinary means; and finally, became a ‘state of government’ grounded in the population and resorting to the ‘instrumentality of economic knowledge’ - controlled by apparatus of security through policing. (Foucault 1994d)

The new ‘pastoral power’ in the ‘modern state’ is ‘... *a very sophisticated structure in which individuals can be integrated, under one condition: that this individuality would be shaped in a new form, and submitted to a set of very specific patterns... the state as a modern matrix of individualization.*’ (Foucault 1994h, p334). This individualising tactic is a means of power over the individual, or ‘*the simultaneous individualization and totalization of modern power structures*’ (Foucault 1994h, p336). As described in chapters 2 and 3 of this thesis, the aged care system has simultaneously individualised residents through categorisation and policing of the industry, and this has produced a totalitarian situation, whereby all residents of aged care facilities in Australia have been categorised, standardised, regulated, and policed as subjective individuals. Nursing staff and nursing practice in these institutions has also been transformed through disciplinary means employed by the government, as has the industry, the organisations, and individuals within it.

Gordon (1991, 1994) implies Foucault has extended our capacity for suspicion, vigilance, and doubt about governmentality. He states Foucault's aim is to stimulate reflection and action leading to transformation of thought and action as an open dialogue between the government and the governed - through what is termed 'the manifestation of truth'. (Gordon 1991, 1994) Foucault also terms a 'political spirituality' where he envisages a new foundation of 'governing oneself and others' through practices that use different ways of dividing up true and false from an ethical and moral perspective (Foucault 1994e). Foucault's work is extended further under a social justice framework in the area of the relations of power created by legitimation, law, and the language of 'rights'.

The language of rights serves the political aims and also determines control and how power is exercised. However, this language of rights also offers up to those who are governed - the terms and conditions by which any system, such as residential aged care, can be challenged. (Gordon 1994). This thesis challenges the governmentality of the aged care system in regard to the legislated right of each and every resident to an appropriate level of quality care (CofA 1997) that has been downgraded to an entitlement of an appropriate standard of care according to needs with no acknowledgement of the need for nursing care (CofA 2001c). There is no specific component referring to the quality of nursing care and this thesis questions what might and might not be an appropriate standard of nursing care - the level being dependent on the knowledge development and the education of those actually providing the nursing care, who are non-nurses.

Savoir and Connaissance

Nursing is a practice based profession requiring education, training, and experience and this fits well in what are termed *savoir* and *connaissance*. Foucauldian interest is in the role of knowledges at the practical level and the term *savoir* or knowledge with 'know-how' for any practice context is described and sits well with nursing. He also terms *connaissance* as 'the work in order to know' – the experiential learning and knowledge formation. It is the domain of possible recognitions within a discipline and there are also 'epistemes' or knowledges that

allow governing to occur and the governed to be governed. These workings and mechanisms of knowledge are expressed through relations of power that determine the dominating truth. (Foucault 1984d) As Foucault explains:

I use the word “*savoir*” (“knowledge”) while drawing a distinction between it and the word “*connaissance*” (“knowledge”). I see “*savoir*” as a process by which the subject undergoes a modification through the very things that one knows (*connait*) or, rather, in the course of the work that one does in order to know. It is what enables one both to modify the subject and to construct the object. *Connaissance* is the work that makes it possible to multiply the knowable objects, to manifest their intelligibility, to understand their rationality, while maintaining the fixity of the inquiring subject. (Foucault 1994f, p256)

An individual’s rationality and truth is based on their specific knowledge and the power relations in play at the time. In this thesis, these concepts are used to illuminate and highlight the application of these terms to what is known in nursing as nursing praxis or knowledgeable nursing actions.

Any discipline, such as the residential aged care system in Australia, is composed of organisations using technical, administrative, juridical, and medical apparatus that aim to take care of the dependent elderly, the criminal, or the mentally ill. Governments also aim to take control of these organisations and populations, as well as the labour force in these services. Residential aged care has organisations within the discipline that aim to care for the dependent elderly whilst at the same time also controlling the labour force for their bottom lines. Foucault (1984d) states there is a third element of any practice that involves the definition of relations to the self and others as possible subjects - defined as the ethical perspective of individuals or groups of individuals. This ethical perspective is actioned by compliance or dissonance, and together with the power relations, will determine the outcome of which discourse dominates leading to docility and a normalisation of the practice according to the dominant discourse.

The *savoir* determined by the practice field may not meet rigor in the scientific paradigm, but it is dominated by discourses of ratification and validation through instrumental means that are determined by the government to be of measurable benefit and efficacious (Gordon 1994). Foucault’s interest is in analysing power

‘from below’ or in the practice field that allows, supports, constitutes, and constructs domination and power relations (Foucault 1994e, 1994h). This is described as being like ‘capillary networks’ or ‘circuits of power relationships’ that involve moral choices by individuals (Gordon 1994). The analysis at the micro level of power relations in the field of nursing practice in residential aged care is important. Research focuses on the conduction of others according to the governmentality, and analysis is focussed at the point of power relations in play for the practice – at the practice level. The micro power relations are identified not only in the dissenting counter conducts, conflicts, illegalities, or antagonisms (agonisms) - but also in the normalisation of practices, compliance, and silence of other ‘truths’ to the domination present in that practice.

Questioning The Truth

According to Foucault the researcher needs to question what truths have been constituted in any practice, such as nursing in residential aged care. This thesis explicates the construct of nursing care in these facilities where antagonisms and discontinuities are analysed from the data about the practice. Nursing provision has political influences upon it, as well as the necessary knowledge (savoir) to practice (connaissance) as nursing praxis. In the political, epistemological, and ethical nexus of what is nursing practice in residential aged care, chapters 8, 9, and 10 will demonstrate that the questioning of these truths for nursing care - from the aspect of conflicts and contradictions revealed in the discourses - has been a worthwhile way to approach data analysis. To reinforce this, Foucault provides the following explanation of an approach to research and questioning.

The work of an intellectual is not to form the political will of others; it is, through the analyses he (sic) does in his (sic) own domains, to bring assumptions and things taken for granted again into question, to shake habits, ways of acting and thinking, to dispel the familiarity of the accepted, to take the measure of rules and institutions and, starting from that re-problemization (sic) (where he plays his specific role as intellectual) to take part in the formation of a political will (where he has his role to play as citizen). (Foucault cited in Gordon 1994, pxxxiv)

Despite the consistent and continual conflicts and recommendations around the nursing care provision in residential aged care, the government has determined another truth concerning what is nursing and the quality of nursing care residents receive backed up by statistics, accreditation, rights, and complaint mechanisms as described previously. The following statement describes a danger when governments profess or prescribe a 'truth' such as what has occurred with nursing in residential aged care.

... nothing is more untenable than a political regime which is indifferent to truth; but nothing is more dangerous than a political system that claims to prescribe the truth. The function of 'truth telling' is not made to take the form of a law, just as it would be vain to imagine that it inhabits, as of right, the spontaneous play of communication. The task of truth telling is an endless work: respecting it in its complexity is an obligation no power can dispense with. Unless to impose the silence of servitude. (Foucault cited in Gordon 1994, p xxxix-x)

Questions are asked about nursing care practices in residential aged care and how these have been constructed and transformed through the governmentality of the aged care system. The conduct of nursing practice is questioned and analysed from differing individual perspectives with the aim of teasing out the knowledges in use, and how one truth about nursing care practice is accepted over another.

Foucault (1994g) does not aim to 'solve a problem' but suggests a way to 'approach a problem' through questioning relations between experiences and the power yielded. The resident who requires nursing care in an aged care facility (institution) is to be inserted into the following description of 'problematizing' relations in the realm of being aged and dependent and nursing is to be likened with the professions.

...this problem deals with the relations between experiences (like madness, illness, transgression of laws, sexuality, self-identity), knowledge (like psychiatry, medicine, criminology, sexology, psychology), and power (such as the power wielded in psychiatric and penal institutions, and in all other institutions that deal with individual control)

...Our civilization has developed the most complex system of knowledge, the most sophisticated structures of power. What has this kind of knowledge, this type of power made of us? In what way are those fundamental experiences of madness, suffering, death, crime, desire, individuality connected – even if we are not aware of

it – with knowledge and power? I am sure I'll never get the answer; but that does not mean that we don't have to ask the question. (Foucault 1994g, p311)

This thesis aims to analyse discourses about the nursing care of highly dependent residents in an aged care facility in order to determine what knowledges are in use to ascertain nursing care needs and guide nursing practices. The connection between the experiences of residential aged nursing care from the residents and relatives perspectives; the knowledge used by nursing care staff; the power relations created (between the government, agencies, staff, relatives, and residents), and the documentation - all have an effect on the quality of nursing care in these institutions. The object under study is nursing in residential aged care and where the discourses contradict each other, and where they verify each other. To accomplish knowledge about any given practice and to determine the factors that impinge upon the practice is to undertake research focussed at the micro level in the field, as grounded research.

Grounded Research

Research in the field at a micro level will give rise to the truths that are being affected by the governmentality in use. When writing about philosophy in general, Foucault's belief is that the use of rationalisations and rationalistic explanations of existence and governing lead to excessive powers called the 'political rationality'. His interest lies in this link between rationalisation and power. Rather than look at the 'big picture' he views research as much more useful when done in the field at the detailed level, as this grounds the analysis. He contends that this will explicate what type of rationality people, such as non-nurses, use in the field whose rational explanations have been formed and constructed for them. An individual's knowledge and rationale for practice is constituted, in part or in whole, by disciplinary means used by governments or states. (Foucault 1994g)

...the target of analysis wasn't "institutions", "theories", or "ideology" but *practices* – with the aim of grasping the conditions that make these acceptable at a given moment; the hypothesis being that these types of practice are not just governed by institutions, prescribed by ideologies, guided by pragmatic circumstances – whatever role these elements may actually play – but, up to a point, possess their own specific regularities, logic, strategy, self-

evidence, and “reason”. It is a question of analyzing a “regime of practices” – practices being understood here as places where what is said and what is done, rules imposed and reason given, the planned and the taken-for-granted meet and interconnect. To analyze “regimes of practices” means to analyze programs of conduct that have both prescriptive effects regarding what is to be done (effects of “jurisdiction”) and codifying effects regarding what is to be known (effects of “veridiction”). (Foucault 1994e, p225)

It is at this nursing practice level of individual residents and those providing nursing care that this thesis directs its questioning of nursing and how this may have been constructed and transformed by the governmentality and the veridiction implicit in the residential aged care system. The political rationality is exposed through the explanations and evidence concerning the nursing care the residents under study received.

Pastorship

The technologies of power with and in the state are described as the centralising power being a ‘pastorship’ with the individualising power opposite to this but intricately linked to it (Foucault 1994g). The individual against and within the state, and according to Foucault the role of philosophy is to *‘keep watch over the excessive powers of political rationality’* or *‘the new economy of power relations’* (Foucault 1994h, p328). The notion of pastorship in Western societies has developed and results from certain political technologies and it is the politician or minister who plays the role of ‘pastor’ or ‘shepherd’ of the many, becoming an agent of the state.

This pastoral technology has developed to manage individuals within a given society or population (Foucault 1994g). The relation between the one and the many (the individual and the collective) and the political problems concerning the lives of the individuals and the unity of the society provides the rationality that will *‘...ensure, sustain, and the improve the lives of each and every one.’* (Foucault 1994g, p307). Governmental techniques are adjustments made between *‘...political power wielded over legal subjects and pastoral power wielded over live individuals.’* (Foucault 1994g, p307; 1994h). Pastoral power is a power

technique or strategy originating in Christianity and it is linked to the production of truth for an individual (Foucault 1994h). Foucault furthers this notion of pastorship prevalent today identified in the government of individuals extended by their own 'verity' (Foucault 1994g). In other words the governed can be governed because of their individual rationalisations of what the 'truth' is for them, known as veridiction or 'what is to be known' by them. This is applied to the nursing staff as the authority concerning the nursing care the residents receive in residential aged care.

Truths are produced with the aim being to reinforce the state itself and there are always problems with what is termed 'truth'. What interests Foucauldian theory is the relationship between the political organisation and the mechanisms (rationalisations) it uses to control itself and individuals to produce truths. (Foucault 1994g) The type of rationality used in residential aged care that exercises the power of the state to determine the nursing care and who will provide that care in the interest of the state is the focus of this thesis. Chapters 2 and 3 allude to what the government allows to be known in the discipline of aged care and the practice of nursing, and this is explicated as having a type of pastorship between the state and the individuals (the residents and the labour force), as well as the state, the aged care industry, and the nursing profession.

Policing

Knowledge is necessary to exercise state power and hence the art of governing is tied to statistics or measurements and the term 'police' becomes a governmental technology that gathers 'concrete, precise and measured knowledge' to live in an ordered and unified society (Foucault 1994g). Government employs panoptic means through policing to provide further knowledge with which extended power that can then be exerted whether for economic, political, or societal ends. Foucault maintains, however, that there are only reciprocal relationships that act to reinforce one another. Reciprocal relationships also have the potential to create 'gaps' or differences between the intentions of individuals and the state in their symbiotic relationship to one another. (Foucault 1984a) It is argued policing and

conformity have become normalised in residential aged care with one such reciprocal relationship between the government and the industry; however, the differences are highlighted through the relationships at the individual resident level. The residents who participated in this study who were accommodated in residential aged care and required nursing care received this care within a nursing relationship.

The industry and the residents, as well as individuals working in aged care, enter into a reciprocal arrangement with the government of policing, which reinforces the state's control over the system, institutions, labour force, and residents. Governmental rationality eventually becomes one of a system that is able to self-regulate through pastor type relationships, policing techniques, and instrumental means using surveillance, statistics, and classification. Everything is able to be controlled and becomes self-regulating eventually with little interference by the government. (Foucault 1984a) Residential aged care has become largely self-governing and compliant in this aged care system of pastorship, policing, surveillance, and categorisation because of the symbiotic relationship between the state and the industry that has silenced nursing.

Foucault asks the question: 'How is government possible?' and his explanation is an 'idea' of society, whereby the culture of a society or its organisation will influence its rationality. If a society is capable of conformity and proper conduct, it is also capable of revolt and misconduct and that this has an effect on outcomes. Individuals who are being governed within a society have their own reality or truth and there are infinite opportunities for resistance and conflict. (Foucault 1984a) As will be demonstrated in chapters 8, 9, and 10 there are many examples of compliance and resistance present in the discourses surrounding the nursing care of the residents in this study.

Direction for Research

Foucault (1994g) directs research into an historical analysis of governmentality based on two assumptions. Firstly, power is a relation between individuals who

can be subjugated by other individuals or organisations and there is no power without the potential of dissent or revolt. Secondly, the governmentality of individuals by individuals or institutions has a certain rationality involving power relations. (Foucault 1994g) Research and questions are directed to the rationalities evident and the dissonances or conflict in these rationalities. Foucault states his ideas are neither a theory nor a methodology, but he questions how subjects are made of individuals through a means of objectification through their subjectivation. This 'objectivising' happens through 'dividing practices' by labelling or categorisation, for example, the sick and the healthy, RCS category 1 or 8, and the nurse and the non-nurse. How persons turn themselves and are turned into subjects is of interest in this study. It is useful to analyse individuals, - residents, nurses, and non-nurses - where power acts on them in the field, rather than an analysis of the dominating paradigm or a complex governing system. By studying the micro, the macro can be revealed. (Foucault 1984a, 1994h)

The focus of this thesis are the residents whom power passes over and their nursing care, as subjects who are objectified through subjectivation, and whose quality of life is dominated by the system, the industry, the organisation, and the nursing staff. The residents, relatives, and nursing staff are the players in the field through their discourses about nursing care for the residents. The data is analysed using the search for resistance, conflict, and dissonances in the nursing discourses and rationales surrounding the residents at the micro level, which is then related to the macro system of aged care in Australia. As Foucault explains about analysis:

It consists in taking the forms of resistance against different forms of power as a starting point. To use another metaphor, it consists in using this resistance as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies. (Foucault 1994h, p329)

Forms of resistance, struggles, illegalities, deviance, and attempts of dissociation of power relations require analysis (Foucault 1994h). These struggles are viewed as techniques, instruments, or forms of power that resist domination, exploitation, conformity, submission, or subjection to the governmentality of any system. By

focussing on the residents' nursing care the antagonisms of strategies or 'agonisms' are analysed and them problematised.

There are three types of relationships according to Foucault that support, have reciprocal relations, and mutually use one another. These are relationships of communication, power relations (divisions of labour), and goal-directed activities (hierarchy of tasks). These regulated systems and the adjustments are very diverse but whatever the system, the diverse relationships end up in a model, such as the one that exists in residential aged care. Foucault discusses 'blocks' that constitute a system that include the disposal of space (residential aged care facilities); regulations that govern the internal life (The Aged Care Act 1997); the organisation of activities (nursing care and documentation), and the individuals who live or work there (residents and nursing staff). All these constitute a 'block of capacity-communication-power'. (Foucault 1994h)

These blocks, in which the deployment of technical capacities, the game of communications, and the relationships of power are adjusted to one another according to considered formulae, constitute what one might call, enlarging a little the sense of the word, "disciplines". (Foucault 1994h, p339)

In residential aged care enclosure, surveillance, penalty, and hierarchy are all controlled through disciplinary mechanisms that influence the activities, tasks, technologies, capacities, communications, and power relations on the ground. As high care residential aged care facilities provide in the main nursing care, then questioning the nursing care for residents as to the nursing activities, perceptions, tasks, mechanisms, technologies, capacities, communications, and power relations is deemed relevant - given the dependence of the residents on nursing care in the determination of their quality of life.

The theme of power requires analysis as to the 'how' because power relations are linked to capacities and communications. Power relations or the exercising of power is described as 'the way in which some act on others' and this can be either individually or collectively. Power from this view is not a matter of consent or consensus, but is described as actions upon the actions of others and this

exercising of power results in either compliance or dissent. (Foucault 1994h) The following describes how the exercising of power is important in that:

... it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions. (Foucault 1994h, p341)

The notions of conducting and controlling the actions of others and the exercising of power are a matter of governmentality and Foucault (1984a) argues that the interconnections of power relations rather than dominations are the areas of study that will explicate the rationalities in use in any practice.

In regard to liberty and liberal thinking, the relationship between freedom and power is inseparable as power cannot be exerted unless there is freedom and together with this, the possibility of provocation, therefore, freedom and choice cannot be assured by the state, even though government rhetoric is one of 'choices' in aged care provision.

At the very heart of the power relationship, and constantly provoking it, are the recalcitrance of the will and the intransigence of freedom. Rather than speaking of an essential antagonism, it would be better to speak of an "agonism"³ – of a relationship that is at the same time mutual incitement and struggle; less of a face-to-face confrontation that paralyzes (sic) both sides than a permanent provocation. (Foucault 1994h, p342)

Foucault (1994h) contends that even though institutions are the embodiment and crystallisation of power relations the organisations are too complex and complicated to research. He states that analysis, elaboration, and questioning about the agonisms as political undertakings that occur in the field of practice are what require exploration in order to explicate the effects of the system of control on that practice.

Central to the contention that power relations have been progressively governmentalised are the mechanisms where power relations are elaborated, standardised, regulated, rationalised, and centralised as state institutions. The analysis of power relations demands the following points to be considered: the

system of differentiations or differences; the types of objectives pursued; the instrumental modes; the forms of institutionalisation; and the degrees of rationalisation. (Foucault 1994h) As such, this thesis focuses on the differences in the discourses about the nursing care, the residents' quality of life, the documentation about the resident and their nursing care, the perceptions of nursing staff on the residents' nursing care needs, and the rationalities given for the nursing practices.

Strategies

All statements and discourses have attached to them what Foucault describes as tactics and strategies. These strategies, how discourses are built up or discarded, form a political nexus along with knowledge or truth. As well as these, there is an ethical component of any practice or discourse.

... that which implies that one can define the general set of rules that govern the status of these statements, the way in which they are institutionalized, received, used, re-used, combined together, the mode according to which they become objects of appropriation, instruments for desire or interest, elements for a strategy. (Foucault 1972, p115)

All discourses have a political, an epistemological, and an ethical intent and form. Foucault (1994q) takes a theoretical ethical stance in opposition to the strategist, in that his interest lies in revolts, resistances, and violations of any given situation in the practice field of an institution or discipline. A critical analysis according to Foucault (1994r) consists of analysing the assumptions, familiar notions, established, and unexamined ways of thinking on which any practice is based and which also determines what truths are to be known (or not known). The taken for granted practices and policies, such as the documentation in residential aged care.

It does not matter whether a text is written or oral – the problem is whether or not the discourse in question gives access to truth. (Foucault 1984e, p363)

Foucault (1994k) asks the following questions from his ethical stance on what he terms *'the technology of the self' that is at once political, epistemological, and ethical: 'What are we in our actuality? What are we today? What are the relationships between our thought and our practices? How have we constituted*

ourselves?' (Foucault 1994k, pp403-404). In this thesis, further to these questions asked of nursing practice in residential aged care is the question: How has nursing practice been constituted by others (chapters 8, 9, and 10) and the state (chapters 2 and 3). The actual nursing practice and the rationales behind that practice are examined and deemed important for the residents in receipt of nursing in residential aged care and also to the nursing profession. The analysis of the nursing care discourses from the field uncovered themes in constant contradiction to each other, as well as being inconsistent with evidence based nursing practice and quality nursing care, hence the resident's quality of life.

The mechanisms in play as power relations are strategies for achieving ends through conducting others activities - resulting in insubordination or domination. This may induce complacency, antagonistic reactions, impotence, or confrontations, but any point or juncture of an adversarial nature or disparity there is an opportunity for analysis, transformation, and change and that this is perpetual. (Foucault 1994h) Discourse is described as being *'both an instrument and an effect of power; but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy'* (Foucault 1994h, p101). Discourse becomes dominant or it acts as a contradiction and then it is in conflict. Any point of resistance becomes a basis for change or a new starting point for transformation to occur. Within the same strategy there can be contradictory discourses, as well as comparative facts. (Foucault 1972, 1976)

The relationship of the individual to the state foresees the following scenario about security and services, and if applied to residential aged care there may be some cause for concern, especially in the extreme case:

Today a problem of limits intervenes. What is at stake is no longer the equal access of all to security but, rather, the infinite access of each to a certain number of possible benefits. We tell people: "you cannot consume indefinitely." And when the authorities claim, "You no longer have a right to that," or "You will no longer be covered for such operations," or yet again, "You will pay a part of the hospital fees," or in the extreme case, "It would be useless to prolong your life by three months, we are going to let you die" – then the individual begins to question the nature of his relationship to the state and starts to feel his (sic) dependency on institutions

whose power of decision he (sic) had heretofore misapprehended.
(Foucault 1994i, pp367-368)

Ethical choices and ethical problems are of paramount importance when any marginalisation or dissent occurs in any given system or practice. To only take a sociological stance is to ignore the ethical considerations that are played out at an individual level (Foucault 1994i). Power plays are continually acting out in the discourses on an object such as nursing in residential aged care, and along with this there is a constant questioning, resistance, confrontation, discontinuity, reinforcement, compliance, and exercising of law through regulations. Discourses are immersed and integral to the object under study - in this thesis nursing care in residential aged care facilities. Foucault (1972) discusses 'learned discourses' and apparatus set up to produce 'truths' and he encourages an 'analytics of power' through discourse analysis (chapters 8, 9, and 10), and the discourse's historicity (chapters 2 and 3).

In this thesis, the production of truths about nursing through the historicity of residential aged care, as well as a discourse analysis about nursing practice uncovered 'truths' that have been transformed by the governmentality of residential aged care. Foucault (1976) discusses the mobile nature of discourse and the complex nature of circumstances that give rise to discourse through strategies, mechanisms, and structures. This mobility is where discourse is transformed and where it has the capacity for transformation.

Power is exercised from innumerable points or positions. Relations of power come about because of differentiations and convergences, and also have a productive role. Manifestations are a result of forces that come from the social body as a whole. These forces bring about redistributions, realignments, homogenizations, serial arrangements and convergences and 'Major dominations are the hegemonic effects that are sustained by all these confrontations' that come from below and are forever manifold. Power is exercised through calculation and discourses are used to support power relations. Discourses are immersed in multiple and mobile (polymorphous) power relations. (Foucault 1976, pp94-98)

In summary, the crucial centre of power relations is one of an ethical, epistemological, and political nexus on the individual and state level. Although

governmentality implies control and domination in the system, the individual relations also have interconnected and symbiotic aspects to it. Through studying the agonisms, dissonances, and discontinuities in nursing practices and the rationales behind them at the micro level - the ethical, epistemological, and political nexus that constitute the 'truths' for nursing practice can be exposed. This chapter applied the concepts of governmentality as described by Foucault to the discipline of aged care and the practice of nursing. This theoretical background forms the basis of the data collection and analysis regarding the nursing care of residents in a residential aged care facility.

The political governance of aged care as it has affected and transformed nursing practice on an individual basis is elucidated in chapters 8, 9, and 10. The problematisation of the issues arising out the data that is necessary for transformation is outlined in chapter 11 according to the discourse analysis. The ethical, epistemological, and political questions inherent in any practice are applied to the practice of nursing in residential aged care, as well as Foucault's perspective on reform and change.

The following chapter focuses on discourse analysis and the methodology used under a Foucauldian philosophy that guided an analysis of junctures and discontinuities in discourses about nursing practice within an aged care facility. The aged care discipline is controlled through the governmentality of the industry, the labour force, and the residents and this is actioned through discourses about nursing practice. The next chapter describes what is meant by discourse and the methodology of discourse analysis under a Foucauldian perspective. The case study design used to collect the data at the practice level relates to the nursing care discourses for three residents accommodated in a residential aged care facility.

Chapter 6

DISCOURSE ANALYSIS METHODOLOGY

In the previous chapters, Foucault's philosophy was discussed from the perspective of the disciplines and governmentality of residential aged care. Discourse analysis is discussed in the first section of this chapter according to the direction of the analysis, and the second section explains the case study design used to collect the data in order to undertake the discourse analysis. Any system will have an affect at the ground level of any practice and the nursing care provision for residents of an aged care facility is the specific object to be analysed. This was accomplished through collecting and analysing the different discourses around the perceived nursing care needs and the nursing practices for three highly dependent residents. The interest of this thesis, guided by Foucauldian thought, is in the analysis of the agonisms, discontinuities, contradictions, and conflicts in the various discourses referring to the same practice in the specific domain of nursing.

The role of knowledge and discourse is useful and necessary to the exercising of power because they serve a practical purpose of maintaining power. It is not important whether they are true or false and analysis of discourses about knowledge for any practice is an identifiable collection of utterances or texts about the object to be known. The dominating discourse, theme, or collection of enunciations constructs what may be said, by whom, in what context, and with what effect. This is governed by disciplinary means and discourse analysis '*...casts a new and sometimes cold light on a series of modern alliances between moralization, science, and power*' (Gordon 1994, pxvi) – alliances between the ethical choices, the dominant knowledge, and the political relations. The knowledge and rationales behind nursing as a practical domain was analysed using alliances and alienations around the discourses in regard to: what knowledge was in use in nursing care provision; and where these converged and diverged, as well as how nursing was shaped and structured in its practice in residential aged care, namely, its construct.

Foucault has no methodological prescription for research and only claims to define a 'zone' of research that focuses on discursive practices that are constitutive of knowledge, power, and morals (Foucault 1972, 1991, 1994h). Central to the area of research are the relations of power/knowledge/subject identified in discourses about a given practice or discourse (Gordon 1994). In this thesis, the practices and discourses that construct knowledge or truth about nursing in residential aged care are analysed with the residents as the vehicles for the study. The methodology underpinning the discourse analysis uses a Foucauldian interpretation and to do this, his earlier works on the constitution of knowledge are explained together with how discourses or discursive formations can be analysed to explicate the power, knowledge, and ethical relations in the discourses about any given practice, such as nursing.

Archaeology of Knowledge

Foucault (1972) explains the archaeological constitution of knowledge through discourse that he claims is not a science. The aim is to find differences in discourses and constitute them as objects in order to analyse them, define them, and expose differences. Before his revelation that he had essentially studied power relations the term 'archaeology' was defined as a construct that:

...simply indicates a possible line of attack for the analysis of verbal performances: that of the statement and the archive; the determination and illumination of a domain... (Foucault 1972, p206)

Discourses are constituted by relational determinants and there are many influences on the discourses about a practice. The aim is to analyse different discursive practices within a domain – the analysis of enunciations, regularities, positivities, rules of formation, archaeological derivations, historical factors, relationships to science, social formations, documentation, and epistemological descriptions. Archaeology has the capacity to describe the different junctures of dissension, irregularities, and contradictions. The discursive formations form an archaeology through a mapping of discursive practices - their form, relations, constitution, and the domain being governed, in this case, nursing practice.

The unification of discourse about any object is accomplished by the silencing of other discourses that are contradictory to the dominant or chosen discourse. The purpose of discourse analysis is to maintain all the discourses, whether adopted or rejected, ultimately aiming to unify the discourses into one that dominates all the discourses. The act of silencing or making a certain discourse dominant is in order to make a discourse more understandable and usable. (Foucault 1972)

Archaeological analysis individualizes and describes discursive formations. That is, it must compare them, oppose them to one another in the simultaneity in which they are presented, distinguish them from those that do not belong to the same time-scale, relate them, on the basis of their specificity, to the non-discursive practices that surround them and serve as a general element for them. (Foucault 1972, p157)

The term 'archive' describes the rules of any practice that allow either the survival or the modification of statements and texts as discourses. Archaeology is applied to a description that questions statements at the level of their existence in practice, that is their enunciative function, their discursive formation, and the archive system to which they belong. (Foucault 1972) It is proposed the constructed discourses about nursing care practice are being determined by the government and have come to dominate and silence the nursing profession's discourse about nursing practice in residential aged care.

Discourses

In order to analyse discourse, what is silenced and runs underneath what is actually said is important, and the said and not said are essentially saying the same thing. Discourse also involves what is not said – the subtext and the silenced. The analysis of discourse as the interpretation of the 'hearing' of an 'already-said' that is at the same time a 'not-said'. This allows the domination of the 'said' and the written, which become the accepted discourses. However, what is not spoken and not written is as important as what is spoken and written.

The manifest discourse... is really no more than the repressive presence of what it does not say; and this 'not said' is a hollow that undermines from within all that is said. (Foucault 1972, p25)

When describing the historical nature of how the object and discourse of 'sexuality' has come about, Foucault talks of the silences, as well as what is actually spoken and/or written. Research focuses on what is spoken about; who does the speaking; the positions and viewpoints from which they speak; the institutions that prompt people to speak about the object; and how it is put into discourses or silenced. (Foucault 1976) These are important questions and in this thesis the concern is the residents' nursing care as the domain and the differing discourses about nursing as a means to analyse the nursing practices. Foucault discusses the analysis of institutions or disciplines taking two directions – an historical analysis that has bearing on the situation as it is today and this has been dealt with in this thesis in chapters 2 and 3; and also examination of subjects through discourse analysis on what is spoken or written, and what is not spoken or written about the object 'nursing care'. Multiple silences are integral to any spoken or written word as the discursive formation to be analysed (Foucault 1976).

Accepted ways of being, talking, and thinking that are enunciated require analysis in that they do not come about of themselves and have underlying rules that construct them. It is these justifications or rationales for any practice that require continual analysis. It is necessary to question how one discourse or statement comes to be in existence or in domination, and not another discourse or statement of truth. A statement is a unit or 'atom' of any discourse and any statement may contain more than one unit, but it is the *enunciative* function of the statement that is of interest. Discourses are those statements produced and constituted by a group of statements that refer to the system of formation. The interest is in the enunciation of statements about nursing practice rather than their logical, semantic, and grammatical construction, or who stated it. A statement about any one object is not the same from one statement to another statement - nor from one individual to another. (Foucault 1972) This thesis analyses discourses written and spoken as differing positionings about the same object under study - being nursing practice in residential aged care for three highly dependent residents.

There are many positions from which the subject can be studied and constituted as an object. As such, there are different positionings about the same thing that

individuals and organisations speak or write about – thus making them into objects. (Foucault 1972) In this study a number of different ‘positionings’ in the discourse on nursing care are analysed. Nursing care is questioned and objectified about each subject from the differing perspectives of the documentation, the RNs, the CWs, the relatives, and the non-participant observations as the discourses about the same object. In the discourse analysis questions are asked as to how the discourse came into being and how it has persisted over other discourses.

The analysis of statements...it questions them as to their mode of existence, what it means to them to have come into existence, to have left traces, and perhaps to remain there, awaiting the moment when they might be of use once more; what it means to them to have appeared when and where they did – they and no others. (Foucault 1972, p109)

Foucault’s (1972) belief is that analysing all statements that relate to a given object in a field of knowledge, such as nursing, is one way of determining the ‘relations’ between statements about the same thing. Analysis of discourses around a given object constitutes the domain, and analysis needs to question the divisions, dispersions, or dissonances. The interest is not in the individualised statement or unique statement, but in its variations. Discourses are ‘...*practices that systematically form the objects of which they speak*’ (Foucault, 1972, p49). Analysis of discourse or a discursive formation aims to describe the relations between the different elements of discourse about a given object. Discourse analysis is centred on nursing practice as the domain or object under study through analysis of the differing discourses about the same resident and the same nursing practices. The aim is to link together the ‘... *historical and theoretical analysis of power relations, institutions, and knowledge, to the movements, critiques, and experiences that call them into question in reality. If I have insisted on all this “practice”, it has not been in order to “apply” ideas, but in order to put them to the test and modify them.*’ (Foucault 1984f, p374).

Concerning written pieces of documentation or text for analysis, Foucault (1994c) states that what is important is what is written, what it conveys, what is not said, and what it relates to in its reality. He describes a matter of ‘real existences’ in texts that form part of the ‘dramaturgy of the real... texts that played a part in the reality they speak of – and that, in return, whatever their inaccuracy, their

exaggeration, or their hypocrisy, are traversed by it: fragments of discourse trailing the fragments of a reality they are part of.' (Foucault, 1994c, p160). Texts or discourses can be questioned as to the power behind the utterances, for example, the documentation in residential aged care relating directly to the nursing care planning of the resident are questioned on the ethical, epistemological, and political levels.

All the ingredients of the ordinary, the unimportant detail, the taken for granted, the obscure, the unexceptional days, and even a life can be told - and essentially must be told, and better still - recorded. They become describable and transcribable in any organisation precisely because the practices are traversed by mechanisms of power. (Foucault 1994c) At the core of this thesis is an aim to describe the every day occurrences of nursing care in a facility through the discourses about nursing care for the highly dependent residents. The recording, transcribing, and analysis of nursing care discourses aimed to expose and provide evidence of the everyday experiences of the residents in regard to their nursing care at the personal level.

Institutional Analysis

When analysing a practice in an institution, such as residential aged nursing care, there are two distinguishing 'things' that Foucault (1994j) believes need inclusion. Firstly, the rationality or the aim of the institution is a program of aged care to provide nursing care for the frail, incapacitated, and elderly that is sustainable; and secondly, the results or outcomes being the resident's quality of life. He states that the outcomes rarely coincide with the aims of the program. This discontinuity in the aims and outcomes has two possibilities - either reform or utility. In this way, the use of any discontinuity or revolt is a means of further control and also a means to new ends. These strategic configurations are the constructs of new rationalities and accompanying discourses that affect actions to achieve an end or a transformation. (Foucault 1994j) Discontinuities have been apparent in residential aged care since 1975 as described in chapters 2 and 3, and this thesis proposes that new knowledges, discourses, and actions are being formed in aged care that are transforming residential aged care and nursing. This, obviously, is

significant to the nursing profession and the public, as aged care facilities are perceived by individuals in society as providing nursing care - whether delivered by nurses or non-nurses. The individuals providing the nursing care are identified by the public as nurses and the institutions are identified as existing primarily for the delivery of nursing care.

Foucault (1994k) states measuring practices against objectives of an institution or discipline is also necessary to question '*... practices, their professed purpose, the means they employ, and the intended or unintended results these means may have.*' (p395). With human freedom being central to his thinking, he states that what he tried to analyse is firmly grounded in practices. What is necessary to study is the logic of those practices by subjects who either accept or reject practices in which they participate and who are subjected to involving an ethical choice in compliance or dissent. As such, all is 'unstable' and changing and this is linked to practices and strategies that are used to obtain institutional or personal objectives. (Foucault 1994k) The disciplinary practices and strategies employed in residential aged care institutions are strategically directed at the resident's nursing care needs and dependency in providing the service, but as this thesis will expose, these disciplinary means and aims do not meet the desired outcomes for the residents in this study as the subjects.

The Object and the Subject

There is an alternation between the exploration of the object and the creation of a methodology. Studies on institutions are one fiction (truth) and this fiction can be verified or invalidated like any other fiction or truth. Foucault (1994f) essentially views all truths as being fictions in that they are made up and constituted by individuals with the state - both from the inside and the outside. His studies on the archaeology of knowledge, the penal system, medicine, psychiatry, pedagogy, and sexuality are ways of 'carving out an object and of fabricating a method of analysis' and any method is constantly evolving. His study of an object and subject are exploratory and it is only by reflection on what is found and the processes used that any methods develop. The aim of discourse analysis is one of

transforming the relationships that individuals have with their knowledge and truths in order to create new relationships between the individuals and institutions. Through this process persons are able to experience what they are and how their practices have been constituted both in the past and the present. (Foucault 1994f) Different explanations for the object under study are ever present and he views experiences as being purely subjective, but also as something that can be passed on. Through the process of analysis of any given object the encounter and the way it has come to be as it is, is at the core of an analysis. There is not one truth but questioning is directed at experiences and the reality of the reigning truths. The knowing subjects in this thesis were those who wrote the documentation, the relatives and the nursing staff of the facility who had knowledge of the nursing care, and myself as a RN and researcher who observed the nursing care. The object to be known is the nursing care for the residents as analysed from the differing discourses about the residents' nursing care provision and rationales for that provision.

Analysis

Foucault (1994a) suggests two lines of analysis of research namely: the history of knowledge domains as they are connected to social practices assuming that 'truth has a history'; and discourse analysis - not in the sense of linguistic facts or structure - but in the sense of an analysis of games of strategy, domination, evasion, and struggles. Foucault (1994i) calls for the analysis of 'actual situations' in the practice setting at the interface where individuals' ethics (their sensibilities, moral choices, relations to themselves) become apparent. It is here at the interface between an individual and the institution that 'dysfunctions, malaise, and, perhaps, crises arise in the social system' between the individual and the state (p367). In order to study nursing practices through the differing discourses the case study method is used in this thesis to construct what the perceived nursing care needs of residents are, as well as the delivery of nursing care in an aged care institution. The discourses around the residents as the case studies are beneficial in gaining the detail necessary to uncover any dysfunctions and problems of the aged care system at the practice level.

Although ethics is viewed by Foucault (1994j) as occurring in discourses and practices he also discusses what he terms ‘chatter’ of the dominating discourse. This is pertinent in this thesis in that the rhetoric of the government for the past 30 years concerning aged residential nursing care has been consistently successful in silencing the profession of nursing and RNs to the point of docility, and being complicit to the system of control. In the following, Foucault describes a chronic condition of ‘chatter’ recognised in the aged care system today.

And for a hundred and fifty years now, exactly the same notions, the same themes, the same reproaches, the same critical observations, the same demands have been repeated, as if nothing has changed – and, in a sense, nothing *has* changed. In a situation where an institution presenting so many disadvantages and provoking so much criticism gives rise only to an endless repetition of the same discourses, “chatter” is a serious symptom. (Foucault 1994j, p385)

The consistent chatter of the government in regard to nursing is found to be insidiously dominating nursing discourse, whereby nurses continue to be dominated by a rationalist rhetoric of quality of care ensured by accreditation, documentation, funding, and the complaints scheme. The analysis of the discourses from the nursing staff, the relatives, the documentation, and myself as an observer have become another sounding board for the object ‘nursing care’ that challenges the government’s consistent instrumentation and accreditation rhetoric.

On Evidence

According to Foucault (1994a) in providing ‘evidence’ to establish a ‘truth’ the following are to be put aside in research, namely: the introduction of methods of inquiry historically into the juridical system present in Western society; and the grand theories of knowledge and their ideologies found in science, economics, and politics. This is not because these are unimportant, but because it is necessary to discard them in order to delve into the micro power relations of everyday practices that are at play in and with the macro power structure that constitutes them. This micro depth of analysis is also much more manageable for the purpose of collecting evidence, and is more likely to yield results reflective of the macro system than attempting to study the macro system itself. (Foucault 1994a)

Those wishing to establish a relation between what is known and the political, social, or economic forms that serve as a context for that knowledge need to trace that relation by way of consciousness or the subject of knowledge. It seems to me that the real junction between the economico-political processes and the conflicts of knowledge might be found in those forms which are, at the same time, modes of power exercise and modes of knowledge acquisition and transmission. The inquiry is precisely a political form – a form of power management and exercise that, through the judicial institution, become, in Western culture, a way of authenticating truth, of acquiring and transmitting things that would be regarded as true. The inquiry is a form of knowledge-power. Analysis of such forms should lead us to a stricter analysis of the relations between knowledge conflicts and economico-political determinants. (Foucault 1994a, pp51-52)

As such, the analysis of this thesis focuses on the knowledge-power conflicts in the discourses around the nursing care for residents. These contradictions are then problematised and related to the economic and political determinants that exist in the discipline of aged care that have an effect on the nursing practice in these institutions.

Foucault (1994c) describes ‘miniscule’ commotions and functions in the elements of disparity, conflict, or difference. He describes this as ‘*A disparity between the things recounted and the manner of telling them; a disparity between those who complain and those who have every power over them; a disparity between the minuscule order of the problems raised and enormity of the power brought into play; a disparity between the language of ceremony and power and that of rage or helplessness.*’ (Foucault 1994c, p171). This thesis also analyses the disparities and conflict in discourses, the apparent contradictions, and the differences in the perceptions of nursing needs of highly dependent residents and their actual nursing care. Foucault asks the ‘how’ questions of practices within disciplines and institutions for the purpose of analysis and does not claim truth. (Foucault 1994e) It is a simple illumination of how nursing care is constructed in its context as it existed for three residents affected by the macro system.

The discontinuities in practice discourses are a starting point for analysis in that these raise the problems that need to be solved. The interest is in how the forms of rationality inherent in the practices come to be and by what means do the

practices exist or do not exist. By ‘eventalising’ practices in the discourses both the ‘true’ and the ‘false’ in the practices can be established.

These programmings of behavior (sic), these regimes of jurisdiction and veridiction aren’t abortive schemas for the creation of a reality. They are fragments of reality that induce such particular effects in the real as the distinction between true and false implicit in the ways men (sic) “direct”, “govern”, and “conduct” themselves and others. (Foucault 1994e, p233)

The following questions about society and the disciplines and institutions society produce are central to Foucault’s thoughts and include: *How is power exercised through the state and institutions. What are the forms of constraint? What are the constraints at the level of everyday lives? How is it accepted and how is it produced? What is silenced? What are the discontinuities? What are the influences of state at the individual level? What are the power relations and how is power exercised?* (Foucault 1994f, p283). Problems can be localised, but this does not mean that these particular problems are not general problems in need of solution or transformation. In every localised and individualised problem there is a need to find a solution at the micro and macro levels.

Pluralism and Possibilities

Any ‘utterances’ about anything forms the accepted knowledge that is subjected to divergence, oppositions, and differences resulting in continual transformations. Foucault directs an inquiry to study ‘ensembles of discourse’, such as nursing care, and to describe the relations, changes, and redistributions that occur to reach a result. Discontinuities and sameness in discourses become describable because of their very difference or sameness. The aim is to describe *‘the field of possibilities, the forms of operations, and the types of transformations’* that characterise an individual’s discursive formation of nursing care and their dependency on other formations, such as the government, the organisation, and other individuals. (Foucault 1991)

The events and discourses that allow the existence of statements (or render them possible) and allows them to be said (or allows them to emerge) is of interest. The analysis of discourses explores the domains of the discourses and their

archaeology. It is important to examine how discourse is manifested, as well as what is concealed and how it has transformed in the field it is speaking of – the context where discourses manifest. Foucault (1991) proposes that the analysis of discourses is a description of their existence and the practical field to which they belong, such as the description of nursing care in a residential aged care facility. It does not matter who is speaking or writing, but the fact that something is said or written is significant, and all discourses have consequences. He views thought and the resulting discourses as being the way in which humans face their reality and act as individuals in Western society. (Foucault 1994s)

The discourses on nursing care and what is stated about the nursing care are the focus of this thesis and not the participants as subjects. The author of any text is absent (or not present) for the purpose of the analysis, in that any discourse or text should not be analysed in relation to the author or who is making the statement, but in relation to its structure, forms, and relationships. In Foucault's view, 'who' is speaking is not as important as 'what' is spoken. (Foucault 1984c) The fact that something is said or written and what allows it to be said and written is the interest for inquiry and analysis (Foucault 1972). In this study the discourses of the participants focus on the spoken word, observations, and the written text when questioning the nursing care for the highly dependent residents.

The following questions are asked of the residential aged care system and the discourses about the practice of nursing care from a Foucauldian perspective.

What forms of nursing practice characterise residential aged care?

What power relations underlie nursing practices?

What forms of knowledge (*savoir*), types of knowledge (*connaissance*), and relationships of knowledge emerge from the discourses about nursing care?

There are a range of pluralisms and possibilities in any discourse in that what is said or written can take any direction according to the dominant discourse and what has been stated are made explicit, as well as what has been silenced. Study at the micro level of practice will expose the relations between the micro and macro levels of control through analysis of the dominant discourses about the nursing care.

Foucault gives no clear guidelines to methodology, however, the research zone or space is established. The interpretations will be evidenced by the discourses around the residents as the subjects concerning their nursing care as the object for analysis. Discourse analysis is grounded in the practice area of study and this requires examination in both depth and detail at the micro level. As such, the next section of this chapter deals with the case study methodology chosen for data collection. Case study design allows both depth and detail deemed necessary for an analysis of the discourses about nursing in residential aged care at the micro level in the field, according to the Foucauldian theoretical underpinning of this thesis.

Case Study Design

The approach of the case study method for the collection of data to produce evidence is an appropriate method for the purpose of this thesis. In order to get the necessary detail and depth for analysis of the micro power relations and the knowledge and ethics used in the nursing care of residents, the discourses about nursing care are attained through the use of case studies. Foucauldian theory directs research to the field of practice at the detail level and the study of discourses at the micro level. In this thesis on nursing care in a residential aged care facility, the case study design has been chosen for the purpose of data collection because of its applicability to the context, the theoretical underpinnings of Foucault, and the complexity of nursing practice in such an institution.

Many studies use case study method in different disciplines, and in the nursing research literature it is identified as a valuable tool in collecting detail from the clinical area. The resulting data is grounded in nursing practice and, therefore, valuable to nursing research and practice. The following section describes the case study method and the justification for its use in this thesis. Studies about the individuals in this study relate to the collective social context through their nursing care, and through subjection and objectification further understandings are made possible. The outcome will be ‘a truth’ for nursing care in a residential aged

care facility and not necessarily 'the' truth of nursing in other like facilities, but it is 'a truth' (Foucault 1994a, 1994e, 1994g, 1994h, 1994m, 1994v).

Justification

The aims of qualitative research using the case study approach are to have a holistic and humanistic view of nursing; create an in-depth understanding of the complex social settings in nursing; provide an important part of scientific advance with research; encompass social and cultural experience in their natural settings; generate theories and hypotheses for further testing; and provide insights and directions into difficult questions (Chien 1996). Case studies are used to describe rather than explain (Gottschlich 2000), and they can be either exploratory, descriptive, or explanatory (Yin 1994; Darke, Shanks, & Broadbent 1998; Pegram 1999; Vallis & Tierney 1999; Bergen & While 2000; Hewitt 2000; Peacock 2001; Hewitt-Taylor 2002; Yin 2003a, 2003b). This thesis describes and explores the nursing care provision of highly dependent residents in an aged care facility. It does not aim to explain or provide a theory, but aims rather to provide insight, explanation, and direction to the difficult questions concerning the quality of nursing care for residents accommodated in aged care institutions. It is exploratory, descriptive, and explanatory in its utility.

Case study is, in the main, a qualitative methodology. It can also have a quantitative structure, however, it is identified as useful when data is inaccessible to empirical description (Chien 1996; Charlton & Walston 1998). This thesis is qualitative and uses a combination of both the exploratory, descriptive, and explanatory case study design as described by Yin (1994, 2003a, 2003b) as the means of analysing the object nursing care as it relates to the residents as the case studies as subjects. Case study research has the potential to 'put flesh on bones' and is able to convey the human dimensions of policies and service provision (Gray 1998) and although this was an aim of this thesis, the negative practices that will be exposed were not an expected outcome.

Research in case study design is an important means of investigating health care practice and policy and is useful for doctors to illustrate phenomena or nurses to illustrate practice (Keen & Packwood 1995). The design is described as ‘the social research equivalent of the spotlight or the microscope’ (Hakim 1987 cited in Bryar 1999) and this is compatible with the micro level of discourse analysis necessary according to Foucault. The resultant snapshot is a ‘slice of the action’ that is detailed and analysed in depth and is valuable in studying the particulars (either direct or vicarious) of everyday practices (Prior 1995). Case study research has developed into a ‘science of the singular’ and is constructive in order to understand things in the ‘all-together’ and in context (Sandelowski 1996). Accordingly, this thesis aims to put the nursing care of residents in an aged care facility under the microscope at the detailed level in order to describe, explore, and explain the construct of nursing care for the residents as the case studies. Furthermore, case study design is compatible with conducting research at the micro and detailed level according to the theoretical underpinning of this thesis.

Investigation of nursing care for residents in their real-life context, as a phenomenon, is clearly important, evident, and has multiple sources of influence or discourses (Yin, 1994 cited in Robsen 1993; Darke et al. 1998; Sharp 1998; Vallis & Tierney 1999; Hewitt-Taylor 2002). The methodology is described as having ‘contextual inclusiveness’ and the aim can be theory testing or theory generating through the exploration, explanation, and description from a number of sources or discourses (Ragins 1995; Rolfe 1998; Bergen & While 2000). Case studies are examined in real life contexts with the inclusion of as many aspects that are relevant to the case viewed as being valuable in providing insight into practice. The multiplicity of factors that influence a practice, such as nursing care, includes the social context and the organisational culture (Hewitt-Taylor 2002), as well as the individuals receiving and providing the care. The discourses about nursing care in this study are derived from five different sources for each of the case studies, and are analysed in the context of the field around the residents themselves and their nursing care.

Multiple case study design is used to research the similarities or differences between the residents, as the units of analysis, in regard to their nursing care

provision (Bergen 1992; Darke et al. 1998; Gray 1998; Bergen & While 2000; Yin 2003a). For each unit of analysis (resident), there are subunits and subsets of data (discourses) that form or make up the units of analysis. The units of analysis are each of the residents, and the subsets of data are collected from discourses provided by the RNs, the CWs, the relatives, non-participant observations, and the documentation for each resident as the unit. Five discourses or subsets of data regarding the nursing care for each of the residents are analysed totalling 15 in number.

Although the case study method is valuable to nursing it is infrequently used as a method in nursing research. Encouragement for its use in nursing research as a method is given in order to investigate the day-to-day observations and interventions that constitute nursing practice (Barnard 1983; Woods 1997). The benefits of using case study include: the research can be conducted in the natural setting; and because of this it is grounded or embedded and this allows for rich description (Woods 1997; Yin 2003a). This makes possible or allows for a detailed study of all aspects of an individual case or cases, such as highly dependent residents of a residential aged care facility. In order to investigate, question, and observe nursing practice in the day-to-day reality of the residents - this thesis sought data in the natural setting from those who received the nursing care and those who provided the nursing care; as well as the documentation that prescribed nursing care, myself as the researcher who observed the nursing care, and the relatives who also observed the nursing care and provided care. The depth, richness, and detail of using a case study design will be evidenced in chapters 8, 9, and 10 where the findings of the discourse analysis are described.

The case study method is a viable approach to clinical research that can yield important findings and can also include the interpretation by the researcher about the reality of what is happening in the actual data as part of the collection - especially if there are contradictions (Smyth & Pesto 1989). As Foucault states research and inquiry should focus on contradictions and dissonances and the case study method, therefore, was deemed the most appropriate method of data collection for this study. Most agree that case study research is appropriate when there are 'how' or 'why' questions asked of nursing practice (Gray 1998; Bryar

1999; Bergen & While 2000; McDonnell & Jones 2000; Yin 2003a), and this is also complementary to the Foucauldian underpinning of the thesis in that the ‘how’ and ‘why’ questions are paramount to analysing a practice, such as nursing in an aged care facility.

Validity, Reliability, and Generalisation

Although generalisation is not an aim of case study research the case study may have applicability to other cases or persons in similar situations or institutions (Woods 1997; Gray 1998; Sharp 1998; Bryar 1999). In case study analysis, as well as comparing with other case studies, the analyst seeks out patterns that are compared with other units of data, leading to the identification of recurring themes and replication, and this thematic analysis is compatible to Foucault’s theoretical stance. A strict cycle of analysis is undertaken on the units of analysis and each separate data piece within the same case (within-case analysis) that is then compared with the results of other cases (cross-case analysis). This cycle of analysis leads to analytical generalisations (cross-case synthesis) and the results of case study research can be viewed as ‘mirroring’ other similar cases in their natural setting. (Yin 1994; Cowley, Bergen, Young, & Kavanagh 2000; Yin 2003a) The residents as the case studies and their nursing care may produce similar results with other highly dependent residents in other institutions implying a possibility for transferability.

The use of the terms validity and reliability are deemed to be inappropriate in case study research in the qualitative paradigm (Sandelowski 1996; Bergen & While 2000). Theoretical generalisations and explanatory theories are viewed as valid outcomes in case study research even though they are considered a weak basis for generalisation in the empirical sense. It is argued by case study researchers that generalisation is a redundant concept for case study research and analysis is based on the ‘categorical aggregation of instances’ (Bergen & While 2000). More is learnt about the ‘particular’ and the interpretation of these particulars is through an analytical generalisation. A case study may be transferable to other people in other nursing homes and the terms of transferability and ‘fittingness’ are more

complementary terms that can apply to case study research, in that persons and settings can be essentially similar and recognisable. (Rolfe 1998; Yin 2003a) Rather than validity the term 'authority' is preferred to acknowledge the reasonableness and authenticity of the research, and there can also be a 'shock of recognition' when the case study method is used (Rolfe 1998). These arguments support Foucault's line of inquiry. Through the objectification of a practice or the subjectivation of individuals to examination a collective effect on individuals can be revealed. This collective effect on individuals finds them having similar experiences when in similar contexts.

The aim of case study research is generalising to theoretical propositions but not to populations (Woods 1997; Charlton & Walston 1998; Gray 1998; Sharp 1998; Bryar 1999). Sharp (1998) contends that nursing, in its essence, is a case based or case managed profession and case studies can be the preferred method of nursing research, and may be epistemologically in harmony with experiences of others, and a natural basis for generalisation (Stake 1978). It is proposed, therefore, that nursing research is compatible with case study methods, and the issue of generalisability should not be focussed on - in order to elicit the full value of this methodology.

The focus of case studies is the particularisation rather than the generalisation, however, the generalisations produced from the research can be used to explore, develop, test, refine, and refute questions and propositions about nursing practice (Sandelowski 1996). Other researchers have used the case study method as a means of reconstructing theory or extending theory, as well as connecting the micro to the macro as to how the field situation is shaped by external forces (Ragins 1995). This is compatible both with the theoretical underpinning of Foucault and the aims of this thesis, and it will be argued that nursing care in the field is being shaped by external forces that constitute the discipline of the residential aged care system that is constructing the nursing care therein.

The two stages of case study design include firstly pattern matching, whereby several pieces of information from the same case are related to some theoretical proposition; and secondly, replication logic, which is analogous to multiple

experiments, whereby the results of the entire case or unit are compared both with other cases and with the proposed theory (Bergen & While 2000). In this thesis, pattern matching is used as evidence for the proposition that nursing care is being affected by the governmentality of the system; and also replication logic, whereby each case is compared to the other cases through a cross case synthesis. Construct validity, internal and external validity, as well as reliability are the qualitative measures of case study design and are commensurate with social science methods (Yin 2003a), as well as nursing research.

To be exemplary in case study research the case study must exhibit five characteristics namely significance, completion, consideration of alternative explanations, sufficient evidence, and be composed in an engaging manner (Gray 1998). This thesis exhibits these five characteristics and has undertaken the strategies identified as forming the process of case study research that include the selection of the cases and the context, external validity, triangulation, and the relationship to theory based on the definition of the case study inquiry (Keen & Packwood 1995; Darke et al. 1998; Gray 1998; Pegram 1999; Vallis & Tierney 1999; Bergen & While 2000; Peacock 2001; Hewitt-Taylor 2002). Triangulation in data collection uses multiple methods and sources of data suitable to the study (Bergen & While 2000). In this research these include documentation, non-participant observations, and interviews with those associated with the nursing care of the residents as the case studies.

Case study research is valuable where complex questions have to be addressed in complex circumstances that have multiple layers and changing shape. No one method is sufficient to capture all salient aspects of a practice and case studies typically use multiple methods or triangulation in order to address this (Keen & Packwood 1995). The selection of the cases aims to ensure there is no misinterpretation of data that is typical of the phenomenon being investigated (Keen & Packwood 1995) - in this thesis, three highly dependent residents in receipt of nursing care in an aged care facility. Case study design incorporates replication logic by which the results of one case study are compared or 'matched' with the results of subsequent ones (Cowley et al. 2000), and this is undertaken in this thesis, whereby the data of one resident is compared to the data sets of the

other two residents and synthesised into themes and subsequently problematised from a nursing perspective.

Case Studies in Nursing

Many nursing research studies have used the case study method and the areas of study are wide and varied ranging from a study on the experiences of RNs providing palliative care to a study of one resident in a nursing home, and a study about patients' views of their quality of life, as well as others (Powell 1989; Bergen 1992; Kent & Maggs 1992; McCormack 1992; Dale 1995; Ragins 1995; Madjar & Higgins 1996; Rolfe 1998; Bryar 1999; Smith Campbell 1999; Irwin 2000; McDonnell & Jones 2000; Graneheim, Norberg, & Jansson 2001; Smith & Topping 2001). A case study pertinent to this thesis includes the assessment of care needs of a person in a community setting and the relating of the findings to the current policy about this service. A taxonomy of assessment for care needs and recommendations for future programs are made based on one case. (Cowley et al. 2000) Another case study conducted in Australia is used to explicate the plight of the funding of aged care based on the relative dependency of a resident as not meeting the reality of care needed for the resident who had motor neurone disease necessitating living in a nursing home. The multiple methods of data collection includes an empirical analysis of time spent with the resident and provided evidence for the resident's reclassification through highlighting the flawed instrument in use at the time. (Zuch & De Bellis 1996)

There are some disadvantages or limitations recognised in case study research in addition to a lack of generalisability. These limitations include the large amounts of data generated and its management; the time consuming nature of the research; and the issues with protecting the anonymity of participants (Woods 1997; Gray 1998). Great effort has been made in this thesis to protect the anonymity of the aged care facility, the residents, the relatives, and the nursing staff. The time consuming nature of this research, because of the ethical considerations and the amount of data that was generated, attest to the limitations and disadvantages described above; however, the richness, depth, and detail of the data has been

necessary to provide strength to the evidence concerning the quality of nursing care in aged care being affected by the government's legislation, regulation, and standardisation to the detriment of the residents' quality of life and nursing.

In summary, the appropriateness of the case study method to this thesis has been explained through the identification of the similarities between this method and discourse analysis in accordance with the theoretical underpinning of the thesis. The complementary nature of case study and discourse analysis from a Foucauldian approach can be found in their common focus being in the field or at the level of practice, as well as the study at the micro or individual level to elicit the detail, depth, and complexity of the aged care system. Although the results from the analysis cannot claim generalisability, the results may be transferable and common to other highly dependent residents in other aged care facilities - given the hegemonic system in place that has control and is having an effect on nursing in these institutions. The methodology that combines discourse analysis and case studies about nursing care provision have been determined to be appropriate for the purpose of the questions posed, and for the direction of the subsequent data analysis.

This chapter has explained the methodology used in directing the discourse analysis according to the philosophical underpinning of Foucault and the case study design. The following chapter describes the implementation of the research and includes the ethical considerations, as well as the setting and the recruitment of the three residents as the case studies. A description of the residential aged care facility, the residents, and their relatives will be provided to contextually situate the subjects of the research. The methods of data collection and the framework used for the discourse analysis will also be elucidated.

Chapter 7

THE CASE STUDIES

The following chapter covers the implementation of the study and describes the ethical considerations of the research, the residential aged care facility as the setting, the recruitment of the participants, and the introduction of the three residents Anna, Ruby, and Cynthia and their respective relatives Joe, Ben, and Betty.

During the study a research journal was used to enhance the processes of ethics approval, access, recruitment, note taking, data collection, reflections, and the discourse analysis. This journal served to notate possibilities, contacts, comments by participants, thoughts, conceptualisations, impressions, and conversations in the form of notes. Although my journal did not actually form part of the data analysed, it is used in this chapter to describe the ethical journey, the nursing home accessed, and the participants. The following uses some of its content, most notably in the description of my impressions of the residents, their relatives, and the nursing care following the observation periods.

Ethical Considerations

The ethical considerations for the study centred on autonomy, informed consent, anonymity, confidentiality, and security of personal information all of which followed the national ethical guidelines used for research on humans (CofA 1995, 1999, 2000b). The principles underlying ethical conduct were observed prior to the access, in the recruitment, and during the data collection. The original research proposal was to include the video and audio taping of the nursing care for highly dependent residents in one nursing home over 24 hour periods using ethology as the methodology (Morse & Bottorff 1990; Solberg & Morse 1991; Bottorff 1993; Morse, Solberg, & Edwards 1993; Bottorff & Morse 1994; Bottorff 1994a, 1994b; Bottorff & Varcoe 1995; Morse & Intrieri 1997; De Bellis 1999). Ethics approval was granted for this research by the Social & Behavioural Research Ethics

Committee of Flinders University, and subsequently challenged before approval by the North Western Adelaide Health Service Ethics of Human Research Committee as will now be explained.

Following approval from the university's ethics committee, letters of introduction requesting consideration of participation in the research were sent to all Directors of Nursing (DONs) of RACFs in metropolitan Adelaide, a total of 235 at the time. Response to this mail out yielded an interest by 8 facilities in having video and audio equipment installed in their facility for the purpose of data collection. However, upon further communication with management at these facilities, only one nursing home was prepared to participate and allow the installation of the equipment and the research to proceed. Unfortunately this organisation's ethics committee did not grant ethics approval for the video and audio installation, so it was necessary to amend the methods of data collection.

The concerns of this ethics committee associated with the facility centred on the possibility of an outside person or visitor entering the resident's environment and being filmed having not given consent. It was argued that this would require retrospective consent according to the Commonwealth Privacy Act of 1988, whereby a person who unexpectedly visited the resident was not aware of signs posted on the doors of the residents and the facility itself. The complex legal difficulties encountered by pursuing ethology with this ethics committee, despite assurances of anonymity and efforts to gain retrospective consent, resulted in the video and audio taping of residents and their nursing care not being pursued. Instead, the methods of audio taped interviews, non-participant observation, and document analysis were subsequently approved by both ethics committees. This ethics journey resulted in a considerable delay in accessing an organisation and potential participants, and also restricted data collection to the one aged care facility that was willing to participate in the initial methodology. The outcome was positive in that data could be collected without delay that would have otherwise entailed further lengthy ethical debate to remove the obstruction.

The Residential Aged Care Facility

The facility that consented to participate was a 32 bed high care facility in metropolitan Adelaide. It was a not-for-profit organisation and had gained full accreditation six months prior to the data collection period. The negotiations and data collection covered a time frame of seven months and during this time the researcher became a familiar face in the organisation as visits to the facility were frequent to meet with management and nursing staff. The facility had very few distinguishing features compared with other facilities of this type that catered for highly dependent residents.

The facility had been modernised in the previous 10 years and all rooms were either one bed or two bed rooms without ensuites, and there was a large corridor and smaller corridors that connected rooms and wings. It appeared comfortable for residents, relatives, and visitors. I was welcomed into what could be described as a friendly and open culture. During the visits that occurred in the daytime it was always busy with people constantly moving about in the corridors, and there was a loud speaker system that broadcasted messages and calls to the nursing staff. There was a nursing office off of the main corridor, and there were outside areas and gardens, a community shop, and access to a day therapy/community centre. From a cultural and environmental perspective it appeared to be like other high care facilities visited previously by myself. The facility was situated in a lower to middle socio/economic suburb, which was known as a blue collar working area.

The Staffing Scenario

There was 24 hour RN supervision and the nursing structure included a Director of Nursing (DON) who was also the Chief Executive Officer (CEO), one Clinical Nurse Consultant (CNC), one Clinical Nurse (CN), and several RNs, ENs and careworkers (CWs). A CNC was on site Monday to Friday 8am-4pm and there was 24 hour RN or CN cover (one only). The ENs and CWs had a varying roster with the most nursing staff on at any one combination of shifts or overlap of shifts

being five. The RN on duty was responsible for all 32 residents in the facility and their day to day care. A number of meetings with the management and RNs were necessary to determine possible participants. Two information sessions with the nursing staff about the research were undertaken and the information sheets were also distributed to all nursing staff. The information sessions were well attended and all persons present indicated assent and support, and appeared confident in their nursing care provision. Further written consent was sought from individual nursing staff willing to be interviewed about a particular resident, as well as the individual nursing staff observed interacting with the resident during the observation periods.

Recruitment of the Case Studies

Further meetings with the CNC and CN identified which residents and/or relatives they deemed would be suitable to approach to participate in the research. Nursing staff members who knew the residents well and who would be prepared to be interviewed about the resident's nursing care were also identified as potential participants by nursing management. It is important to note here that the CNC and CN acted as intermediaries in the recruitment of residents and staff for the research and this has been previously identified as having both negative and positive results (Madjar & Higgins 1996). However, in accordance with the requirement of the ethics committees and the organisation, it was necessary for the CN to approach the resident and/or relatives about participating in the research. As such, the CN had veto rights over who was or was not approached and a number of residents were not considered on the CN's recommendations for varying reasons.

The major research criterion for the selection of potential case studies included that the resident be considered to be highly dependent on nursing care. The RCS category was not considered in selection with the main criteria being who the CNC or CN considered to be highly dependent. If the resident had problems with their cognition or communication, a relative or guardian was required to be available who was close to the resident and their care needs and who frequented

the nursing home. The next of kin was to provide consent on behalf of the resident if the resident was unable to do this. The relative was to be interviewed instead of the resident and would provide consent for the non-participant observation of the resident's nursing care, as well as the resident's records being accessed.

The residents selected as potential participants all had some form of impaired cognition or communication problems. The CNC and CN also had exclusion criteria that included their own assessment of individual residents. For example, those who were excluded included residents who were considered not highly dependent, one resident who was grieving, another who was recently new to the nursing home, another resident and husband who were Italian speaking only, and a number of residents with dementia or impaired communication/cognition who had no relatives who visited or relatives who visited infrequently and were, therefore, not familiar with the resident's nursing care. During this process a total of 15 highly dependent residents and their relatives were identified as suitable to be approached to participate in the research as the potential case studies.

Once residents or relatives indicated their interest in participating in the research to the CN they were contacted by me in person or by telephone to briefly explain the research, arrange a meeting, and provide written informed consent. Data collection then proceeded with each of the residents as a sample unit with sub data sets from the current documentation on each resident, audiotaped interviews with a CW, a RN, and the relative about each resident's nursing care needs and provision, as well as the observation of each resident's care for two hour periods. From the 15 potential sample units three residents and/or relatives consented to participate in the study and data collection proceeded. The other 12 potential participants or their relatives either refused, were acutely ill, died, or could not be contacted for consent. A description of the three residents who form the sample units for the data subsets follows. Pseudonyms for the residents and their relatives and generic titles for the nursing staff have been used to protect the identity of all participants.

The three female residents who consented were given the pseudonyms of Anna, Ruby, and Cynthia. The pseudonyms for the relatives of these residents are Joe,

Ben, and Betty who are respectively two husbands of Anna and Ruby, and a mother of Cynthia. As well as the relatives, three RNs and three CWs participated in the interviews and a total of two RNs and eight CWs consented and were observed caring for any one of the three residents. Miscellaneous persons were also observed during the non-participant observations, such as three domestic staff and a doctor who came into the resident's room whilst the data collection was in progress. Another resident, named Irene, was in the bed next to Anna and as such became part of the environment in the non-participant observation of Anna. Irene was also the comparative subject of part of Joe's interview about his wife Anna's nursing care needs. The following are profiles of the three residents and their respective relatives who consented to participate in the study. All three residents were unable to be interviewed because of their communication difficulties and, as such, the relatives became the informants for them and had significant knowledge of their loved ones, their nursing care, and the aged care facility. Cynthia was able to verbally consent to her participation, but wished for her mother to do the interview with me because of dysphasia.

Anna

Anna was 84 years of age with the admission diagnoses of Alzheimer's disease and arthritis. Her dementia was now in the end stages and she had been in the nursing home for a period of 4 years, and was considered a long time resident. According to the CN, Anna was highly dependent in all activities of daily living and was mainly bed ridden. She shared a room with Irene who was also bedridden and in the end stages of dementia. Anna had no apparent communication abilities other than making noises, opening her eyes, and swallowing food and drink with full assistance. She had mild to moderate contractures and appeared to sleep most of the time. She was becoming more bed and room bound at the husband's request because of her deteriorating condition. Anna's RCS classification was high care category 2. Her husband, Joe, was committed to participating in Anna's nursing care as his main focus in life, and this became very evident in the data collection.

Joe's Story

According to the CN, Joe was totally devoted and committed to caring for Anna. He came in every day, twice a day since her admission - a session at lunchtime and again at teatime. The CN commented on his tender loving care for his wife and that he was very aware of her needs and care as he was there every day without fail for up to 5 hours. On meeting Joe, who spoke in broken English, he was very keen to participate in the research and extremely willing to consent, and the subsequent data collection methods for the discourses were implemented.

Joe had cared for Anna at home prior to her admission to the nursing home and had only reluctantly agreed to admit her when it was apparent that he could no longer lift her, and she had become incontinent at times. He was an emotional and sensitive man, and was often in tears when he talked about the predicament of his wife and their lives together. Joe's need to talk was apparent and he was keen to verbalise anything to do with Anna and her nursing care. He was more than willing to give information about his experiences, and this was evident during the initial meeting and the consequent communications to set up the interviews and observation. Joe and Anna had two sons and a daughter, but they visited infrequently as Joe stated it was too upsetting for them.

Ruby

Ruby had been a long time resident for 8 years and was 71 years of age. Her admission diagnoses were Hypertension and Alzheimer's Disease. The CN stated Ruby was highly dependent and could not do anything for herself and she had very little or no communication or cognition left. She was considered in the end stage of dementia and was totally reliant on staff for all her needs. Although the CN stated that she appeared to sleep most of the time, Ruby did get up in a 'comfy' chair, but that this was mainly for her husband Ben's benefit to socialise with the nursing staff in the lounge room. Ruby was classified as high care RCS category 3, despite her total dependence.

Ben's Story

According to the CN Ben visited almost every day at lunchtime and was well known and 'liked' in the nursing home. A meeting was set up by the CN for Ben, as the next of kin, to consent to participate in the study on his and his wife's behalf. Ben was a fit and active elderly man who visited his wife as much as he could, being most days around lunchtime to assist with her meal. He stated he came often to the nursing home out of a sense of duty and because of his marriage vows to his wife. Ben had cared for Ruby at home until it had become necessary to admit her because of her increasing confusion and wandering behaviours. He was very willing to participate in the research and consented to the data collection. He was active in a men's support group whose wives or mothers had Alzheimer's Disease and it had helped him considerably to understand Ruby's condition. Although Ben and Ruby had three children Ben stated they did not visit often, however, Ruby's sister who lived in the country came and visited when she could.

Cynthia

Cynthia had been a resident of the nursing home for six months. Her admission diagnoses were astrocytoma and seizures. The CN commented Cynthia was the most highly dependent resident in the aged care facility because of her obesity, and the facility was not really suited to Cynthia because of her young age of 32 years according to the nursing staff. Cynthia's mother Betty, her next of kin, wanted Cynthia kept where she was because it was important she be able to visit everyday. If Cynthia was admitted to another institution perceived by others as capable of caring for her more appropriately, Betty would not be able to have the frequent contact she now had. Because of her prognosis, Cynthia was considered to be requiring palliative care as treatment had failed to cure the tumour. She was not, however, in a specialist palliative care program.

The CN stated that Cynthia's main physical problem was her obesity and she had become bed and room bound because of this as there was no chair available that could take her weight. Cynthia was considered totally dependent on nursing staff

and she needed 5 staff at a time to attend to her hygiene, positioning, and toileting needs. Cognitively, Cynthia still understood everything going on around her, but her speech had become slurred and she took an extraordinary amount of time to answer questions or get her needs across - and then only in one or two words. Cynthia indicated to her mother that she wanted to be a participant in the research and she instructed her mother to consent on her behalf. Cynthia, despite the perception of her high dependence and time consuming care by all concerned, was categorised as high care RCS 3.

Betty's Story

Cynthia's mother, Betty, had cared for Cynthia at home until her weight gain and increasing immobility, seizures, and some incontinence precluded this. It was necessary to find accommodation as she required 24 hour nursing care and Betty was willing but unable to provide this. Betty visited Cynthia twice a day around lunch and teatime and according to the CN Betty often spoke for Cynthia to nursing staff and visitors. The CN stated that Betty was very familiar with the nursing staff and was the one who knew about Cynthia's needs as she would often advocate for Cynthia's care, as well as participate in her nursing care. On meeting Betty - who was also very willing for Cynthia and herself to participate in the research - she stated that Cynthia had given her verbal consent to be part of the research and that Cynthia was very keen to participate and have her mother participate on her behalf regarding her nursing care.

It was evident Betty's priority was to have constant and consistent contact with Cynthia and advocate on her behalf. She would come in everyday at both lunch and tea time. Cynthia's father was divorced from Betty and both had re-partnered. The father visited Cynthia regularly and, according to the mother, they had a good father / daughter relationship. Cynthia had no brothers and sisters and previously had many friends through her work before she was diagnosed, but her friends no longer visited. The mother stated Cynthia used to love computers but was unable to use them any more and she now mostly watched TV, loved to eat, and also sleep. Cynthia had liked doing crossword puzzles but this was becoming more and more difficult as her condition worsened.

Betty considered that Cynthia was deteriorating and was highly dependent on nursing staff and she required a number of them, and this was a problem. In the initial meeting, Betty stated that Cynthia was incontinent of urine and faeces because there was not enough staff on at any one time to get her onto a bedpan. She recognised Cynthia's obesity was a problem for staff, but did not want Cynthia put on a diet because she enjoyed her food so much. Betty stated it was a shame her daughter's weight now precluded her from getting out of her room, but she had previously broken two chairs and she could not fit into them any more. Betty did not want Cynthia moved to the other side of town as nursing staff had been proposing because Cynthia needed her to come in every day and she could not afford the petrol or the time if Cynthia was to be moved far away from her.

Summary of the Residents and their Relatives

The three residents had many similarities but also many differences and this confirmed the individuality of the dementing and/or palliative care experience in residential aged care for highly dependent residents. The residents were all described and perceived as highly dependent by the CN and CNC, but they were not categorised at the highest dependence level of RCS 1. This indicated a broad mismatch of categorisation and actual dependency on nursing care from the nursing perspective inherent in the system. Each resident had their respective next of kin come in daily and all the relatives were well known to the nursing staff. In turn the relatives, as well as Cynthia, knew the regular nursing staff and they were on a first name basis with them. Cynthia had a terminal neoplasm and was considered to be requiring palliative care and, as such, she was different to Anna and Ruby in her age, diagnosis, prognosis, abilities, cognitive function, and communication. Because of her age and diagnosis she had very different needs to Ruby and Anna who were elderly and had dementia. Cynthia's close relationship with her mother was very evident during the data collection process, as was the relationship of Joe and his wife Anna. Anna and Ruby had end stage dementia and were similar in age, morbidity, diagnoses, and social ability and both had attentive caring husbands who visited daily.

The relatives were aware of the nursing care their relative received to varying degrees. Joe, in particular, participated in all aspects of nursing care for Anna. Joe, Ben, and Betty had all cared for their loved ones at home for a period of time before admission to the high care facility. They continued their active care and came in at mealtimes to help their love ones. In the case of Joe, this was for approximately 5 hours every day for the past four years; in the case of Ben, he came to the facility on most days for 1-2 hours for the past eight years; and in the case of Betty, she came in every day, twice a day for up to 5 hours for the past six months since Cynthia's admission.

The relatives were more than willing to talk about the residents' nursing care needs in an audio taped interview. They also consented to have the residents' documentation and records accessed; to being interviewed; have nursing staff interviewed about their relative; and proceed with the observations of nursing care. Following written consent from the relatives the data collection process took a specific order because of possibility of tainting by the documentation of the nursing care, to the questioning about nursing care, or the observations undertaken of the nursing care. The interviews with the RN, CW, and relative concerning each resident occurred before the observation of the resident and the observation took place before the collecting and reading in detail of the documentation. The following is an overview of the methods of data collection and the analysis framework used.

The Interviews

The audio taped interviews with staff and relatives occurred concurrently over a period of time in a 'quiet' area or room in the facility. It is to be noted the supposed quiet areas were not actually quiet environments. The nine interviews varied in length from 40 minutes to 2 hours with the interviews with nursing staff being shorter in length than the interviews with the relatives. Staff tended to give staccato routine answers to the questions, whereas the relatives had more time and seemed to have much more to say. The fourteen functions of nursing practice

were used as prompt questions about the resident's nursing care needs in the interviews for both the nursing staff and the relatives (Henderson 1966). This nursing framework had common understandings of nursing terms by non-nursing persons interviewed. The questions adequately covered the nursing domain and the assessment of nursing care needs, and yet were still understandable to non-nurses including the CWs and the residents' relatives.

The questions encompassed the following nursing functions according to Henderson's (1966) nursing theory and included breathing, eating and drinking, elimination, movement and positioning, sleep and rest, body temperature and infections, hygiene, grooming and dressing, security and safety, communication and autonomy, worshipping, religion and spirituality, accomplishment and cognition, activities, recreation, and curiosity (Henderson 1966, p16-17). Further questions were included relevant to any medications the resident was taking and their administration, as well as any advance directives in place. As such, these semi-structured interviews used informal and open questioning and according to what was said, further questions were spontaneously developed requesting information, detail, or description. All of the interviews were transcribed verbatim for the purpose of the analysis. Following the interviews with the relatives, RNs, and CWs, the non-participant observations were arranged, and the documents pertaining to the residents were then photocopied completing the data collection (data subsets) for each unit of analysis (resident).

The Non-Participant Observations

The non-participant observations (NPOs) were of two hours duration each and were undertaken during lunchtime on weekdays. Previous research had determined persons with dementia in aged care facilities may be nutritionally compromised if they required full assistance with eating and drinking (Mitchell, De Bellis, Willick, & Roder-Allen 2001; De Bellis, Mitchell, Willick, & Roder-Allen 2003; Mitchell, De Bellis, Willick, Roder-Allen, & Willick 2003). As all three residents required full one to one assistance with their meals it was deemed as an appropriate nursing activity to observe together with the hygiene and

continence care routinely undertaken following meals. As two of the relatives were in at lunchtime, all the periods of the NPOs included the relatives interacting, communicating, and providing assistance to the residents.

Data was collected in the observations using field notes that were transcribed within 24 hours of the data collection. What was observed, done, and said around the resident was recorded. I was seated next to the resident, out of their sight, and away enough not to intrude on any activities. Both Anna and Ruby were unaware of the observations taking place. Cynthia was aware of my presence and purpose and chose to interact with me on two occasions during an observation. There were occasions when unexpected visitors were introduced or a domestic staff member made comment or asked a question, or a doctor said 'hello' to me. Common to both the interviews and the observations was the level of noise present in the environment for the residents. Appendix 1 details my immediate impressions following the non-participant observations for Anna, Ruby, and Cynthia.

The Documentation

Following the interviews and the observation the documentation for the resident was accessed and photocopied for the purpose of analysis for each resident. The analysed documents included the current volume of case notes and all other associated documents, assessments, and programs pertaining to the residents. These documents covered the period of research and previous to the research for a period of up to two years. The documentation consisted of all records pertaining to the resident including their classification, resident care plan, night care plan, assessments, medical histories, letters, medication charts, observation charts, progress notes, medical notes, and monthly summaries necessary for validation and accreditation. The documents for the residents were the last data subset to be incorporated into the analysis with each resident's discourses analysed firstly from the interview transcripts followed by the incorporation of the field notes, and finally the integration of the documentation about the residents' nursing care.

The Analysis Framework

Analysis was structured according to case study methodology, whereby the first level of analysis involved the reading of text and data subsets for each sample unit including the residents' documentation, interview transcripts, and field notes. This yielded general themes to guide the concepts and themes for each of the residents separately until the fifth level of analysis. In this level the sample units and their data subsets were melded for overriding themes and this entailed a further four levels of analysis resulting in the final themes. Initial analysis took the form of coding and clustering around common themes for each resident known as the case analysis. The cases were then compared using cross case analysis and the final levels of analysis incorporated all three sample units and their respective five data subsets as a cross case synthesis.

All data fitted into one or more of the final categories or consequent primary themes common to the three residents. Following a Foucauldian line of inquiry, analysis of the discourses took the form of looking for conflicts, commonalities, discontinuities, agonisms, and discrepancies between what was said in the interviews, what was observed, what was written in the documentation, and my interpretation as a RN. The analysis outline provides the titles to the themes under which the relevant data sits. An outline of the analysis framework is provided in Appendix 2. The data moved between the themes and the cases throughout the deconstruction, construction, and reconstruction of the concepts. The seven themes finally constructed and conceptualised were common and evident in each unit of analysis focusing on the resident's nursing care provision.

This chapter began by considering the ethical dimensions to the research and then described the setting for the research, the recruitment of the participants for the research, and the methods used in data collection. The three residents as the primary participants of the study were introduced as subjects concerning the nursing discourses about them. The data collection methods included the use of audio taped interviews, non-participant observations, and analysis of documents that constitute the discourses about nursing care. Finally the discourse analysis framework described the structure and the levels of analysis using an individual

case analysis, cross case analysis, and then a cross case synthesis as ten levels of comparative analysis. The data questioned the discourses at their points of difference, similarity, conflict, and contradiction when referring to the same resident, nursing practice, or nursing care need.

The following three chapters describe and provide evidence for the findings under seven themes. Although some of the data crosses over into the other themes, these concepts of the nursing care provision in this facility are specific enough to alert, alarm, and concern the residents and their relatives, the nursing profession, the government, the industry, and the public. Because RNs are accountable and responsible for the nursing care provided by non-nurses, the following three chapters paint a perilous situation for the nursing profession, the residents, and their relatives. As will be argued in chapter 11, this discourse analysis exposed a situation as an undercurrent of the present aged care system and has been constituted by it - to the detriment of these residents' quality and quantity of life. The following three data chapters explain and describe the nursing care for these three residents. Through an open door the residents' quality of life appeared satisfactory, but exposing what was behind the door, through a detailed analysis of the nursing discourses, finds another truth revealed that is collectively entitled 'a discourse of neglect'.

Chapter 8

A Discourse of Neglect - Part A

The following three chapters describe the discourse analysis. A number of levels of analysis as outlined in Appendix 2 were undertaken pertaining to the units of analysis each containing five data subsets of discourse. The analysis began with separate case analyses, followed by a cross case comparative analysis, and finally a cross case synthesis. The ensuing seven main themes in the next three chapters were evidenced across all three cases. The data organisation could have taken many forms; however, the resulting findings were common in all the discourses. The analysis for differences regarding the nursing care for the residents revealed an overriding theme of neglect. This is the first of these chapters where the descriptions from the analysis and disparities are highlighted.

Many anomalies, contradictions, discontinuities, and conflicts were analysed in the data and themes have emerged from these differences, and also the similarities. The structure of the next three chapters takes the form of describing each theme and providing examples from the discourses with the main body of critique discussed in chapter 11 where the findings have been problematised. Under each of the themes the three residents' discourses are used, which entails constantly moving in between the three cases in each theme. The residents, as the units of analysis, had five data subsets generated for each consisting of individual interviews with an RN, CW, and the relative, as well as observational field notes and the document analysis as the sub units of differing discourses. Emphasis was not focussed on the residents as individuals experiencing residential aged care, but instead focussed on the perceived nursing care needs and the nursing care practices as the object under study for each of the residents. The residents were the vehicles by which nursing practice could be brought under the microscope.

The residents were determined by the RNs to be highly dependent on nursing staff and relatives for all of their care. Both Anna and Ruby were elderly and had end stage dementia, whereas Cynthia was a young person with a terminal cerebral

tumour. All the residents had neurological impairment, but Cynthia still had some cognition and was able to interact with others to some extent, despite her expressive dysphasia. The relatives of the residents were all informants for the research, together with the nursing staff, the documentation, and myself as a RN and researcher.

The following themes are described in the next three chapters with appendices used for long scripts of data.

- Indecent Haste - When a Minute is a Half an Hour
- A Risky Existence - When Safe is Unsafe
- A Documentation Quagmire - When Funding Drives Discourse
- Under the Sheets - When Incontinence Becomes Normalised
- Misdirected Stimulation - When a Home is Not Homelike
- Non-Autonomy - When Practices are Unethical
- Vigilance and Advocacy – When You Have to be There

INDECENT HASTE – When a Minute is Half an Hour

Indications of an indecent haste and hurriedness of the nursing staff was observed, documented, and filled the discourses. Nursing care was hard work, nursing staff were busy, and they did the best they could with what they had. All discourses acknowledged the facility was often short staffed. The nursing care was observed to be quick, rushed, unsafe, and mechanistic. The discourses revealed hurriedness, distortions of time, and staff ‘busyness’ in direct contradiction to the time afforded to the residents and relatives themselves. The environment was one of haste and getting things done with all staff continually on the move and actively doing something. All the relatives stated that nursing staff did the best they could in the circumstances of being short staffed and busy. The title ‘a minute is a half an hour’ came from Joe, Anna’s husband, who requested help from nursing staff and a minute of waiting turned into over half an hour. The following are themes that contain descriptions and examples that relate to this ethos of haste by nursing staff in this residential high care facility.

The Resident Timed

All of the three residents' discourses about their nursing care revealed mechanistic nursing practice determined by a lack of time and being shortstaffed. The residents' nursing care was talked about according to the time the nursing activities took, and then this was further related to the residents themselves in that the residents were known by the nursing staff according to the time taken for their nursing care. The observations of the residents' care contradicted what was stated by the nursing staff and relatives, with what was written in the documentation.

In Anna's case, the discourse from the CW when speaking about Anna's meals was one of the CW needing to take the time necessary as 'it takes how long it takes'. The CW emphasised Anna's slowness in eating and the time that was needed. She also stated that Anna did not eat much at breakfast and that she was difficult to feed although it was much better when Joe was there to do it. This implied that when Joe was not there Anna did not eat and drink much, was a 'slow eater', and that this was difficult. The CW implied this was because of a lack of appetite and Anna's choice of not eating, however, the rationale of 'slow eater' would indicate that time allowed for nutrition and hydration of residents was restricted and insufficient, as one CW explained about Anna.

CW: Ah, well, staff would feed her and um, and spend as much time with her I suppose until she's had her lunch. Yeah, I think it depends on how well the staff know her too. The staff that are here permanently usually know Anna very well, tends to know what... Yeah, yeah. That's our job isn't it, to look after the residents. I mean I think we can take that role, like the lady next door, to feed her. Yeah, for sure, but if it takes that long to feed her, it will take that long to feed her and that's that. Yeah. She won't get her own, no, no she can't move her body to look after herself or feeding, and when she drinks fluids, she guzzles them, she loves drinking. Yeah, she'll just keep drinking and drinking, which is good... we just look after the residents and even if it's like one o'clock in the afternoon, we'll just keep going. You can't rush people, you can't rush, you can't tell them hurry up and eat. They'll eat when they're ready and you just have to wait until they're finished and if you're running behind, that's just tough (laughs) you can't do much about it or they will be undernourished. (Data CW Anna p37)

The CW stated that Anna loved drinking and described this as being ‘good’. The implication was that a resident who did not drink well or who had swallowing difficulties would be a problem and a ‘bad’ drinker or ‘not a good drinker’, which then becomes the rationale for abandoning nutrition and hydration for residents. A good drinker was someone who ‘guzzled’, ‘loved’ drinking, and would ‘drink and drink’ because this meant less time had to be spent on their hydration. This would be problematic for a resident who was slow, had dysphagia, or was at risk of aspiration where nursing staff were also pushed for time.

In contradiction to above CW’s discourse and at the same time in support of it - the resident in the next bed to Anna, referred to as Irene, formed part of the observation of Anna’s environment and also Joe’s discourse. Irene’s care epitomised the rush and consequent undernourishment of a resident when inadequate time and care was devoted to the activity of providing nutrition and hydration. Irene was emaciated, cachexic, and totally dependent on nursing staff in all activities. Furthermore, a CW took 3-4 minutes to provide food and fluid to Irene at lunchtime. Irene’s intake was insufficient because the CW abandoned the meal after a couple of spoonfuls of food were given.

Anna’s husband, Joe, stated that adequate drinks were not given by nursing staff because they did not have time, and he had observed this occurred mainly on the weekends when there were agency nurses on. He believed this was occurring because the nursing hours had been cut and residents, such as his wife, needed time to assist them to eat and drink, and that is why he came in everyday as he explained in the following excerpt.

Joe: Half an hour, no even longer. Yeah, if she eats better than half an hour, if she doesn't then it takes her 45 minutes, yeah. But I don't know if she eats... I take the time, I've got the time, it's alright, yeah. Yeah, yeah and that's better to feed slower, because I see some who is with the next lady (Irene), they give her sometimes for five minutes, who will give, but then she coughing after, because they never give anything but slops here. She coughing and coughing but she start to reflux. Yeah, oh yeah. Yeah, maybe she have, but for sure she wouldn't have, she wouldn't get, she wouldn't get the same and I bring always a vitamin in the morning, yeah, and I give a drink and I know she drinks, yeah, yeah, but the nurses, if she doesn't drink or doesn't eat, they just go somewhere else! That's it... Well if the nurses go to another people, that nurses feed them,

that's why they go so quick, yeah. Yeah some, some takes the time, some takes the twenty minutes before finished, yeah. But some, it's a very quick. (Data Rel Anna p38)

Joe's observations of what the care was like for residents such as Irene ends up with Joe rationalising excuses for the nursing staff concerning Irene's care, whereby he states that she must not be hungry; or she must be much quicker than his wife; or the nurses were in a hurry because there were other residents to attend to. Joe talked of the quickness of nurses feeding Irene for five minutes and that it would be the same for his wife if he did not come in. In contrast, the technique and approach of Joe when he was giving Anna her lunch could only be described as remarkable and very different. The verbal, intimate, and tactile attention given by Joe and needed by Anna to eat her whole meal was time consuming, and nursing staff did not appear to have the luxury of time.

In Ruby's case the RN commented during the interview that a resident like Ruby was more 'physical care' and 'less time consuming' than those residents with whom the staff had to talk into doing things or who had to be 'argued' with to get them to comply with care. According to one RN, Ruby was classed as a highly dependent resident but she was actually less time consuming for staff than the residents who were exerting autonomy, resistance, or difficult behaviours. Although Anna and Ruby were classified as two of the most highly dependent residents in the nursing home - they actually took less time than those residents considered less dependent according to the RCS classification. There was a contradiction in the term 'dependency' in that what the nursing staff classed as highly dependent and what the RCS classified as highly dependent were different. The RN explained in the following excerpt.

RN: Um, no more than any other general nursing care person. But it's generally, you're doing everything for her. They actually take up less time than people you have to argue with or talking to, support or people you have to stand back and talk them into it. It's actually, it takes less time, but it's more, more physical work, just less time consuming. (Data RN Ruby p41)

During an observation of Ruby two CWs came into her room to attend to her hygiene and positioning needs. The time taken by these two and then three CWs in total was five minutes from beginning to end. During this time Ruby's

incontinence pad was changed, she was repositioned, and she was chastised. There were no passive limb exercises undertaken, no grooming of her hair, no oral hygiene, and no offer of a drink. This mechanistic and hurried care was also observed with both Anna and Cynthia, and was at the same time contradictory to all three residents' documentation and the nursing discourses about each resident's needs. In this same observation, the husband Ben gave Ruby her lunch consisting of a main meal, dessert, and a cup of tea. This took a total of 30 minutes and Ruby ate it all and ate well. She did slow down towards the end of the meal, but Ben persisted with verbal encouragement and patience. A CW stated it took Ruby about 20 minutes to eat her main course, desert, and have a drink and this implied that the CW took less time than Ben, and may have cut the meal short.

One CW talked of the mechanistic process of eating and drinking and the slowness of residents during mealtimes like Ruby. It was also implied by this CW that the meals were too big and this could be interpreted as her perception being 'too much' to be given in 'too little time'.

CW: We feed her. Full assistance, I mean again, because of her dementia, she doesn't know that there's a meal there, or that there's a drink there, she's full dependent on nursing care, but like with most of our dementia feeds, it's all very slow and the time. It's not like you know, putting it, shovelling it in and to somebody's, you know one after spoon after another with dementia's, you've got to be very slow and I mean sometimes they may hold it for awhile in their mouth before they'll swallow it. They might pocket the food, and take their time, but then they'll swallow, then you know they're ready for the next spoonful. Yeah, so at the moment she's alright. It could take a good 20 minutes. Good 20 minutes if they've got there hot vitamised food and it's, you know it's like one spoonful at a time and it can be very slow, when she's not swallowing straight away, and then after that it's a big desert. You know a big jelly & custard, or pureed fruit. It depends on the resident, they're all (different). Yeah but it could take a good 20 minutes for Ruby to get through a hot dinner, then her desert and then her drink as well. Give her adequate fluids at the time, if she's awake. (Data CW Ruby p115)

The CW's perspective in the above indicated it took too much time to feed residents like Ruby their meals, as well as the meals being too large. This contraindicated the observation of both Ruby and Anna where all of the meal and drink was consumed and the amount did not appear to be 'big'. This distortion of

the amount of meal and the time afforded to give the meal was important in that if a CW judged the meal to be too big for a person like Ruby, who slowed towards the end of her meal, then it would be easy for a CW who was rushed to cease the meal short of nutritional requirements. As such, the motivation for the encouragement of the resident to take food and fluid would be limited by time factors rather than guided by the resident's nutritional needs.

The sub theme of the residents being timed in their activities of daily living and their dependence on nursing staff and their relatives for their activities revealed nursing staff rushing care and timing nursing especially in the areas of hygiene and nutrition. This reduced the nursing care to that of timed activities and this was then transposed to the individual residents as to how long the activity took. This was detrimental for the residents in that the timing of any nursing care was being driven by the time afforded, and not by the residents' nursing care needs.

Time Stressed

This sub theme of haste identified mechanistic care being determined by the number of nursing staff and the time allowed for nursing care. Thus nursing staff were under stress to accomplish all of the basic care within a limited timeframe. Time was at a premium to the activities necessary and the minimal was done in the minimum of time with the minimum of staff. The discourses revealed an overriding or ubiquitous environment of haste that was produced by pressure on the nursing staff who undertook the nursing care. Any deviation from the normal routine care that may take extra time or extra staff was viewed by the nursing staff negatively, and this was transposed onto the residents in the form of the resident being slow or not-good, resistive, non-compliant, or difficult.

During an observation two CWs came into Anna's room stating they were there to 'sort out' Anna. This whole hygiene check and repositioning took no longer than 4-5 minutes and was done in a very mechanistic way. The whole episode of changing Anna's Kylie (absorbent sheet) was rushed and also unsafe as it was completed by one CW who carried on after the other CW had been called away by

the intercom. The bed brakes were off and the bed moved until it was jammed against the locker. The CW did not use a lifting aid as was directed in the documentation, and instead lifted Anna in the bed manually by herself employing none of the principles of manual handling.

In interview a RN stated Joe was aware of the stresses and strains nursing staff were under. This implied it happened all the time because Joe was there everyday and would see this. Joe also commented in interview on the shortages of staff, the hours cut, and the use of agency nurses. The RN was 'grateful' for Joe being there every day and caring for Anna because this took the pressure off of the nursing staff. Thus, there was a reliance on the husband for the care, observation, assessment, interpretation, and reporting of any problems with Anna. Essentially staff did not have the time to accomplish what Joe could because he had the motivation but more importantly – he had the time. Joe was vigilant of Anna's skin integrity and stated in the following his perception of the timing of Anna's nursing care.

Joe: I went to sister and nurses to tell the, that Anna needs the clean up. It was half an hour before they come. Yeah, it's a long time half an hour. It a burns. It burns when you lay there in that (urine and faeces). Yeah, they said, we busy. We be there in a minute. Yeah, we be there in a minute, but a minute is a half an hour (laughs). (Data Rel Anna p36)

The nursing staff would not, could not, or may not have the time for meeting all of Anna's needs because of the stresses placed on them and, therefore, the emphasis on time and getting things done by the nursing staff were paramount.

Similar concerns with Ruby were raised in relation to time. Ben, Ruby's husband, acknowledged during interview the busyness of nursing staff who were 'flat out', however, he qualified this with a statement that despite this busyness there was always someone available if he should need them. This raised questions concerning the responsibility of actively seeking out 'someone' rather than being informed of any problems. Furthermore, Ruby was unable to actively seek assistance if she needed something. One RN belied the state of hurriedness that permeated this facility in the following excerpt:

RN: Well they're meant to give her a top and tail when they change the pads, cause she's on incontinence pads and in the afternoon it's just like a quick top and tail before she settles. (Data RN Ruby p42)

The words that CWs were 'meant' to give Ruby a 'quick' top and tail implied that she was not sure it was being done, and the use of the adjective 'quick' also gave the impression of things being done as quickly and as efficiently as was possible given the context. It was also inferred by the use of 'afternoon' and the phrase 'settles for the night' used in the one reference that Ruby was settled for the night in the late afternoon or early evening. This would create a substantial length of time between Anna's repositioning and the potential for any fluids to be offered to her.

The 'busyness' of the nursing staff appeared to be a large problem for the mother of Cynthia, Betty. Her understanding of why nursing staff were too busy was that it was related to cuts in staffing hours, and in her view there was a shortage of nursing staff. There were not enough nursing staff on to be able to provide for Cynthia's nursing needs, which were extremely complex and required 4-5 persons assisting at the one time.

Betty: As I've said before, they're not as quick as you would want them to be but then that would apply to all the others as well, so, and I think mainly it's, it's lack of staff. They just can't be everywhere at the same time. But as I said the response is not always there for Cynthia, simply because she needs so many people to help her. I'm not saying they don't want to - I'm saying that they just haven't got the time. (Data Cynthia Rel p46)

Betty advocated and argued for additional staff hours through her representation on the residents' committee at the facility, but this did not get her anywhere and she had become docile and accepting of the situation. It was normal for nursing staff to be busy. There was no indication during the interview that Betty would complain using the government scheme in place. Betty also stated she had noticed the difference one postgraduate RN had made to the general calmness and less busyness of the nurses, as there was more time to deal with things.

A CW interviewed about Cynthia's nursing care needs also stated that the nursing staff did not have the time and it was 'impossible' to meet all of Cynthia's needs

both physically and socially. The lack of time and staff numbers for Cynthia's care was described as being 'frustrating' by the CW. The RN stated that there was a great amount of help and time given by Betty caring for Cynthia, which in the RN's view was necessary because Cynthia got 'demanding'. It can be assumed that if the time allowed for care was not adequate, what may be deemed as 'demanding' may well be an expression of need by the resident. This need expressed through difficult behaviour may not be met or not met in a timely and appropriate manner. The RN indicated that pressure was taken off the staff by the mother taking the load and caring for Cynthia. This was also the case with Joe and Anna. It was implied by this RN that she did not have the time to do regular assessments of Cynthia, and was reliant on the mother to let her know of Cynthia's needs or problems, and this was the same for the other cases. This RN also stated that the rosters, overlapping of shifts, and the routine had all had to be changed for Cynthia to accommodate her nursing care needs and the mother's wishes.

This sub theme of the nursing staff being described as time poor and the organisation short staffed caused stress on the labour time, nursing staff, and the nursing care had become mechanistic and rushed. As well as the residents being described on the basis of the time it took to provide their nursing care, the discourses and activities were constituted by the routine, system, and labour available - rather than the residents' nursing care needs. The following sub theme describes another perspective of this hurriedness and haste from the relatives who described residents having to wait for nursing care, especially in Cynthia's case.

Wait on Time

The residents had to wait for their nursing care and it was delivered according to the routine of the organisation, the number of staff present, and not their assessed needs. There were a number of references to the waiting and care not being provided in a timely manner. The nursing staff all commented on the amount of time Joe, Ben, and Betty spent helping in the care of their loved one. This tone was one of being very grateful to the relatives being able to help because it took the pressure off of nursing staff who then had more time.

In the following extract Joe described his concern about pressure sores developing with Anna, and the necessity to take the care into his own hands because he could not wait for nursing staff to come and undertake the care.

Joe: Yeah. I'm a real nurse, yeah (laughs). They have to be turning around every two hours in the bed, but it hasn't, but they doesn't do it. Some of them does but some doesn't. Some does it three hours, three and half hours later that I am staying there. I do myself. I don't go ask the nurses or sisters. I do myself. I do this. Yeah, it's always red when you turn her around, yeah, that's why I turn her around, yeah. (Data Rel Anna p40)

Joe believed he had to care for Anna's skin integrity because if he did not do it the staff would not be able to do it as frequently as it needed to be done. The waiting he did for his wife to be repositioned and have hygiene needs attended to was another contributing factor to his belief that it was easier to do the care himself, and also his belief of 'having to be there' described in the last theme on vigilance in chapter 10. The documentation stated Anna was to have two hourly repositioning and hygiene needs attended to, however, the husband's discourse contraindicated that this was accurate, and it appeared staff were not able to meet this timeframe of nursing care.

Cynthia's data was particularly indicative of the rushed and hurried ethos of the facility and the effects this was having on the nursing care provision, and the residents themselves. The palliative care nature of Cynthia's nursing care needs was non-existent in the discourses. Her care was viewed to be extremely problematic and required time consuming assessment, care, and evaluation but this was not evidenced. She needed at least four nursing staff to attend to her needs because of her obesity and she had become bed and room bound. Cynthia would have to wait 30 minutes or longer for sufficient nursing staff to gather in order to use a bedpan and this delay led to her having faecal incontinence together with urinary incontinence. This was a direct result of staff not being able to gather and provide for Cynthia's continence. Furthermore, the configuration of staffing meant that Cynthia had to wait until very late morning, lunchtime, or even after lunch for a full bed wash until the parents complained. Following the complaint, this was then changed to 0600 before night staff finished their shift so that the

numbers were present, but this was not satisfactory for the mother or Cynthia - who loved to sleep until breakfast time.

Cynthia's case exemplified the ways in which the dignity of residents was being compromised by the rushed nature of care. The mother's explanation of the problem of Cynthia having to wait for nursing care was revealed in the following extract.

*Betty: I really couldn't fault the nursing staff because they try to get there as quickly as possible, which is not always straight away. One night in particular, she waited, she pressed the button for the bedpan and she waited an hour and a half and it was too late, and that was simply because there was not enough staff to cover the afternoon shift. And that's another thing, I really believe they need another person on afternoon shift to just to be able to come more quickly because of the amount of nurses she needs. If two of them are at tea, then there's no one to come to fix her up, and so she does it in the bed, and then she's still got to sit in that until they come to, until they come back from tea. So that's a bit, not very good. ... Yes but it's too slow sometimes, so you know.
... and it's simply because she needs so many nurses, and there just isn't, I mean there's a lot more through the day, but even then, they can't always come straight away which I mean you can't expect them to be at her beck and call but, and that's what I say because she needs so many nurses it's hard for them to get them all together to get down there, and in the meantime she just sits in whatever she's done... (Data Rel Cynthia p44)*

Betty also stated clearly in interview that she had to be here during lunch and tea to ensure Cynthia had her needs met. The underlying rationale of Betty's reasoning about having to come in every day for meals implied nursing staff could not be there for Cynthia or did not have the time for the one on one care needed during her meals.

The nursing staff documented excuses and explanations in the progress notes when they were not able to accomplish an appropriate time frame for Cynthia's hygiene needs. The short staffed and hurried nature of the facility was further evidenced by an extraordinary entry in Cynthia's progress notes by a CW who documented an apology for not being able to attend to Cynthia's full sponge in a timely manner because of being short staffed. It was apparent from the following text that the documentation was used as a tool by the nursing staff to vent some

level of frustration at not being able to provide timely nursing care for Cynthia. This notation was also written retrospectively the following day and implied the CW wanted to make a point that carried forward into the following day.

14-1-01 1135hr Cynthia attended to at 1300hrs yesterday, a full body sponge given and ADL's by 4 Nursing Staff. Apologised to Cynthia for being so late but explained we were short one nurse for a period of time, Cynthia accepted this with a nod of her head + a sigh! (Data Doc PN p45)

The fact that the CW recorded this sigh from Cynthia demonstrated this was a common occurrence or rationale given to Cynthia who had come to accept her situation as the norm. As such, Cynthia had become docile in a system over which she had no control as an oppressed person. It had become normalised for her as demonstrated through this acceptance of her untimely care caused by being short staffed.

Betty also raised concerns about Cynthia's safety and the possibility that Cynthia could have a seizure and that no one would know or be able to help.

Betty: The only thing that worries me about her safety is, that is if she seizes and no-body comes like quickly - like that hour and a half I was talking about before - what if it took an hour and half for them to pop their head in the door - she's been seizing for an hour and half. If she gets to ring the bell. Yeah. Which she always used to know before this last bout that she was going to seizure - she would know. I don't know how, could she could never tell me, but she did used to know and she would come inside and sit on the lounge, take her glasses off and she'd go into a seizure but whether she can still do that - no I don't know - whether she could still know? Cause she hasn't had a seizure since she's been in here so I don't know whether she'd be able to press the button or whether she'd think, or something, or I'm going to have a seizure. I don't know that and that's what I mean - the monitoring part of her worries me a little bit - that she might be seizing for quite some time before even they even got oxygen on her - that does worry me a lot. (Data Rel Cynthia p3)

The mother's anxiety about Cynthia's predicament demonstrated long periods of time between nursing care and an inadequate monitoring of Cynthia who could now be left for up to 8 hours because she was on a wave mattress to reduce the number of times nursing staff had to reposition her.

Cynthia had become bed bound and room bound. This had occurred five weeks previous to the data collection, and because of this her hair had not been washed for at least a period of five weeks, and possibly seven weeks. One RN stated she was planning to have Cynthia's hair washed in one week's time making it six weeks in total since it was last washed. Betty had complained that Cynthia's hair was starting to smell and needed to be washed. All the discourses contradicted each other in regard to Cynthia's hair care.

RN: Washing her hair in bed is a difficult task and she's got such lovely long hair and she really is proud of it and she likes to keep it well maintained. Hard to brush her hair when she's in a bed. (Data RN Cynthia p30)

The nursing practice needed to wash a person's hair in bed required simple equipment and was certainly achievable in Cynthia's case. The RN was unaware that Cynthia's hair had not been washed for a number of weeks and stated it was a difficult task just to brush her hair. The discourses revealed residents had to wait on time for their care that was determined, in the main, by the number of staff available to undertake the care and the time afforded to them, as well as their knowledge and capability. The delays in providing nursing care in a timely manner were evident, as was the rushed and busy nature of nursing staff.

In summary of this theme of haste described in the discourses it was apparent that there was an entrenched milieu of staff busyness and staff not having enough time to accomplish meeting the residents' nursing care needs and this was attributed to being short staffed. Foucault (1977) states that the time and activity of any discipline or organisation is scrutinised with the aim of gaining the maximum cost effectiveness and efficiency through the imposition of a mechanistic program. This program assures control of the system and its mechanisms become a force for the docility of the workforce and an acceptance of the situation. In a discipline, such as aged care, the system capitalises on the activities of the labour force through the control of their time and activities. This is scrutinised through the increasing mechanisms that minimise the time available to perform the activities in a practice.

Control of time can have both positive and negative effects and the disciplinary system of residential aged care was having a negative impact on the nursing care these three residents received in this facility. The haste and busyness of nursing staff was constant and normalised, and delays in care made apparent were detrimental for the residents. There was a resignation reflected in the discourses from the relatives and the nursing staff of 'that was how it was' and their belief that nothing could be done about it. All of the participants were resigned and had become docile to this normalised environment of haste.

This situation for nursing was constituted by the system of governance in an alliance with the organisation, and it had impacted on the nursing care provision for these residents with time being a dominant factor. In this capacity of limited time any unpredictable event would be a potential problem that could be dangerous and put the residents at further risk. In this analysis, however, even the predictable side of nursing care for the residents uncovered unsafe practices and untimely care. The basic security concerns described in the following theme on safety in this facility were based on further discourses about the nursing care for these residents where time had a significant part to play, but there were also other factors requiring additional consideration.

A RISKY EXISTENCE – When Safe is Unsafe

The residents' safety and security needs were found to be continually and consistently compromised and the following two major themes provide detail related to either negligent or unsafe practices, or a combination of the two. The negligent practices focussed on the medical and nursing assessment, and the unsafe practices focussed more on the nursing care provided for the residents. The analysis uncovered mistakes, contraindications, discontinuities, and conflicts in nursing practices that were deemed to be unsafe. Although the nursing home had been accredited in the past six months the nursing practice or non-practice appeared to be normalised for these three highly dependent residents. Accreditation implied a minimal level of safe practice; however, this was not supported in the data generated from the case studies. Some of the sub themes

only focus on one resident's data subset, but the themes are recognised across the three cases under negligent and unsafe nursing.

Negligent Practices

The negligent practices included untreated hypertension for Ruby and Anna; chronic conjunctivitis with Anna; and an ascending urinary tract infection (UTI), an undiagnosed deep vein thrombosis (DVT), and medication errors associated with Cynthia's care. These non-practices involved a lack of communication and assessment between the CWs, the RNs, and the general practitioners. The analysis revealed a number of contradictions and disparities in the residents' care and treatment, and or non-care and non-treatment.

Untreated Hypertension

The documentation in both Anna and Ruby's casenotes revealed a number of anomalies in regard to their blood pressure (BP). The records in their casenotes were poorly completed and recorded. It was apparent the CWs doing the observations did not understand how to assess and document blood pressure readings appropriately. In Anna's case the GP had documented in the medical notes that the antihypertensive medication had been ceased for Anna, but her readings became progressively higher in the previous three months with blood pressure readings of her diastolic above 100mg. Anna's husband, Joe, was unaware of this hypertension as he stated Anna's blood pressure was normal and she was off her antihypertensive medication. Neither the RNs nor the GP monitored, assessed, or took appropriate action regarding Anna's ongoing hypertension.

Ruby was also hypertensive and had been taken off her antihypertensive medication. The doctor had requested weekly blood pressure readings because of this, but her BP had not been recorded for three months. The last reading for Ruby was 176/124, but the observation chart was not dated. Ruby's ongoing hypertension was not reported, noticed, or assessed by a RN or GP, and Ruby's husband, Ben, was also unaware of Ruby's hypertension.

Ben: Ah she's on nothing now. Originally she came in, she was on tablets and doctor took her off all medication and personally I think she was less, less irritated than when she was on medication, you know, she sort of went a lot, lot quieter. She was originally on blood pressure tablets. Once she was in here for awhile they took her off them because her BP was good. I think probably because she had lost all knowledge and worry and that sort of thing. (Data Rel Ruby p17)

Both Anna and Ruby were at risk of complications for their untreated hypertension, however, both their husbands believed their wives were no longer hypertensive. There were no records of this being reported to the RN, assessed appropriately, or acted upon. The documentation for both Anna and Ruby had contradictory entries, were not dated, and were incorrectly recorded by the CWs.

Anna's Untreated Conjunctivitis

Anna's case notes stated that she had no allergies, however, Anna's medication chart stated she had an allergy to Soframycin eye ointment, but this was not documented anywhere else. In the resident care plan CWs were instructed to 'apply eye ointment', but what ointment was not specified. This contradictory and confusing information was putting Anna at risk of an allergic reaction. It was constantly documented by the CWs in Anna's progress notes she had 'mucky' eyes, but this had not been assessed by the RNs or the GP. The CW also indicated in interview that Anna's eyes needed special care because they were 'mucky'. During the observation of Anna it was noted she had a purulent discharge from both of her eyes and she had difficulty opening her eyes. Joe cleaned his wife's eyes with a flannel whilst waiting for her lunch because of this obvious discharge. One CW reported the following in the progress notes that demonstrated the level of assessment and treatment for Anna's chronic conjunctivitis over a period of months.

1845: residents left eye had a lot of discharge and very red – nurse treated eye with a good clean. (Data DOC Anna PNs CW p244)

There were no references in Anna's care plan about the treatment or care of her eyes, and it appeared her conjunctivitis had become normalised and, therefore, it had remained unassessed and untreated. There was no documentation directing CWs how to care for Anna's eyes, despite consistent documentation in the

progress notes of the infection being present for a number of months, as well as my observation of a purulent discharge from both her eyes.

The Development of Cynthia's DVT

Unsafe situations bordering on negligence were identified in the discourses centred around Cynthia's nursing and medical care needs, which were much more revealing of the risk to her life and indeed, her premature death. The details of these practices were only revealed in the retrospective cross analysis of her documentation and are summarised in the following. The development of Cynthia's DVT can be tracked through the documentation to have developed undiagnosed for a period of more than four months. The pain assessment and management observed and analysed from the discourses was of a poor standard. Throughout the progress notes, Cynthia's complains of pain in her right leg, as well as in her back and abdomen. Her complaints of pain were not assessed, described, diagnosed, or treated appropriately. In the documentation, it was reported that if she complained she was in pain - the only treatment given was the administration of two paracetamol repeatedly, and then there were no further entries until the next complaint. Over a four month period of the DVT developing and going undiagnosed, as well as Cynthia having an untreated but diagnosed UTI, there was no pain assessment undertaken by any of the RNs or the GP regarding her pain and she was simply given mild analgesics.

Cynthia's consistent complaints of pain had become normalised and she was described as being difficult, demanding, moody, or non-compliant and this was traced through the progress notes completed by CWs and countersigned by RNs. Appendix 3 gives a running commentary drawn from Cynthia's progress notes regarding the development of her DVT until it was finally diagnosed. In support of this, the nursing practices of passive limb exercises and range of movement (ROM) exercises were not undertaken to prevent a DVT from forming. Furthermore, the commentary in Appendix 5 on Cynthia's rashes, pain, and positioning lends further evidence to the reasons why her DVT was not diagnosed. The mother was also concerned during the interview about Cynthia's

cramps in her right leg and the positioning of her right foot and had been worried about this for a number of months. The DVT was diagnosed one week after data collection.

This standard of nursing practice was unsafe and did not meet the standards of care, a duty of care, and could be viewed as negligent through a lack of assessment of the clinical manifestations. An appropriate assessment was not undertaken, and the GP may not have been informed by nursing staff of Cynthia's persistent symptoms. It had become normal for Cynthia to complain of her right leg pain, as well as her abdominal and back pain, and she was labelled as demanding or 'difficult'.

Cynthia's Untreated UTI

Before and during the same period Cynthia was developing the thrombus in her right leg, she was also getting repeated indwelling catheter (IDC) induced UTIs, which had become acute on chronic. The documentation revealed an underlying struggle by the CWs and RNs to keep the catheter in situ because of the problems of her obesity and her having become bedridden. The GP documented the UTI could not be treated whilst the IDC remained, however, the GP did not order the removal at this time, but directed that Cynthia's temperature be monitored. Cynthia's temperature was not taken once and the IDC remained in for a number of months after the pathology report. It was finally removed and left out after continual blockages and leaking, but Cynthia was not treated with antibiotics. The language used and the reading between the lines found nursing staff pressuring for the IDC to be kept in, despite putting Cynthia at risk of an ascending UTI and the risk of nephritis. Appendix 4 relates a commentary from the tracing in the progress notes regarding the development of Cynthia's chronic UTI and the struggle to have the IDC remain in situ by the nursing staff. No appropriate nursing assessment of Cynthia was undertaken during this period of the untreated DVT, UTI, and continual complaints of pain and feeling unwell continued. This poor standard of nursing assessment bordered on negligent nursing practice.

Cynthia's obesity was very problematic for the nursing staff and they wished for the IDC to remain in situ. She continued to gain weight to a stage where she was bedridden and room bound. The nursing staff stated in interview that her obesity was caused by the amount and type of food Cynthia ate and that she was 'spoilt'. This was questioned during the analysis because of the signs and symptoms of fluid retention and other manifestations described in Cynthia's progress notes. Her untreated ascending urinary tract infection could have also been a factor in her weight gain, if the infection had reached the kidneys and there were notations of anuria, oliguria, and polyuria. In the following excerpt from the interview with Betty she described what appeared to be Cushing's Syndrome. Her weight gain may also have been caused by acute kidney failure, and this could also have been a contributing factor rather than her caloric intake and love of food.

Betty: Yeah most of the drugs she's on are anti-seizure and they've just gone up and up and up over the years to try and control, and swapped around with different ones and yeah.... the only one they're decreasing is her dexamethasone because that was up to 28mg a day which I thought was too high and questioned. Because that was also putting weight on her, she got very jowly and hair growing everywhere, so and in the past when she's had a high dose of dexamethasone her neurologist always bought that down slightly, down to a well, when she was still home she was only on 4mg a day and when she was in hospital it went up to 28mg (Data Cynthia Rel p155)

No assessments were undertaken or documented in regard to her weight gain, and nursing staff instead referred Cynthia to a dietician. It was possible the weight gain could have been caused by fluid retention as she exhibited dependent oedema. This may be due to her high doses of dexamethasone or complications from the IDC induced UTI that may have caused problems with her kidneys. Assessments in this direction were not undertaken by the RNs or the GP.

Cynthia's Medication Errors

Medication errors were revealed in the analysis of Cynthia's prescriptions and the documentation in her progress notes as one incident, as well as her mother's knowledge of other medication errors that had occurred. The documentation stated supervision and help was required for Cynthia to take her medications. It was documented in the progress notes that Cynthia was refusing to take her tablets

and one RN documented this because she could not establish whether Cynthia had taken her tablets or not. Her medications, including benzodiazepines were left with Cynthia and this dangerous practice was significant given her documented symptoms of despondency and depression and her need for assistance. Cynthia had had previous experiences of the wrong tablets being given to her and she was probably questioning whether the tablets were the correct ones. The mother was also concerned about a number of medication incidences that had occurred with Cynthia.

Betty: Yeah, but if they (RNs) happen to make a mistake, Cynthia would take any medication they gave her though. If a mistake was made she wouldn't question what they were giving her, not anymore, she would have once upon a time, but she wouldn't now. And that has happened but I was here at the time so she didn't take it. And that was not, not by regular staff, that was by agency yeah. Three times its happened since she's been here and every time was an agency. Not that I'm saying they're not good nurses but what I'm saying is they, when they come here they don't know each individual patient. They got to... but it shouldn't happen because her medications are all in those blister packs and it's got morning, lunch, teatime, bedtime - so how can you make a mistake? I mean one day she was given a little Italian lady's medication and that possibly I think she was a diabetic, diabetic medicine, I think, and that maybe could have sent her into a seizure, how does anyone know? But I was there see and I said 'this isn't Cynthia's tablet'. And she said 'yes it is' and I said 'no it's not'. I said she doesn't have a tablet like this. So she went back and she said 'ohh' and she said 'by rights I should put a report in about this but seeing as she didn't take it I won't' that's what she said. But I think she still should have because if I hadn't been there, Cynthia would have swallowed it. That's right. (Data Rel Cynthia p24)

A serious medication error that Betty was unaware of was also revealed in the analysis of the documentation. This medication error was ongoing because of the documented behaviour of the 'doctor being in a rush' in the progress notes and also failing to come into the facility to address the prescriptions when requested on numerous occasions. This resulted in a mistake in the transcription of the prescription and this was not picked up for 17 days. This medication error involved anticonvulsant medication and resulted in an underdosage of Cynthia's medication placing her at risk of convulsions. The following demonstrates the beginning of a chain of events contributing to this serious error.

10-1 2300 – S/B DR @ 1800 – to review drug sheets – DR in a rush – Did not finish drug sheet – Topiramate am dose not included – prn not written. Previous Drug Sheet remains in use till he returns. DR has also left his Medical case here – Surgery Notified. (Data DOC Cynthia PN p44)

Following this entry, what ensued was a commentary of a documented chase that spanned one month by the RNs for the doctor to attend the facility and write up Cynthia's medication chart. Because of this GP's persistent non-attendance, it became necessary to transcribe Cynthia's medications to a new medication chart and in the transcription an error was made. The doctor's hand writing as to the number of doses was illegible on the old chart. When the doctor finally attended the facility he changed the medication and it was documented the doctor spoke to the clinical nurse manager 'at length' with no description of what this conversation was about. The doctor was again contacted ten days later regarding Cynthia's medications and the doctor directed staff to then check and inform him of any 'errors'. Later that day it was documented that no further medication charts had been received from the doctor and the medication chart remained unsigned. The mother was fearful of Cynthia having a convulsion in this facility, but at the same time did not know of this medication error. Betty believed that Cynthia's anticonvulsant medication had been increasing – not decreasing.

The above sub theme of negligent practices was identified in the discourses through the tracking of the contradictions between what was observed, said, known, and written. The following theme of unsafe nursing practices were less life threatening, however, these were no less important as they had a large impact on the residents' quality of life, the relatives as carers, as well as the working life of the nursing staff.

Unsafe Nursing

The unsafe nursing practices spanned all of the discourses for each of the residents. These were revealed in the contradictions between the discourses about what was said, documented, or known about some aspect of the residents' nursing care needs or provision. These contradictions occurred between what was stated

by the relatives and the nursing staff with what was written in the documentation, what was observed, and evidence based nursing. The disparities uncovered between the discourses related to a questionable or poor standard of nursing, whereby the residents were continually at risk, as were the nursing staff.

When asked a question about safety and security, the nursing staff responded by talking about the restraint of the residents. The residents' safety was a matter of needing to restrain Anna and Ruby and contain Cynthia. The residents did not or could not move and this was considered 'good'. The emphasis on restraint and containment of the residents to provide a safe and secure environment failed to take account of any number of other risks. The CWs acknowledged bedrails, the advantage of comfy chairs in restraining residents, and making sure the breaks were on for the bed and equipment. Ruby's husband Ben also believed that safety for Ruby was a matter of her 'being very good' by not falling out of bed as had happened to her once previously. The RNs' responses to the question of safety also referred to the residents not being able to harm themselves, and there was an acceptance that all was being done by the nursing staff in regard to residents' safety. Any program or discourse that only had the aim of preventing residents harming themselves would ignore the other important aspects that can place residents in risky situations.

Anna's Weight Loss

According to the documentation Anna had experienced a weight loss of 8 kgs over the past year and a loss of 3 kgs in the previous month. There was no acknowledgement of this weight loss other than numerical recordings in the weight chart. There was no documentation in the progress notes in reference to these observations, even though it was directed by the dietician that Anna was to have her weight monitored. The dietician also stated Anna's weight was to be reviewed in 2 months but there was no documentation of this review having taken place in the ensuing year. The speech pathology assessment stated a different current weight to that on the weigh chart, and although monthly weighs were requested there had been no assessment or comment made about Anna's weight

loss in the previous three months. The monitoring of Anna's weight was not occurring and, therefore, it was not assessed or addressed as a problem.

At Risk of Aspiration

All three residents were at risk of aspiration and choking, but the discourses were contradictory and confusing. In Anna's case, the speech pathologist directed Anna to remain upright for 30 minutes after meals and she was placed on a vitamised diet and thin fluids, but this directive was not carried over into the resident care plan or into practice. During an observation of Anna she was laid flat on her right side by the CWs very soon after eating a full lunch. There was also one episode of Anna choking documented in the progress notes, however, there was no assessment or subsequent modification made to thicken Anna's fluids. The husband Joe, however, stated that he thickened Anna's fluids every day himself. In the interviews both the CW and RN were not aware of any problems with Anna's swallowing or that Anna had had a previous choking incident. Anna was at risk of aspiration because of the contradictory documentation, knowledge, and practices around her positioning, nutrition, fluid consistency, and increasing dysphagia.

In Ruby's case, a speech pathologist had made an assessment of Ruby four months previously because of Ruby's difficulty in drinking and episodes of coughing and choking, however, there was nothing documented by nursing staff about these episodes in the progress notes. Ruby was placed on semi-thickened drinks by the speech pathologist, but there was no follow up assessment in the casenotes by the nursing staff and this was in conflict with other documents relating to Ruby's meals and drinks. Thickened fluids was not stated in Ruby's care plan and during the observation there was water on Ruby's bedside cupboard for her to drink. The night staff were instructed in Ruby's care plan to give her a glass of cordial at 0630. The resident care plan from the dietician stated Ruby was 'currently' on a vitamised diet with thin fluids contradicting the speech pathologist. The RN also stated that Ruby was on ordinary fluids and if she did need thickened fluids this could easily be arranged. A CW who knew Ruby well stated she did not know whether Ruby was on thickened fluids or not. Despite

Ruby's need to be on thickened fluids because of the possibility of aspiration evidenced by documented choking incidents, she was at continual risk of being offered thin fluids.

The care plan did not record Ruby's food to be vitamised as the speech pathologist and dietician had recommended, nor did it state the food was to be cut up as Ruby no longer wore dentures. The CW stated that Ruby was on a vitamised diet, however, it was observed Ruby's food was not vitamised and had to be cut up at the bedside. These differing discourses in the casenotes, discourses, and observations between the nursing staff, the speech pathologist, the dietician, and the documentation were deemed unsafe nursing practice.

Betty was also concerned that Cynthia may choke because the nursing staff did not position Cynthia properly before meals. She was unable to move herself and was often left in awkward or inappropriate positions. In order for Cynthia to be able to eat independently she needed to be sitting up and set up appropriately. An observation reinforced the mother's concern because Cynthia was laying flat and not positioned upright to have her lunch. Cynthia herself asked for the bed control and moved her bed head, however, this only pushed her head upright and not her torso, with her chin sitting on her chest at a right angle. She appeared to be extremely uncomfortable and found it difficult to eat.

Anna, Ruby, and Cynthia were at continual risk of aspiration, reflux, and choking for varying reasons and this continually compromised their safety. The conflicting documentation added to the confusion around the potential for aspiration and choking. Unsafe practices concerning the positioning of the residents for meals in combination with the unclear consistency of food and fluids to be provided, together with the busyness of nursing staff added to an environment of risk for these residents. It was found it was not only the residents who were at risk, but also the nursing staff.

Unsafe Manual Handling

This sub theme of unsafe manual handling placed the residents, especially Anna and Cynthia, the nursing staff, and others at risk of injury. One incident concerned Anna being positioned by one CW in an unsafe manner; and the other incident concerned Cynthia's positioning and hygiene needs, which put six persons at risk during the observations. The incident with the CW lifting Anna by herself and the bed brakes not being on has been described previously.

The other incident of note occurred during an observation of Cynthia whereby she nearly fell out of bed in the process of being repositioned and having her hygiene needs attended to. Again the bed brakes were not on and in this instance the bedrails were not up at the time. The four CWs turned Cynthia and the bed moved, and this nearly caused Cynthia to fall out of bed. If it had not been for the two CWs and myself bracing our selves against a wall and holding Cynthia back, she would have fallen onto the floor.

Unsafe practices included contradictions between what the nursing staff verbalised and did, against what was documented and evidence based practice. For example, it was documented that the blue mobile bath had tipped when Cynthia was turned one time and its use was ceased a number of weeks ago. The resident care plan did not get changed or updated and continued to direct CWs to shower her on the blue bed bath. Despite five persons now being required for repositioning, the documentation still directed one CW with a mechanical lifter to assist in getting Cynthia up, showered, dressed, and out and about. Although Cynthia's care plan was dangerously out of date it was signed by an RN at the end of each month as being current and effective with no changes in six months.

The resident care plan also stated that Cynthia could mobilise in a comfy chair and if the plan was followed by anyone 'not knowing' the unwritten routine Cynthia would have certainly been in danger. Pushing the bed out of the room with Cynthia in it had taken five staff on the first occasion and was then perceived as an occupational health and safety issue, and consequently was no longer offered to Cynthia - being the reason she had become room bound. Despite the contradictions relating to Cynthia's safety, a CW in interview was sure that Cynthia was totally safe and secure.

CW: No we have four people at all times for when we are turning her for safety so she doesn't fall off the bed. We use Slippery Sams at all times for skin integrity and moving her. She has both, she has bedside rails up, both sides up at all times. We always make sure that she is up the bed, not too far down, because she is quite a tall lady. We tend to maybe prop her legs up with something, with pillows. She's always, she has her emergency bell if she every needs any assistance. Her overway, her siderails are always up, but she has her overway just in case she falls out of bed. Yeah, well that's mainly, basically safety because she's always in bed so there's, we always make sure her bed's in the proper position, not in the doorway or anything like that, it's always up near the wall and we tend to move it a little bit, it depends on what side she's turned on, so she can watch the TV. She's safe. (Data CW Cynthia p84)

Although the CW believed Cynthia (and all the residents) was safe, the differing discourses surround manual handling, mobility, hygiene, and the use of equipment implied otherwise. A routine had been established for the hygiene and positioning needs of the three residents, but this did not match with the documentation, was not undertaken safely, and was rushed. The safety of the residents appeared to be further compromised when questions were asked of the nursing staff about potential emergency situations concerning the residents.

In the Event of an Emergency

The participants were questioned specifically about the safety and security of the residents. Their responses raised concerns for the evacuation policy of the facility and a RN's understanding of the policy as she articulated it. An RN stated that dependent residents, such as Anna, would be left for evacuation by the fire brigade in the event of a fire in the following interview extract.

RN: ...they know that the ambulatory people first, and those that need assistance afterwards. ...Those that can (are evacuated first), the (dependent) people are left til the very end in fire any case. The fire brigade are there, then they are the experts on how to move that type of people. We do the best we can, we keep them as safe as we possibly can, yes, and the staff as well. (Data RN Anna p10)

This RN believed the policy directed staff to evacuate ambulant residents first and to leave the highly dependent residents until last for firemen to evacuate. The nursing staff responsibility in an evacuation of residents in a fire would be to

move those residents in the closest proximity to the fire first - regardless of their dependency.

As described previously, Cynthia was at risk of seizures because of an under dosage of her anticonvulsant medication, but also because of her cerebral tumour. In Cynthia's documentation prominently on the front of the case notes was a sticker with the words 'alert record'. There were no references in the documentation as to what this alert was, and there were no records, planning, instructions, or documentation referring to Cynthia's likelihood of having a seizure. The following was a CW's response to a question about Cynthia having a seizure and a number of concerns were raised.

CW: Well if she had a fit, I'd definitely call the RN straight away and she would come in and inspect her. I'd make sure that her breathing was OK, for me, and I'd check her mouth, all the first aid stuff. Yeah, I haven't really been around when she has a fit, but her mum has explained what happens when she has one and she becomes very shaky and jumping around type of thing, but fortunately we haven't really had that here yet, but definitely go through the procedure of calling a registered nurse and I'd just take it from there. (Data CW Cynthia p29)

It was determined from the discourses that if Cynthia had a seizure, the nursing staff had very little knowledge about how to manage this situation, and there was no documentation of the potential for seizures or directives in the event of a seizure. It was also questioned whether persons such as Anna, Ruby, and Cynthia would be safe in the event of a fire requiring their evacuation as they were essentially bed bound, could not move, and were fully dependent. The risk to Anna, Ruby, and Cynthia described above was further compounded by the following sub theme concerning the problems associated with the use of agency nursing staff and the residents' safety and continuity of care.

Risk in Using Agency Staff

All of the discourses alluded to the regular and continual utilisation of agency staff in this facility, and there were identified problems associated with the provision of nursing because of this. References were made about the use of agency staff and how this had, among other things, increased the residents'

chances of experiencing mistakes or poor nursing care, and how it impacted on the continuity of care and the workload of nursing staff. The nursing staff and relatives believed the use agency staff was inappropriate for the individualised care the resident required because it was necessary to 'know' the resident. On a number of occasions in the observations it was noted the CWs from the agency expressed not knowing what to do, where they should go, and whom they should be helping. The following are two discourses, one from the observation and the other from Joe.

NPO 1219 - Another CW came in with a tray and asked the CW with Irene where she was supposed to be or who she should be giving the lunch to and she was directed by the careworker. She stated she was just lost and thanks - a joke was made of it. (Data NPO Anna p10)

Joe: Some from agency is very good, some is good – some is not. And agency they say it doesn't matter, tomorrow I won't be here. Yeah. That's true. (Data Rel Anna p95)

Ben also did not like the turnover of staff or persons 'off the street' or 'strangers' nursing his wife Ruby. He talked of the drastic changes and the cost of nursing home care and implied the funding was overriding the quality of care. He directly related the staffing and the use of agency staff to an increased risk when he talked about drawing the line and thinking twice about the situation. He believed it was important for nursing staff to know Ruby for her continuity of care.

Ben: Mainly weekends. Yeah. I know things have changed over the years under different management, different management have different ideas and that sort of thing. Cause the cost of running a business, you know, you got a draw the line, but I think there comes a time when you've got to think twice about it, you know, because otherwise the, you lose that person and the continuity. That's right. Yeah, yeah, well the normal staff probably know how to handle her. If somebody comes in straight off the street as the saying goes, will probably handle her a lot different, probably upset her. It's like everything though, the government always trying to cut down on things. (Data Rel Ruby p41)

During observations it was apparent there was reliance by the agency CWs on the regular CWs. Knowledge and information transference between the permanent nursing staff and the agency nursing staff occurred verbally on the floor whilst with the residents and going about their work. The CWs did not refer to the

resident care plan and relied instead on asking questions of each other or making their own decisions. The resident care plans and other documentation for these three residents were mostly in conflict with the residents' nursing care needs. This will be described in the following chapter under the documentation theme. Despite the reliance on permanent nursing staff for the direction of nursing care, there was a further risk in that the regular RNs and CWs also demonstrated a lack of knowledge and understanding about the residents' nursing care needs, as described in the next sub theme.

Not Knowing the Resident

The nursing staff interviewed professed to know the residents well and many had been employed for a number of years. However, the nursing staff did not demonstrate knowledge of the residents themselves, their nursing care needs, or their medical histories. In regard to Anna, the RN talked extensively about the urinary tract infections (UTI) Anna had acquired over the years. Anna had no such history of these infections and it was not alluded to in any of the discourses other than by this RN. Anna had been diagnosed with one episode of pneumonia in the past, but had not had any UTIs. Anna's husband, Joe, was aware of the documented episode of pneumonia, however, he stated that he alerted the staff to Anna's illness and asked for the GP to come. This was reinforced by a RN who commented nursing staff were reliant on Joe to report any problems with Anna. This RN also acknowledged she had not done a full assessment on Anna.

There were other discourses that revealed the nursing staff, especially the RNs, did not know the residents. The fictions that the RNs created regarding the residents are dealt with in the next chapter under the documentation theme. The lack of knowledge about the residents also extended to the knowledge and experience of the CWs. The following excerpt from the interview with a CW demonstrated her misunderstanding of Cynthia's pathophysiology.

CW: Well for a start she needs full assistance with all of her personal hygiene due to her being close to a quadriplegic, she can still use her hands. (Data CW Cynthia p30)

Cynthia's diagnosis was not quadriplegia as she only had some right sided weakness. This raised questions of the nursing approach for someone who had

quadriplegia, as compared to Cynthia who had a terminal cerebral tumour and required specialist palliative care. This ‘knowing’ CW’s knowledge and understanding was poor and placed Cynthia constantly at risk of inappropriate care. A palliative care approach was not acknowledged, recognised, or acted upon in any of the discourses. The level of knowledge and understanding was typical of other nursing staff, as will be further demonstrated in other themes in the following chapters. Overall, the level of knowledge required for an appropriate standard of nursing care was lacking, as was ‘knowing’ the residents as individuals. The following sub theme relates to the residents and their integument care – a specific domain of nursing practice.

The (Mis-)Management of Rashes

The three residents all had problems with their integument. In Anna’s case her skin care was overseen by Joe, but it was a different matter with Ruby and Cynthia. According to documentation by CWs, Ruby suffered with long term rashes to her armpits, breasts, and groins, and Cynthia also suffered from persistent rashes. Ruby and Cynthia’s rashes were constantly reported in the progress notes, but no documented assessments were undertaken by either a RN or the GP. The CWs inadequately assessed the rashes, treated the rashes, and reported on the rashes in the documentation.

An RN stated Anna did not have or get decubitus ulcers and this was contrary to other evidence. This RN described Anna as having infected pores on her skin, but there was no documentation, no comments made by the CW, or comments from the husband about these infected pores – which did not actually occur or exist. The husband, Joe, describes below how he treated Anna’s decubitus ulcer.

Joe: (laughs - points to the back) I help, it gets sore up here. Sore, it gets (pressure) sore... it's alright now. You know but that's why the gauze when I saw her that, but that, I tell the nurse some kind of, doesn't care much the sisters didn't watch out really. I never. When I come, one kind nurse from outside, a sister, she said I want to have a look your wife's back, bottom. And she looked, and she took everything off and washed, just like in hospital. She have, she had ointment and washed and cleaned and then she put the cream And put the cream and the dressing on and I was so relieved. I don't see her because I never saw her before and I always a good

look at Anna's back for a couple of weeks and then, I do it myself again. I got a very good cream from Germany and I always do it myself and put the cream on and I get good. (Data Rel Anna p105)

The resident care plan instructed the CWs to use numerous creams when caring for Anna. She was to have Prantal powder under her breasts, moisture cream to her face and legs, sorbolene cream to be massaged into her arms and legs, Ungvita to her groins, and emollient cream applied to her sacral area and buttocks. During an observation there was no use of creams and Anna was repositioned and her genitalia washed with a wet flannel. The following example demonstrated the confusion in the use of creams in one CW's entry countersigned by an RN. Here two creams were used for Anna's decubitous ulcer, which would be contraindicated.

1345: Residents sacral area broken down. Ungvita ointment applied. Husband applied & packed Zinc Cream on Sacral area. (Data DOC Anna PNs CW p247)

In reality, and perhaps fortunately, Joe the husband was the only person who applied creams to Anna's skin and he purchased these creams and applied the creams himself on a daily and as needed basis. Joe stated in an interview that it was not the regular staff that helped heal the sore on Anna's sacrum, but a 'kind' nurse who was not a regular and also by the cream he bought from Germany and put on himself. He dressed the wound himself everyday, but there was nothing documented of this.

In Ruby's case her rashes were ongoing and had been for months according to the documentation by the CWs. These rashes were continually referred to in her progress notes as 'red', 'crusty', and 'angry' (please refer to Appendix 8). Various creams were applied as treatment by the CWs and included four different choices of creams and powders. It was apparent from the minimal description of the rashes and the various creams used that this was according to the judgements of CWs. No documented assessments were undertaken by a RN or the GP of Ruby's ongoing severe rashes, and there were no instructions for CWs in the application of creams. The continence theme in chapter 9 further discusses Ruby's rashes in relation to the use of incontinence pads by nursing staff.

Cynthia's various rashes were similarly poorly managed. Rashes were constantly mentioned and poorly described by the CWs in her progress notes, but there were no documented assessments undertaken and no treatments prescribed and implemented. It was written and stated by the CWs that a variety of creams were used on Cynthia according to their preference and the availability of the cream at the bedside and there were a number of creams for the CWs to choose from, including medicated creams. The commentary tracked in the progress notes on Cynthia's positioning and management of her rashes can be referred to in Appendix 5. The following excerpt from a CW describes her knowledge and treatment of rashes for Cynthia.

CW: Ah well there's a variety of different creams, there's been vitamin E cream, there's been ungvita ointment cream and ungvita baby cream. She's had different types of creams for, if she has thrush, canesteen cream and she's also had sorbolene cream. It just depends on what's wrong with her but because she's a reasonably big girl, she does tend to have rashes, heat rashes, and stuff like that. So we really have to maintain that and keep a good eye on that. She can't move properly either, so she's sort of in one spot and that tends to aggravate her skin. Yeah so we apply what's necessary for cream. (Data CW Cynthia p30)

Betty talked about a new rash in an interview and also during an observation where she verbally requested for the RN to look Cynthia's rash when she was turned next, but this did not occur. One week later Cynthia was diagnosed with the DVT that had extended up to her thigh and this could have accounted for this new rash that was not assessed in a timely manner. The analysis of the discourses revealed poor practices in the management and prevention of skin rashes for the three residents. The RN was far removed from the bedside and the assessment of skin rashes and appropriate treatment was lacking. It was determined rashes were assessed and treated by the CWs at the bedside.

In summary of this theme of unsafe practices, other than being extremely and continually unsafe and risky for the residents, there were also instances of negligence on the part of the GP and the RNs. The standard of nursing care provision was of a poor standard and did not meet the RN competencies or even a basic standard level of nursing care. Each resident had a right to an appropriate

level of care according to their needs, however, it was evident this was constantly being compromised.

This chapter has dealt with two of the major themes centred around the time and activities of the nursing workforce, as well as unsafe practices – some bordering on negligence. The milieu of haste that permeated this facility contributed to the unsafe practices and risk to residents, together with the knowledge and skill (or lack there of) possessed by the nursing staff for the provision of care. The following chapter presents a further three major themes relating to the documentation of the nursing care, the practices around continence management, and issues concerning the stimulation and socialisation of the three residents and the environment in which they lived. Having addressed the major concerns of unsafe and negligent practices and the ethos of haste, the five themes addressed in the following two chapters will be no less disturbing or comforting to any stakeholders in the aged care system.

Chapter 9

A Discourse of Neglect - Part B

The previous themes of haste and unsafe practices were compounded by other considerations that contributed to a discourse of neglect. This chapter focuses on three themes concerning the residents and includes findings about documentation issues, the continence management system, and the misdirected stimulation, environment control, and socialisation of the residents. The documentation was mostly found to be fictional and not related to the actual nursing care delivered or evidence based nursing practice. The continence management for the three residents was not managed well, if at all. The stimulation and socialisation of the residents became a major theme because of the rationales given on the part of the nursing staff that appeared to be driven by the justification for funding. The nursing staff controlled the environment of the residents and this was inappropriate from a number of facets. The contradictions evident in the analysis were the most marked and prominent in the area of the residents' documentation. This is important because the documentation necessary for funding is based on care planning that is not resident centred or useful for nursing in day to day practice, and it is used by the department for validation and accreditation purposes.

A DOCUMENTATION QUAGMIRE – When Funding Drives Discourse

The documentation was not useful for an appropriate quality of nursing care. The written records for each resident were in conflict with each other, other discourses, and the actual nursing care observed, as well as evidence based practice. Some documentation was in direct opposition to what was actually done in practice, or should be done as evidence based nursing practice. The experiential knowledge of the CWs determined the nursing care provision, and the resident care plan and other documentation was only useful to a validator to justify the resident's categorisation or an auditor for accreditation. The documentation was

largely ignored by the CWs in their actual nursing care, even though it was regurgitated during their interviews. In other words, what was said and documented conflicted with what was practiced or should be practiced.

The documentation anomalies were obvious for these three residents, especially when comparisons were made between all the discourses about the resident. Furthermore, much of the documentation in the progress notes was demeaning and denigrating to the residents and did not meet a professional or ethical standard of nursing documentation. The next sub theme describes the documentation from the aspect of it not reflecting the reality of the resident's care described as discourses being against each other, the creation of fictions, and fraudulent documentation by the nursing staff. What was documented was carried through by the RNs and CWs in their interviews, however, it differed to the practices, the relatives' views, the residents' needs, and evidence based nursing practice.

Frictions, Fictions, and Fraud

The resident care plans directed the CWs what to document and enter in the progress notes and records. These directions required the CWs to make clinical nursing judgements, which they were instructed to document in the progress notes on each shift. Any changes to care, the interventions they used and why, and the outcomes of these interventions were to be documented and the transference of the nursing process to the CWs was evident. There was, however, no evidence in the progress notes of this nursing process being used by the CWs or the RNs. With all three residents the documentation directed CWs to document behaviours of the residents concerning what triggers were present, what interventions were used, and the outcomes, as well as the frequency - even though none of these residents had any 'behaviours'. Extra documentation was expected in the directive for the CWs to record in the progress notes when there was time spent with the residents for their lifestyle preferences and time spent talking to the family. There were no entries in the progress notes concerning this and given the first theme of haste and other discourses it was questionable whether time spent on such activities was possible.

Nursing staff were also to document time spent ‘one on one’ with the residents and any other activity, for example a massage or the playing of music. There was no documentation in the progress notes of any of these having ever occurred. Instead the progress notes of the three residents were used by the CWs to justify why the resident care plan was not complied with, as well as tracking defaecation. The progress notes were found to be ineffectual for any ongoing assessment of the resident’s nursing care or continuity, provision, and evaluation of nursing care. The resident care plans were dangerously out of date and contained fictions about the residents.

Relatives as Carers

Joe, Anna’s husband, was at the facility everyday for 5 hours a day for the past 4 years providing care for Anna. The RN raised the benefit of Joe being there everyday to perform care and how he was in control of Anna’s care and assessment. The staff were very ‘happy, grateful, and glad’ he came in every day, to give Anna her lunch and tea, but there was no acknowledgement of his participation in the documentation or any of the other nursing care practices he performed. During an observation Joe undertook a thorough assessment of Anna’s skin and he participated in or undertook all aspects of her care including her nutrition, hydration, hygiene, lifting, positioning, and social needs. Although staff in the interviews acknowledged this, the documentation mentioned that ‘the husband visited’ once. His level of participation was not documented or acknowledged and it suggested he visited only occasionally, if at all.

In Ruby’s documentation it stated that Ben required a lot of care and interaction with the staff, when in fact it appeared Ben required very little attention and interaction with the staff. It was written in the care plan that the husband visited ‘between 1100-1130’, but there was no documentation about Ben giving Ruby most of her lunches. The documentation implied that the husband visited for half an hour when he actually visited most days and spent approximately one and half hours with Ruby that included giving her lunch. This was also the case with Cynthia in that her mother, Betty, cared significantly for Cynthia on a one to one

basis for approximately five hours or more every day. Betty's partnership and participation in caring was not acknowledged at all in the documentation. To acknowledge the relatives significant participation in writing would threaten the categorisation of the resident with the potential of a decrease in funding

Mobility and Ambulation

The CWs continually justified in the progress notes why Anna was left in her bed or put back to bed after her bath instead of dressing and ambulating in a comfy chair. The use of aperients, faecal oozing, or the husband's request were the reasons given for keeping Anna in bed. The progress notes were used to justify the non-compliance to the resident care plan as the following extract demonstrates and is as it was written by a CW.

1400: Residents HusBand Asked if he would like Resident up today and he stated that we could Leave her in Bed. (Data DOC Anna PN CW p249)

Joe did not want Anna sitting in the comfy chair because this had caused the decubitus ulcer on her sacrum that was caused by an exposed wooden plank on the comfy chair that found Anna 'screaming in pain'. Anna had been nursed in bed at Joe's request for a number of weeks at the time of data collection. The resident care plan, however, stated that Anna ambulated every day in the comfy chair in direct contradiction to the husband's wishes. Further to the resident care plan directing the CWs to get Anna up into a comfy chair and be fully dressed, it also stated that she attended the community centre and mass services, both Catholic and Uniting Church; was having music therapy and also pet therapy. However, according to Joe's discourse and the reality; Anna had not attended the community centre for two years; did not go to mass services of either denomination and had not done for a number of years; and because of her deterioration was not interested in any pet therapy or social activity. In his view she was better nursed in her bed in her condition.

Ruby's case was very similar to Anna's, whereby her documentation stated she was to be dressed and assisted into a comfy chair every day, and attend various activities. Ruby's husband, Ben, was adamant Ruby did not attend church services

and that she would get absolutely nothing out of them. The RN on the other hand believed Ruby did attend church regularly and that she responded to it well 'with a smile'. At the same time the RN stated that it was 'hard work' to get Ruby up and dressed and into a comfy chair to get her to the church services, that she did not actually attend. In fact Ruby was mainly nursed in her bed and slept most of the time, and she had not participated in any activities for a couple of years. As with Anna, Ruby's progress notes contained justifications by CWs almost daily as to why she was kept in her bed.

Anna and Ruby were essentially now nursed in their beds and did not get up in comfy chairs, but this contradicted the written resident care plans that were out of date. This also applied to Cynthia who had become bedridden and room bound for six weeks. Her resident care plan, however, instructed CWs to ambulate Cynthia in a comfy chair to sit outside, participate in activities, and go to the community centre. To update the care plans to reflect the residents' needs and changing conditions could threaten the level of classification for funding - if a validation visit was to occur, so in order to maintain funding, care plans were not updated.

Repositioning

During the interviews the CWs stated the residents were left to sleep from 1330 until teatime at 1700. In the documentation, however, it stated that the residents were to be 'turned' two hourly and Anna and Ruby were on two hourly turn charts during the day. During interview Joe described the need to reposition Anna and that he had signed documentation that stated it would be done every two hours. Joe commented that the nursing staff did not do this every two hours and did not write down the correct times on the charts. He questioned why they had to 'cheat' in the following extract.

Joe: I sign the papers six or eight months ago from my sister here. Some they sign. Oh yeah, and another what I wanted to put correct time on these sheets. Some I noticed they doesn't put the correct time – they cheat. Yeah, but yeah I want the correct time. Yeah. One time one nurse the most, she put it half an hour difference and I looked there. And I thought why, why, why? She, it doesn't matter; it doesn't take so long to turn her around. People, yeah, and you when the time comes you come and turn around and it just takes a

couple of minutes for two of them, that's it, easy, yes. As long as I come here and can see myself. Yes. That poor woman Irene, she never gets anybody here. (Data Rel Anna p98-9)

In the reality of practice, Anna and Ruby were not repositioned every two hours and were left for periods of up to three, four, or six hours at night. In Cynthia's case she was repositioned every eight hours because she was lying on a wave mattress, but her documentation stated she was to have two hourly repositioning when she was in her bed.

Oral Hygiene

The three residents' oral care documentation stated they were to have their oral hygiene needs attended to after meals during their hygiene, continence, and repositioning care. In the observations this did not occur with any of the three residents, and the relatives reinforced oral care for the residents did not occur with Anna and Ruby at all, and only in the morning with Cynthia. The nursing staff reiterated oral hygiene was undertaken according to the documentation, but this was not the reality. In Anna's resident care plan it stated she wore dentures, however, Anna had not worn her dentures for over two years. Oral hygiene was to be performed by CWs after meals, however, there were no explicit instructions and it was not actually done.

Ruby's care plan stated 'Staff attends to her mouth care – mouth toilets to be attend by staff after meals. Lip therapy applied to lips', as it was written. The lip therapy was not described and there was no equipment in the Ruby's room for mouth toilets. The documented pretence of oral hygiene did not actually occur with Anna and Ruby and the following was the RN's view of lip therapy for Anna and also provides insight into this RN's understanding of Anna's care.

RN: Yes, he's, yes he's (Joe) here for mealtimes. He feeds her lunch and for dinner. That's what he's there for, and then he'll tell, inform us about Anna and am little bit concerned about anything to have to do with her, her lips are too dry, and we put that in the plan and we make sure that they put it on her and put that in and ask staff to review the care plan the same day, to make sure this is done. I will tell Joe, well here you are, the lip therapy is over here, put it on after you have finished feeding her at lunchtime and then put it on

again after you have finished in the evening. He also keeps us pretty well up to date in relation to her feet, although she's seen by a podiatrist every 3 months. (Data RN Anna p103-4)

In addition to oral hygiene needs, there were discrepancies between the discourses in all other areas of nursing care for these residents.

Grooming

In contradiction to the RN's above statement about Anna's foot care, Joe stated he looked after Anna's toenails and fingernails. There was no record of who cared for Anna's nails in the documentation, but in reality it was Joe and Anna was not visited by the podiatrist. The residents' documentation directed hair grooming was to be done by CWs after repositioning, however, the residents' hair was not groomed during the observations and it was left unkempt, flattened at the back, or sticking up following their repositioning. Furthermore, it was not documented who cut Anna's hair, but Joe stated his daughter had always cut Anna's hair when she needed it and that this was free. A RN, despite Joe's statement about haircuts, stated the following:

RN: Oh one other thing also, as part of her grooming, as well, he'll indicate when he will have the hairdresser to, to, for a haircut or something of that nature. And again, I said the hairdresser, she's put on the list every, and everything necessary, or Joe requests that. Her hair, because she has a very thick head of hair. Yes. (Data RN Anna p103-4)

The only recorded complaint from Joe in the progress notes was an entry that he had complained his wife's hair had been cut by a hairdresser without his permission, and that this had cost him \$9. There was no documentation or direction as to who was to cut Anna's hair - even though Joe had specific wishes regarding this.

Exercises

Anna and Ruby's care plans stated that they had the *potential* problem of getting contractures and muscle wastage and limb exercises were to be performed when they were repositioned to prevent these from occurring. The documentation of

exercise and physiotherapy programs was disparate with the practices that occurred and the needs of the residents themselves. The documentation concerning passive limb exercises, range of movement (ROM) exercises, and physiotherapy were out of date, inappropriate, not undertaken, and not evaluated for each resident. For example, in Anna's physiotherapy plan she was to have daily ROM exercises with nursing staff and a twice weekly intensive exercise program with the physio aid as outlined in the care plan. When the care plan was referred to there were no directions for any exercise program.

During the observation periods it was noted that both Anna and Ruby had moderate contractures of their arms and legs including their hands and feet. The relatives also spoke of Anna and Ruby's contractures and that exercises were not actually undertaken by nursing staff. Joe acknowledged the reality of Anna's contractures and non-exercise program in the following extracts that contradict the nursing staff and documentation discourse of preventing contractures through exercises.

Joe: She just lays in bed very still and always hands like this. Yes. Always keep them there and I said to her why you keep your arms there? And no answer, I don't know, but always, always keeps there. I think it's a baby sleeps like that or she keeps more on the side once she's in bed... They don't move her arms. Oh I don't know. I never saw it. But I used to do myself. More than about two years ago. (Data Rel Anna p107)

One CW stated that Anna had ROM exercises every morning, however, this CW went on to state that these exercises were actually the movements which occurred during normal hygiene and dressing of Anna, such as putting Anna's arm through her nightie. The RNs also believed that ROM exercises occurred with Anna and Ruby and that they did not have contractures.

RN: ...there isn't any natural movement or nothing possible to this patient to move other than the eyes. The necessity is primarily to identify who is next to her so there is always that head movement, but the rest of the body movement, no I don't believe there are contractures. Yeah, they put her through range of movement, because she doesn't move her arms. I think it is a matter of flexibility rather than contractures. (Data RN Anna p108)

This fiction for funding was reinforced by another RN in Ruby's documentation where it was written a physiotherapy program was provided to prevent

contractures from occurring. This documentation as the 21 day summary was a specific requirement for funding and validation of Ruby's RCS category, and it described Ruby receiving care that she was not actually receiving.

RN: Yeah we always do passive range of movement. Generally, while we're doing the hygiene, we'll do that range of movement exercises with her, if she'll let us. We find occasionally she doesn't want to. ...there's a bit of stiffness to the arm and leg moving joints, but not actually contractures. A lot of the time it was resistance, like it's 'get out I don't want to be moved today', yeah. (Data RN Ruby p80)

It was apparent the documentation and nursing staff discourse about non-existent exercise programs and the denial of contractures present was a pretence for funding purposes. To undertake exercise on contracted limbs would be extremely painful, not needed, and not necessary in a palliative care approach for end stage dementia. To acknowledge the existence of Anna and Ruby's contractures would contradict intensive exercise programs that, if documented, attracted more funding. Contractures were clearly evident with both Anna and Ruby and physiotherapy was not carried out, even though there was an enormous amount of documentation to purport that this was done, and it was also supported and carried through in the nursing staff discourses.

In Cynthia's case her physiotherapy and exercise program were important ways to maintain her muscle strength and prevent complications such as the DVT, obesity, increasing weakness and paralysis, and decubitus ulcers. The documentation stated Cynthia was on an intensive and extensive physiotherapy program, but there were no instructions as to what this entailed or the frequency of the physiotherapy and exercises. Again, the CWs' understanding of ROM exercises was incorrect and the exercises that were stated by the nursing staff as being done were not actually undertaken according to her mother, Betty. The following extract describes a CW's articulation of ROM exercises for Cynthia. The second extract reinforces the RN's distance from any programs, nursing care, and the residents themselves. Again, the nursing staff reinforced what the documentation stated, but this was not the reality of the practices.

CW: Yes, we do range of movements on Cynthia, we move her arms up and down and we tend to have that involved in her personal hygiene, like when we go to wash her in the morning we tend to ask

her to help lift her leg up and her arm, you know, up above her head like if we wash under her armpits or something you know and move her head and yeah, so we do range of movements (Data CW Cynthia p83)

RN: ...they're like rubber bands and she does exercises with those, they're attached to the bedrails on the bed, they're her physio exercises. Range of movement exercises are always done with ADLs - so when they're washing and dressing her they'll encourage her to do her range of movement exercises, and there's a physio program but I am not quite sure exactly what is on that because the physios do that one. (Data RN Cynthia p83)

Further evidence supporting the lack of exercise for Cynthia in contradiction to the documentation included the development of Cynthia's DVT and her paresis. The extent of the physiotherapy she received can be described as minimal to non-existent and had actually been abandoned for a number of months because of Cynthia's malaise and her being 'difficult' in her non-compliance.

Ruby's Behaviours

Ruby's resident care plan stated that she had the 'Potential for physically hitting out at staff attending to her care needs due her possible being frightened (sudden movements)' or she might 'yell out'. The desired outcome of this section was 'To minimise episodes from occurring' which implied that these behaviours were a frequent and common occurrence. Ruby had no history of this type of behaviour that was explicit in her resident care plan. Almost one and a half pages of the care plan were devoted to what CWs should do during these 'episodes' that Ruby had the potential to display. According to her husband, Ben, Ruby had not displayed any difficult behaviours for over 2 to 3 years. The CW also describes Ruby's actual profile of behaviour below, which did not match the documentation.

CW: I haven't seen any (behaviours) from Ruby, no. (Data CW Ruby p118)

There was nothing written in the progress notes or medical notes about any difficult behaviours, nor was it acknowledged or hinted at by her husband or nursing staff, and it was not observed. It was, however, documented in the resident care plan.

The RN in the following excerpt discusses ‘boistrous’ behaviour from CWs that implied could be a common approach by CWs for causing behaviours in any person in Ruby’s situation.

RN: Basically, yeah, we found that some staff would just go in there a bit, because they've got louder voices, or they're a bit more boisterous and that would startle her. So we'll go in quietly, talk to her soothingly the whole time you're in there like you can't always keep your eye contact with her because she doesn't maintain it but she likes gentle touch to her shoulders or her arms, nowhere else, occasionally she'll let you touch her hair unless you're combing it, but yeah, we did find the staff were, once they got through the idea that you had to actually approach her in this way, she doesn't hit out anymore. Which is not going to be much good for the RCS. Yeah, because once you've prevented the behaviour you cut out your funding, but ah, what else with her? (Data RN Ruby p77)

The admission that any lack of ‘hitting out’ by Ruby would actually affect the funding and that this was not ‘good’ points to a resident care plan geared toward extra weighting for funding based on the interventions stated, but not needed in practice.

In summary of this sub theme concerned the fictions, frictions, and fraud in the documentation, which contradicted practices and the perceptions or interpretations of nursing care for these residents and their relatives. The documentation contradicted what nursing staff stated, however, the nursing staff tended to repeat what was in the documentation, rather than what they practiced. As such, it was revealed to be a charade with fictions created in order to gain or retain funding levels. Although care was written in the residents’ care plans, these were not referred to, were not reflective of practice, nor useful for practice. The documentation had been constituted according to the RCS instrument and the documentation requirements for the justification for funding, rather than evidenced based nursing practice. The care plans were not appropriate for persons with end stage dementia or a person requiring palliative care. In the following sub theme on documentation the focus is on the documentation directly putting the residents in danger if the care plans happened to be followed by a RN, EN, or CW who did not know Anna, Ruby, or Cynthia.

Out of Date and Dangerous

Each of the three residents' care plans were found to be out of date and contrary to the current nursing care provided. The outdated period ranged from six months in Cynthia's case, to up two years in Anna and Ruby's cases. The instructions for CWs to supposedly follow were not only out of date, but also confusing and contradictory in themselves and, therefore, potentially dangerous for the residents and nursing staff. Each resident had a program evaluation sheet that required the RN to check and update the resident care plans every month and sign for their effectiveness. This had been ritually signed every month by RNs as having been 'reviewed and found to be effective' for each resident, despite being extremely out of date and not indicative of practices. It appeared the resident care plans were maintained in a status quo because to remove or change anything could be a threat to funding if audited in a validation visit by the department.

Anna's resident care plan stated that she was showered in a shower chair. The CWs either gave Anna a full sponge or they bathed her in the mobile bed bath. This was because the shower chair had tipped over on previous occasions. Joe and the nursing staff knew she did not use a shower chair and this had been happening for a number of months, but the documentation was not updated. Another entry in Anna's resident care plan was ambiguous and confusing in that it directed CWs to *'use the electric lifter to get Anna onto the bed bath while on the shower chair'*, and this was in order to maintain her safety. No nurse would use both a bed bath and a shower chair at the same time. Anna's resident care plan was not changed for a period of 18 months, was not effective, and had not been evaluated, even though signed off every month by the RN. The same was the case for Ruby.

Cynthia's resident care plan was also out of date and reflected the care delivered six months previously on her admission. Cynthia had deteriorated significantly since her admission and her care had changed. The current practices for Cynthia and the documented care were in contradiction and if the documentation was followed by unknowing CWs, could have been dangerous for all concerned. The resident care plan stated that Cynthia was to ambulate in a comfy chair and be showered in the blue bed bath. Cynthia's care plan stated that 2-3 staff was

required, whereby at this stage it was necessary to have 4-5 nursing staff for her hygiene and positioning needs. According to the resident care plan, however, Cynthia was to be toileted using the lifter, she could sit in a comfy chair, and be bathed in the mobile bed bath, but all these practices would be dangerous for her because of her obesity and the requirement of four nurses. The physiotherapy evaluation form was out of date and stated she was still transferring with the lifter and a sling to either a comfy chair or the bed bath, and that two nurses were required. Two tick boxes were set up in her resident care plan for classification as either 'dependent' or 'assistance required'. Despite Cynthia's high dependence this was ticked as 'assistance required' that implied a level of independence she did not have.

Further to the above, Cynthia's social interests were documented as computing and sitting outside, even though these were no longer possible. Cynthia's IDC had not been in situ for approximately six weeks, however, the documentation stated it was still in situ and required emptying. In the night duty care plan Cynthia's hygiene and repositioning needs were completely different to the resident care plan, which was incorrect. Cynthia's resident care plan stated the RN was to ensure all tablets were taken, however, the evidence suggested this did not occur. An assessment was to be undertaken if Cynthia had frequent pain relief, however, she was not assessed despite continuous documented complaints of pain, feeling unwell, and treatment with paracetamol. The documentation was consistently in contradiction to the 'routine' of the nursing care that was practiced and known by the regular nursing staff, or more specifically, the CWs.

As care plans are designed to prescribe nursing care and should be referred to guide CWs in practice, the concern is one of the potential of a critical incident if CWs did actually follow a resident care plan that was out of date. Compounding the fictitious nature of the residents' nursing care maintained in the documentation, another aspect concerned the quality of the documentation in the progress notes and charts, as well as the language used by the CWs about these three residents. This raised ethical questions regarding the residents' dignity and integrity.

Demeaning Documentation

The documentation for the three residents revealed demeaning and sometimes denigrating entries about the residents, the facility, and other nursing staff. The progress notes for the residents were completed mostly by CWs and countersigned by RNs with occasional entries by the RNs. Many of the entries in these notes were illegal, irrelevant, inappropriate, and well below a professional standard of nursing documentation. Most entries used these important and legal records as a forum to record bowel activity; to justify why the care plan was not followed; to express opinions; and make judgements, as well as to vent their frustrations.

The language the CWs used was not of a professional level and words such as ‘belly button’, ‘tummy ache’, and ‘mucky’ were common place in the discourses both verbal and written. The progress notes in Anna and Ruby’s case were running commentaries on their ‘oozing bowels’ following ‘ii suppositories given’, or ‘stayed in bed at husband’s request’, ‘OK to stay in bed’ or ‘stayed in bed because of oozing bowels’. This phenomenon will be discussed in greater detail in the next theme regarding continence management, however, the undignified consistent recording of bowel activity in the progress notes for Anna and Ruby could be questioned as to its relevance and appropriateness, especially when bowel charts were also provided for this type of recording.

An entry in Anna’s progress notes by a CW exclaimed the number of blue sheets nursing staff had used during one shift. In another entry in the progress notes a CW ordered staff to use a Kylie instead of the incontinence pads because of Anna’s rash and there was no further documented assessment of this rash. There was scant documentation on wound care and only one assessment was documented and recorded in Anna’s progress notes and read ‘sacral area skin breakdown’. The visits by Anna’s doctor were noted by the RN in the progress notes and every entry was followed by the notation NFO, meaning no further orders. In both Anna and Ruby’s cases there were no documented assessments by the doctor or RN spanning approximately two years. In Ruby’s case, one entry in the progress notes in very large writing expressed frustration by one CW who

reported that Ruby was *'found laying in a pool of urine, Resident was on a draw sheet instead of a Kylie?'* but this was not addressed any further nor was it subsequently made clear in the resident care plan that determined Ruby was to use incontinence pads 24 hours a day.

The unprofessional and unethical nature of the documentation in the progress notes by the CWs was demeaning and judgemental. This especially seemed to be the case with Cynthia's documentation. She and her mother were labelled and described as 'demanding' or 'being a problem'. For example, when Cynthia was at the height of a number of serious illnesses and wanted to remain in bed, the nursing staff documented behavioural reasons, such as Cynthia's 'bad' mood, non-compliance, being difficult, refusing to do things, and complaining. Cynthia's documentation of nursing care was determined by the analysis of the discourses to be inappropriate, misinterpreted, and poorly assessed by the nursing staff resulting in an inappropriate standard of care that threatened Cynthia's quality of life and quantity of life. Extracts from Cynthia's progress notes are replicated in Appendix 6. These demonstrate the unprofessional, unnecessary, inappropriate, and irrelevant nature of the CWs documentation.

Cynthia's care was not attended to in a timely manner because of the short staffed nature of the nursing home and the CWs frustration with this was documented in her progress notes. The progress notes were also used by CWs to question other practices, for example faeces being present in Cynthia's vagina for 24 hours. Comments were made about Cynthia's mental state and 'moodiness' to justify when she was not compliant with being repositioned or when she asked to be put back to bed. Her non-participation, non-compliance, and refusals to participate in the care or activities prescribed and planned for her became a battlefield in which Cynthia had to make her needs known through being difficult or demanding as her only means of expressing her needs. The examples in Appendix 6 from the progress notes demonstrate their use as a means of venting frustration and making unfounded judgements about Cynthia. Her complaints of pain, fatigue, despondency and demands retrospectively could have been caused by an ascending UTI, a developing DVT in her right leg, and possible Cushing's Syndrome and/or acute renal failure evidenced by her weight gain, dependent

oedema, the large diureses followed by oliguria and anuria, hirsutism, and an incurable cerebral tumour.

This tension between Cynthia's illness and the nursing staff was contributed to by the documentation that directed the nursing staff to undertake various activities of socialisation, diversion, exercise, stimulation, and participation for Cynthia. Instead of thorough ongoing assessments, it appeared she was consistently trying to make her needs and preferences known. She was manifesting her illness and this was wrongly interpreted as 'behaviours' or 'being difficult' by the nursing staff. Cynthia could only make her needs known by being difficult or non-compliant because she was losing her speech and could not express herself. The demeaning, denigrating, and inappropriate entries by nursing staff were indicative of an inadequate appreciation of the purpose of progress notes for the ongoing assessment, planning, and evaluation of a resident's medical and nursing care.

In summary of this theme on documentation, the discourses of the staff indicated the provision of nursing care that was not actually provided. Not only were fictions created, but also the documentation was fraudulent, dangerously out of date, incomplete, and contradictory. What was not accounted for in the documentation also became important, for example the non-recognition of the relatives' participation in the resident's care. As well as the poor and unprofessional documentation by staff about the residents in the progress notes, the entries were not prescriptive of care, continuity of care, or in the prescription of nursing. The documented care not only contradicted practices and evidence, but was also found to be demeaning for the residents.

The entries demonstrated a lack of clinical knowledge, assessment, and the recording of the ongoing progress of the residents. For Anna and Ruby, the progress notes contained running commentaries on 'oozing' bowels, how many suppositories had been given, rationales for the residents being left in bed, and some recognition of what could be termed 'integument care' with references to rashes and treatments with various creams. The residents' documents also contained fictions about them, for example Ruby's non-existent aggressive behaviours. In Cynthia's case, the resident care plan was dangerously out of date

as was the case with Anna and Ruby, but also her non-compliance with nursing care was the main subject of documentation by the CWs in the progress notes, as well as her complaints of pain and being unwell, which went unassessed.

The next theme revealed the continence management system in this facility and the documentation regarding the residents' continence needs were in contradiction to evidence based nursing practice. As part of the regulatory systems in place, residential aged care facilities are required to provide ongoing continence assessment and management for all residents. This theme on continence management highlights the futility of this requirement for funding being justified through the residents' documentation in the case notes. The system in place in this facility for the residents' continence management was found to be poorly assessed and managed at the bedside and the documentation necessary for competent continence management was non-existent.

UNDER THE SHEETS – When Incontinence Becomes Normalised

The three residents had problems associated with their continence management. Both Anna and Ruby were incontinent because of the neuronal degeneration of end stage of dementia. Cynthia was incontinent of urine and faeces, but she did not have to be. She still had control of urination and defecation, however, she was unable to wait for nursing staff to gather to toilet her in a timely manner. A standard two page document related to using 24 hour incontinence pads was in all three residents' case notes; even though Cynthia did not use incontinence pads and Joe did not wish incontinence pads to be used on Anna. This document entitled 'The Continence Management Program' was a list of instructions framed into what to do and what not to do in using the 'system' of absorbent pads. The standard document was provided by a consultancy contracted to the facility, which also sold the incontinence pads to the facility. Continence management for the residents, as required by the funding mechanism and accreditation process, was not individually assessed, planned, and evaluated as there was no indication of initial or ongoing assessments.

The aim of this system was to *'ensure the comfort and dignity of the residents by keeping them dry all of the time'*. The following themes highlight the problems with the use of incontinence pads as a regime, as well as concerns with the management of the residents' faecal elimination and Cynthia's bladder retraining. Continence was an area of conflict between the nursing staff themselves and also with the residents, the GP, and the relatives. The data revealed a product driven system that nursing staff abided by regardless of any wishes or contraindications of those concerned. A regime was implemented for Anna, Ruby, and Cynthia, however, the discourses of what was documented, practiced, and known (or not known) about continence management in this facility was constantly in contradiction.

Product Driven Management

The continence management system in this facility was based on the use of various incontinence pads to be used during the day and night. Please refer to Appendix 7 for the program in place that was used as evidence for each resident receiving appropriate assessment and management. The use of the term "DON'T" a number of times was consistently ignored by nursing staff. For example, DON'T use any creams with the pads, which the CWs constantly documented they did. The document also reinforced an underlying checking system for the stock of the pads, in that if extra pads were taken from the cupboard this had to be recorded.

It was also stated on the directions for incontinence pads to use a drawsheet and not a Kylie (more costly), even though in Anna's case Joe had requested a Kylie be used and not the incontinence pads. His request was complied with during the day, but not at night when he was not there. The nursing staff 'knew' that Joe did not want pads used, however, the documentation and a RN stated Anna was using the system and the night care plan also directed the night nursing staff to use incontinence pads.

The following transcripts describe firstly what Joe had to say about the pad system and his anger. It demonstrated it was a struggle for him, which was persisting. It was a continual 'fight' between Joe and the nursing staff for them

not to use incontinence pads as was directed by the documentation. Joe identified the cause of Anna's groin rash to be the pads and he categorically did not want them used on Anna. Following Joe's description of this dilemma, one CW expressed the same sentiments as Joe on the use of absorbent pads in this system for the facility. The RN's view of the system was disparate with both Joe and the CW, and again demonstrates the RN's distance from the bedside.

Joe: And even in bed, she been leaving in that wet pad, and I thought that's what it is from, that rash. And I said no more pads. ...And it (pad) stays there, yeah. And I said I don't want them, and when they come, they always, I see the pad and I throw away. But, now they put in a wardrobe there, no pads, for good, but they put her in one, sometimes even I said, take the pad off, and when I come at four o'clock the pad was on. That makes me angry with furore. Yeah. And I asked them to take it and they doesn't take it. Yeah, I am fighting that, yeah. (Data Rel Anna p158-9)

CW: Yes, she's incontinent of urine and faeces. She has a Kylie, um she has her Kylie on her bed at her husband's request. She was on pads but that tended to give her a rash between her legs so Joe found that to be a bit of a problem. He preferred her on a Kylie. Which is, actually I agree with that anyway. Really it does help.... Pads can cause rashes in other residents as well. Yeah (Data CW Anna p157)

RN: No, she's managed on the continence, the program, and I think she has the, the, one the (name) products in place for... Yes, one of the (name) continence pads. ...ever since we, we, we did a full continence, bladder and bowel assessments on all the residents, and this program was put in place, we don't have a problem. ...ever since they put that program (continence system) in place, it's been, it's been very good. (Data RN Anna p158-9)

The RN had no knowledge of the husband's request to keep Anna pad free and stated that Anna was in the system of 24 hour absorbent pad use. The RN believed the system the facility had adopted worked very well and she demonstrated she did not know Anna and her needs, or Joe's wishes. The RN went on to state that the continence program actually prevented constipation and diarrhoea. She appeared to have a lack of knowledge about managing continence and was reliant instead on the product driven continence management system used by this facility for all residents who were incontinent, that was managed by the CWs.

In contrast to Anna, the continence management program was fully implemented for Ruby in that incontinence pads were used 24 hours a day. Ruby's husband, Ben, did not look under the sheets as Joe did with Anna, and instead he placed his trust in the nursing staff to 'keep her clean'. Ruby's progress notes continually referred to inflamed rashes of her groins to which the CWs had applied various creams. There were no documented assessments of the rashes by a RN or GP, even though repeatedly referred to in the progress notes by CWs. The incontinence pads together with the indiscriminate use of creams continued, and the groin rash persisted, and was not assessed or treated. Again the continence management system form was placed in Ruby's case notes. One specific 'DON'T' of using this system was to avoid the use of creams and talcs with the pads. In Ruby's case creams were used frequently and could have been a significant contributing factor to her persistent groin rash, especially in light of Joe and a CW's discourse of the incontinence pads causing groin rashes.

One CW in the progress notes wrote Ruby was put onto a Kylie because of her groin rash, which again implied that the persistence of the rash was being contributed to by the use of incontinence pads. Other CWs stated that the incontinence pads 'must' be replaced as a solution to the groin rash. Incontinence pads were viewed as more convenient to staff and saved time, and the system was viewed to work by the RNs, even though it caused rashes. Ruby having a groin rash had become the 'normal' for her and it continued to be unassessed and untreated, or treated inappropriately by CWs.

Cynthia's case notes also contained the standard instructions for the system, however, she did not actually use incontinent pads and was nursed using Kylie's that were changed every eight hours. As such, the system had become the overriding continence management for every resident who was incontinent of urine or faeces, regardless of individual needs. This system had become normalised and accepted, despite evidence to the contrary around the three case studies, as well as evidence based nursing practice. It appeared this system was audited as satisfactory for the purposes of validation and accreditation by the departmental agents.

The Normalisation of the Incontinence Regimes

This sub theme focuses on other regimes in place (or not in place) for this facility in the management of the residents' incontinence. Anna and Ruby were both on the same regimes for their faecal elimination. Cynthia, however, unlike Anna and Ruby, was cognitively aware and could determine when she required aperients. Cynthia had the ability and potential to remain continent of both urine and faeces, but she was disabled by her circumstance and was not able to maintain her continence because of the resources, regimes, and routines of the facility. The incontinence of all three residents had become normalised and accepted. Ongoing assessment, planning, competent management, and evaluation were not apparent.

Anna and Ruby's Faecal Incontinence

In both Anna and Ruby's progress notes were continuous documentations about faecal oozing, suppositories given, whether they had defecated or not, and additional aperients that had been given. The use of the progress notes for this documentation served no real purpose. There was also a daily record of bowel management that could give all this information at a glance, however, it was not completed correctly and contradicted itself. The bowel records for Ruby and Anna were minimally filled out or not filled out by the CWs and the key for the chart was not used accurately. Other than concerns about the continual faecal oozing that Anna and Ruby experienced according to the progress notes, there was no documentation about individualised assessments. Glycerine suppositories were directed to be given every three days and according to the nursing staff this was the same routine for all residents like Anna and Ruby in this facility.

The giving of suppositories or the not giving was determined and managed by the CWs in this facility. In the residents' care plans unspecified suppositories were to be given by a RN or EN every three days. In contradiction, the bowel management chart stated suppositories were to be given every four days by the CWs. Aperients were also prescribed and administered at the discretion of the RN on an as needed basis. The administration of suppositories and additional aperients for Anna and Ruby were not justified in the progress notes. It could not

be tracked as to when Anna and Ruby had suppositories and no documentation gave all the information necessary for appropriate assessment and management of the residents' faecal elimination. From the analysis it was determined that the use of the aperients, the lack of assessment, and the contradictory directions were the cause of Anna and Ruby's continual faecal oozing that the CWs documented in the progress notes.

The CWs were directed to record the results of any suppositories given on the bowel chart and also in the progress notes. This may account for why every second entry was about suppositories that had been given and the ensuing faecal ooze following their administration. This direction for the CWs to assess constipation, administer aperients, and document was not elimination management according to evidence based nursing practice, and neither was it individualised or resident centred.

The RN hinted at the regimented nature of the facility's bowel regime used for Ruby and Anna as the standard means of controlling incontinence in all residents. The RN believed that Ruby required suppositories because of constipation in contradiction to the progress notes, and it was not documented anywhere that Ruby suffered from constipation. Reference to the dialogue during the interviews with a CW, a RN, and Ben about Ruby's regime, the use of incontinence pads, and her rashes can be referred to in Appendix 8. The illusion of a continence management program was actually a continence non-management program that aimed to satisfy validation and accreditation requirements, and not effectively manage and maintain continence.

Cynthia's Continence Non- Management

Cynthia was aware and totally reliant on nursing staff to maintain her continence. She had managed to avoid the continence management pad system used at this facility, even though her case notes contained the standard sheet describing the use of the 24 hour pad system. Cynthia had become incontinent of urine and faeces caused, or at the very least hastened, by the CWs not being able to gather to help her in time for her to be continent. Cynthia's incontinence was managed with

the use of a Kylie absorbant sheet on her bed with hygiene undertaken eight hourly.

The discourses revealed how Cynthia had given up and simply urinated and defaecated in bed because to get at least four staff together when she needed them was an impossibility given the staffing arrangements and the workload of the CWs. Cynthia did ring the bell for a bedpan to defecate especially when she was catheterised, but also 3 to 4 times a shift for voiding when her catheter was finally removed. When the IDC was removed and remained out there was no program implemented for her to regain or maintain her continence, despite what a RN stated about this being the case. Both Cynthia and the nursing staff had given up and had become resigned to her incontinence and a routine of three times a day hygiene and positioning. A RN and a CW describe Cynthia's predicament in the following interview extracts. The CW was more 'in tune' with Cynthia's continence than the RN and the documentation of the nursing care. The mother's description of the nursing staff not getting to Cynthia in a timely manner was explained previously in the theme about waiting for nursing care.

RN: Her bowel management - it's just she calls to get put on the pan and we usually do something if that is what she wants. No, she doesn't actually need a suppository - we do have Sorbolax which we give her when she needs it. She was on it daily but we found that was too much and she was just oozing out. It's just when she knows she needs to go she'll ask for it. We'll offer it every day and she'll say no. Yep. She knows when she does or doesn't need to do. (Data RN Cynthia p92)

CW: She's on Kylies at the moment due to incontinence, so we do that and then we change her bed linen whatever needs to be changed. She's incontinent of urine and also of faeces. She does ring to use her bowels. She uses the bell for her bowels and we just slip a pan underneath her for that and that tends to work, sometimes she has an accident, but she is incontinent of urine. So that's why she's on Kylies. (Data CW Cynthia p124, 162)

When Cynthia's IDC was finally removed and left out she did not receive any bladder retraining and Cynthia was not put on a course of antibiotics. The following excerpt from an interview with the RN describes bladder re-training for Cynthia that was not actually undertaken, as yet another fiction.

RN: Well she's recently had her catheter removed so we don't have to worry about catheter care anymore, but we do still need to do continence care and try to get her onto a bedpan at times, making

sure she's clean. ...Yep, she is trying to relearn how to use her bladder - she's had a catheter in for six months now and actually put it in when she went to hospital. OK - what we're doing at the moment is just waiting for her to say she feels the need to go and then putting her on a bedpan - just so she gets use to that feeling of actually wanting to go to the toilet. She actually asks to go probably 3 or 4 times a day but she's incontinent more often than that - stress - generally when we check - because we check 2 hourly anyway. When you go in and check you would give like hygiene, wash just down below just to keep her fresh because of the skin... Then you've got your four staff have to go down there if she needs to get on a pan - which she usually rings minimum two times probably four times a day for that and it's more if she has actually had bowel medication - she's more anxious about it... She does sometimes - she'll say 'look I think I need to go to the toilet' and we encourage that because we try and get her back some continence but having a catheter in for six months didn't help and having it all out rather than being taken out and clipped off - didn't help much either. (Data RN Cynthia p124, 162)

Although the RN demonstrated some knowledge about bladder retraining following the removal of an indwelling catheter it was not implemented in Cynthia's case. She instead was 'allowed' and even encouraged to be incontinent because of her condition and the complexity associated with providing her an appropriate level of nursing care in order for her to be continent. Initially she had become anxious and then rebellious. Finally both her and her mother had become resigned to the reality of the situation, whereby she would just urinate or defecate and then ring the bell.

In summary of this theme concerning the residents' incontinence and continence management, the facility used a product driven system that required the use of 24 hour incontinence pads. This was in order to satisfy the requirement of a continence management program for validation and accreditation purposes with the evidence provided by inserting a standard document in each of the residents' case notes. The incontinence pad system was the dominant discourse for any resident with incontinence and was forced on them unless there was resistance, such as in Joe's case. Clinical decisions were being made by the CWs about what aperients were to be given and when, the treatment and non-treatment of rashes, and the use or non-use of incontinence pads versus the use of Kylies. Cynthia's inevitable urinary and faecal incontinence was contributed to or hastened by the

inability of at least four staff to get to her in a timely manner to allow her to be continent. Whilst incontinence had become normalised for the residents, in Cynthia's case, it was in an undignified manner because of a lack of human resources, time, capacity, and equipment. In the next and final theme of this chapter the environment of the three residents, as well as their stimulation, diversions, activities, interactions, and socialising needs are described and commented upon according to the differing discourses.

MISDIRECTED STIMULATION – When a Home is Not Homelike

The ethos of hurriedness and haste introduced in chapter 8 was compounded and accompanied by an extremely noisy and public environment for these three residents in this facility. The stimulation and 'non' stimulation of the residents were also issues of contention, as were the perceptions by staff on the residents' cognitive abilities. Overall, the environmental and social needs of the residents perceived by the nursing staff, implemented by the facility, or directed by the regulations were inappropriate and disparate in various areas for all the three residents.

The rhetoric of the government is based on accommodation in a homelike environment rather than a therapeutic or clinical environment for the provision of nursing care. This is challenged in this theme where the environment, rhetoric, and socialisation for the residents were in contradiction to their needs, wishes, and evidence based nursing practice, as well as a homelike environment. The residents and their relatives did not have control of their environment and it was the CWs who determined this for them. The CWs constructed the residents' environment in part guided by the documentation requirements to justify the maximum funding possible, but also guided by their preferences, experience, and knowledge.

Environmental (Non-)Considerations

During the visits, interviews, and observations for this research there were constant noises in the residents' environment. This also extended into their rest

and sleep periods following their nursing care. The facility was also a public environment affording little privacy and security with a number of different people who walked into the residents' rooms with no apparent reason during the observations.

Following lunchtime, a natural rest time for the residents, the environment remained extremely noisy during all of the observations. Televisions and radios were blaring, loud announcements were coming through the intercom, a CW would break out into song, the sinks outside the rooms were used, water was heard running, paper towels were ripped from noisy dispensers, cupboard doors were opened and closed, trolleys went past, conversations and laughter were heard, and nursing staff called out to each other. In one incident two CWs loudly joked and laughed in the corridor about how the CW had caused a resident to end up 'in a mess' during lunch and it was audible in the resident's room. When Joe was interviewed about Anna's nursing care needs the interview took place in the 'quiet area' created in this facility (required for accreditation). This was an alcove in the main corridor with a screen and it was extremely noisy. Furthermore, it was impossible to find a quiet area for any of the interviews with nursing staff and relatives. The environment was not only noisy, but also extremely public and residents were afforded little privacy, peace, and quiet.

A number of people walked into the residents' room during the observations. In Anna's case this included a GP who walked into the room, looked at the resident in the next bed to Anna, whilst speaking her name (Irene), and then he left. As this resident was not a participant of this study, it could not be determined what the purpose of this visit was - but it took no longer than five seconds. Also, a domestic staff member proceeded to dust the whole room whilst both Anna and Irene were having their lunches. This was not only disturbing to Joe who was giving Anna her lunch, but it was also an unhygienic practice whilst the residents were eating. Another domestic staff member came in during the same observation of Anna during her rest period and proceeded to change the curtains surrounding the two beds, which was a noisy activity. In yet another incident an agency CW who was lost came into the resident's room to ask another CW where she was

supposed to be, what she should be doing, and with whom. She was directed to 'feed' another resident.

Anna was in a share room with Irene with the TV in the middle of the room so both residents could view it. The TV was on very loudly even though neither Anna nor Irene showed any interest in watching or listening to it. No one paid any attention to the TV with Joe keeping his back to it. The CW giving Irene her lunch did, however, watch it. The use of the TV was an inappropriate stimulation intervention for Anna (and Irene) who had end stage dementia, but the CWs had it on and the only person observed to be watching it was a CW. The CW whilst watching the TV was also undertaking other activities of singing, talking, and assisting Irene with her lunch, which was abandoned after two or three minutes. In Anna's case the TV was on loudly to stimulate Anna and Irene who did not need stimulating and only indicated a need to sleep, eat, and drink. The nursing staff when interviewed believed the TV was stimulating for Anna (and Irene), as well as Ruby whilst also acknowledging that Anna and Ruby slept most of the time and had no cognition left.

The issue of sleep for the residents took on different positionings in the discourses, whereby: the RNs knew very little about the residents' sleep and rest patterns; the CWs wanted to keep stimulating the residents whilst also acknowledging their interest in sleep; and the relatives acknowledged that Ruby and Anna slept most of the time and they no longer had any interest in anything. One CW's perspective about Ruby's sleep, stimulation, and rest can be found as Appendix 9. In these excerpts the CW names the the activities Ruby was provided with. Activities with Anna and Ruby did not essentially exist and were not needed, however, the nursing staff discourses were filled with these stimulating activities that were articulated as 'needed' by the residents - as determined by the documentation and weightings for activities in the RCS instrumentation. It was not acknowledged by any of the nursing staff that persons with end stage dementia required increasing periods of sleep as a consequence of the degenerative progression of dementia.

In Cynthia's case, the nursing staff acknowledged she was cognitively aware, however, because of her expressive dysphasia she could not make her nursing and environmental needs known. The nursing staff did not recognise Cynthia's individual sleeping needs and her activities were timed to suit the staffing of the facility, rather than Cynthia's wish to sleep until breakfast time. This need for sleep was not acknowledged in the documentation. The relatives did, however, recognise the residents' need for sleep, in contrast to the nursing staff. They acknowledged their relatives needed sleep and rest rather than activity and stimulation. This was not accepted by the nursing staff because of the noisy nature of the environment that had become normalised, and also because the nursing staff reiterated the direction of the documentation in order to lay claim to funding. The nursing staff and relatives perceived Anna and Ruby to be totally unaware of their environment and surroundings and did not respond to their environment. Therefore, the nursing staff largely determined the environment in regard to the residents' interactions, stimulation, activities, and entertainment.

In summary of this sub theme, the residents' so called home was permeated with questionable practices and an environment controlled by the nursing staff who were contradictory in their discourses regarding sleep, rest, activity, and noise. The environment was not adapted to the residents or relatives' needs, and instead was determined by the nursing staff and the documentation that focussed on stimulation and activity for the residents. The environment was noisy, public, and the stimulation and activities in the discourses were disparate and not conducive to the residents needs or evidence based nursing practice.

Stimulation, Socialisation, Activities, and Interactions

In the first theme of this chapter on the documentation driving the discourses about nursing care, the stimulation and activities documented were not actually undertaken with the residents. In this theme these discourses are challenged in relation to evidence based practice and the residents' individual needs regarding stimulation, socialisation, entertainment, and their activities.

Anna

Anna's husband, Joe, had a realistic view of what Anna needed in the way of interactions. His stimulation and socialisation of her focussed on getting her to take food and drink, as well as making sure she was safe and adequately cared for. In this theme of stimulation, Joe's perspective was determined in the analysis to be the most appropriate stimulation for Anna – contrary to all the other discourses. The devout and appropriate stimulation Joe gave to his wife Anna in getting her to eat and drink can only be described as poignant. He would coo to her, touch her, call her endearing familiar names, and speak or whisper to her quietly, up close into her ear. He constantly stimulated Anna to eat and drink and this was where his socialisation efforts were concentrated. His coaxing and giving of Anna's lunch took approximately forty five minutes and it was extremely intense on Joe's part - but Anna did eat all her meal in contrast to what happened with Irene in the next bed. Other than concentrating on assisting with nutrition and hydration Joe did little to stimulate and socialise with Anna leaving her instead to sleep.

Joe had become resigned to the TV being on in the room all the time, but he ignored it as did Anna and Irene. Joe stated that Anna slept most of time, was best left sleeping in bed, and she did not need the TV or radio on. He stated Anna definitely did not need to be up in a comfy chair in front of the TV in the loungeroom, as the CWs continually worked toward and struggled with against the documentation and Joe's wishes. In order to stimulate Anna in accordance with the documentation, the TV was put on and left on in Anna's room and it was loud. Anna and Irene seemed oblivious to the noise of the TV and appeared to sleep the whole time during the observation, when not having their lunch or being cared for. The following discourse demonstrates one CW's positioning in regard to the TV being on in Anna's room, and this is followed by Joe's perspective on Anna's interests, which starkly contradicted the CW's perspective.

CW: She has the TV on during the day from the morning it's put on because she shares it with another resident (Irene). So that's a sort of, the voices and that, it's good stimulation... No, she doesn't watch it, but I have noticed she might turn her head to hear voices, if there's loud noise on the TV or something. She'll acknowledge that, but Joe has the, but if she's in bed during the day, Joe feeds her in the room, and I'm usually in there at the same time feeding the other

resident and the TV's on, and there's a lot of stimulation going on. So that's usually on every day, or if she's in her comfort chair, Joe wheels her out here with the radio, outside where the radio is, so. (Data CW Anna p53)

Joe: Television, she doesn't watch now, for six, six years. Yeah. No, nothing, nothing at all. She was, once she break down, she was not interested in anything anymore. And then when she break down she said I can't sign anymore, yeah, and then she said right I just can't talk anymore so good. And it's come worst and then finish (her interests) yeah. (Data Rel Anna p53)

In the following excerpt about Anna's nursing care needs the RN acknowledged that a person with dementia can be over stimulated. Despite this contraindication to stimulating residents in the middle stage and end stage of dementia whose needs were to be safe, eat, drink, and sleep - nursing staff were intent in their discourses in the stimulation of the residents Anna and Ruby, but not in their actions. Stimulation of the type documented for Anna and Ruby, as well as what was actually undertaken in practice by the nursing staff, was disparate. The RN acknowledged Anna's needs, which contradicted the resident care plan, the CW's discourse, Joe's discourse about his and Anna's lives, and what actually occurred in practice.

RN: They(Joe and Anna) had a wonderful, they really used to enjoy the social life and the community centre, and because they, we found when we give, persisted in continuing on, that sending her to the community centre- it was too much noise, too much, too much activity. Too many things, too much input, too much sensory input and she was not reacting very well to it, for...

Well I don't think she watches TV, no, no I don't think she watches the television. Because she also, a lot of the time she has her eyes closed, ah I think, I think her main communication is the sound, sounds that are communication, input, and of course perhaps, that she groans and moans, or something like that, yeah. (Data RN Anna p55)

The RN remarked about the social nature of Joe and Anna, however, Joe made the point of Anna and him not being social people as they preferred the quiet life and hardly ever used to go out. The RN had a different perspective and it was but one indicator of this particular RN making up stories or fictions about Anna, because of the distance placed between herself and Anna's nursing care.

Ruby

In Ruby's case, the CW's knowledge about appropriate stimulation and her subsequent discourse was not carried out in practice beyond putting Ruby in front of a television in the lounge or having the radio on in her room as described in Appendix 9. In this CW's discourse a new word was created namely 'stimulisation' for what was meant to be diversional therapy, validation therapy, appropriate entertainment, stimulation, and encouragement of any activity. It was doubtful whether Ruby would benefit from any of the activities the CW described or activities that were documented, but the CWs interviewed all had the same rhetoric, nevertheless. This CW's description of how quiet and passive Ruby was in direct contradiction to the documentation that implied Ruby was aggressive and could 'hit out' at staff requiring numerous interventions as described in the theme on fictions. The very word 'stimulisation' implied acting on the resident rather than a reciprocal or resident defined activity that was in the resident's interest – such as sleeping.

As an example, Ruby's resident care plan had two pages devoted to directing CWs to provide as much stimulation as possible for Ruby. This was not what a RN stated about interacting with Ruby, whereby she believed it was a waste of time because of the lack of response from her. In the following excerpts the RN is making up a story about Ruby as she did not attend church services.

RN: Some of the dementia residents will go out and do an exercise class, those that can still basically can move their arms around will like play with a balloon and do some dancing with their arms, but Ruby doesn't seem to be able to join in that. She does go to church, she seems to respond to that, in that her face will light up and she'll smile because she seems to understand what church is, but it's a lot of work to get her into a comfort chair and get her in there, otherwise it's a one to one thing...

The only thing I can think of is it would be really nice if someone could come up with an idea to stimulate people with end stage dementia, because there's not a lot you can do, there's not a lot they can respond to. It would be nice to be able to see them able to enjoy something, like I mean, church, we send her because we know she enjoys it. (Data RN Ruby p78-9)

One RN acknowledged resistance to nursing care by Ruby and made the assumptions that Ruby wanted people speaking and reading to her, she wanted to hear voices, or she wished to listen to the radio. The CW also stated that Ruby wanted the radio on 'all the time' and that if she became resistive it was because the radio was not on. This was not observed during the observation where the radio was not on and other than moaning when she was repositioned, Ruby was at peace, not agitated, and had no interest in interacting.

RN: She can be resistive, if she feels like she doesn't trust the person that's in there or they're not talking to her enough - she'll resist, like become stiff and hold her arms in. But usually once she's heard the voices and she'll relax and let you do it. (Data RN Ruby p89)

As well as the above, the RN believed that CWs sat there and talked or read to Ruby but this was not done, not mentioned by the CW or Ben, and was not observed or documented. This activity would take a luxury of time and it was apparent there was no spare time for nursing staff to do these activities that were viewed as pointless in reality - they put the radio on instead.

RN: We haven't found anything else she responds to apart from someone sitting in her room and just talking to her and reading. She likes voices, we have the radio on for her. If we can't sit there and talk to her we'll have the radio on for her. She seems to stay calm with that on. If you turn it off she gets a bit noisy, like she's lonely or frightened. (Data RN Ruby pp89-90)

The RN's discourse was guided by the documentation of the behaviours that did not exist in order to attract more funding. This was interpreted as unethical and another fiction in the discourses of nursing practices and the residents' nursing care needs.

The activity discourses regardless of anything else had become normalised in this facility because the pretence was necessary for adequate levels of funding. Because scoring was increased with more interventions and activities documented, the fiction of stimulation becomes a dominant rhetoric in the resident care plan and nursing staff discourses. This undercurrent of activity and frequency of activity or stimulation that attracted more funding was permeated into the discourses of the nursing staff who wanted to find ways to stimulate residents who did not have an interest or need to be stimulated.

Cynthia

Cynthia had very different psychosocial needs to Ruby and Anna. As a 32 year old resident with a terminal astrocytoma she required palliative care, she was still cognitively aware, and she needed activities that she was interested in and able to do. Cynthia still attempted crosswords and when not sleeping, eating, or being positioned she watched television, which she enjoyed. Nursing staff viewed Cynthia as requiring more social interaction with people her own age. The majority of nursing staff were around the same age as Cynthia, but the nursing staff did not recognise themselves as persons who could socially engage with her and provide for what they saw as a perceived need. It was apparent during the observations that Cynthia had all the social interaction she wanted and needed through her mother and friends. She chose not to interact socially with the nursing staff possibly because her expression was limited, but also because she had become docile to the nursing care they provided and the lack of time afforded to them. It was apparent that prior protestations on Cynthia's part were misinterpreted or ignored by nursing staff.

In contrast to nursing staff perceptions, Cynthia had a total of five visitors during an observation and there was much social interaction. This socialising mainly occurred between the visitors and Betty with Cynthia choosing to watch TV, eat, and drink – but she listened. Cynthia only spoke and interacted with her mother with some degree of difficulty in her speech and she preferred to ignore any conversation or question directed at her unless she had something to say to her mother. She totally ignored questions she did not want to answer and continued to watch television or eat her meal – but she definitely did not appear to be oblivious or bored. The following CW talked about the amount of social interaction Cynthia needed and also the '*not very dignified*' practice of washing Cynthia's body.

CW: She needs a lot of social interaction. She tends to be surrounded with older people like her family and I've never really seen a young person in here to visit her, so it really relies on the personal carers that are here... Yes while we are looking after her personal hygiene we tend to talk to her about daily life to make her feel comfortable as we're washing her because some of it is not very dignified, like washing her body as such. I believe that if you just

talk to her about things that it tends to put her mind on something else. (Data CW Cynthia p59)

CW: She does that (sleep and rest) a lot. She does. She sleeps a lot. She has an afternoon nap as well -usually after lunch 1 or 1.30. I spose she - we just turn her and make sure she's settled and she'll sleep for a couple of hours. She does sleep a lot. She tends to be very sleepy in the mornings too. She doesn't wake up very well. But once we sort of get her going and start talking to her and make a bit of noise, she tends to wake up. Put the TV on for her and put her overway over her ready for breakfast and ask how's she's going. She seems to be OK. (Data CW Cynthia p68)

Despite the perceived need for interaction with persons her own age, during the observation the CWs did not socialise with Cynthia when attending to her hygiene needs. Five CWs had gathered and the conversations during the procedure were taken up with them communicating the positioning, movement, and hygiene needs of Cynthia. There was no direct communication between them of a social nature during these interactions.

Both a RN and a CW had the opinion Cynthia should have a computer. The mother, on the other hand, did not believe Cynthia wanted or needed a computer and she would no longer be able to manage one, and that this would only cause frustration for her. In Appendix 10 a collection of scripts and discourses are presented concerning the computer, as well as examples of the pressure exerted by nursing staff to have Cynthia transferred to another institution. All discourses concerning each of these issues were in conflict with each other. The mother had Cynthia's best interests as her focus and the staff demonstrated an inability to recognise and provide for Cynthia's nursing care and psychosocial needs with their focus directed to transferring her out, and the tasks to be undertaken in limited time and with minimal staffing.

In summary of this theme, in a 'real' home a person would be provided for according to their needs and this would not be determined by a dominant discourse constituted for the justification of funding or by the preferences of CWs. The discourses were geared toward validation and were contradictory to the actual needs of security, food, fluids, sleep, rest, peace, and quiet for residents with end stage dementia or with a terminal brain tumour. The contradictions were evident

through the level of noise, the public nature of the facility, the discourses and misinterpretations of stimulation, socialisation, and activity. All the relatives, in contrast to the staff, were observed to appropriately direct their stimulation and socialisation with the residents during their care, and this was also evident in their discourses. It was apparent the nursing staff rhetoric about stimulation was inappropriate, driven by the documentation requirements, not actually undertaken, nor indeed needed by the residents.

In this chapter, under the three major themes concerning documentation, incontinence, and stimulation - an environment of neglect was again revealed. The documentation contradictions and incongruence revealed fictions and fraudulent documentation that dominated the discourses of the nursing staff, but did not guide their nursing practices. The continence management system for this facility was exposed as iatrogenic causing rashes with all three residents as a direct result of the regime in place. Furthermore, Cynthia's urinary and faecal incontinence was made inevitable by the nursing staff being unable to provide a therapeutic level of care to maintain her continence. The discourses from the nursing staff and the documentation revealed inappropriate stimulation and activities that were fictional for the residents, which caused neglect of their real needs that were not competently assessed by those responsible for their day to day care.

In the next chapter, two further themes are presented. Firstly, concerning the autonomy and non-autonomy of the residents and their relatives and the ethical reasoning and practices of the nursing staff; and secondly, the burden placed on the relatives because of the nature or construct of the nursing practices in this facility based on the system in place that is totalitarian and disciplinary in nature and having an effect on nursing care.

Chapter 10

A Discourse of Neglect - Part C

The previous three chapters have described themes focussed on the physical needs of the three residents, as well as aspects of their social and environmental needs. In this final data chapter firstly the areas of autonomy, religion, spirituality, choice, and advance directives for the residents and the relatives are described, as well as unethical discourses and practices. In the second theme, the burden placed on the three relatives of the residents is examined from the viewpoint of their vigilance.

Throughout the data ethical reasoning was questioned because of what the data contained that included contradictions and conflicts regarding the autonomy afforded for both the residents and their relatives. Some of the conflicts contravened the residents' legislated rights and others created confrontations between the relatives and nursing staff. Others included the ethical reasoning, language, actions, approach, and documentation of the nursing staff. These discourses revealed disturbing practices that did not meet ethical competency standards for nursing care delivered, supervised, or delegated by nurses.

NON-AUTONOMY – When Practices are Unethical

The autonomy of the residents and relatives was questioned in the analysis of the data and during the interviews a specific question was asked about the resident's autonomy and any choices they had, as well as their religious and spiritual needs. The documentation also addressed ethical aspects through the incorporation of advance directives and notations in the progress notes regarding choices afforded by the nursing staff. Furthermore, during the observations a number of instances of unethical discourse and approach on the part of CWs' were evident. This theme addresses the resistances and conflicts of the relatives with nursing staff, the choices and non-choices afforded to the residents, their advance directives, and unethical discourses.

Resistances, Conflicts, and Power Relations

This sub theme describes those discontinuities where there were disagreements or underlying tensions between the discourses for each of the residents. In Anna's case there was a number of conflicts between what Joe wanted for Anna and what the nursing staff actually provided. On the other hand, in Ruby's case Ben was not in conflict with the staff and he praised the care Ruby received as he believed the nursing staff 'knew best'. Cynthia had some means of expression and tried to exert her autonomy and express her needs to the nursing staff. Any expression by Cynthia of her needs was often met with an inappropriate response by the nursing staff. She mostly communicated her needs through her mother as her spokesperson and advocate. The power relations were evident, but it was apparent there were continual underlying struggles for the relatives in order to make their wishes or concerns known and be actioned on behalf of the residents. It was acknowledged by the nursing staff that the relatives had the final say or the ultimate power, however, the nursing staff did not agree on occasions or they were 'following the resident care plan' and not the residents cues. Both Anna and Cynthia's situations are explained because of the evident conflicts when strong advocates 'cause problems' for the nursing staff.

Anna and Joe

During the interview Joe indicated he did not believe that Anna had any choices other than maybe turning her head away if she did not like the food. When his wife was crying out in pain he argued with the nursing staff that the comfy chair was the cause and that this had created a decubitus ulcer. When he inspected the chair it was found to have deteriorated to a hard plank of wood on the seat. He believed his wife was better off left in bed because of her condition, but he was constantly struggling against the resident care plan that stated the CWs were to get Anna up, dressed, and ambulated in a comfy chair every day for her to undertake various activities. This had not been the case for approximately two months as Joe had managed to keep Anna in her bed every day – by being there.

The nursing staff complied with both the documentation and Joe by keeping Anna in bed and then documenting the justification for this. Every day it was documented that Anna had remained in bed because of Joe's request or with his 'permission'. Faecal oozing or incontinence was the other common reason. Hence, the nursing staff did leave Anna in bed as Joe wished, but the progress notes were full of justifications as to why Anna was left in bed against the resident care plan. The progress notes, instead of being used professionally, were used to justify the conflicting practice to the resident care plan. The denigrating, unnecessary, and demeaning nature of the CWs' records of Anna being given suppositories and faecal oozing in the progress notes to justify not getting her up, ambulated, and stimulated as directed was deficient. The documentation was undignified for the resident, unethical, and did not meet a professional and ethical standard of documentation. It was not individualised or resident focussed and did not take Joe's wishes into account, whereby he continued to have to advocate for Anna to be left in her bed on a daily basis.

As was the case with Ruby, any form of what the staff called 'resistance' in Anna was actually interpreted in the observations as Anna's response to the care being provided to her. In moaning Anna could have been expressing her pain at having being moved, which could be painful. It could be also be interpreted as a resident with end stage dementia exerting what little autonomy and independence they had left. In contradiction, the RNs, CWs, and documentation all labelled this type of behaviour as 'resistance' or 'resistive' behaviour. This language implied that nursing staff understood moaning and resistance as being difficult or a problem, whereby they labelled the resident as non-compliant to the resident care plan. A CW demonstrates her interpretation of Anna's responses to care in the following extracts.

CW: Yeah she does she responds with her eyes and with her hands and sometimes she, um, can be resistive as well, with something that you might do for her. She might just automatically move her hand, or be quite difficult to turn or whatever, because she might not want to, and stuff. But she's on a two hourly turn chart so we do have to turn her regularly. (Data CW Anna p85)

CW: No, she's got no choice. I think if she's groaning or something, I think if it's enough for you to realise that she might want it to stop, but usually, we go by her care plan. We look at her care plan and

we go by what Joe wishes for her to have. So Anna can't speak for herself, so we go by what the care plan said and we go by what Joe wishes as well. We usually, what Joe says, goes, this type of thing. (Data CW Anna p6)

This CW essentially ignored what she interpreted as resistive behaviour, instead following the resident care plan, but Joe's wishes overrode this. The problem, however, was that Joe's wishes were not documented in the resident care plan because to do so could reduce the weighting through RCS funding. Because of this Joe's wishes were sometimes not followed as a result of the contradictory care planning.

In the following excerpt a RN described how she would encourage and even manipulate Joe to go away and have a holiday. Although this RN thought she was considering Joe's best interest, her approach was actually going against Joe's wishes and his need to be there for Anna everyday.

RN: So whether he (Joe) seems more relaxed and that relaxes his interaction with her and doesn't make it so much of a burden. And doesn't make him feel so tired, you know when it's 365 days a year, 2, 3, 4, 6 hours sometimes a day. It's a huge. He hasn't, he hasn't taken a holiday since, ever since, you know, she's been here. He would feel too guilty probably or...Well, look, I've just been successful with another resident who, who, the wife of another resident, she had been looking, coming in to him, and I persuaded her to go away to Melbourne for some lawn bowls contest, and she went away, um when she was back by the Monday after, she said she was feeling very guilty but having gone away, but she felt she was glad she did go, because she came back so much more relaxed and felt that she could really go now. I am not really sure if Joe is ready yet, at this stage, for something like that. But certainly, it's, it's something I can hold at the back of my mind, to perhaps... Maybe now that this lady has done it, Joe yes I can, I can just try and manipulate the environment to get her to talk to him about it, so he can see that he might um... (Data RN Anna p66)

Joe was only happy when he came to the facility to ensure Anna was being looked after and cared for. Joe did not see it as a burden because he just wanted to be with his wife, and if he was not there he would be thinking about Anna - especially whether or not she was eating and drinking. The manipulation on the part of the RN was of ethical concern even though it was apparent her motives were altruistic.

Joe had other conflicts with the nursing staff that have been described elsewhere including the non-use of the incontinence pads, the time between repositioning Anna, as well as the time required to meet Anna's hygiene needs for incontinence. He dealt with this by being there and advocating constantly for Anna's needs and this will be described further in the theme on vigilance. For Cynthia, there was a different set of circumstances, but it was still evident that Betty, her mother, struggled to have appropriate care implemented and for her wishes to be taken into account.

Cynthia and Betty

In Cynthia's case, her resistance and her mother's conflict largely centred on her socialisation, her illnesses not being assessed, her obesity and food intake, and her basic needs not being met. Concerns were also raised as to how Cynthia and her mother were viewed, talked about, and treated by the CWs. The first example centres on the autonomy and socialisation CWs afforded to Cynthia during one episode of hygiene and repositioning. Another example demonstrates the CWs' (non) consideration for Cynthia's needs and beliefs of how Cynthia should live her life. Yet another example concerns Cynthia's obesity and love for food and the interpretations nursing staff had of this situation that was highly problematic for them.

Appendix 12 provides a commentary from an observation where five CWs came in to provide nursing care to Cynthia. The episode, as well as being unsafe, was also undignified for Cynthia and her wishes were not really sought, acknowledged, and acted upon. The hurriedness of the CWs' interactions with Cynthia who needed extended time but was not afforded this, was demonstrated in excerpts from the field notes when she had her hygiene and positioning needs attended to - but not her exercises, oral hygiene, rest, socialisation, and entertainment. The CWs talked over Cynthia and answered the questions they asked Cynthia for her - unless it was a closed question. She was asked for her consent, but there was no reply - and the CWs did not wait anyway. On another occasion, she was asked if she was 'OK' and Cynthia answered no and then yes and then the CWs left. The CWs asked Cynthia questions about the care they were

undertaking, as if to ask her consent, whilst at the same time performing the care. The CWs did not leave Cynthia so that she could watch the TV that she wished to watch. She could no longer see the TV because of the position she was left in. She accepted this with an audible huff and closed her eyes with her glasses on, the TV on, the lights on, and the door open. She then appeared to be trying to sleep. The CWs did not leave the environment for her to be able to either sleep or watch TV.

Cynthia's documentation stated nothing about nursing staff waiting for Cynthia to answer questions and that she answered in monosyllables, nor was there any reference to her taking a long time to express herself and her needs. No other communication aids had been suggested. Cynthia seemed to be resigned to the fact that she could not communicate her needs to CWs and had become, in the main, docile and compliant – with intermittent acts of rebelliousness. These were termed difficult and regarded as non-compliance by the nursing staff. She expressed her dissatisfaction on a number of occasions by sighing, groaning, or being 'difficult'.

Betty: Well she can (communicate) but if you've got lots of time to wait. You really have to wait until she gets, gets it out, and sometimes she can't get it out at all so you don't know what she wants, really. Which, and that probably makes it very hard for the nurses as well, when she presses the button, she can't always answer on the intercom, so they have to come down and even then, they might, they've got to go through lots of things and when they hit on it she just says yes. You know, so, so that's not that good now. (Data Cynthia Rel p153)

One CW was compelling in her opinions and beliefs about Cynthia. She believed Cynthia had no dignity and did not feel comfortable with herself. Contrary to this CW's perspective, Cynthia seemed very confident and comfortable with her body and it appeared she had become accustomed to others caring for her and resigned to the routine of the home.

CW: Physically she's cared for very well. Emotional needs I don't believe that they're being met the way they should be. That's frustrating. And sometimes it's, I don't know whether I'm, it's frustrating, but it's sad to you know like, to sought of, if she was a lot smaller, she could, you know, she'd have a bit more dignity. Well that's right, I mean, you know. She has a lot of skin problems and she's quite big and I'm sure she knows that. She doesn't feel very comfortable about it. (Data CW Cynthia p6)

Her needs, privacy, and dignity did not appear to matter in that the practices were extremely mechanical and task oriented especially for somebody who was as cognitively aware as Cynthia. She was living in the facility, it was her home, and she was dying. These aspects appeared to be silenced by other dominant discourses such as time, the care plan, and ill informed opinions.

It was evident in the discourses there were conflicts over Cynthia's obesity and her food intake and this occurred mainly between her mother, as her advocate, and the nursing staff. This was compounded by conflicting and contradictory documentation about Cynthia's weight and what her diet was to include or not include. From one CW's perspective, Cynthia '*just needed to be put on a diet and treated normally*'. The allowing of Cynthia to eat what she wanted when she wanted was not the 'right' approach according to this CW. She believed Cynthia was 'spoilt' in relation to her food and this was the cause of her being overweight. This increasing weight may have had other causes as described previously, but the CW believed it was because Cynthia was allowed to eat what she wanted. Allowing Cynthia to eat and drink what she wanted would be an appropriate palliative care approach, but as demonstrated in the following example, the nursing staff did not appreciate the terminal nature of her condition.

CW: If she wasn't as big as she was, she could get up. She could go out. She could be put in the comfort chair or a wheelchair, in a taxibus and go to the shops, you know, go out to the pictures or something, just live a normal life...

It would be good if they could just sort of focus on her diet a little bit more. I mean I think, you know, some people think that you know, oh that's it, it's a waste of time now she's in her bed, it's going to be hard for her to lose weight, you know, just give her what she wants now because you don't know how long she is going to live for, but she's living for today and tomorrow and the next day and you just go on as normal. You treat her like a normal person and you just have her on a diet. You just go through the same old things - you do the same old things that you do the same things everyday. You don't need to worry, oh she's gonna die in a few months or a year - oh don't worry about it - let her go - let her do. But that, I don't always see it that way. I think look, she's got a life, she's got to live a normal life like everybody else and I don't think it's dealt with that way. (Data CW Cynthia p70-1)

The resident care plan and other documentation were contradictory in regard to any directions regarding Cynthia's nutrition and hydration. The documentation stated Cynthia was on a normal diet with her likes being icecream, jelly, and chocolate drinks. The GP and a RN called a dietician to come in and visit Cynthia without consulting the mother or Cynthia about this. When the dietician visited it was written in the notes about Cynthia's 'desire' to lose weight. Although the dietician recommended that Cynthia be restricted to one desert and two milk drinks per day, there was nothing in the documentation regarding this and it was recorded there were 'no restrictions' to her diet. Further documentation recommended Cynthia have toast, biscuits, and milkshakes.

It appeared the CWs and RNs complied with the mother and Cynthia's wishes, even though the dietician was summoned and recommended some constraint. There was a continual underlying struggle going on, whereby the staff wanted Cynthia's weight reduced because of the problem in caring for her with limited staff and inappropriate equipment, compared with what the documentation stated, as well as what Cynthia wanted in relation to her likes and dislikes.

CW: I mean I know that she tends to be spoilt a lot... She eats very well. She eats too much. And a lot of the time she eats the wrong things. Apparently she was sort of on a special diet as such. We've tried to lose a little bit of weight but, it doesn't seem to be happening, the family do bring things in which they shouldn't really bring in like chocolates and stuff like that. But you can't really stop that. But it's not good, I mean, she's just not losing any weight at all, she's putting it on more than losing it. (Data CW Cynthia p127)

The mother did not view the obesity as a problem and wanted to let her eat what she wanted. The mother's resignation to Cynthia's weight and care problems was that she would just have to wait for nursing care and could eat what she wanted. An RN interpreted the problem as Cynthia needing to do something about her weight, but Cynthia continued to enjoy her food and was eating what she liked.

Other incidences of Betty advocating for Cynthia's needs and coming into conflict with nursing staff provided examples of struggles that have been described elsewhere under other themes. These included: Betty standing firm in not transferring Cynthia to another institution; having to persuade nursing staff to wash Cynthia's hair; requesting a private room; asking for pains Cynthia was

experiencing to be assessed; asking for rashes to be assessed and treated; wanting the IDC removed and left out; wanting Cynthia to having timely hygiene; having to buy equipment at her own expense or not being able to buy appropriate equipment; and by asking for extra nursing staff to be employed. A RN who spoke about Betty and her strong advocacy role acknowledged that Betty had been ‘difficult’ and ‘demanding’ in the past, but that she was better now – meaning she was compliant with the system and constraints in place.

In summary, the questionable autonomy for the residents and relatives, the apparent conflicts, and the different interpretations revealed underlying dissonances between the nursing staff, the documentation, and the relatives Joe and Betty, as well as Cynthia. These practices and discourses were unethical, but there were more perspectives and the following sub themes focus on choices or non-choices given to residents with respect to the ethical conduct of the nursing staff, and the autonomy afforded the residents and their relatives.

Choices and Non-Choices

The autonomy of the three residents was highlighted in the above theme through the conflicts and contradictions underlying nursing care between the relatives and the nursing staff, and also Cynthia herself and the nursing staff. This theme concerns the choices of the residents themselves. The questioning in the interviews was framed around any choices and autonomy the residents had, and also what was observed during interactions between the residents and the CWs and any autonomy afforded to the residents.

Joe believed Anna did not have any choices in any aspect of her life other than turning her head if she did not like the food. He overtly and covertly made choices for Anna and carried them through in his personalised care for her. Nursing staff also perceived that Anna had no choices left, however, they emphasised Joe was the person who they would ask on Anna’s behalf. Joe was identified as the person to question regarding any aspect of Anna’s care, as well as the one identified who would raise any problems or needs with nursing staff.

In Ruby's case, the nursing staff did not perceive Ruby had any autonomy. As well as the language being about resistance, the nursing staff exposed a mechanistic view of Ruby's nursing care and used language that objectified Ruby. For example, when asked about Ruby's breakfast a CW replied 'she's a weetbix' and she gave some indication about decisions made in regard to abandoning nutrition and hydration if it appeared Ruby did not like her food as there would be no point in giving it to her.

CW: It depends, sometimes you might put food in her mouth and she might, screw her face up and you think, she doesn't like, might be rhubarb or something, but, and if she did that then there's no point in trying to give her the rest, she's not enjoying it. (Data CW Ruby p88)

The question raised in this discourse implied that the slightest indication of disinterest on Ruby's part would be a rationale to stop the meal and this had obviously occurred with this CW.

During the interview with Ben, Ruby's husband, he indicated that any autonomy afforded to Ruby was more in response or reaction to the environment and that he had given up trying to keep Ruby active and involved socially. The husband stated that Ruby had begun to react negatively to social contact, she was not interested, and she was unaware of what was going on. Ben acknowledged Ruby's choices would be non-existent and he believed there was no cognition left in Ruby other than for eating, drinking, opening her eyes, and making sounds. During an interview with Ben a CW interrupted us and called Ben 'love'. This CW stated to Ben that she was going to give Ruby 'a really good wash' and not a bath today (as was directed in the documentation). Although this was a façade of giving Ben (if not Ruby) a choice, there was no choice in reality and Ben willingly complied. Ben stated in interview that the nurses 'tried' and 'did their best' on a number of occasions.

Cynthia on the other hand was cognitively aware and still had some need to determine her life, environment, interactions, entertainment, and nursing care. During an observation a number of unethical practices were observed, as well as instances of Cynthia exerting her autonomy, making choices, and getting across

her wishes. Most notable was the treatment of Cynthia by a CW who came into Cynthia's room asking the visitor, myself, and then Cynthia if she could take the spare chair - as she was actually picking it up and leaving the room. The visitor and myself did not respond as we waited for Cynthia to answer her, but the CW was out of the door with the chair before Cynthia firmly answered 'no' in a loud voice. Cynthia viewed this chair as her mother's chair and the mother had just gone out of the room for a minute. Cynthia demonstrated her annoyance and her offence at this and persistently struggled to tell her mother with the help of the visitor. Cynthia was very aware that her rights had been violated and she was angry that the chair had been taken against her will. She was essentially ignored.

A CW and RN believed Cynthia had choices in choosing which shirt she would wear for the day and in choosing what she ate. The mother believed Cynthia had limited choices. Cynthia exerted her autonomy during an observation by choosing to interact or not interact and choosing to watch TV and eat her lunch with five visitors present. Mostly Cynthia deliberately ignored a visitors' question or comments and would continue to eat and watch the television. This was accepted by and acceptable to the persons present who interpreted this behaviour as Cynthia's choice. Her need to eat her lunch, watch TV, and not answer people because she had speech difficulties was appropriate in the circumstances and not interpreted by anyone present as being rude, moody, or cognitively unaware. The nursing staff interpreted this type of assertiveness or expression by Cynthia as resistance, non-compliance, being moody, ignoring them, or being demanding. It was evident that Cynthia exerted her wishes and made choices mainly through her mother's advocacy, but when her mother was not present Cynthia was left to her own means. There were documented notations in the progress notes where it was recorded in derogatory tones that Cynthia was refusing to be turned on to her side, did not wish to do her exercises, did not want to get out of bed, wanted to be put back to bed, or had to demand to be put back to bed.

The following described Cynthia's manner and her ability to exert choice as an example of her autonomy and means of coping that could be misinterpreted as her being rude or moody. During an observation a visitor and Betty started talking between themselves. In response to this conversation Cynthia got hold of the

television control and turned the volume up very loudly to drown out their talking. The visitor and mother immediately said goodbye. Cynthia expressed to her mother and visitor that she wanted to watch the TV and not listen to them talk and they realised this without taking offence. As another example of Cynthia's ability to be autonomous during my introduction to her she invited me in and indicated for me to sit down. This demonstrated she had some control over her environment that was her home. Consequently my approach was one of an invited guest, and aside from the verbal consent to participate in the study, I had the sense Cynthia wanted me to be there to observe her nursing care. She knew the purpose of my visits and was looking for another advocate because of her experiences of powerlessness in certain situations. In summary of this sub theme concerning autonomy, Anna and Ruby had little choice; and Cynthia was continually struggling to make her needs known.

Advance Directives

Further choices were offered to the three residents' relatives in the form of advance directives should the resident's condition deteriorate, which had been implemented because of the accreditation requirements. All three residents had advance directives in their case notes, but these directives were unclear in part and were also legally questionable with signatures missing. The nursing staff did not know what the directives were when questioned in the interviews. The CWs deflected this to the RNs, and the RNs deflected this to the case notes, chaplain, or the GP. The national strategy and guidelines for a palliative care approach in residential aged care facilities found this facility dealing with dying issues inadequately.

In Anna's case, one RN did not know whether advance directives had been completed and stated it was up to the chaplain who visited regularly. She stated that doctors were not very good at advance directives and there was a committee looking at 'that sort of thing' headed by the chaplain. The RN describes Anna's advanced directives in the following excerpt and the direction of packaging these for all residents on their admission to the facility.

RN: Well that I can't tell you (advance directives), because that is something that we've only just recently taken on board. I know, I can't tell you, unless I actually look at her case notes, I can't tell you. That's something I have to, I've not followed through on, because we now have a chaplain who is dealing with that issue. The legal aspects of these things are really quite worrying at the moment, in terms of, of testamentary capacity and mental competence and that sort of. Competence, how do you define it, who can and can't, and of course the doctors aren't very helpful in those sorts of issues so it's something that we have a committee that's working on those advance directives. For the residents, after and, and of course with this, the accreditation, we are doing is trying to make it part of our whole package. And so, every time somebody applies, well we say OK this is what, who we are and we have to make this, you have to make these decision, decisions, before you come into us. Um, but I mean this is nine years down the track, how do you put it, it invites all sorts of comments. Um it's something that bothers, let alone to tell somebody, seven or nine years ago. (Data RN Anna p86-7)

The RN articulated difficulties in this area of advance directives because to address this meant dealing with a resident's death, however, she appeared to be more concerned with the legal ramifications, the accreditation requirements, and the difficulty in predicting when and how death may occur - rather than the wishes and choices for residents and relatives.

In Ruby's case the advance directives were signed by Ben and an RN, however, there was no signature from the GP. This document was dated four months previously and stated as a tick box that, *'The emphasis of management will be on Good Palliative Care highlighting the relief of symptoms and discomfort. NO artificial measures designed to supplant bodily functions will be undertaken.'* It was the standard one page document used for all of the three residents utilising tick boxes and in all cases signatures were missing. Ben did not acknowledge any advance directives in his interview and he was prepared to leave it all up to the nursing staff as he believed they knew a lot more about it than him. On another form titled the Resident Care Directive Form it stated that Ruby was to remain in the nursing home and would not be transferred to an acute care facility. Ruby was to receive pain control and/or palliative care to maintain her comfort and dignity, and the document was signed by a RN, Ben, and the GP three years previously.

Cynthia's advance directives consisted of the standard document for this facility and not a legal schedule under the Consent to Medical Treatment and Palliative Care Act of 1997. This form had a tick box and was signed by the mother, an RN, and the GP following a conference held between the mother, a RN, and the chaplain. It was mentioned a number of times that the mother did not want Cynthia approached or engaged in discussing any matter to do with her death, despite Cynthia being quite capable of comprehending and making decisions for herself given an appropriate approach and communication. Her mother, Betty, did not want Cynthia to get upset and was acting as a gatekeeper in her protection, but at the same time Betty was not giving Cynthia any autonomy in these matters as an adult.

According to Cynthia's advance directives there would be no cardiopulmonary resuscitation and '*during end stages do not transfer to acute care facility*' and this was signed by a RN and the mother. Betty stated that she wanted Cynthia treated for any acute condition, such as epilepsy, and Cynthia was treated with anticoagulant therapy at the facility - when her DVT was finally diagnosed. There was also a standard and lengthy palliative care plan proforma in Cynthia's case notes that was completely empty of entries. There were no assessments, referrals, or directions as to Cynthia's palliative care needs, which were significant, extensive, and complex. This was in contradiction to best practice principles and a palliative care approach in aged care.

Together with advance directives, the participants and the documentation were questioned regarding the residents' religion or spirituality viewed as being a psychosocial need for persons under an ethically based provision of service. The following sub theme found conflicts in the interpretations of the residents' needs in this area according to the differences revealed in the discourses.

Religion and Spirituality

As previously described in the theme on documentation, fictions were created by the nursing staff and also written in the documentation concerning the nursing

staff getting Anna and Ruby dressed, up in comfy chairs, and taken to the church services. The nursing staff further claimed that both Anna and Ruby were religious and that they got a lot out of these services. The reality was neither Anna nor Ruby were religious, and they had not attended church services of any denomination for many years. It was apparent fictions were created in order to claim the meeting of religious and spiritual needs necessary for funding and accreditation. For example, in Ruby's case a CW who claimed to know Ruby well was ignorant of Ruby's history, religion, and belief system. This CW believed she had a responsibility to get Ruby to any services provided at the facility and she thought Ruby might be a Catholic - but Ruby was not. The CW stated she relied on Ben, her husband, to say anything to her or request that Ruby be taken to any services, which he had not done. The rhetoric of fulfilling the residents' religious and spiritual needs was a narrative designed for the regulations and not the reality of practice.

Cynthia had refused to have the chaplain visit her and it was stated by the mother that Cynthia was a confirmed atheist and not religious and this was made very clear by the RN and Betty's discourses. Another unethical discourse viewed as a potential threat to Cynthia was the way one CW approached Cynthia's spirituality. The following extract describes one CW's perspective about Cynthia's spiritual needs.

CW: I actually have spoken to her about God, being a Christian myself. She doesn't really tend to want to talk about it. I sometimes wonder if she really knows what's going with her and how, about her illness and that, I'm not really sure how much she knows about it. I don't know whether she feels, knows that she's getting better or she will eventually die. Yeah, I get a little bit concerned about that sometimes. I wonder but I can't just ask her like that. I mean that's up to the family to do that. Her spirituality I don't think she really has one. The chaplain does come in to see her. I don't know what they discuss. I've wanted to talk to her about God but I think there's just a special time for that, you know, you've gotta - the right place, the right time. Yeah that's right. (Data CW Cynthia p68)

The CW believed Cynthia was 'not spiritual' and was missing out because she, the CW, was herself a Christian and thought she was spiritual and able to give guidance to Cynthia, who in her view was lacking spirituality. This CW had every intention of finding an opportunity to espouse her own religious beliefs upon

Cynthia, despite the mother and Cynthia's expressed wishes to the contrary. This CW believed the chaplain visited Cynthia, however, this chaplain visited all three residents according to the documentation and the nursing staff, but in fact he visited none of them.

Still further unethical communications and practices required description and the following sub theme examined other discourses evident in the data that were questionable in their ethical reasoning. These discourses were from the perceptions of the nursing staff or their opinions, the approach and language of the CWs to the residents, and also their practices that have not been detailed elsewhere in other themes.

Unethical Discourses

During the observations and interviews some of the nursing staff displayed behaviours that require specific description. The first of these examples concerns Anna and the behaviour, manner, and practice of a particular CW during an observation. This same CW was observed to be practicing in an unsafe manner and was discriminatory in her interview responses. She was the CW who abandoned Irene's lunch after spilling it over her and who loudly joked about this in the corridor with another CW. In the previous theme on spirituality, she was the CW who intended to spiritually educate Cynthia. She was named the singing CW because of her constant singing of the one line 'I am woman, I am invincible' loudly during the whole of one observation both in the corridor and in Anna's room. She repeated this on a number of occasions in the corridor as she went about her work, twice during Irene's lunch whilst she also watched the TV, and immediately after she directed another CW to go in response to an urgent call over the intercom. The singing of the one line by this CW appeared to be ignored by others, and it appeared to be an accepted and normal occurrence. It was, however, out of place in an environment of elderly, disabled, demented, and frail women who were obviously not invincible and in whose home this CW worked. It was unethical and unprofessional, but also disreputable to the nursing profession as this CW was called a nurse by the relatives.

In Ruby's case a number of CWs were revealed to be communicating unethically with Ruby. One CW attending to Ruby's hygiene and repositioning needs made denigrating and negative parent to child chastisements to Ruby - all be it in an endearing way. When Ruby was moaning at being repositioned the CW stated that she would have to smack her and also tell Ben about it. When the CWs had finished another CW asked Ruby whilst touching her cheek '*how was that – oh did we disturb your peaceful sleep?*'. There was absolutely no response from Ruby who appeared to have very little resistance and who settled quickly. This infantilisation of Ruby by the CWs in their communication was denigrating, whereby Ruby was treated like a child or a baby because she could only make incomprehensible sounds and, therefore, was perceived as not cognitively aware. As such, any utterances by Ruby were ignored and silenced. As well as these discourses, the two CWs also laughed loudly in response to Ruby's moan at being repositioned.

A CW stated she had not seen any behaviours from Ruby that indicated that she was in any pain and, if she did, she would report it as a '*tummy ache or something*'. Any deviation from Ruby's normal pattern of behaviour would alert the CW to report to the RN. This CW would make a clinical judgement as to whether to report any pain to the RN and the RNs were also reliant on the CWs for this assessment and this clinical judgement. The repositioning of Ruby was not considered as painful for Ruby in any of the discourses, but her pain was apparent during the observation in response to her being repositioned.

CW: I haven't had to report ever, that I feel, that Ruby's in any type of pain. I'm not really sure what her medications are, what she's on but you know, but there's some people when they're moaning and groaning and grimacing, you say, yep, they've got some degree of pain, you report it, but with Ruby I've never had to report yet since I've been here that I feel she's in any type of pain. No. That would be to the contrary of what she normally is and I would straight away, that would be reported that Ruby's in some type of pain. Yeah she might have a tummy, it might be tummy ache or something going on inside, but I've never seen that with Ruby. Yeah, I've never seen that. Yeah. (Data CW Ruby p90)

When Ruby's husband, Ben, was asked about an emergency or if Ruby's condition deteriorated suddenly he responded with almost total trust that the nursing staff knew best, would make the right decisions, and would let him know.

Ben: No I'd leave that to the nursing staff, because they know more about it than I do you know, cause I think a if she needed it they would act you know, they'd probably ring me perhaps and tell me. But they, they'd always ah let me know, you know if there's any real changes or anything like that. (Data Rel Ruby p120)

A CW contradicted Ben's view of the nursing staff 'knowing more' than him about advance directives or measures to be taken in an emergency or sudden death. Appendix 11 highlights the level of this CW's clinical judgement and ethical reasoning regarding Ruby in such an event. This CW had no knowledge of the advance directives and made a judgement based on her view that in the event of Ruby aspirating, choking, or stopping breathing all of which Ruby was prone to, then she would leave Ruby to get an RN. In her opinion, it would be better if Ruby was left to die peacefully and she would not resuscitate her. It was determined by the CW that leaving Anna to get the RN was quicker than waiting for anyone to respond to a bell. This would pass responsibility upward to the RN, and in this CW's view, it was good that she did not know what she should do in this type of event. It was implied by this CW that she would be judging and acting and she did not have any knowledge of appropriate nursing practices around aspiration, choking, or the death of a resident.

A number of unethical practices and communications were noted from Cynthia's data. Throughout the interviews Cynthia was referred to as a 'girl'. Her mother, Betty, called her a 'big girl', the RN called her a 'bright girl', and a CW a 'large girl' and a 'lovely girl'. This was alongside the other discourses of Cynthia swearing at the staff, being demanding or difficult, refusing to participate, or being spoilt and moody. In the following extract a CW uses condescending terms when talking about the 'levels of mind' between herself and Cynthia. This CW was in a position of power, whereby Cynthia would have no choice in what subject the CW would decide to talk about when she was interacting with her. There was also an unrealistic expectation by this CW that Cynthia could lead a normal life.

CW: Talking to her and discuss about herself and how she feels about her situation, although she really doesn't talk about that much. Yeah well just really I mean I'm the same age as Cynthia so I sort of try to meet her needs. I'll tend to try and look at her, I look at me if I was her and what I would like to talk about. So I have to really, sort of, because we're the same age but I have to try and go to her level as well as her trying to be at my level of mind, type of thing...like I just talk about my life and what's happening in my life and she seems to understand she just, she can't respond as quickly as what I could. We tend to do most of the talking - she answers yes, no, she might want to talk but she just can't seem to get it out. It takes a long period of time for her to think about what she wants to say but when it comes to her saying it she's forgotten, she forgets about it. And that tends to frustrate her, but I think, that's all to do with her social activities, the lack of it. Yeah and she forgets. But we usually, we give her a lot of time to answer but yeah, but her communication is not the best, I mean she'll definitely tell you whether she likes something or not or whether she's in pain and things. But, we do, I tend to do a lot of the talking when I'm with her and she just listens and she might smile and laugh, you know. She's got a good sense of humour. She knows what we're talking about. She's very observant yes. Well I think Cynthia's a lovely girl, she's got a lot of potential. It's very sad that she can't live a normal life, which I feel that she could if she had the right stimulation. Being the same age myself, I look at that and I think wow you know, it's a bit sad and all the things I do in my life to what she could be doing. (Data CW Cynthia pp67-68)

The CW appeared to be unaware of the progression of a terminal condition such as an astrocytoma and the resulting deterioration of someone suffering from this, as well as Cynthia's expressive dysphasia that was interpreted by this CW as Cynthia forgetting what she was going to say. The CW's statement that Cynthia had a lot of potential and could lead a normal life if given the right stimulation was of concern, whereby the CW had a very limited knowledge of what Cynthia's nursing care, medical care, palliative care, and socialisation needs were. This CW based her perceptions of Cynthia's needs on what she herself liked to do in her 'normal' life and also believed that Cynthia should just be treated 'normally'.

The ethical issues identified in the data were a threat to the quality of nursing care being provided to these three residents and, therefore, their quality of life. The issues centred on conflicts between the residents and relatives with the nursing staff, with what was observed, and what was stated in the documentation. The issue of choice for the residents was described from the perspective of the resident

that essentially found little or no autonomy for Anna and Ruby. Any utterance by Anna and Ruby was regarded as resistance. On the other hand, Cynthia tried to exert her choice and express her needs, but was resigned to the control exerted on her existence by the nursing staff. When she tried to express her needs the nursing staff interpreted this as defiance. Concerns were also raised regarding advance directives and the spirituality of the residents. Finally, the unethical language, manner, and practices observed or talked about were depicted and included the infantilising and demeaning communication with Ruby and denigrating discourses concerning Cynthia.

There was a strong undercurrent of non-autonomy for the residents in the discourses, which was compensated by the relatives who played strong advocacy roles. This was particularly evident in Cynthia and Anna's cases. This advocacy by two of the relatives caused altercations between Joe and the nursing staff over Anna's nursing care, as well as, between Betty and the nursing staff over Cynthia's wellbeing. Ruby's husband was more compliant with the dominant discourses and practices and preferred to leave it to the nursing staff as they knew best and he trusted them.

In the day to day running of the facility nursing staff were in control, but the relatives had some power in that if they wanted something or said something, then it was supposedly addressed. There was not always agreement as to what was needed or the choices and autonomy allowed for the residents and their relatives. The interpretation and belief of the relatives was one of vigilance, checking, and protection on behalf of the residents. This aspect is described in the following final theme around the residents' relatives including insights into their burden and their perspectives of the nursing care and the nursing staff. It also describes the reliance of nursing staff on the relatives for assessment of the residents.

VIGILANCE, TRUST, and ADVOCACY – When You Have to be There

The relatives Joe, Ben, and Betty were eager to participate in the research and were open in their interviews. Their ‘truths’ and beliefs were honest accounts of what occurred, however, they all held back as if that they did not want to tell the whole truth. Essentially they were attempting to protect their relatives in order to ensure their nursing care, as well as wanting to protect nursing staff and the organisation. These protective silences were caused by the dominant discourse of the system. The relatives had become resigned to the workings of the facility and the scheme under which it functioned, and they did not make use of the complaint mechanisms available to them. All of them qualified their responses with statements that implied nursing staff did the best they could given the circumstances. The relatives generally believed the government and the funding of the facility determined the situation, and they did not perceive the problem to lie with nursing staff – although there were exceptions.

This theme discusses differing aspects of the relatives’ relationships with the residents and the nursing staff. Joe and Betty were both vigilant and strong advocates, whereas, Ruby’s husband, Ben, was trusting of the nursing staff and did not look or question any of Ruby’s care. The theme of vigilance discusses the relatives’ perspectives, but also the reliance the nursing staff place on the relatives for assessment and to raise any problems concerning the residents.

This theme on the relatives’ vigilance, especially in Anna and Cynthia’s cases, was analysed from the contradictions in the data focussing on the relatives ‘having to be there’. On the one hand the relatives had to be there, and on the other hand they had nothing but praise for the nursing staff for doing the best they could in the circumstances. Joe’s belief that he had to come in was based on Anna not being alive if her care was left in the hands of the nursing staff. Ben, however, did not question and did not know about Ruby’s underlying conditions, and his outlook was different to Joe and Betty’s approach. In Cynthia’s case, the mother continued to challenge nursing staff about her daughter’s care needs and condition, and she had also become compliant. To be able to know, challenge, and advocate one has to be there and be present, and both Joe and Betty were very

visible in their vigilance and each visited every day for up to six hours a day. Ben on the other hand, simply trusted.

Joe's Vigilance

Joe was not happy and was anxious if he had to worry about whether Anna was getting enough to eat and drink and he could not be elsewhere at mealtimes. He had to be there to check on things, give care nursing staff were unable to give, and he implied that if he did not come in and check, then she would be dead or be living like Irene (the woman in the next bed to her). Irene was totally reliant on nursing staff for her care and, in Joe's view, this care was poor. As such, he had to come in for Anna's wellbeing and survival. Appendix 13 demonstrates Joe's reasoning and drive for him having to come in every day to care for Anna. Joe believed the care was adequate, but this was only because of the time he also devoted to his wife's care and the advocacy he demonstrated. His need to come in everyday was reinforced with incidents concerning Anna's care and Joe had to make sure everything was alright by being there because he did not trust that his wishes would be followed or appropriate care would be undertaken. A CW and a RN viewed Joe's relationship with his wife as one of Joe being dependent on caring for his wife - rather than Anna being dependent on his care, which was more the case.

In contradiction to Joe's discourse in Appendix 13, the following extract from a CW interviewed about Anna demonstrates a misinterpretation of Joe's motivation or 'dependence', as well as her belief that Joe was happy with the care provided to his wife.

CW: I know that Joe, he doesn't want her to die. He's very, I don't know, really, how he'll cope when she goes because, well she is his life here, she's his life, that's right, that's exactly right. Once she goes, I don't think he'll know what to do with himself because he spends most of his time here. He gets up, comes in, goes home in the afternoon for an hour or two and then comes back and spends every evening with her til at least 6 or something like that and then he'll go home but it's sort of like, it's his life here, and we're his family really too, because when he comes here, because he talks to us and other residents' family as well... he's a big part of our lives as well, so I really don't know what will happen when it comes to that time.

Very upsetting for everyone concerned. Yeah, so we're not really sure, how we will deal with that (laughs). ...He's very happy with the care that Anna has. He's, and he's a real help too. He's very happy with what happens and he does, if he feels like he's not happy with something or whatever, he definitely talks to the staff, yeah. (Data CW Anna p131-3)

As part of Joe's vigilance he also added extra things to Anna's food and fluids witnessed during an observation and talked about in his interview. Joe added butter, Sustagen, and vitamins to Anna's food, as well as thickener to her fluids. He believed that if he did not do this, then the food would not taste very nice, would not be nourishing enough, and would be the wrong consistency. He brought these extras from home every day and added them when the meal arrived. Nothing was documented about Joe's adaptations to Anna's diet and these were not mentioned by the nursing staff. It appeared the nursing staff did not know about the additives and Joe did this in a covert manner as part of him being vigilant and ensuring adequate nutrition.

Joe: But sometimes it's nice food, sometimes it's not tasty. I provide myself, I take it to my wife Anna. If it's not so good food, I don't want, if you see it's not so good, you don't like it to give it. Because she was a very good cook. She liked very good meals. Yeah and when you give her like that, but her eats slowly. I put the butter always in. I put in butter, yeah, I mix a little bit more tasty. Yeah. That's right, yeah. Oh yeah. And when I give her food in the morning I put in there Sustagen in, mix it and once she eats I feel so good. (Data Rel Anna p141)

As well as Joe having to be vigilant with staff about the use of incontinence pads, Anna not getting up in the comfy chair, and him needing to come in to provide food and fluids, he had other reasons or incidents that reinforced his need to maintain vigilance. For example, in the following discourse about Anna's bowel management, it was again apparent that Joe was the one who assessed and came up with solutions and then he had to struggle to have any changes implemented on a number of occasions, finally becoming compliant to the facility's incontinence regime, but dominant through his vigilance and advocacy.

Joe: One, one time they came, they said they going to give it (Lactulose), I said alright I give it by the food, but they went off, alright and they give it. And they give it for three and oh she, I thought what's happening and she was on fire, sometimes screaming, and all the time sore, and I said that sugar is not (good) with the food. So they give her drink to wash it down. Yeah, and

after about thirty minutes it come down, and I told the sisters. That why maybe, yeah, and I said now one day will be given, I give it with the food, yeah, yeah. I put that with desert and that stuff a bit in, so it's spoons full and so she doesn't feel anything and I thought, I'd try myself and I tried and oh, it did very sweet and sticky. It no wonder when you, yeah. She was very against tablets, she never took a tablets when was her good, yeah, yeah. That's what happens. Yeah. I used to give her senekot. And the girls start suppositories, two yeah. (Data Rel Anna p160-1)

The above examples, together with other incidences previously described, implied that Joe could not really trust the nursing staff or what they recommended, but had finally complied with certain things such as the bowel management program. In other incidences he simply took over the care such as her nutrition and hydration, maintaining her skin integument, and her positioning. In some instances he had become covert in his care as this was easier than advocating continually. This was also a similar to Cynthia and Betty who had a strong relationship based on Betty's advocacy. Ben, however, was different in his relationship with the nursing staff and the facility.

Ben's Trust

In Ruby's case, Ben's approach to his wife's nursing care was one that if he was not aware of anything wrong - then everything was alright. Ben stated Ruby's care was good and he had nothing but praise for the nursing staff because there had never been any problems that he was aware of. However, Ben's perspective was also revealed in the example of Ruby falling out of bed once and this being her fault. Ben did qualify the level of his trust in nursing staff with statements of '*not that I know of*' or '*I'm not here 24 hours a day so I don't know really.*' (Data Rel Ruby p150). The extract below describes how he could not complain about the nursing staff, but it can be argued perhaps he should have inquired further into Ruby's nursing care - given her untreated hypertension, severe rashes, and inappropriate interventions that were documented and practiced.

Ben: There's never been problems no. No, I can honestly, honestly say that. You know. I've heard of different nursing homes and know the people that have problems but I can honestly say that I've never had any complaints from the nursing staff or the other staff, not mistreated here or anything, you know? (Data Rel Ruby p145)

Ben: (The staff) Always very obliging and very what can I say, very helpful. Always say hello and that sort of thing, you know. No I couldn't, couldn't, have nothing to say at all. (Data Rel Ruby p110)

When questioned about Ruby's skin care and specifically whether she had any rashes, Ben stated 'No, no. No rashes. No nothing that I've seen anyhow put it that way.' (Data Rel Ruby p110). In contradiction, it was documented that Ruby had ongoing red, angry, and severe rashes in her armpits, under her breasts, and in her groin as described in the themes on unsafe practices and continence. As such, Ben did not look under the sheets as Joe did. This could be viewed as an undignified practice by some relatives and as such, problems can remain hidden. His trust in staff meant he did not question and had an acceptance of nursing staff 'knowing what is best' – as the experts.

Ben did not believe Ruby knew he was there when he visited or that she had any cognition, but out of a duty and his marriage vows he came in and contributed significantly to her nutritional care. His need to come in and help can be attributed to a sense of duty and as long as she was clean he was very happy with her care. Ben chose not to have access to Ruby's body, did not check on the nursing care or what was documented, and nursing staff did not report Ruby's hypertension and problems with rashes to him. His trust also extended to Anna's GP whom he did not see very often.

Ben: Ah not a lot (see the doctor). I see him occasionally but ah he's an excellent doctor. He would, I know he'd be out here if he thought any - he'd get in touch with me. You know. (Data Rel Ruby p110)

It appeared the relatives may only have been informed about certain things on a need to know basis. To be kept fully informed would entail the relative constantly being there, challenging, and questioning nursing staff. Ben put full trust in the doctor and the nursing staff and he was totally reliant on them as to what was best for Ruby, as long as she was clean.

This trust Ben placed in the nursing staff was unfounded according to the evidence in this study. In truth, Ben's reliance on the GP to keep him informed was in turn reliant on a RN informing the GP; the RN was in turn reliant on the

CWs to bring up problems; and both the RNs and CWs were reliant on Ben to identify problems to be addressed. Ruby's rashes were not a problem and did not require addressing with Ben as they had become normalized and not spoken about with him. During an observation of Ruby, Ben was reading the turning chart for her that showed the times of repositioning and in what position she was left in. Although Ben put all his trust in the nursing staff and the GP, however, he too did some limited 'checking' as described above. Cynthia's mother, Betty, had a similar relationship to Joe with the nursing staff and the facility. Rather than vigilance, her role was one of advocate because Cynthia was vigilant and observant and thus was still able to inform Betty of her needs or alert her mother to a problem.

Betty's Advocacy

Betty's vigilance and care was highly visible and overt, and her strong advocacy of Cynthia's care needs was apparent. She made it her business to know about Cynthia's needs, wellbeing, and she had access to Cynthia's body. Cynthia now only spoke through her mother and the mother and daughter relationship was close and strong. Cynthia relied heavily on Betty to communicate her needs and make them known to the nursing staff. Betty stated that she had to come in to make sure Cynthia was 'OK' and to ensure she got everything she needed - even the little things. This implied that if she did not come in, then Cynthia's nursing care needs would not be met.

During one observation at lunchtime Betty was extremely attentive and 'in tune' with Cynthia's needs in a meticulous and intensive way. Nursing staff did not check on Cynthia during her lunch, but it was common knowledge with nursing staff that the mother came every lunchtime and teatime - even though this was not documented. The staff did not have the time to be with Cynthia on a one on one basis and, therefore, could not fulfil all of her needs and wishes during mealtimes, which were very important to Cynthia. The extract from an interview with Betty's implied that nursing staff treated Cynthia well; however, at the end she implied a possibility of catching them out and her need to protect.

Betty: I mean, yeah, she has a fair few visitors, like her friends and her family. Well I'm here twice a day so that takes up about 5 hours a day of my time. Yeah she has quite a few visitors from, and as I said the staff are nice to her all the time. I've never known anyone to be nasty. I wouldn't want to catch them either. (Data Cynthia Rel p152-3)

The nursing staff again revealed their reliance on Betty to raise any problems with Cynthia. The problem was, however, that when problems were raised by Betty with the CWs or RNs - they were ignored, poorly assessed, had no intervention, or the intervention was questionable. Betty had more time than the nursing staff and was able to communicate with Cynthia, whereas it was observed the nursing staff were not enabled to communicate effectively with Cynthia or knowledgeable enough to perform adequate assessments.

Betty very much held the locus of control over Cynthia's wellbeing and what she got and did not get. The nursing staff acknowledged this control and staff eventually bent to her will or persistence on a number of occasions as described in the theme on conflicts, but both Betty and Cynthia had become docile in other areas. To reiterate these conflicts, the mother had to argue for: Cynthia not to be transferred to another institution; to have her IDC removed and for it to remain out; to have her full sponge completed earlier in the morning instead of after lunch, and then to advocate to change this again from well before breakfast to after breakfast; to have her hair washed after five weeks; to be assessed in regard to her rashes, complaints of pain, and other symptoms; to resist buying a computer which would cause frustration; and to complain that not enough physiotherapy was undertaken. Betty had also instructed the nursing staff not to talk to Cynthia about advanced directives or anything about dying or death, and that Cynthia did not want to see the chaplain. The following extract from a RN's interview confirms Betty's advocacy, as well as a reliance on Betty to raise concerns about anything to do with Cynthia's care.

RN: We do actually have a good rapport with Betty - it's taken a while to build but we do have a good rapport with her mother in particular and she is the one who will come with problems or concerns and she is the one we'll go to as well because she's here everyday and we can spend, I'll spend half an hour with her at times, but on a daily basis it's usually for maybe 5 or 10 minutes just checking in with her to see how they're doing. And if there's

anything that Cynthia has told her that she hasn't told me. (Data RN Cynthia p154)

The RN believed there was no problem with Betty 'now', which implied there had been problems or conflicts previously. The advocacy on Betty's part for Cynthia was justified with her knowledge of Cynthia's wishes before her condition deteriorated and she became dysphasic. The mother knew that Cynthia never wanted to be put in a nursing home and this could have been another reason for Betty's vigilance and advocacy motivated by a level of guilt. However, in this case it was more out of love and protection.

Betty: Well Cynthia's always said in the past when she was quite you know, lucid in her thoughts, she would say 'don't ever, ever put me on a life support machine'. So that was her wish and it's also my wish that she wouldn't go on that because down the line you are going to have to make a choice then to turn it off and I don't know that I could do that. I could do it at the time when she was in a lot of trouble - it would be hard - but for them to say to me I think it's time to - I don't know that I could even do that. Death. So it would probably be better at the time - that if they thought it was necessary to do it - right there and then. Well if it came to that at the hospital - they asked the question then because she was really, really bad and they didn't think she would pull out of the seizures at all so they asked me then and I said no. Cause they were talking about doing tracheotomy and life support and I said no. I said that we don't want that. But you know, as I say, it might only be a one off seizure so you're not going to just let her go - I would want her treated for that... Well during a seizure if her heart or lungs collapsed, the same thing applies. I really can't see the point in putting her through this any longer. Yeah, yeah. I know Cynthia would hate, if she was like of real sound mind, she would hate to be in the situation she's in now. I mean she always asked me don't ever put me in a home. Well, I mean it got, it's just at the stage where I wouldn't be able to look after her at home anyhow. I have mentioned (another institution) to her and explained to her what, what it would be like out there, that there would be people her own age perhaps or a little bit, you know in their 40s and 30s and that, and I said but if you went there your visits from the family would go, drop, and she said well in that case I'll stay here. (Data Cynthia Rel p154)

Cynthia's primary need was to be near her mother who could advocate on her behalf because she had been made docile by her condition, the discourses and silences, the system, and the way the facility and nursing staff worked, which resulted in her oppression. She was not able to control her environment and

needed her mother there to support her in this facility. The overall impression of Cynthia was of a person who was defying the system, rebelling, reluctantly complying, and who needed her mother there to challenge and provide for her care needs.

Nursing Staff Vigilance

The nursing staff relied on the three relatives in their discourses to report anything about the residents to them. The RNs' discourses also found a reliance on the CWs and relatives in bringing up any problems and reporting any changes on the residents' needs, behaviours, or conditions. Contradictory to this, however, was that even when problems were reported by the relatives or the CWs to the RN via the progress notes, these were often not acted upon by the RN and, therefore, not acted upon by the GP. There was a reliance by the doctor on the RN, the RN in turn relied upon the relatives and CWs, and the CWs in turn were reliant on the relatives for the assessment of the residents' nursing and medical care needs. This hierarchical model of nursing assessment and vigilance was an underlying problem in this facility.

The CWs deflected their discourse to the RN on only three issues to do with nursing practice namely resuscitation, the potential for seizures, and the medications prescribed. These were viewed by the CWs to be the responsibility of the RN and not something they would comment on. This had the implication that everything else determined to be nursing care was interpreted by the CWs' as being their responsibility. This gave the CWs silent permission to talk about nursing practices in their discourses and it gave them an authority in being knowledgeable, even though they were not knowledgeable. It also gave them permission to make clinical decisions about nursing practices at the bedside that were, unfortunately, of a very poor standard.

The reliance of the nursing staff on the relatives to raise problems or issues added to the burden of the relatives and their need to be vigilant and continually inquiring, especially in Joe and Betty's case. The reliance on relatives and CWs to

conduct continual assessments was defective because of the lack of knowledge and expertise in nursing care by these persons to appropriately assess what was essentially complex nursing care. The GPs relied on the RNs who relied on the relatives and CWs. The RNs were distanced, the CWs did not possess the necessary capacity and capability essential for an appropriate quality of nursing care provision, and the relatives, although not possessing nursing knowledge, had the advantage of knowing the residents at a level not displayed by the nursing staff. Competent assessment as imperative to appropriate interventions was lacking in this facility because of the structures in place that were determined by the system.

The following theme reinforced the need for vigilance and advocacy on the part of relatives and described the relatives' perspectives of the nursing care staff, whereby they judged the nursing care staff as being good or not-so-good nurses, regardless of whether they were a RN, EN, or CW, as all were 'nurse' from their perspective.

Good Nurses and Not-So-Good Nurses

All the relatives called the nursing staff 'nurses' and this included any person who provided personal care to Anna, Ruby, or Cynthia. The three relatives also mentioned the use of agency staff used by the facility as not being an ideal situation, whereby agency staff caused medication errors and did not care; or did not know the residents as described in the previous theme on agency staff. The relatives, especially Joe and Betty, believed that if they were there every day, their loved ones could be protected from the not-so-good nurses or the nurses that did not know the residents. All three of the relatives determined, in general, that agency staff were not-so-good because they did not know the residents.

Joe stated that there were 'good nurses' and 'not so good' nurses. He clearly identified who was a good nurse because of his observations and interactions with nursing staff over the years.

Joe: I know them all. I know when they are good... But some is not. That's important too. Real nurse or what, straight away I knows it.

But what they washing, what they doing if very good. You got some good nurses and not so good. Yeah, yeah. Who takes care and who doesn't want to. (Data Rel Anna p95)

One CW viewed 'new' staff as a burden to the regular staff whether they were from the agency or employed by the organisation. A further concern arose with the possibility of this CW directing any agency or new nursing staff to the resident care plan. Given that the documentation was found to be dangerously out of date and did not reflect the changes in nursing care, and as such did not appropriately and accurately document nursing care needs - this would be unsafe if a CW attempted to follow the resident care plan for any of the three residents concerned.

CW: Usually the agency people that we get, are the same ones, if they're good, we have them back, so they're actually like normal staff, because we call the same ones back all the time. So that's good, so they come in and they know residents and it's better that way I think, than having someone that's never been before, because it's like you're doing two peoples' job anyway. Because they're just, they're following you around, and you've got to tell them everything, so that's just a waste of time, personally, but you need someone that comes in and just gets down to the nitty gritty and knows what's doing with them. There's care plans there, and if the staff, they want anything, they ask. Some of them are quite hopeless (laughs). Yeah. (Data CW Anna p8)

As described previously, Joe's perception of the nursing care Irene (in the next bed to Anna) received was insightful and used as an example of what could happen if a resident did not have a relative to come in and care for them. Joe had witnessed Irene's day to day care for a number of years, including the care she did not receive. The care she received added to his motivation for vigilance and from his perspective the care provision was lacking. He minimalised his concerns with statements such as '*perhaps she's not hungry*' or '*perhaps she has a reflux*' and this may be the reasons the nursing staff did not spend the necessary time helping her to eat and drink. He had seen Irene physically deteriorate more rapidly than his wife into end stage dementia, emaciation, and cachexia and he had observed the amount of time spent by CWs giving her lunch and tea and attending to her needs. Irene was often Joe's justification for 'having' to come in to care in order to maintain his happiness and keep his wife alive. The implication that Joe would feel guilt if Anna was left to the routine care was based on his observations that some (or most) of the nurses were 'not good'. Joe's need to come in every day

was fuelled by what he observed, what he had struggled against, and what he had experienced with Anna and Irene's care.

In Ruby's case, Ben also spoke about the use of agency nursing staff, which he considered might not be ideal for his wife because they did not know her. He also complained about the turnover of nursing staff and the lack of continuity of care but he did not criticise nursing staff. Unsafe practices in Cynthia's care were threaded throughout the themes. Because Cynthia was cognitively aware her situation was different and my interactions with Cynthia revealed to me her wish to participate in the research and for me to observe the nursing care. During an observation she checked with her mother if I was still in the room to make sure I was observing. She wanted me there to bear witness and advocate concerning her nursing care and how she was treated. She was reassured by checking that I was there during an observation of her nursing care.

Cynthia lifted her head and pointed to her left indicating or asking whether I was still there and mother told her yes I was, and I moved so she could see me and we made eye contact and I stated I was still there and Cynthia smiled and rested back. (Data NPO Cynthia p155)

It was my belief that Cynthia's willingness to be a participant in the research was because she wanted to expose the nursing care in the nursing home and what was happening to her.

The relatives' vigilance, trust, and advocacy combined with the inappropriate care from the nursing staff found numerous instances in the discourses where there were contradictions and differences. The three relatives believed the nursing staff did not have enough time to undertake all the nursing care needed of their loved ones, however, no mention was made of their qualifications, capacity, and knowledge in the provision of nursing care. In Anna's case, Joe did as much as he could himself and also kept watch on Anna. In Ruby's case, Ben would check up on some things, but was reliant and trusting of the nursing staff. Betty also felt compelled to come in and advocate or check on things for Cynthia's because staff did not have the time to listen and, therefore, did not often respond appropriately.

The situation in this facility placed an added burden on the relatives – especially Betty and Joe. Relatives had to come in and participate in a resident’s care and they did this out of their love, but it is another matter to *have* to come in to ensure that nursing care, nurturing, and nourishment are given to their loved ones. The relatives could sense the environment of neglect and they blamed this on the system or the government.

Summary of the Findings

The nursing care these three residents received or did not receive under the seven major themes in the previous three chapters allowed detailed description, explanation, exploration, and examination of the nursing care construct at the micro level. All data from the three cases were incorporated under these themes constituted by the differences and contradictions. Through the examination of the detail and by making comparisons of nursing care provision for the residents according to the differing discourses - what was revealed constituted unsafe, unethical, mismanaged, and unprofessional nursing practices some of which bordered on negligence from a nursing and medical perspective, as well as abuse of the residents.

Discontinuities, contradictions, and conflicts between the discourses were obvious, especially those relating to the documentation of the nursing care when compared to the actual nursing practices observed and the evidence based nursing practice required. Given that one resident was a 32 year old with a terminal condition and the other two residents had end stage dementia, the so called homelike environment was inappropriate for these three residents’ quality of life. The quality of each resident’s existence was mostly determined according to the provision or non-provision of an appropriate standard of nursing care. Fortunately these three residents, in contrast to Irene, all had relatives who contributed and participated in their nursing care, which at some level compensated for the incapacity of the nursing staff in their nursing care provision that they were unable and incapable of providing.

The data analysis revealed the haste and hurriedness that formed the culture for residents in this facility, together with the noisy and public nature of the residents' environment. The time afforded to the nursing staff was crucial to their nursing care provision, and the residents were labelled according to how time consuming their nursing care was. The nursing care provided was reduced to a minimum in order to ensure a basic or custodial level of nursing care provision for all residents. Compounding this was the short staffed situation of the facility, which revealed residents had to wait for lengthy periods of time to have their care needs attended to the detriment of their quality and quantity of life.

Both negligent and unsafe practices were exposed through the analysis of the data, as well as the misinterpretation or non-assessment of clinical manifestations and cues from the residents. The residents were further placed in danger in regard to their safety and security because of the poor assessment practices of the nursing staff, non-treatment of medical conditions, as well as in the capability apparent in handling any emergency. A palliative care approach was non-existent for all three residents. Nursing staff were also placed at risk through their practices, and the RNs were continually compromising their competencies in nursing. The RNs did not know the residents and there were no documented nursing assessments. Because they were not familiar with their day to day nursing care they created fictions around the residents that could be directly related to the documentation necessary for funding. The RNs were relegated to administration, documentation, emergency, and medication tasks as their scope of practice.

The documentation and nursing staff rhetoric were of providing care that was not actually provided. This included stimulating the residents, getting them up, and exercising them - when in actual fact, the only stimulation provided, other than minimal conversation during the nursing care provision, was turning the TV or radio on. The documentation was out of date, unsafe, confusing, standardised, and at times demeaning to the residents. The progress notes were used by the CWs and RNs to vent frustrations and give opinions. It was of poor quality and stated very little about the resident's nursing care needs and actual progress - unless it related to the administration of aperients and faecal incontinence in Anna and Ruby's case, or non-compliance or moodiness in Cynthia's case. Furthermore,

the documentation directed the CWs to nursing interventions that were not required, not practiced, and not based on evidence.

The continence management system in place was exposed as product driven, poorly assessed, and mismanaged for all three residents. Individual assessments were not evident and incontinence had become normalised and standardised. Faecal continence management was determined by the CWs and Anna and Ruby were nursed in their beds because of continual faecal oozing according to the CWs' documentations. Furthermore, the 24 hour incontinence pad system in place in this facility was iatrogenic in causing rashes for both Anna and Ruby. Although Cynthia's incontinence may have been inevitable, she prematurely became incontinent because of mismanagement and the inability of staff to meet her elimination needs for her to remain continent for as long as possible.

The discourses about the residents' environment, stimulation, and activities exposed a disabling environment for peace and quiet, rest and sleep, and appropriate activities according to the residents' needs. The discourses all conflicted with each other and the environment that was determined by the CWs was inappropriate for a homelike environment conducive to their needs. Unsuitable stimulation, entertainment, and rest were talked about or provided for – regardless of what the documentation stated or what was needed.

Unethical practices, behaviours, and conversations by the nursing staff were a constant theme throughout the data subsets. Residents had little or no autonomy and the relatives were involved in confrontations with the nursing staff regarding the nursing care. Any dissonance by the relatives or resistance was misinterpreted as resistance, a problem, and a difficulty by nursing staff, despite the legislated rights of residents for autonomy, advocacy, and an appropriate level of care. Any advance directives were poorly understood and the residents' spirituality and dignity were largely ignored – despite the rhetoric and the documentation. The nursing staff also displayed unethical behaviours and language in their practices and documentations.

All of this resulted in the residents' relatives either having to be vigilant and actively advocating for their loved ones, or in Ben's case placing full trust in nursing care staff and the GP. Vigilance on the part of RNs and CWs was deficient in the reliance on the relatives of these residents to undertake daily assessments and report any problems to the CWs or RNs. The RNs were reliant on the relatives and CWs for assessment, and it appeared the GPs were reliant on the RNs. All persons who provided care for the residents were considered to be nurses by the relatives as they identified the 'good' and the 'not good' nurses - some of whom were not nurses.

The overall environment was one that was disabling rather than enabling of quality nursing care. As such, there was actual or at the very least potential for abuse, neglect, insecurity, and even danger. It was a perilous environment for residents, nursing staff, and the facility; whereby a concoction had been created of untrained, unqualified, and uneducated non-nurses providing nursing care for these residents that was hurried, poorly assessed, and driven by governmental rhetoric, and then compounded by the CWs' limited knowledge base. The facility was also portrayed as being short staffed that added to the dangerous nature of the residents' existence and the working lives of nursing staff. This contributed to the frustration of the nursing staff, as well as an increase in the relatives' burden. The relatives Joe and Betty were adamant they had to come in to check on things and provide care to fill the gaps created by the system deficits in this facility, which was importantly, an accredited facility.

The results, although disturbing, are significant and the implications for the nursing profession, the government, the industry, and the public are far reaching. By researching the minutiae of nursing practice, the macro level of control and the system's consequences for resident care have been exposed as having influenced nursing care negatively for these three highly dependent residents in this aged care facility. Through the open doors of this facility the nursing care provision appeared satisfactory. Behind these open doors, however, it was a different picture.

In the following discussion chapter the analysis is brought together and synthesised under a number of different issues identified as important and problematic for the standard of nursing care in residential aged care and, therefore, the profession of nursing. The problems exposed need to be addressed if quality of care is to be attained and maintained in residential aged care facilities providing high care - whether for one resident or all residents. The nursing profession has serious considerations to undertake, whereby nurses and nursing has been silenced, made docile, transformed, undervalued, and eroded. It is proposed that this will be at the peril of highly dependent residents in residential aged care facilities and their quality of life. The standard of nursing in this institution has implications for gerontological nurses, non-nurses, the nursing profession, the industry, and the government. The following discussion chapter constructs the nursing care in this facility where the findings are problematised and related to the system in place – the aged care discipline.

Chapter 11

THE PROBLEMATISATION OF THE NURSING CONSTRUCT

Chapters 2 to 5 positioned residential aged care in Australia as a large centralised bureaucracy in order to control and provide services for persons (the young and the elderly) who require 24 hour intensive and extensive nursing care in the short or long term, mostly until they die. These services are required to be sustainable, meet minimal quality of life standards, and provide for the rights of each resident. According to government rhetoric this is achieved through the accreditation process, the instrumentation used to justify funding, and the complaints mechanism scheme. The complaints resolution scheme is about to receive a \$90 million injection with major reforms announced by the Minister for the Ageing (27th July 2006) in the Australian media, and a commissioner is to be appointed to investigate abuse; however, until the system is reformed, abuse will continue and has the potential to increase.

The nursing care for the three residents in this accredited high care facility was based on practices that were operating in an open system of examination, standards, and rights. When the data was interconnected and analysed in detail many disparities were evident 'behind the open doors'. In order to achieve a separation and description of the complex networks and sequestrations that may have an effect on the nursing care provision at the ground level, the Foucauldian notion of problematisation of the findings was useful. This involved the deconstruction and reconstruction of the findings from the previous three chapters into problems. The object to be known was the nursing care provided to the three residents and this has been problematised according to the relationship to the aged care discipline and the literature. The issues are significant surrounding the conflicting discourses and practices in this aged care facility for these three residents and their nursing care. The formulation of the problems is deemed a necessary step in enabling an open discussion of their significance in order for transformation to be possible (Foucault 1984g).

In this chapter, the problems identified from the research are summarised and related to the aged care system, as well as previous research undertaken in the area and the recognition of further research directions. The aim is to contribute to the development of ongoing evidence based nursing practice in residential aged care that will enable quality of nursing care to be assured, which was not the case in the facility in this study. The identified problems highlight the possibilities to create a new way of being for residents and the nursing care they receive in residential aged care facilities that are hegemonic by nature and totalitarian in their control.

The Quality of Nursing Care – The Rhetoric versus the Reality

The rhetoric of the government is one of providing adequate resources, quality of care, accreditation, classification of relative dependency for funding, and protection for the consumer through a complaint mechanism and legislated rights. The reality for the residents in this study was something different. Throughout the data analysis it was clear the residents' nursing care needs and the relatives' wishes were not being met appropriately. The nursing care needs identified, written, and talked about were in contradiction to what occurred in the reality of practice or what should occur as evidence based nursing. There were evident disparities between the documentation and the discourses of the nursing staff, the actual practices observed, and evidence based competent nursing. The differences were found to be continually antagonistic and this created confusion as to what were the actual nursing care needs for these residents. In this study, the reality of nursing practice differed to the rhetoric of the provision of an appropriate minimum standard of care.

The rhetoric from the government and others continues to be one of quality in aged care with outcomes commensurate with indicators of a 'model' working system that has been internationally acclaimed (Howe 1998; Beattie 1999; CofA 2004d; Braithwaite 2005; CofA 2005a). However, the rhetoric must be challenged when a snapshot of one accredited facility revealed nursing practices of a questionable standard and quality. It appears that it is only by the leadership of

regulated nurses working in aged care and nursing staff who 'go the extra mile' or who are innovative that an appropriate standard of nursing care can be maintained in residential aged care as reference to the following literature can attest to (Pincombe, O'Brien, Cheek, & Ballantyne 1996; Keatinge et al. 2000; Chandler 2002; Chenoweth & Kilstoff 2002; Wylie, Madjar, & Walton 2002; McAllister 2003; Mantzoukas & Jasper 2004; Yeun-Sim Jeong & Keating 2004; Kelly, Tolson, Schofield, & Booth 2005). One study highlights the permeation of quality of life principles becoming normalised as a means to assess nursing standards and the inadequacy of this process (Courtney & Spencer 2000). North America is also struggling with nursing home culture and the quality of nursing care provided, where quality is defined by a 'deficiency free' status. This equates with a minimum level of quality that is then in danger of becoming the maximum level of quality care possible within the finite resources provided. (Deutschman 2001)

Quality of care cannot be provided within a system where not enough staff are provided to ensure that quality (Mueller 2002). The highest staffed nursing homes provided better care than the lower staffed nursing homes (Schnelle et al. 2004) and understaffing produces hidden added costs (Considine & Buchanan 2001). Mandatory minimum nurse staffing standards have been identified to overcome chronic understaffing and high staff turnover, which results in the neglect of residents in nursing homes (Wells 2004). When there are less staff, an inadequate skill mix, and a higher dependency of residents then the inevitable rush to accomplish tasks becomes normalised and mechanised, as well as carceral or custodial in nature. In this study, these nursing practices were determined to be unsafe for nursing staff and residents.

Ongoing nursing research is required in residential aged care into the quality of life standards used for accreditation and the development of quality of nursing care indicators that are both objective and subjective in measure and meaning. The RNs in aged care nursing require empowerment to develop professionally in order to be able to nurse effectively to ensure the provision of quality nursing care that is person centred, and to progress in organisational change based on reason rather than ritual (Kuokkanen & Leino-Kilpi 2000; Tonuma & Winbolt 2000; Kuokkanen & Leino-Kilpi 2001; Marquis, Freegard, & Hoogland 2004). Other

studies identify a direct correlation between staffing levels and the quality of care provided, and between staffing levels and the optimal care able to be provided (Simmons, Babinou, Garcia, & Schnelle 2002; Schnelle & Simmons 2004; Schnelle et al. 2004). The data from these three case studies further supported this already known phenomenon. In addition, when quality care is not achieved by nurses as a result of a lack of staff, time, and knowledge then nurses experience failure, burnout, disappointment, and even complicated bereavement (Irvin 2000). This at the very least contributes to the poor retention and high attrition rates of qualified nurses and may be the major cause of the movement out of aged care by qualified nurses and the inability to attract them back - already acknowledged by the government in Australia (CofA 2002c, 2002e).

In order to improve quality of care, factors must be identified, acted upon, and barriers to quality improvement addressed. These include inadequate staffing levels, inappropriate skills and skill mix; and the role of data sets such as the RCS or ACFI based on the nursing care, whereby the burden of funding is placed on nursing documentation through the regulatory or disciplinary environment of aged care (Bostick 2004; Parmelee 2004). The rhetoric of quality of care and the reality of nursing care provision are contradictory. Accreditation of a facility does not ensure residents quality of life, and it does not reflect the quality of nursing care provided. To ensure a minimum standard, the government gazes on the facility, the nursing staff, and the residents, but this gaze is ineffectual. The government gaze is a process to justify both the means and the ends, and is not resident centred or useful for nursing.

The Gazes on the Residents

The different perceptions of the CWs, RNs, relatives, documentation, and observations constituted the construct of nursing care for the three residents who were the focus of this study. These different positionings about the same practices of nursing are described in this section where the problems identified emanated from the disparities between them. Foucault (1977) when describing panopticism in a discipline states that examination practices from without and within the

system present a number of different gazes on the subject or object to be known and he termed this subjectivation. The residents and their nursing were subjected to many gazes; however, most were found to be inept for nursing purposes.

The different gazes present in this facility on the three residents and their nursing care needs were contradictory, inefficient, and putting the residents at risk. All constituted differing positionings on the same subject and object and referred to each resident's nursing care. Every discourse or gaze in its isolation appeared to have the necessary integrity, however, when comparisons were made to the other discourses concerning the residents' nursing care, contradictions were exposed that highlighted the inherent problems in this facility innate in the aged care system generally.

The Gaze of the Government

The governmental and agency gazes were omnipresent and a constant threat to funding and staffing levels already perceived to be at a bare minimum. The gaze was one of regulation, standardisation, and legislation focussing on controlling the industry and the residents' bodies through the funding of the relative dependency on nursing and personal care, whilst at the same time making the organisations accountable for the service to the public. The documentation used by the government for accreditation, validation, and funding purposes did not reflect the nursing care of residents or their nursing care needs.

The positioning of the documentation was to satisfy funding requirements, and fortunately resident care plans were not actually followed by the CWs because to do so, in all three cases, would have caused additional risk to the residents and/or the nursing staff. The public and the media, as other gazes, and alluded to in the data, also played a role in the overall subjectivation of residents and nursing staff. The avenue of complaint for residents, relatives, and nursing staff was available even though it was not utilised and this also had a part to play in the subjectivation of the resident. Its very presence becomes a discourse for silencing dissonances; in that this process was available to all involved and if there were any problems they 'should' have been reported. If problems were not reported and the facility

was accredited then problems did not exist according to the government, even when they obviously did.

The documentation, as an instrument for the government and the agencies to gaze for accreditation and validation purposes was corrupt. Although it appeared adequate on the surface or in isolation it did not match the profile of the resident, their nursing care needs, evidence based nursing practice, or the reality of nursing practice. The documentation demonstrated there was little or no nursing assessment undertaken and it was standardised, product driven, and not resident focussed. It was also of a poor standard, incomplete, contradictory, and dangerous and did little to direct nursing care. Furthermore, documentation was found to be fraudulent, demeaning, and denigrating to the residents. As such, the documentation in this facility was unprofessional and did little to inform the progress of the residents for the continuity of an appropriate level of nursing care. The documentation in this facility was provided for the purpose of accreditation and validation, and it was not reflective of the reality of residents' nursing care needs and provision, their dependency, or their quality of life. The documentation was a gaze found to be feigned, and of no therapeutic use for the direction and management of an appropriate quality of nursing care on a day to day basis. As a disciplinary tool of control for the benefit of the government, the documentation was in stark contradiction to any benefit to the care of the residents, and also contradicted evidence of the quality of nursing care provided and the quality of life for the residents.

Nursing documentation is indispensable for quality nursing care and it requires a return to the nursing domain of responsibility and accountability. It has been recommended that funding be separated from nursing care if the ongoing documentation situation is to be cleared and nurses be allowed to nurse and document nursing (Tonuma & Winbolt 2000; ACEMA 2002; Pelletier, Duffield, Gietzelt, Larkin, & Franks 2002; Angus & Nay 2003; Cheek, Ballantyne, Jones, Roder-Allen, & Kitto 2003; CofA 2003c, 2003d). This has been strongly recommended in the past, but consistently not addressed by the government because to do so would entail a completely new model to be implemented, which would be costly (ACEMA 2002; Pelletier et al. 2002; CofA 2002d, 2002e, 2002f,

2002g, 2003c, 2003d, 2004d, 2005a). The priority of costing over the residents' quality of nursing care provision is of concern.

Although other countries also experience problems with nursing documentation in nursing homes and its relation to the quality of care (Hansebo, Kihlgren, & Ljunggren 1999; Martin, Hinds, & Felix 1999; Taunton, Swagerty, Smith, Lasseter, & Lee 2004; Voutilainen, Isola, & Muurinen 2004), the Australian documentation system has specific inherent difficulties because the funding for residents has been tied to the nursing documentation. A further study identified 'unique inefficiencies' in the documentation requirements in the Australian system that constrains expert care by nurses at the bedside (Pelletier et al. 2002). The issue of documentation has been ongoing since the 1987 reforms, but it would seem little has improved. Instead, it appears to be becoming increasingly more complex with additional nursing assessments to be implemented in 2007 for voluntary use by 'anybody'.

It is questioned whether the use of information technology and a computerised system (Pelletier et al. 2002; Cheek et al. 2003; Yu 2005; CofA 2005a, 2005c) will do anything to address the issues at the centre of this study about the three residents' documentation records. It is argued that computerisation may even enhance the problems that exist and may also create new problems, such as an increased propensity for 'perverse' documentation, fictions, or fraud. Another study has recognised the tendency of documentation to be a 'perverse incentive' in that it may cause staff to exaggerate care needs in order to receive more funding, even though these care needs may not actually be provided for (ACEMA 2002). The introduction of a computerised system will benefit nursing care and evidence based practice when weighed against this propensity for perverse documentation and it will certainly be embraced. (Cheek et al. 2003) The caution would be in the increased ability and capacity for computerised documentation tied to the funding causing further propensity for examination and surveillance and, therefore, a further capability and capacity for corruption.

The RCS classification of the three residents did not match the dependency of the residents nor the care required in this study. Dissociation between what nursing

interprets as high dependency and what the RCS categorisation determines for the purpose of funding is necessary. This will not occur with the ACFI to be implemented in 2007. The categories may be collapsed into three categories across low and high care facilities (CofA 2004d, 2005a, 2005b), but this will only accentuate the problems already experienced and evidenced in this thesis. The volume of documentation will be increased and made more complex with the addition of nursing assessment tools and, although for voluntary use, these nursing instruments will soon be necessary to justify funding and will be used by non-nurses. This will compound the quagmire that exists for the nursing profession, the non-nurses, the nurses, and the residents who are the persons placed at risk.

There are serious implications for the governance of residential aged care when the documentation forms the basis for accreditation and the validation of funding through the relative dependency instruments. There are implications for the nursing profession in that the documentation attributed to nursing in residential aged care has become nursing documentation that is of a poor standard, unprofessional, contradictory, fraudulent, and largely irrelevant. The disparities and ambiguities can be related to an unprofessional standard of nursing documentation that has been constructed by the disciplinary nature of aged care through the panoptic forms of examination and surveillance. This panopticism uses false documentation of nursing care needs as the justification and evidence for funding residents.

As an ongoing problem, further research and evidence will be necessary on the funding and documentation practices in aged care facilities, as to how the documentation relates or does not relate to the residents' nursing care needs and nursing care provision. Furthermore, the recognition of personal care as nursing care in aged care facilities requires a political shift if nursing is not to be further devalued and eroded. The paradox of documentation for funding purposes and for the provision of nursing care requires urgent reform, but this is not a new phenomenon. By freeing RNs and ENs from the adherence to government documentation requirements they could return to the bedside leading, participating, educating, and supervising nursing care as leaders of a nursing team.

The Gaze of the Management

The gaze of management of this facility was distant to what was occurring in the practice setting at the bedside, but management was confident of the nursing care provided and the facility had recently been accredited. This confidence by the management was extended to me as a researcher when gaining access to conduct the research. The facility appeared to be a 'normal' type of nursing home with acceptable amenities together with friendly and caring nursing staff. As a RN my gaze was one of an independent researcher with expertise in nursing practice, education, and research. An objective analysis of the data from the discourses about these three residents and their nursing care provision determined that the nursing care was not of an acceptable standard. The institution was a distant gaze on the resident, but this gaze was more directed on the nursing staff. It was distant to the residents because of the confidence displayed by nursing management in regard to the quality of the nursing care provided, which they could not have known about.

The Gaze of the Nursing Staff

The gazes from the nursing staff were directed by their capacity and capability and the expectations of validation and accreditation processes. Direct assessment and observation are a competency for RNs and an important gaze in a high care residential facility for an appropriate standard of nursing care. The distance of the RN gaze is paramount to its claim of accuracy, quality, and truth. The deficits found in the RN role in this facility have also been identified in a number of other studies, whereby RNs who are being distanced from the nursing care are lacking in competency and knowledge (Wells, Foreman, Gething, & Petralia 2004; Hsu, Moyle, Creedy, & Venturato 2005). These are significant issues impacting on the quality of nursing care RNs are able to provide and ensure in residential aged care (CofA 2002g; Cheek et al. 2003; Wells et al. 2004). A greater RN presence at the bedside is required to provide and maintain quality of nursing care (Bostick 2004), and the capacity for an appropriate and effective nursing gaze that is enabling of nursing assessment is crucial to competent nursing.

The positioning of the RNs was one of the management of resources and emergencies, the administration of medications, and documentation. The RNs' perspective became that of making up the care for the resident according to the documentation requirements in order to portray knowledge about the resident. At the same time it was demonstrated the RNs did not really know the residents or what was going on with these highly dependent residents behind their doors or under their sheets. The RNs relied on the CWs and the relatives to alert them to any problems with the residents, and the CWs relied on each other and the relatives to alert them to any problems or to seek direction. The doctors relied on the RN to pass on information about the residents and if no such information was passed on, appropriate interventions were not implemented. The CWs' gazes also determined the nursing care for the three residents with them making clinical judgements according to what they observed at the bedside and their experience, who were not capable of thorough assessments and were lacking in capacity.

The gaze of the documentation was a gaze on the nursing staff and accordingly the nursing staff orientation was directed by the documentation requirements, staffing issues, and the 'routine' of the nursing care. The CWs' gazes were directed to task orientation and what was expected of them, rather than resident focussed and holistic nursing care. Their knowledges, practices, and documentation were poor, whilst at the same time they were authoritative in their discourses about the residents' nursing care and nursing care needs, as well as being ignorant and opinionated. Effective nursing assessment as a necessary gaze for accountability in nursing was missing in this facility because of the ineffective hierarchical assessment of the residents, where everyone concerned relied on everyone else and non-nurses did the nursing work.

The Gaze of the Relatives

The closest therapeutic relationship for the residents and the most knowledgeable of gazes were those from the relatives. Their positionings were ones of 'having' to be there to protect the residents from the system that had been created, and they did this with an acceptance and a resignation that was disempowering. They knew

the reality and were protective of the residents and the nursing staff as they viewed the situation to be out of the control of individuals and the organisation, and also themselves. Rather than any blame being apportioned, the relatives believed the government funding of the facility was the problem.

The gazes of the relatives were profound because of the close and significant contact they had with their respective loved ones. They provided care to the residents on a daily basis, as well as having the motivation of love and caring. The relatives were relied upon by the nursing staff to provide a clinical gaze on the resident for the nursing staff because it was perceived the relatives knew their relatives 'best' and they had the most contact with them. The relatives' gazes also took on the perspective of checks and observation of the nursing staff, but in the main their positionings were resident focussed. As such, the most useful and effective gaze for the residents themselves came from the relatives, because of their focus on the resident, their care provision, their vigilance and advocacy, and in 'knowing' the resident.

In contrast to the intimacy of the relatives' gazes, the other gazes on the residents were distant, superficial, and artificial in that the nursing care provision was constructed according to the governmentality of the system through instrumental means of control. As such, it became a self regulating institution based on disciplinary means regulated to control the system. The nursing staff, especially the RNs, had become agents for the government and were self governing - rather than the agents for the residents in their care and nursing standards. This has legal implications for the RNs who are accountable and responsible for the nursing care provided at a distance by non-nurses at the bedside.

Nursing Practice from a Distance

The policies implemented by the federal government have an effect on the retention and recruitment of nurses in aged care, the documentation problems being experienced, and the increasing complexity of residents' nursing care needs. A changed scope of nursing practice for nursing in aged care has been determined

by the government, which has produced an inadequate skill mix and resident/staff ratio, negative attitudes, and an uneducated workforce. (ANF 2001; McDonald 2001; Wilkes & LeMiere 2001; Happell 2002; Horner 2002; CofA 2002g; Armitage, Kidd, Taylor, & Stein 2003; Cheek et al. 2003; Chandler, Madison, & Han 2005; CofA 2005c) Unqualified and untrained non-nurses have been given the vulnerable bodies and lives of the elderly, and not so elderly to care for, and they are known as 'nurses' and are doing 'nursing' work. If professionalism, knowledge, and standards are removed from somological nursing praxis, then nursing is indeed in peril.

The changing role of the RN moving up the hierarchical structure in the facility was evident in these three case studies. The RNs had become an elite phenomenon in name and they had little or no direct input into the nursing care provided at the bedside. The impact of the government reforms has caused the RNs handing over the fundamentals of nursing work to 'others' and the knowledge necessary for competent nursing practice is thus weakened in this process. The RNs in this study relied on others to bring up problems and make ongoing assessments, make clinical judgements, and appropriately report and document. The RNs positioning of centrality in the panopticon may not be viewed as necessary in the future because of permeation of self governance displayed by the organisation and the nursing staff.

The RNs were removed from direct resident contact through their increasingly managerial role in residential aged care facilities determined by the system. The RNs have become bureaucratic scribes and agents for the government and management, rather than practitioners in the clinical field. Their expertise in managing nursing care is now delegated to CWs and this care is not monitored or evaluated. The reliance of RNs on others for what was considered nursing care in a holistic sense was great, and their expertise of knowing the residents and their nursing needs became eroded and distant because of the system in place. The government's shift to the up skilling and training of ENs and CWs to the level of medication administration and management determines RNs are increasingly viewed as being redundant to the provision of aged care for persons who are highly dependent. (Australian Broadcasting Commission 2006) This is a

dangerous state of affairs for highly dependent residents who require nursing care for any quality of life.

RNs are responsible and accountable for the nursing care they provide to the public under the relevant legislation, standards, and competencies. The data revealed that the RNs in this study did not attain competency in the four domains of nursing (ANCI 2000; ANMC 2006b, 2006a). It was demonstrated the RNs did not know the residents, despite having worked in the facility for a number of years. When the RNs did not know the needs of the residents in this study, they stated they would look it up or follow it up, but on a number of occasions - they simply made it up. The data revealed unethical, unprofessional, and illegal practices, as well as a poor level of critical analysis, clinical reasoning, and judgement on the part of the RNs. The role of the advanced gerontological nurse practitioner becomes somewhat of a paradox. It is questioned whether the role of nurse practitioners will alleviate the risks associated with the distancing of the RNs from the residents and their nursing care at the bedside.

Unlicensed healthcare workers, however titled, are presently a third level of nursing because of the nursing work they undertake. Registered nurses, if employed at all, can delegate, supervise indirectly, be available only, and provide credentialing to CWs. The RNs in this study were disabled to directly supervise, educate, and participate in nursing care and could not realistically be accountable and responsible for the nursing care provided by the non-nurses in this facility. It is argued that RNs and ENs cannot nurse effectively from a distance with nursing care being provided and determined by non-nurses at the bedside with their direction coming from bureaucratic processes rather than evidence based nursing care.

When Anybody Can Do It

The care provision in this facility was delivered by CWs who were untrained, unskilled, uneducated, unqualified, and unsupervised. This coupled with a time constraint lent itself to a poor standard of nursing care and the nursing practices analysed were unprofessional, unethical, unsafe, and disabling. This was a

hazardous situation with actual and potential negative outcomes for the residents and relatives, bordering on abuse.

In Australia, various state legislation and the nurses' boards were created to protect the public from negligent nursing care and also to protect the name of 'nurse'. To be designated 'nurse' meant the acquisition of education and training, enrolment and registration, accountability, and responsibility. The CWs who participated in this study were referred to as nurses by themselves and the relatives. The CWs named themselves as nurses in the documentation and were authoritative of the nursing care in their discourses. Anybody could be a nurse in this aged care facility and anybody could perform nursing work and 'deal' with embodiment issues. Clinical judgements were consistently made by CWs and the residents' progress notes detailed the ways in which the CWs made poor decisions. It was apparent they did not have the necessary knowledge to make nursing decisions in order to provide an appropriate and therapeutic level of nursing care. The government has assigned the fundamentals of nursing care practice to personal care that can be undertaken by any person in the employ of the industry and personal care is not classified as nursing care. This contradicts nursing praxis and somological nursing care of a human being.

In a standard released by the Nurses Board of South Australia, the unlicensed healthcare worker 'does not perform nursing care but rather performs delegated care where they remain responsible for their actions' and 'unlicensed healthcare workers are accountable to their employer for their actions and decisions' (NBSA 2005, p23). Another document identifies their accountability to RNs and employers for all delegated activities (RCNA & ANF 2004). In reality, CWs are not accountable to the RN but to their employer. The RN role becomes one of delegation of what is nursing care, but it cannot be named as such. The government and nurses boards have determined that CWs do not do nursing work and cannot be called nurses - even though they are known and perceived as nurses doing nursing work. There is a strong paradox here that needs to be urgently addressed by all the stakeholders, but especially the nursing profession as the paradigm in question.

A skill mix of appropriately qualified staff according to the residents' nursing care needs is required for quality of care (McKenna 1995; Nay, Garratt, & Koch 1999; CofA 2002g; Cheek et al. 2003; Remsburg 2004; Schnelle & Simmons 2004; Schnelle et al. 2004). Education is further identified as a key indicator to the provision of quality nursing care (Joy, Carter, & Smith 2000; Wilkes & LeMiere 2001), and also the presence of RNs is pivotal to the provision of quality nursing care (Harulow 2000; Cooper & Mitchell 2006). A joint position statement has been issued in an attempt to clarify the roles of residential aged care nursing staff, but this statement falls short of encompassing a third level of nursing that comprises of the non-nurses who do nursing work (RCNA & ANF 2004).

Ongoing research and evidence is necessary to relate skill mix, staffing ratios, and educational levels to the provision of quality of nursing care in residential aged care settings. Despite these issues clearly being identified by the industry, the government, and the nursing profession (Considine & Buchanan 2001; Spilsbury & Meyer 2001; CofA 2002g; Cheek et al. 2003; CofA 2005c), as well as in this thesis - the governmental rhetoric dominates. The rhetoric of the government that adequate resources are provided to the industry for an appropriate skill mix and staff resident ratios to be employed in aged care facilities is called into question. In addition, according to the government, the accreditation and complaint mechanisms in place as the checking mechanism are evidence that the system is working and sustainable, and residents can be assured of quality care (CofA 2004d, 2005a, 2005c). This was not the case in this study for three residents.

A strong, clearly articulated career path for nursing from the unlicensed healthcare worker to the professorial level would pave the way for the control of nursing care and the quality of that nursing care that is presently delivered by unlicensed healthcare workers, however named (CofA 2002g). If the paradox of non-nurses providing nursing care is to be solved unlicensed healthcare workers require identification and licensing as a third level of nursing (Gilmore 2005). If CWs remain outside the nursing profession then the nursing profession, RNs, and ENs cannot be held accountable and responsible for the nursing care provided by others, and the confusion in nomenclature, nursing practice, and roles will continue. The development of a career structure that encompasses CWs into the

nursing profession with clear training and education levels is paramount if quality of nursing care is to be attained in residential aged care (CofA 2002g; Cheek et al. 2003).

The aged care workforce is generally unqualified and untrained, as were the CWs who participated in this research. The RNs were not at the bedside as part of a team and did not know the residents and their nursing care needs. It is proposed that CWs be regulated and licensed as a third level of nursing with an appropriate career structure and minimum training and education requirements along with supervision, delegation, and ongoing credentialing and education by RNs. As part of a nursing team, RNs and ENs are required at the bedside performing care and leading care to ensure and monitor for quality nursing care. The skill mix and the staff resident ratios require regulation and institutions need to be rewarded for staff development programs led by RNs. If unlicensed healthcare workers were to be embraced as a third level of nursing who do nursing work, the contradiction of nursing care being delivered by non-nurses could be transformed into a solid professional career controlled by nurses with accountability and responsibility to the public through legislation.

An Ethos of Haste

Haste permeated the facility and the nursing care for the three residents and it was a normalised environment. The residents, the relatives, and the nursing staff accepted this busyness in the organisation. Relatives stated that the ‘nurses’ did the best with what they had and this implied a resignation to the situation of hurriedness and being short staffed. When criticism was made of the CWs by the relatives it was explained by them as the ‘nurses’ being busy. The concoction of hurried care given by untrained and unqualified CWs to highly dependent residents with complex needs was a recipe for a poor standard of care and placed the residents at risk, and in Cynthia’s case could have caused her premature death.

Appropriate nursing care to highly dependent persons in residential aged care cannot be one of continual quality improvement if the organisation does not have

enough staff and an appropriate skill mix to be capable and able to cope with the nursing care needs of residents. The assessment, planning, implementation, and evaluation of nursing care in this facility was of a low standard. All participants had become resigned to the reality of this facility and had adapted accordingly to 'fit' into the system and comply with the situation, becoming docile in the process of subjectivation and self governance. The discourses revealed nursing staff perceived that they provided a 'good' standard of nursing care with very little knowledge or reflective practice evident.

Previous research has identified limited human resources in aged care facilities contributing to a rushed and hurried provision of nursing care in Australia to the detriment of nursing and client outcomes (Irvin 2000; Wylie et al. 2002; CofA 2002c, 2002d, 2002e, 2002g; Parmelee 2004; Richardson & Martin 2004; Moyle, Iselin, Beaslack-Smith, & Fleming 2005). This environment of time, space, and embodiment is paramount to residents' quality of life dependent on the quality of nursing care provision. The system as a totalitarian or totalising means of control has produced an environment that includes one of haste, mechanised activities, task orientation, increased risk, and a custodial type care for the residents in this study. Further research into time factors and nursing care provision, as well as appropriate staffing levels and resident to staff ratios in aged care facilities is required for safety and to protect residents from abuse.

It is well known the occupational health and safety outcomes in residential aged care are poor and there are high levels of work related injuries (CofA 2002d, 2002e). The responsibility ultimately lies with the government and industry for occupational health and safety levels commensurate with the delivery quality nursing care. The occupational health and safety issue of stress in the workplace found nursing staff working in a hurried and busy environment nursing residents who were dependent, disabled, frail, ill, and palliative without the appropriate knowledge, skills, and approach. This placed the residents and themselves at risk.

Ongoing stress caused by staffing issues for RNs and ENs leads to higher attrition rates and lower retention rates (CofA 2002d, 2002e). This in turn has an effect on the quality of nursing care provision because of the turnover and replacement with

mostly unqualified nursing staff because this has been made possible. Furthermore, the RN is accountable and responsible for the nursing care provision and in this ethos of haste, hurriedness, and distancing of their supervision and direct care then the RNs' stress, burden, and frustration levels would be increased. The RNs then have a choice of complying, adapting, and working the system, or leaving. As such, the dominant governmental discourse becomes normalised and complied with, or rebelled against. The provision and legislation for an appropriate level of nursing care provision including an adequate skill mix and resident to staff ratios are required to encompass the complexity of residents' nursing care needs. This may contribute to solving the problem of there being no time to nurse – and no nurses to nurse.

The Normalisation of Noise

The aged care facility at the centre of this research was a noisy and busy environment that had developed because of the system in place and the uneducated and 'unaware' nature of the nursing staff. Noise levels had become normalised and this was apparent during the observations and interviews. Peace and quiet were not a part of the day environment and it was very public, in contradiction to affording privacy to residents and the claims of being homelike or therapeutic.

Although there are many studies on sleep in various settings including the aged care setting, few relate to the level of noise and its relationship to sleep, wellbeing, and quality of life for end stage dementia. A systematic review recommends the reduction of noise as part of a multidisciplinary approach to intervention, and it is also recognised as a contributing factor to the residents' sleep patterns (Errser et al. 1999; Joanna Briggs Institute 2004). The noise levels experienced in this research required reduction by any standard and future research would be useful in providing evidence for an appropriate level of noise in residential aged care facilities, the acoustic design of facilities, and the residents or relatives having control of the noise production and environment in relation to the residents' sleep and rest and, therefore, their wellbeing and quality of life.

Noise or sound level has been identified as a subjective and physiological stressor, and an annoyance in hospital settings (Topf 2000; Morrison, Haas, Shaffner, Garrett, & Fackler 2003). Another study (Richards, Beck, O'Sullivan, & Shue 2005) relates general sleep disturbance to falls, poor life satisfaction, weakened immune function, poor quality of life, depression and anxiety; as well as psychomotor and cognitive decline, increased sleepiness, fragmented sleep, and less restorative sleep. The research identifies factors that impinge on sleep include the resident being disturbed for care and the noise levels associated with this. A study focussing on agitation in persons with dementia determines noise to be a contributing factor to increased agitation levels in residents, again emphasising the importance of noise levels to a person with dementia and their general wellbeing (Errser et al. 1999; Wylie et al. 2002). In addition, background noise in a aged care facility impacts negatively on the facilitation of conversation with persons who have dementia (Morse & Intrieri 1997). Although the ability to achieve deep sleep declines with normal ageing this would not apply to the three residents in this thesis because of Anna and Ruby's dementia and Cynthia who had an astrocytoma. Their need for sleep would increase with time because of the neurodegenerative nature of their pathologies.

Further research into the noise levels of facilities is necessary to highlight environmental considerations for residents and the effect of noise on wellbeing and sleep practices given the policy direction of residential aged care being homelike, as well as ageing in place. (CofA 1987b, 1997, 2001d; Farvis 2003; CofA 2003a). The nursing staff in this study continually disturbed the residents' sleep patterns and they controlled an environment that was not conducive to sleep and rest. This was because of the normalisation of noise by the nursing staff and the activities of the nursing staff that caused excessive, unnecessary, and inappropriate noise for the residents. In addition, the direction of nursing care to continual activities, stimulation, and interventions for residents by documentation requirements may have contributed to the environmental noise experienced in this facility.

Marginalised Young Persons

The very naming of residential ‘aged’ care facilities marginalises the thousands of young persons accommodated in these institutions. It was evident this marginalisation and labelling of Cynthia occurred in this aged care facility. She required special consideration, but this aged care accommodation was Cynthia’s only choice in her need for 24 hour nursing care, and also her need to be close to her mother who needed to come in and advocate strongly on her behalf. If residential aged care is the only option identified (CofA 2005c) then adequate services by a qualified and educated nursing workforce is necessary to provide an appropriate level of complex care. Residential aged care, as it stands, is neither appropriate nor dignified for young persons - especially if they have any cognition, psychosocial, and complex physical care needs, as was the case with Cynthia.

Approximately 6,000 young persons reside in residential aged care facilities and most do not want to be there because of difficulties identified by associations, the media, and the government (Australian Broadcasting Commission 2004; Bell 2005; YPINH 2005; CofA 2005c). Action rather than research is required in this circumstance where young persons with cancer or disabilities have no choice but to die or reside in aged care homes (YPINH 2005; CofA 2005c). The federal and state governments have announced that persons aged under 50 years of age will be moved from residential aged care and a number of recommendations have been made in order to achieve this (ANF 2006b). This cannot occur for all young persons and the problems will persist if inadequate resources and care provision continues to be given by untrained and unqualified non-nurses in residential aged care facilities for young persons with complex needs.

A recommendation from a government report calls for increased documentation and monitoring regarding young persons in aged care facilities (CofA 2005c). This will not improve the complex care of young persons and will only add to the documentation burden already present for the nursing staff in aged care. Cynthia’s nursing care needs required referral to a skilled palliative care team, however, this did not occur. A palliative care approach can be provided regardless of the

institution, but who provides the palliative care nursing is paramount to the quality of that palliative care. Not only was Cynthia marginalised because of her age, but also because of her complex palliative care needs that were unable to be provided for in this facility to any satisfactory nursing standard.

Palliative Care

The three residents all required palliative care. Cynthia required specialist palliative care, and Ruby and Anna required a palliative care approach because of the degenerative nature of dementia and their terminal phase of care. This need for palliative care was not documented, funded, or identified by the nursing staff in any of the cases. The relatives were providing care that was recognisable in the current palliative care principles and standards set by the national body of palliative care (Palliative Care Australia 2005; CofA 2005c). On the other hand, nursing staff demonstrated very little knowledge or understanding of palliative care. Discontinuities and contradictions were also found in the advance directives for all of the residents that undermined the purpose of these for clear direction.

Persons with cancer require intensive and extensive nursing care and these persons are being accommodated in aged care facilities. Provision for this specialised care requires an adequate skill mix, support system, and resident to staff ratios. Targeted funding and research into the quality of these residents' accommodation, pre-death experience, and nursing care provision requires further exploration and additional resources for an appropriate level of care. Palliative care has been recognised in part in the new ACFI instrument trialled (Australian Government 2005c, 2005d). This acknowledgement in the instrument is based on the technological practices of nursing and does not form part of the specialist nursing care interventions that identify good palliative care nursing, or indeed gerontological nursing (CofA 2000a, 2004a, 2004b, 2004c). It is not known what weighting will be given to a resident known to be dying in an aged care facility according to the new instrumentation and specialist palliative care services continue to be unavailable or inaccessible. The focus on technological nursing procedures in the instrument will cause further fragmentation of the holistic,

person centred, and palliative care nursing required by residents such as those who participated in this study. The new instrument, no doubt, will perpetuate the fracture in nursing by dividing care into the 'personal' care (done by non-nurses) and the 'technological nursing' care (done by nurses). This will further accentuate the hierarchical tensions already present in the system between CWs and nurses, when both are undertaking nursing work.

Persons with cancer accommodated in high care institutions for the elderly require special consideration by the government. Funding provision for specialised palliative nursing care is required that, according to this study, was beyond the scope of staff in this facility. The inability of the nursing staff to provide quality care appropriate to Cynthia's age, condition, nursing palliative care needs is demonstrated in previous research undertaken on palliative care in residential aged care facilities and supports the problem identified in this study (Zuch & De Bellis 1996; Clare & De Bellis 1997; De Bellis & Parker 1998; Parker & De Bellis 1999; Forbes 2001; CofA 2002c, 2002e).

Residents with cancer have different needs to those residents without cancer and are 'heavier' to nurse; have inadequate pain and depression management; and have a low prevalence of advance directives (Buchanan, Barkley, Wang, & Kim 2005). According to the data analysis, this applied to Cynthia. Furthermore, end of life care in nursing homes and hospitals is characterised by unmet needs for symptom management and less support than those who receive hospice services (Teno et al. 2004). Because of the problems identified in providing palliative in residential aged care facilities, a palliative care strategy for aged care in Australia was implemented and the productivity of this strategy is to be commended (CofA 2000a, 2004a, 2004b, 2004c). These guidelines and educational tools are, however, geared to elderly residents and not specialist palliative care services for young persons accommodated in residential aged care who are dying of cancer, such as Cynthia. The palliative care resources provided through the strategy for aged care are lengthy and are for use on a voluntary basis, and are not being taken up in any meaningful way.

Given the time nursing staff are afforded to undertake appropriate care, it is unlikely that the palliative care approach in any meaningful way will be taken up. Education of palliative care and the appropriate utilisation of advance directives is gaining momentum (CofA 2004a, 2004b, 2004c; Department of Health 2005), but further research into the application of anticipatory directives in residential aged care facilities for those with deteriorating cognition is necessary if the directives are to be of any use in ethical decision making and the provision of good palliative care. In this thesis the advanced directives were unclear, illegal, and not referred to anyway. A palliative care approach in residential aged care and palliative care nursing whatever the setting requires increased resources and funding to be undertaken appropriately by educated nursing staff (Froggatt 2001; Miteff 2002). Further research, evidence, and education of these special nursing care needs for young persons, persons with cancer, and persons with terminal conditions will be necessary in acquiring positive changes in practice, policy, and the quality of the palliative nursing care for residents.

Dementia Care

Residents with end stage dementia are considered to be requiring a palliative care nursing approach. Both Anna and Ruby had end stage dementia and were considered in the terminal stages of dementia or late dementia (Koopmans, Ekkerink, & van Weel 2003; Abbey 2006). They could do nothing else other than the activities described and their relatives and CWs provided all care because of their 'full dependence' with 'everything'. Their main activities were reduced to sleeping, expressing vocal sounds, eating, and drinking. Anna and Ruby were still eating and drinking adequately, but this was attributed to their husbands providing and encouraging them with their main meals every day, and not as a result of the nursing staff providing for their nutrition and hydration.

Because of the RCS being one of frequency of interventions, the discourses around Anna and Ruby's nursing care needs were ones of activity and stimulation even though both the residents were docile, passive, and had no interest in these activities. Additional to these were the fictional documented interventions to

prevent agitation and hitting out behaviours that neither Ruby nor Anna displayed. These were all counterproductive to caring for persons with end stage dementia who require a peaceful, quiet, and non-threatening environment together with comfort, security, and a pain free existence - all in a dignified manner.

The discourses and positioning of the staff based on the RCS questions were contradictory to evidence based nursing practice in that to stimulate, enforce activities, make undue noise, and disturb residents who have middle and end stage dementia can cause 'problem' behaviours, agitation, anxiety, loss of sleep, and loss of autonomy, to name but a few. It could be deemed pointless to continue activities requiring interaction and cognitive ability on the part of residents with end stage dementia who are in a vegetative state but still managing to eat and drink. Activity, time, and social interaction with persons who have end stage dementia remain possible and therapeutic in the activity of providing nutrition and hydration. Interactions need to be concentrated on these activities and other studies also reinforce this view (Mitchell et al. 2001; Simmons et al. 2002; Wylie et al. 2002; Mitchell et al. 2003), as did the relatives' interactions in this study during mealtimes.

Previous studies identified disturbing reactions and agitation displayed by residents with dementia caused by such things as undue noises; the nurses' actions and approach especially in activities of daily living; the design of the environment; the education level of the staff; the attention and inattention of the staff; and the nursing staff breaching a resident's privacy, identity, autonomy, or security (Keatinge et al. 2000; Graneheim et al. 2001; Wylie et al. 2002; Landreville, Dicaire, Verrault, & Levesque 2005). The rhetoric of stimulation guided by the funding requirements for residents with end stage dementia based on a fiscal instrument needs to be challenged in its relevance, appropriateness, utility, therapeutic benefit, and cost in regard to nursing practice in this facility. Research into this phenomenon will be necessary to provide guidance for activities and interventions for evidence based nursing practice in end stage dementia care, rather than care directed to justify a funding tool.

Many studies support the need for a person centred approach to dementia nursing care that requires skilled nursing assessment, planning, and interventions using such approaches as dementia care mapping, validation therapy, appropriate activities, sensory therapy, developing positive characteristics of CWs, and improving documentation practices (Callahan, Hendrie, & Tierney 1995; Greenwood, Loewenthal, & Rose 2001; Marshall & Hutchinson 2001; Miteff 2002; Wylie et al. 2002; Mitchell et al. 2003; Clarke & Davey 2004; Cox, Burns, & Savage 2004; Minner, Hoffstetter, Casey, & Jones 2004; Abbey 2006). This was in contrast to the approach used by the nursing staff in the facility in this study and the documentation for the residents when analysed. A palliative care approach is recommended for persons with end stage dementia, however, this requires a level of skilled nursing by qualified and educated nurses (Froggatt 2001; Abbey 2006). This type of nurse was not available at this facility, and the nurses and CWs did not have the capacity to seek the appropriate knowledge necessary for competent practice in this area.

The discourses concerning exercises to strengthen and prevent contractures were not appropriate when contractures had already occurred in Ruby and Anna. Contractures that are already present require gentle, persistent, and consistent physiotherapy (Potter & Perry 2001). This was contraindicated in Ruby and Anna's cases given their terminal conditions and the pain they would be subjected to if undertaken. Fortunately, although the documentation and the discourses gave the false impression CWs did ROM exercises, passive limb exercises, and constantly interacted with Anna or Ruby, this was not observed as occurring and was deemed to be entrenched in rhetoric purely for funding veridiction.

This raises concerns for nursing knowledge and evidence based practice, whereby new 'knowledges' or epistemes were being created by the system in place that had a detrimental effect on the quality nursing care these residents received. These new knowledges formed in this facility appeared to be based on the fiscal tool and the documentation requirements, as well as for accreditation purposes; rather than focussed on the residents themselves, their condition, their needs, and their wellbeing. This has also been raised in previous research studies (Callahan et al. 1995; Greenwood et al. 2001; Marshall & Hutchinson 2001; Wylie et al. 2002;

Mitchell et al. 2003; Clarke & Davey 2004; Cox et al. 2004; Minner et al. 2004). Future research in end stage of dementia care is required concerning the nutrition and hydration needs of residents from the nursing perspective, as well as clinical judgements and interactions with persons with end stage dementia will give guidance into these important areas of nursing practice. There was a dominant perception by the nursing staff of the residents' need for stimulation and activity together with their 'resistive' behaviours, as well as the residents who were perceived by nursing staff as 'refusing' to eat and drink.

Nutrition and Hydration of Residents

In this thesis all the three case studies had issues to do with their nutrition and hydration needs. Cynthia because she was obese, and Anna and Ruby because their respective spouses came in to ensure their wives were nourished. The length of time and perseverance in feeding Anna and Ruby by the respective husbands was very different to what was observed in the CW's nursing practice for Irene who was receiving inadequate nutrition. The ethos of haste, being short staffed, choosing to abandon meals, and not to give fluids were all practices of concern in this study.

The more stressed, depressed, and tired the caregiver becomes in relation to nutrition in Alzheimer's disease, the more likely the consequences of weight loss and under nutrition for the residents (Riviere, Gillette-Guyonnet, Nourhashemi, & Vellas 1999). Similar concerns of inadequate nutrition and hydration being provided in 'nursing' institutions include malnutrition, anorexia, and other problems with the residents' intake of food and fluids. (Van Ort & Phillips 1995; Kayser-Jones 1997; Porter, Schell, Kayser-Jones, & Paul 1999; Schell & Kayser-Jones 1999; Crogan, Schultz, Adams, & Massey 2001; Simmons et al. 2002; Pearson, Fitzgerald, & Nay 2003; Remsburg 2004; Pelletier 2005; Chubb, Mann, Coleman, & Sibbel 2006). It would appear to be an ongoing problem for most Western countries and residential aged care services and this is attributed in part to the unskilled, untrained, and unqualified workforce providing the care in a stressed work environment. This situation makes it possible to abandon the giving

of meals an all too easy judgement for CWs to make in that a resident refused to eat or drink, a resident did not like the meal, or it was too large.

The risk for Anna and Ruby was evident in the poor documentation and lack of knowledge about the residents' potential for aspiration or choking and need for nutrition and hydration. The modification of the fluid consistency was not adhered to for Anna and Ruby as recommended in the documentation, the literature, and other guidelines for the management of persons with dysphagia (Lee-Chiong 1998; Shanley & O'Loughlin 2000). Oral hygiene is identified as a nursing practice essential to adequate nutrition and hydration (Fitzpatrick 2000; The Joanna Briggs Institute 2004), however, in this research all three residents did not receive oral hygiene following their meals. Ongoing research and education is required in the areas of the nursing care for persons with dysphagia and their risk of aspiration, the oral hygiene practices for residents in aged care facilities, as well as their overall nutrition and hydration.

In Cynthia's case the issue of obesity became one of a struggle between Cynthia and her mother against the nursing staff and the documentation. Her predicament became increasingly problematic and frustrating from a nursing provision perspective because of the lack of resources and or knowledge to cope with her needs. The nursing staff had much to say about Cynthia's diet and blamed her obesity on her intake, but they considered themselves powerless to control her intake and it was left up to Cynthia. At the same time the nursing staff relinquished control of Cynthia's intake they also indicated resentment and frustration because of the problems with Cynthia's 'obesity'. This combined with scarce human and mechanical resources and their knowledge about nursing practice was problematic, however, solutions were unable to be found by the nursing staff in this facility and no appropriate assessment and problem solving skills were evident.

It is well documented that nutrition and hydration are essential to a person's wellbeing and quality of life and it forms a large part of nursing practice in these institutions. If nursing care surrounding the assistance of eating and drinking for residents is not resident focussed and appropriately assessed then the nutritional

needs and wishes of the residents are not being taken into account (Porter et al. 1999; Riviere et al. 1999; Crogan et al. 2001; De Bellis et al. 2003; Chubb et al. 2006). End stage dementia nursing care and the time and effort taken to assist persons in this situation with their nutritional intake requires practice change through further research. The system has created an ethos of scarce resources in staff, time, and knowledge creating an environment of risk and a poor standard of practice. The question of nutrition and hydration in end stage dementia and palliative care are crucial to the practice of quality nursing care at the bedside in these institutions for highly dependent residents.

Continence Management

The three case studies all had problems or issues concerning their continence management, even though a program for each resident was viewed to be working by most of the nursing staff. The documentation reflected this management of continence that was affirmed and made dominant through the accreditation process; however, it is little more than a screen for what was determined to be the mismanagement of continence. No promotion of continence occurred in Cynthia's case and the rights of Anna and her husband to participate in care were not upheld. As a direct result of the product driven system, Ruby suffered from persistent and severe groin rashes caused by the incontinence pads used by the regime in place.

Absorbent products are associated with increased incidence of skin problems when disposable products are used (Brazzelli, Shirran, & Vale 1999). Further studies have identified challenges to aged care continence management and recommendations have been made that include the skilful management of incontinence and the need for well educated staff and research especially into the continence products used (Dunn et al. 2001; O'Connell, Ostaszkievicz, & Day 2005). The quality of continence management in aged care facilities is identified as being influenced by the skill mix, resident to staff ratios, and effective communication. Individuals may also have particular needs that may differ to the general population in relation to their incontinence. (Johnson, Ouslander, Uman,

& Schnelle 2001; O'Connell et al. 2005) These same areas of concern were identified in this study for the residents. To protect the residents and their integrity, it will be necessary to challenge the product driven system common in residential aged care facilities, as well as the promotion of continence in persons who wish to remain continent for as long as possible, such as Cynthia.

Concerns surrounding the pilot assessment framework (ACFI) released by the government for incontinence assessment include that 'any' person is invited to use them. Prescriptive measures regarding constipation management are also given for 'anybody' to implement - before any referral is undertaken to nursing or medical care. (CofA 2005b) Assessment and interventions using these assessments by untrained and unqualified healthcare workers in aged care facilities is placing the residents at an additional risk for what is already inappropriate continence regimes as demonstrated in the facility in this study. Contemporary research is required into the continence management systems in aged care facilities, especially the product driven nature of regimes. The clinical decisions being made by CWs regarding continence management would be another area of research in order to provide evidence of the need for and benefit of having qualified nurses providing the nursing care, educating about continence, and practicing the nursing process competently.

The Unethical

Foucault terms the governmentality and disciplinary nature of Western organisations as the carceral society. Because of the very nature and mechanisms of control used for the 'good' of a society will enable the possibility to naturally produce 'illegalities' and 'delinquency' and this is because of personal moral choices. There will always be resistance balanced with compliance in the workings of any system that scrutinises and examines the subjects of that system in order to control them. (Foucault 1977) It is proposed that the unsafe and negligent practices demonstrated in this study could be explained in these terms in that these questionable practices have come about through an oppressive system that is carceral and custodial in nature. This in turn determined that the nursing

staff must make ethical choices concerning care and that this then had negative consequences for the residents and their nursing and medical care.

Moral choices made by the nursing staff and the relatives were evident in the data. The choices for the resident were extremely limited, firstly by their conditions, and secondly through power relations between the nursing staff and the relatives. Unethical practices were observed and appeared to be normalised. A number of discourses in the data focussed on the residents and relatives' autonomy and situations were identified that highlighted rights were being compromised - and this was consistent. The nursing staff stated that Joe, Ben, and Betty had the 'last say' and as such, had the power to determine care that impacted on the nursing staff; however, resistance by the nursing staff to requests or choices were found to be common. The ethical positionings in this facility were as simple as a person taking what Cynthia believed to be her mother's chair away without her permission, yet this was an important indicator of the unethical conduct and power imbalances revealed in this facility and the control exerted by the nursing staff through the disciplinary means evident.

The legislated rights of residents (DCSH 1987; Ronalds 1989; Foucault 1994u; Zuch & De Bellis 1996; CofA 2001c) were compromised in the residents and relatives' loss of autonomy. These then became overt and covert struggles of power in the discourses when the resident resisted or the relative advocated on the resident's behalf. Behaviour disturbances in a person with dementia can be directly related to negative interactions around the resident's privacy, identity, autonomy, and security (Graneheim et al. 2001; Mullins & Hartley 2002). Power relations permeated all the discourses around the three residents' nursing care provision in this study with domination and oppression changing according to the players, the situation, and the context.

Nursing staff in this facility seemed unaware of rights and ethical conduct in residential aged care, as the government asserted was the case. Instead the residents were denied these social justices in practice at the bedside. Research into the power relations and autonomy in residential aged care is important, however, the overriding power of control by the government inherent in all the discourses

finds the disciplinary means of examination, documentation, validation, accreditation processes, and the giving of rights in contradiction to quality nursing. These mechanisms of control seeped into all the discourses and were creating new knowledges about nursing in this facility, and these were contrary to resident centred care and evidence based nursing practice.

The legislated rights of residents are reproduced in Appendix 14 (CofA 2001c). In this residential aged care setting these rights were continually compromised on a number of levels despite accreditation and the lack of complaint. As such, the government can be challenged on the provision and upholding of the rights of residents and the ethical conduct expected in these institutions. Residents' rights are at risk in Australian nursing homes because of the approach of nursing staff (Tuckett 2005). Furthermore, nursing practices such as those revealed in this study, were and are putting RNs at risk of contravening the nursing profession's codes of ethics and professional conduct, as well as meeting competency and this has been alluded to in other studies (ANCI 2000; ICN 2000; ANC, ANF, & RCNA 2002; Tuckett 2005). This situation, caused by the system, is placing RNs at risk of punitive measures and deregistration, whilst the non-nurses who actually provide the majority of the care remain unaccountable to the nursing profession and the public. As such, non-nurses become authoritative about nursing care and make ill informed judgements and decisions that effect nursing practice and, therefore, the residents themselves.

It is in itself an ethical dilemma to have an expectation to provide quality of nursing care within limited material and human resources. The capacity of residential aged care facilities to provide a quality service is crucial to this ethical dilemma. Residents have the right to choose and refuse in the government and industry rhetoric, but in practice their rights are compromised, especially their right to quality of care according to their needs. This is in part due to the disciplinary system constituted that uses regulation and surveillance as a means to determine the care provided and also who can provide that care. Some Australian studies have uncovered critical and ethical aspects of nursing practice in residential aged care (Pincombe et al. 1996; Gattuso & Bevan 2000; Powers 2001; Nelson 2004), the value and complexity of nursing in these institutions (Cheek et

al. 2003), the paradox of the reforms and nursing practice (Angus & Nay 2003), and the identification of the enhancers and inhibitors to change processes and improve practices (Tonuma & Winbolt 2000; Chenoweth & Kilstoff 2002; Irving 2002). This thesis identifies another issue that questions the capacity for quality nursing care to be able to be provided in aged care facilities determined by the system and its governmentality in play.

Research on these critical and ethical issues in nursing will be necessary to review the continued existence and changes occurring for the nursing profession concerning ethical issues around the residents' dignity and honour, the quality of nursing care, the capacity to provide nursing care, and the scope of nursing practice. The ideology of social justice and ethical conduct were nothing more than rhetoric, when the reality in this facility was associated with struggles, non autonomy, disempowerment, discursive practices, conflicting discourses, dissent, and the production or propensity toward unethical practices including the verbal and written language in use and what was demonstrated in the practices observed, and the rationales behind those practices.

The Language in the Discourses

Language used about the residents and their nursing care needs had overtones that were patronising, demeaning, objectifying, and denigrating. Discourses such as providing hygiene being referred to as coming to 'sort out' the resident, or undignified comments about threatening the resident with having to 'give a smack', or 'tell on them' after the resident made a noise at being moved. This infantilising of the resident appeared to be normalised in this facility. Discourses by the nursing staff about the residents' resistive behaviours, argumentative behaviours, moodiness, non-compliance, and stubborn behaviours were interpreted differently in the observations undertaken and the subsequent data analysis.

Persons with end stage dementia who are labelled to be in a 'vegetative' state may in fact still have some functional and cognitive abilities and this highlights the

importance of making CWs aware of preserved cognitive functions in end stage dementia so the resident's quality of life can be improved (Boller, Verny, Hugonot-Dierner, & Saxton 2002). Further to this, however, were the undignified, belittling, and infantilising interactions, singing, and conversations of the nursing staff in this study and the misinterpretation of the residents' expressions of their needs.

The ethics of language and its meaning to the residents and relatives requires ongoing research around the professional and ethical capacity of nursing staff in residential aged care facilities. The use of descriptors in the discourses both written and verbal by non-nurses, who were viewed as 'nurses', was alarming as to their judgmental tones, incorrect assumptions, opinions, and patronising connotations. Entries in the progress notes were demeaning for the residents, as well as undignified when continual reference was made to bowel activity. Documentation by the CWs included notations about being short staffed, their opinions, and their judgements about the residents, especially in Cynthia's case. In the CWs' discourses references were made to the residents that were demeaning and undignified. This is in contradiction to an ethical and professional approach to nursing care (Lawler 1991; Potter & Perry 2001) and the language used in the discourses did not reflect the principles of ethical conduct, nor the competency expected in nursing practice (ANCI 2000, 2001; CofA 2001c; ANC et al. 2002; ANMC 2006b, 2006a).

Nursing is again under threat of being eroded, devalued, and silenced even further if the language used by nursing staff in aged care does not meet an ethical and competent standard of nursing practice and documentation and this places nursing in disrepute (Elliott 1989; Parker & Gardner 1992). Research into the language used in regard to nursing care for the residents, both written and verbal, exposed the hegemony caused by an uneducated and unqualified workforce who were providing nursing care of a questionable standard in a rushed environment under a panoptic field. Language and communication of nursing care through documentation, as well as verbally in action and on reflection, are paramount to the continuity of care, holistic care, quality of care, and a professional and ethical standard of care for residents.

Power Relations

There were several power struggles revealed in the analysis that made evident the power relations and conflicts that formed an undercurrent in the provision of nursing care for each resident. These conflicts were both overt and covert power relations that were said or not-said, documented or not-documented, observed or not observed. Most were in antagonism with each other when referring to the same nursing practice or resident need. In the main, these struggles focussed around the relatives advocating for their relatives' nursing care needs, but also occurred between the nursing staff themselves, and the RNs with the GP.

The vigilance and relationships between the relatives and residents with the nursing staff were apparent. Central to the relatives' roles was the care provided by them, their advocacy on behalf of their relatives, the disempowerment experienced by them, and the time spent in the facility by them that was not formally acknowledged in the documentation, but gratefully accepted by nursing staff. Many studies have researched the relationships between family or carers and the nursing staff of aged care facilities both in Australia and other countries, but all emphasise the importance of equal and responsive partnerships between the relatives and nursing staff for an improved quality of life for residents (Hertzberg & Ekman 2000; Kellett 2000; Hertzberg, Ekman, & Axelsson 2001; Sandberg, Lundh, & Nolan 2001; Bauer & Nay 2003; Edwards, Courtney, & Spencer 2003; Hertzberg, Ekman, & Axelsson 2003; Isola, Backman, Voutilainen, & Rautsiala 2003; Moyle, Iselin, Baeslack-Smith, & Fleming 2005).

Best practice for nursing interactions with residents' relatives is in the development of a partnership with them, but this will not be achievable whilst there is no formal acknowledgement of the relatives' input, knowledge, and care. Partnerships cannot exist where there is an imbalance of power and relatives feel disempowerment, as was the case in this study. Research into the struggles and vigilance of relatives and carers who advocate for their relatives as residents in aged care facilities, may expose further insights into these barriers of true partnerships between the relatives and nursing staff very evident in this facility.

The additional burdens placed on the relatives of this study were demonstrated through the unnecessary struggles the residents endured in caring for their loved ones. Instead of a true partnership in providing care between the relatives and the nursing staff, the relatives were continually on the alert and aware of having to advocate for appropriate assessment and nursing care. This resulted in more vigilance and participation in nursing care on the part of relatives, as well as a constant need to check on things. This added to their burden and although previous research has recognised burdens associated with placing relatives in residential aged care, there has been little research into this vigilance that was apparent with the relatives of these three residents in this facility.

The Hegemonic Structure and the Quality of Life

The government views the system of accreditation to be working through the achievement of minimum quality of life standards. Funding is conditional on accreditation and validation, using the resident's relative dependency on nursing care as the measurement evidenced in the documentation. The government views this funding to be sufficient for proprietors to employ an appropriate skill mix and level of staffing. The minimum quality of life standards have become the benchmark to be attained and the legislated rights and complaints resolution scheme ensure this is the case, according to government rhetoric.

The hegemonic or totalitarian state created by the federal government department to provide services in aged care for these residents is evidenced by the disciplinary nature of the legislation, regulations, standards, documentation, and classification of residents. Within the discourses of the aged care discipline, nursing has been slowly silenced and made docile, whereby the funding as well as the system's mechanisms and technologies are determining the nursing care provided to residents, and also the very nature of nursing. The system itself has generated an inappropriate skill mix and inadequate staffing levels for the provision of quality nursing care that is professional, evidence based, resident centred, and managed at the bedside by RNs as the leaders of nursing teams.

The disciplinary nature of aged care has permeated the time afforded to staff to provide nursing care and also the knowledge level base of the nursing staff. The governmentality as a sequestered, mechanised, and hierarchical system has constructed and objectified the residents and the nursing labour force. This has caused both of these bodies to become docile within the complex power relations and technologies of the discipline. Other studies have identified the docile bodies of the aged persons in residential aged care (Winch 1994; Chater 2002) and the silencing of nursing discourse in aged care (CofA 2002g; Angus & Nay 2003). As discourse analysis aims to uncover cultural hegemony (Lupton 1992) this thesis uncovered the nursing care for the three case studies through the discourses that were documented, observed, and talked about in relation to their nursing care needs. The hegemonic nature of the system has the potential and aim to affect the ground level and, therefore, all residents and their nursing care will be affected by the system - all may be similar in effect and experience. Therefore, all residents have the potential to be nursed in a similar manner to the case studies in this thesis.

The hegemony constructed by focussing on the aged dependent body, subjectivation, cost containment, and regulation has ignored and negated the individual needs of residents for an appropriate quality of nursing that is intensive, extensive, and complex and this was clearly demonstrated with the case studies. Unless nursing practice along with medical practice is assigned the value and consideration of adequate resources, and as long as expenditure control remains the primary goal of the governance - quality aged care is at risk of being unsustainable (Fleming, Evans, & Chutka 2003). The standards and indicators for accreditation are based on quality of life standards for residents rather than focussing on the quality of nursing care provided to the high care residents that were not commensurate with professional nursing care standards, ethics, professional conduct, and nursing competencies. It did not appear to matter whether the documentation was accurate - as long as it was done to the satisfaction of the requirements for validation and accreditation. In negotiation through the system and by adapting to it, the inappropriate nursing practices around these three residents had become normalised. This situation produced

corruption and delinquency manifested through the system of control and its instrumentation and also in response to it.

The nursing practices have been constructed within a system that has become self regulating through its hierarchical structure, agents, and means of examination for the subjectivation of the industry, the residents, and the labour force. Research into the tensions and conflicts between nurses and CWs in a nursing home setting in the United Kingdom was the outcome of the ongoing struggle of nursing for professionalism, recognition, and status. Conflicts between the different levels of nursing staff are also the manifestation of the macro forces that impact on nursing practices, for example in the governance, paternalism, medical domination, and hierarchical subordination inherent in any system. (Jervis 2002)

Angus and Nay (2003) recognise the paradox of the aged care reforms, as well as the marginalisation of nursing discourse relating specifically to the policy of ageing in place. It is argued by them and others that the marginalisation of nursing discourse and the position it holds is one of a 'rear vision' (reaction to change rather than initiation of change) and public policy having neglected nursing. The reasons for the subjugation of nursing discourse is not only attributed to problems of identity in nursing itself, but also to the tensions between the containment of costs versus the resources needed for the provision of an appropriate level of nursing care. These tensions define the boundaries that may be damaging and a means by which the constraints can also be challenged. (Angus & Nay 2003; Cheek et al. 2003)

Nursing discourses can act as a catalyst in addressing the importance of economic rationalisation and quality health care and the tensions created between the two in the form of governance, the system, resources, and support (Chou, Boldy, & Lee 2002; Angus & Nay 2003). Organisational and structural reform in aged care organisations could be achieved if participatory processes included flattened hierarchical structures and 'true' support and transparency on the part of management and also the government (Chenoweth & Kilstoff 2002). Rapley (2003) describes the hegemony of service provision and research about quality of life as a cultural object where he identifies a corporate, market driven, and

managerial focus of government policy that is inherent in all forms of institutions in Western culture. The rhetoric of quality of life for residents fails to account for the 'self' or the experiences of the persons themselves in assessing their individualised quality of life determinants innately based on their need for nursing care.

The discourses of government centres on quality of life as one organising construct as an objectified outcome of service provision. However, that quality may be lost when quality of life is made into a measurable object and not focussed on the persons themselves as receiving the services. The service, in the main, is nursing and includes accommodation regardless. When nursing is coupled with the hegemonic state, and corporatisation and managerial effectiveness become dominant, this allows or disallows any possible changes at the organisational level (Beil-Hildebrand 2002; Rapley 2003). The rhetoric of accreditation and quality of life standards by government identifies quality of nursing as one minor aspect of this policy. Furthermore quality of life and its measurement, in order to be reflective of the reality and the multidimensional aspects of life, necessitates both subjective and objective measures (Rapley 2003; Verdugo, Schalock, Keith, & Stancliffe 2005), as well as nursing measures. The accreditation presently in place in the Australian system uses objective measures only and is deficient by not focussing on the quality of nursing care, which is necessary for the residents' quality of life.

In this thesis, the informants on the quality of life indicators in this facility did not match the objective outcome standards used for accreditation or the instrument used for validation of nursing care. If standards are met and the facility accredited then the government claims quality of life is present, but this is not the reality. The quality of nursing care for the residents was in a continual struggle against the hegemony geared toward the documentation and justification for funding, which then became the benchmark for assessing the quality of nursing care. The profession, the industry, and the government cannot ignore the quality of nursing care being provided in facilities such as the one in this study, because nursing care for highly dependent residents is at the essence of the residents' quality of existence.

In Summary

The problems of aged care nursing practice can be identified in the rationalisation, governmentality, and the disciplinary nature of human services and institutions in Western cultures. A number of important pieces of text highlight the same concerns that have emanated out of this thesis around nursing practice in residential aged care and provide further evidence of a system in conflict with the nursing profession (ACEMA 2002; CofA 2002c, 2002d, 2002e, 2002f, 2002g; Angus & Nay 2003; Cheek et al. 2003; CofA 2004d, 2005a, 2005c; Cooper & Mitchell 2006). The juncture occurring in 2003 that sowed the seeds for further changes can be traced back to a number of government reports, whereby the concerns about nursing practice in residential aged care found the nursing profession silenced by the dominant discourses of the government (CofA 2002c, 2002g, 2003c, 2003d, 2004d; Australian Government 2005a; CofA 2005a, 2005c).

In summary of this chapter where the construct of nursing has been problematised, the state of governmentality was perilous for these residents and their relatives, as well as the nurses, non-nurses doing nursing work, the nursing profession, the industry, the public, and the government. As such, aged care nursing practice and the quality of nursing care for residents in similar institutions providing high care requires further research. This study emphasised some of the causes for concern for three residents' nursing care in an accredited residential aged care facility. Questions need to be asked about the nursing care of other residents in the same facility and also in like institutions in Australia given the hegemony of the system. The possibility exists of the transferability of the findings to other facilities and even between aged care systems of other countries that provide institutionalised 'high care' to the elderly (and also to young persons); whereby what is essentially nursing care can be undertaken by 'anybody' with resources at a bare minimum.

Whilst rights are legislated, accredited, and legalised they ultimately serve the political ends that allow for the furthering of control over individuals by the dominant power. These rights also offer up the terms by which any challenge can be made to a system by an individual or corporate body. (Gordon 1994) Regimes

that repress people, whilst at the same time invoking human rights, are viewed as contradictory and this allows for transformation to be a possibility. Ethics are involved in any ‘rupture’ when things begin to lose their self-evidence or when the things that “go without saying” are challenged (Foucault 1994o, 1994p, 1994t). There are always tensions where ‘rights’ are concerned because to invoke them challenges the normal, the evident, the status quo, or the accepted ways of doing things. In describing the technology of the self, ethics is viewed as a ‘very strong structure of existence’ within an authoritarian, disciplinary, or juridical structure such as aged care. (Foucault 1984e)

The cacophony created by the aged care disciplinary system is potentially dangerous to the resident, their relatives, the nursing staff, the proprietors, and ultimately the government who are accountable to the public. This is a described phenomenon (Foucault 1977) whereby every practice or discipline by its nature also has its inherent dangers. But the main concern for the residents and the quality of nursing care provided to them lies with the nursing profession under the concept of nursing praxis, including knowledgeable and competent practices, and acceptable standards provided in an ethical and professional manner. If the capacity for this is lacking, as was the case in this study, then the ethics of the system can be challenged.

The relations among science, politics, and ethics and how these interact with each other in the formation of a discipline, such as aged care, includes a political structure, a scientific base, and a moral practice where each affect and interfere with each other. Three fundamental elements of any experience include a game of truth (epistemological), the relations of power (political), and the relations one has to oneself and others, which culminates in a moral dimension (ethical). Critical analysis aims to see how the different solutions to any problems might be addressed through analysis of how they have been constructed and constituted; and how these in turn have resulted from difficulties encountered in any given practice. The problematisation of any practice drives the possibility for a solution and a response. (Foucault 1984g)

The following chapter concludes this thesis with the meanings of the nursing care provision based on what the data revealed and the limitations of the thesis are also acknowledged. The conclusions are addressed from the perspectives of interested parties in residential aged care nursing based on the three case studies. From this, the ethical, epistemological, and political (ethico-epistemo-politico) question regarding aged care nursing practice will be formulated in relation to the questions guiding this thesis. The final section of the concluding chapter discusses Foucault's notion of reform and how this might apply to residential aged care as a discipline in need of further transformation for nursing to be assured at an acceptable standard. The conclusion chapter does not offer solutions, but from a nursing perspective highlights the meanings and areas where change is urgently required because of the problems identified.

Chapter 12

CONCLUSION

The evidence and questions in this thesis have meaning and consequences for all stakeholders in residential aged care and the problematisation of nursing care provision in this aged care facility for three residents has revealed a precarious concoction. This facility was an environment that was incapacitating and where hours and staffing levels were at a bare minimum in maintaining a custodial level of care. Untrained, unlicensed, unregulated, uneducated, and unqualified nursing staff carried out the nursing care and also made decisions about nursing care. These non-nurses were supervised by RNs from a distance and the nursing practices were in part controlled by the disciplinary means employed to monitor the system, as well as the CWs' experiences and capabilities. The resident was at the end of this governmentality that was affecting nursing care provision.

The perilous nature of care for the residents produced actual or the potential for abuse, negligence, and poor practices. It also created new nursing 'knowledges' that were not evidence based. The safety of residents was compromised, despite government rhetoric one of achieving a high standard of aged care that was sustainable, of quality, and under control. The claim was one of residents being protected through their legislated rights, the accreditation process, and the complaints mechanism, however, the disciplined nature of aged care in Australia has given rise to dissonances, conflicts, and agonisms in nursing practices that are realised at the bedside, as evidenced in this aged care facility. The management, nursing staff, residents, and relatives reinforced the system and the mechanisms of control and this was to the detriment of the residents, their relatives, and ultimately the nursing care they received. All were docile and silenced by the system through mechanisms of panopticism, normalisation, subjectivation, domination, and self governance.

In contradiction to the government oratory, discourse analysis of the data concerning nursing care for the three highly dependent residents as the case studies revealed the following about the object 'nursing' in this accredited facility.

1. Residents were ineffectually scrutinised and examined by many different gazes.
2. Nursing practices were of a poor quality and standard.
3. The residents lived in a noisy and public environment.
4. The nursing staff were rushed and hurried in the provision of nursing care.
5. The non-nurses lacked direct and indirect supervision by nurses.
6. The RNs did not participate in the actual nursing care.
7. Non-nurses were providing a poor standard of nursing care to the residents.
8. Residents and relatives were marginalised in the discourses and the environment was conducive to power struggles.
9. Relatives had to remain vigilant for the residents' security.
10. Nursing discourses were directed to the funding requirements and not the nursing care needs of residents.
11. Nursing practices were not reflected in the documentation.
12. Nursing care needs were not commensurate with the residents' categorisations.
13. Non-nurses and RNs based nursing care on poor clinical judgements.
14. Much of the nursing care was not resident focussed or evidence based. Furthermore, nursing care was mismanaged, unsafe, disabling, and lacking in critical or clinical reasoning
15. Nursing care was lacking in the absence of a palliative care approach, best practice dementia care, competent nursing assessment, adequate nutrition and hydration care, and continence management.
16. Nursing practices were unethical and unprofessional.

These problems occurred at the micro level of practice in this facility for these three residents and can be directly related to the aged care system in their constitution. This was accompanied by a silencing of nursing and nurses in the global sense as described in chapters 2 and 3. The limitations of this study and its relation to the overriding, encompassing system of control may be questioned by some in that it was one nursing home and three residents. It could be argued, however, that it was a portrayal of what was happening as one construct of aged care nursing. If it can happen in a facility that is deemed to be a 'good' nursing home, then it can happen in any aged care facility in Australia as part of the same system that accommodates highly dependent residents.

Description, exploration, explanation, and subjective meanings in this study, as a qualitative research methodology, were justified in the richness of the data produced, in the detail of the data, and the depth of analysis about the nursing care the residents received. The interpretive paradigm, although limiting in subjective bias and interpretation, may still be replicable and find similar material to analyse. The study was only one construct or one truth of the nursing care concerning the three residents, but this truth, it can be assumed, may be similar for other highly dependent residents in any residential care facility providing high care because of the hegemonic system in place.

Case study design has been criticised for small sample size, the inability to generalise, and the lack of positivist evidence from a quantitative perspective. In this thesis the amount and detail of the qualitative data generated and the depth of that data has given insights into what had occurred in the practice of nursing care for these highly dependent residents. It was an analysis of nursing practice at the miniscule and detailed level at the bedside from the perspective of conflicts, dissonances, and disparities concerning nursing care and through this, issues of concern were raised concerning all involved. The findings cannot be generalised and applied to all highly dependent residents in residential aged care facilities and generalisation was not the aim, however, the evidence that this nursing care is occurring at all in an accredited facility is of concern. It is the possibility of transferability to other highly dependent residents in other like institutions that

raises serious questions about a similar substandard of nursing care occurring elsewhere under the discipline of aged care in Australia.

The use of discourse analysis of the data allowed meanings around nursing care to be explicitly described in their context and affect. These meanings were either covert or overt, but the discourse analysis at a micro level and the subsequent cross case synthesis allowed the exposure of nursing care that was of a questionable standard. Indeed, the management of the facility that participated, as well as the nursing staff, believed the provision of nursing care was of a 'good' standard and this appeared to be the case on the surface at the basic level. Behind this open door, however, were hidden practices that the discourse analysis was able to deconstruct and reconstruct as a nursing care construct. The practice level of any discipline and the discourses about an object such as nursing care in the field with the ensuing microanalysis describes and exposes the system of control, as well as the overt and covert effects of that system on the object under study, in this case being nursing care. In this thesis the effects of the system in the domain of nursing practice at the bedside were revealed.

Criticism of Foucault has raised questions about his philosophical and research approach. His framework for the disciplinary nature of institutions in Western cultures, however, has allowed a critique of a government controlled system that is residential aged care in Australia. Through an analysis of the historical reforms and the governmentality of aged care, links were made between the federal controlled system and the nursing care practices on the ground. The focus on discontinuities, conflicts, and illegalities in the discipline that uses panoptic means provides particular insights into practices, in this case nursing. Foucault's strategies for analysis have exposed the strategies and the resultant effects on the residents' nursing care. Persons and agencies outside of the nursing profession constructed nursing care and new epistemologies were being developed. Nursing and nurses have been silenced and the dominant discourses are eroding the value, as well as the reputation of nursing. The use of Foucault has enabled an exposure of what was happening to aged care nursing and this was a standard well below the expectations of the nursing profession.

The research questions that guided the thesis are reviewed in the following section by a summation of the findings. Solutions, answers, and recommendations were not the aims of the research and according to a Foucauldian perspective, are inappropriate. Instead, the aim is for change and transformation to be made possible when there are problems such as what were revealed about nursing practice in this thesis. The problematisation of the nursing care has the aim of accomplishing a possibility for change through opening up dialogue until another dominant discourse can be constituted, which will be more commensurate with nursing and ‘nurses’ in residential aged care, and gerontological nursing practice.

In Answer to the Research Questions

The three research questions articulated at the beginning of this thesis have been addressed throughout the various chapters and these concluding remarks highlight the salient points.

1. How is nursing practice situated in the Australian government’s rhetoric, reviews, and reforms?

The nursing profession finds itself in a perilous situation and largely being silenced, despite nursing being the core business of residential aged care. The government has been surreptitiously eroding the very nature of nursing through the aged care reforms, and is determining what nursing care is and what nursing care is not, as well as who can provide nursing care and undertake nursing work. The reforms have not been sympathetic to the issues raised by nurses that directly affect nursing care provision, such as the documentation issues that have resulted in a continual struggle for the nursing profession, the nurses, and the non-nurses who provide nursing care, as well as the residents who receive the nursing care. Nurses have become sandwiched between providing resident focussed nursing care that is of quality and based on evidence, with providing nursing care determined by agencies and persons outside of nursing. Nursing practice has been eroded to technological procedures and nurses have become bureaucratic scribes far removed from direct nursing care and the persons they supposedly care for.

2. What are the discourses around the perceived nursing care needs of highly dependent residents in a residential aged care facility from the perceptions of the RNs, the CWs, the residents, the relatives, the researcher, and the documentation; and, do these discourses conflict and why?

These perceptions and discourses about nursing care for the three residents were continually in conflict with each other. When objectifying nursing care as the focus of this study, the discourses from the various sources were disparate and each view was a different description of the same thing. More often than not the discourses were in direct conflict or contradictory to each other - none more so than the documentation compared to the reality of the nursing practices. These incongruent discourses about the nursing care provision for the residents have ramifications for residents' care generally, in that it was not resident focused, of quality, or evidence based and instead was funding focused. The standard of the residents' nursing care provision was being affected by the converging and differing positionings about nursing care, and this was in turn negatively influencing the nursing care provided to the point of negligence and abuse. Furthermore, the situation found in this facility had become normalised, complied with, and accepted by those concerned.

3. How do these discourses constitute, construct, and influence what are nursing care practices for highly dependent residents in a residential aged care facility?

Because of the divergent discourses that constituted, constructed, and influenced the nursing care for the residents, the nursing was not of an acceptable standard or quality and was being driven and constructed by non-nurses at the bedside, as well as through the governmentality of the disciplinary system. This construct for nursing care provision was dangerous to the residents, the nurses and non-nurses, the industry, the government, and the public. It was difficult for nursing to be identified in aged care clinical practice when it was being eroded and silenced in subtle ways, both in the field and as a result of particular junctions of reforms in an historical sense. The domain of nursing practice was being eroded, devalued, and denigrated. Furthermore, new nursing knowledges were being created by the system in place and this was not compatible to evidence based nursing practice.

The construct of nursing practice in this aged care facility was a disadvantaged one that was out of the control of the nursing profession. The nursing profession has been swept along by the centralised discipline through a managerialisation and corporatisation of the aged care industry, whereby nursing labour and, therefore, nursing practice has been sacrificed for the self-regulation requirements necessary for funding. It was very apparent that this situation placed an increased burden on the nurses, the non-nurses who were nursing, the relatives, and the residents in receipt of the nursing. Nursing care was not recognised as nursing and was being determined by non-nurses. This paradox urgently requires the nursing profession to act at a national political level.

The meaning for the residents and their relatives.

The situation in this facility meant a risky existence for the three residents and their relatives. The nursing care was at the discretion of the CWs who had a limited knowledge base and limited time. The residents received nursing that was custodial in nature and of an unacceptable standard, and through their subjectivation were nursed as objects in a mechanistic way. They were not safe when nursing care was being undertaken - or not undertaken. They had no choices and any independence exerted by them or their relatives was misinterpreted and ignored by the nursing staff who did not identify this as part of ethical nursing practice.

The residents' existence and their meanings were lost in the discourses of what was determined as their nursing care needs, but their actual nursing care needs were not being assessed and met. In contrast, the nursing care was viewed from the documentation perspective to be of an acceptable standard. This was ensured by the accreditation status of the facility and the lack of complaint by the residents and their relatives. In the analysis of contradictions unsafe, unprofessional, unethical, disabling, and mismanaged practices were consistent. This nursing standard subjugated vulnerable residents to neglect, as well as psychological, physical, and emotional abuse.

The burden on the vigilant relatives was immense and although they cared for their relatives and spent time with them, this was not motivated purely from wanting to care for their loved ones, but was also a matter of believing they had to come in, check on things, and provide care. They did this otherwise, in their belief it would not get done and would not be of an acceptable standard - or their relative could die. For example, their loved one would not get enough to eat and drink. This referred to life and death issues and also permeated into all the aspects of nursing care. Understandably, the relatives displayed protective behaviours to the residents in response to the system in place that had constructed the inadequate nursing practice in this facility. The implications for the residents and their relatives were real and it would appear the residents were susceptible in an institution designed to care and protect them. This facility did not uphold the legislated right of each and every resident to quality care according to his or her needs.

Implications for the nursing profession

The evidence detailed a hegemonic state of affairs that was placing the residents of this facility in the position of receiving custodial nursing care that was unsafe and even negligent. The dominant discourses were subjecting the nursing profession to the possibility of disrepute when the quality of nursing care was affected at the resident level. The implications of this for the nursing profession are numerous. Further education incentives for nursing staff and the specialisation of the role of the RN to be one of an advanced practitioner in aged care may further distance the RN from the bedside. The nursing profession values the role of the advanced nurse practitioner in aged care; however, this should not be at the expense of further distancing RNs from residents who require complex nursing care. The resources allocated for the education of aged care nursing staff are being concentrated at the CW and EN level, and not in bringing already educated RNs back to the bedside.

Increasingly RNs are accountable and responsible in residential aged care for care they are not able to provide or supervise. In this study, the RNs were responsible and accountable for the nursing care provided, but the nursing care was delegated by them to CWs. The RNs had no control of the nursing practices undertaken by the CWs and were far removed from the bedside and practices. The CWs were ultimately accountable to their employer and not the RN delegating nursing work. The RN was very much providing 'indirect' care and supervision from a distance with delegation of nursing practices to unlicensed, unregulated, unqualified, and untrained CWs - who were not being monitored. This further added to the paradox of CWs not performing nursing work and, therefore, not needing direct supervision of their practices. The continuing role of the RN for indirect supervision, delegation, and credentialing will further impact on the quality of nursing care provided for residents such as Ruby, Anna, and Cynthia.

Nursing legislation states only ENs and RNs are entitled to use the name 'nurse' and provide 'nursing' care. The government has separated out personal care from nursing care so that anybody can provide this nursing care to the detriment, devaluation, disrepute, and erosion of nursing. The nursing work undertaken by the CWs was not informed by nursing knowledge, evidence based practice, nor recognised by the government as nursing care. The nursing care was directed and delegated from a distance by a mixture of indirect RN supervision, relative advocacy, the documentation requirements, the time available, and the knowledge and experience of nursing staff. There was an appearance of a provision of a minimum standard of care necessary, but this was directed to achieving validation, accreditation, and avoidance of complaint that would bear a financial punishment. The nursing care actually provided did not relate to the documentation necessary for validation and accreditation that was essentially fictitious, and did not meet evidence based nursing practice. There were new nursing knowledges being formed because of the documentation for funding requirements and practices being in the control of the CWs, and this was having a direct negative effect on the quality of life for these residents. The nursing profession is urged to claim back the domain of nursing that the government relegates as 'personal' care and technological nursing care.

The question of nursing practice has been problematised and the regulation and standards that control nursing emphasised. The question of where the nursing profession stands in the control of nursing in residential aged care is one for concern. The RNs and ENs are leaving or disappearing upwardly in a hierarchical structure as agents of the government or organisation - rather than agents for the residents, their nursing care needs, and the provision of quality nursing care. Unlicensed health care workers, however named, require recognition as a third level of nurse accountable and responsible to RNs, the nursing profession, and the public possessing a minimum qualification in training and education by RNs. This may go some way to rescuing the quality of nursing care revealed in this study. Most importantly, licensing of CWs would allow the three levels of nursing to actually nurse as a team in a competent manner and allow the recognition of the somological work being undertaken by CWs as the domain of nursing and nurses.

Issues for the industry

The industry is presently highly scrutinised by the federal government excepting where it matters the most to the government, namely in the financial management realm of the industry. Proprietors have been reluctant to provide financial records and statements to the government as evidenced in the Hogan Report (CofA 2004d). Management practices are scrutinised in the accreditation process along with the documentation on nursing care, but the government has been unable to effectively examine the financial records of facilities for the purpose of further cost efficiency.

The staff development and education of the nursing workforce has been recognised as an ongoing problem. The government has recommended that if an aged care facility surrendered its financial records, extra funding for the education of their staff or for them to improve their skill mix could be applied for by them. The requirement that the organisation provide their financial records as a condition of this funding for education and an appropriate skill mix, will also entail participation in government surveys, data collection, and reviews. The government has recognised the need for an improved skill mix and further

education, but the organisation will be penalised by having to make application and then disclose their financial records, as well as comply with further scrutiny, as the department deems necessary. In some organisations, education and skill mix are low priorities and so the voluntary participation in this incentive with these conditions will not be attractive to them.

Nursing labour is the major cost to facilities and whilst a capitalist and corporate design pervades the system, it will be the nursing labour costs that will be sacrificed to make an increasing profit or surplus. The strengthening of complaint mechanisms and the accreditation processes for the accurate evaluation of the quality of nursing care provided may further expose nursing practices in the facilities. The industry, nursing profession, and government need to be prepared for the consequences. Funding for RACFs is dependent on nursing documentation and the quality of life standards used for accreditation. To challenge these on an organisational and political level will require the government to be called into question and to make account for the quality of the nursing care able to be provided. The government, as the state, is ultimately accountable and responsible and aged care policy must reflect the value of nursing in residential aged care by regulating for qualified, educated, and trained nurses across three levels, as well as an appropriate skill mix and staff to resident ratio for all residential aged care services that care for highly dependent residents in need of nursing care.

Challenges for the government

The reliance by the government department on the documentation, accreditation process, and complaint mechanism to argue that quality of life is being provided in residential aged care is an open door to what was occurring at the bedside behind the open doors. The government is seemingly ever vigilant and gazing but it is not taking responsibility for what are real concerns around the quality of nursing practice in residential aged care. The general direction has been that nurses are not required to do nursing work because it is not nursing work, and the industry maintain they cannot get qualified staff anyway. The reasons for the high attrition, low retention, and poor recruitment of RNs are silenced in the various

government reports, and so the general dominant view includes RNs not being available and, therefore, others can do the nursing care, renamed personal care, at the discretion of the service providers. The government has taken away the fundamental nursing practices that are part of the nursing domain and, as such these practices are deemed to be able to be done by anybody.

The government's reliance on documentation for the basis of accreditation was a charade, whereby it was classed as a truth and evidence of quality nursing care, but in reality the documentation did not match nursing practices undertaken by non-nurses who were unable to be directly supervised. The nursing documentation did not reflect evidence based practice or resident centred care. It was framed and directed at funding requirements to determine the residents' relative dependencies - not their dependency on nursing care. It would seem this tension will continue with the new instrument and funding model proposed for 2007.

The government's new reform has given what are essentially nursing assessments over for use and interpretation by anyone in order to justify funding through additional documentation to assess nursing care needs and dependency of the residents. The government funding instrumentation needs to be separated from the nursing care provision and nursing documentation as recommended by the Hogan Report (CofA 2004d). Funding and categorisation could easily be based on a minimum data set separate to the nursing care provision. The added burden of justification for funding through the documentation - if removed - would go some way to solving the problems being experienced in aged care by the nursing staff and would contribute in bringing RNs back to the bedside, to lead the nursing team through their release from the documentation requirements.

The government can be challenged through the legislated rights of residents of residential aged care services, and these may be the only means by which the system in place can be confronted with the reality of nursing undertaken by non-nurses. All the legislated rights of the three residents in this accredited aged care facility were breached. Most importantly, the right of the residents to quality care that was appropriate to their needs was not upheld. This right is paramount to all the other rights set down in the legislation. This is precarious for a government

that relies on the accreditation, documentation, rights, and complaint mechanism in answer to any challenges posed. All questions have a political, epistemological, and ethical constitution and ramification in their construct (Foucault 1994u) and discussion now turns to this critical concept and the case for change.

The ethico-epistemo-politico question

According to Foucault (1994u), individuals have the right to speak out against abuses of power, and a duty to bring testimonies of the oppressed and the suffering to the government's attention - as the governing body holding the power and, as such, accountable to the Australian public. Foucault also raises the importance placed on discourses that dominate whereby those persons who govern use discourse and disciplinary means in order to control all other discourses. 'Good governments' appreciate any indignation or challenge to the system, and it is the will of individuals in the reality of practice where exposure of the effects of the system is made possible (Foucault 1994k), as was the case in this thesis.

Any question has an ethical construction that emanates from choices made by persons in either rebelling, compromising, or by complicitly self-governing. Questions also have an epistemological construct in that discourses whether said or not said are constructed through power relations and subjectivation to an object that is knowable - resulting in dominant discourses that become accepted and acceptable. Questions also have a political base culminating in power and knowledge in a strategic relationship between the subject and the state. (Foucault 1984f) This research supported the Foucauldian aim of opening up problems in nursing practice that have moral, epistemological, and political constitutions to them, as well as their consequences that may be negative or positive.

Nursing practice in aged care has been constructed by a governmentality that has ethical, epistemological, and political arms and implications. Ethically the government and the nursing profession cannot claim quality of nursing care in this aged care facility that was recently accredited. Epistemologically, nursing practice

and nursing knowledge were eroded and constructed by non-nurses and governmental instrumentation; and, politically, the nursing profession was having little influence on the governance of the aged care facility in which the core business was nursing.

Reform in aged care is required if the system's ramifications for nursing are to be addressed. In the following concluding section suggestions are framed for further reform and transformation in the aged care discipline to enable nursing care to be delivered in an ethical, professional, and competent manner. To do this, it is necessary to frame reform and transformation in Foucauldian terms as related to the residential aged care discipline and nursing practice.

A Case for Change

Foucault (1984g) describes analysis and questioning of politics about the problems being experienced in practice over which the government has control is necessary for any transformation or reform. Reform entails an acceptance and critique of the possibilities, going beyond what has become normalised, questioning what has been constituted or constructed, thereby leading to transformations (Foucault 1984b). Dissent, challenges, and questioning is something to be taken seriously by government and embraced because it is here at the point of conflict that oppression is made evident - thus allowing for shifts and changes. Any oppression provides the opportunity for resistance, revolt, or non-compliance by the oppressed - just as there is also the opportunity for compliance and docility. (Foucault 1994q) Criticism and dissent, necessary for any transformation to occur, are disruptive, transformation can only occur openly in turbulent atmospheres of continuous critique. It is a matter of making the need for transformation urgent so people are prepared to address the issues. Many things can be changed in a system if contingencies are focussed upon rather than the necessities; identifying what is arbitrary and contentious rather than what is rational; and probing into the complex, transitory, and historical nature of practices rather than the fixed variables (Foucault 1994r).

It is the work of researchers to collaborate with practitioners to reshape ways of thinking and working by questioning the historical formations and the systems of thought that operate (Foucault 1994j). Overall, reform involves analysis and critique not of the system, but instead dialogue about the conflicts and confrontations with the dominant discourses that construct the system. It is using this recipe of exposing contradictions in the practice of nursing in a residential aged care facility as an agenda to create an awareness of nursing care provision that is in need of change.

... an agenda for political reform based in a new respect for those who govern for the governed, the acceptance that the conduct of government must be rationally justified to and accepted by those whom it affects, and a practice, on the side of the governed, of participative cooperation with government, without unconditional complicity, compliance, or subservience – neither shoulder to shoulder, nor on bended knee, but, as he (Foucault) put it... “upright and face to face”. (Gordon 1994, pxxxvii)

The ‘critical attitude’ is described as ‘a will not to be governed’ or ‘the art of not being governed’ in a particular way or ‘at that price’ (Gordon 1994, pxxxix). This thesis has raised questions as to what cost, both human and material, and to what length the economic rationalism on the part of the government will go - together with a complicit industry and nursing profession. It is only by challenge and dissent to open up discourses that transformation will be possible.

Any reform will not come about through a planned exercise, but will come about through conflict, confrontation, and resistance by the people who are being dominated. In residential aged care facilities in Australia presently, the government and the industry surreptitiously dominate the nursing profession, and this domination and control is affecting the very nature of nursing and how it is practiced. It is the people to whom the reality of the domination forms part of their practice or existence, who through challenging the status quo will make any reform possible. (Foucault 1994f) Nursing as a profession is being subsumed by the discipline of residential aged care, whereby nursing is not identified and valued for its complexity and intellectual challenge. The subjectivation of nurses and nursing practice as an objectified practice of personal care is in effect silencing nursing and nurses in residential aged care. This thesis aimed to open up

the dialogue around nursing practices occurring in residential aged care to allow for transformation and shifts to occur.

The following were areas from this thesis for opening up discussion where further collaboration, dialogue, and the possibility of reform can be focussed.

1. The claiming back of personal care into the domain of nursing care.
2. Regulated minimum nursing staff levels and nursing hours that are adequately funded.
3. A minimum nursing staff resident ratio with an appropriate skill mix.
4. Requirement for 24 hour direct RN presence in all facilities who accommodate high care residents.
5. A return to the concept of team nursing with RNs as the team leaders.
6. Separation of the funding instrument from the provision of nursing care and the introduction of a minimal data set (MDS) for funding purposes.
7. Documentation returned to nursing and not used for the purposes of funding, but for the purposes of nursing care.
8. A third level of nurse be licensed who require a minimum qualification and training and who are accountable to RNs, the nursing profession, the nurses boards, and the Australian public.
9. The ongoing education, training, and development of nursing care staff at all levels by RNs.
10. Addressing inherent problems with staffing and documentation to bring RNs back to the bedside.

Through this thesis my aim was not to indict or deride any individual or organisation and I do not propose to have the solutions. My aim was to question and open up dialogue within the nursing profession, together with the relevant government bodies and aged care organisations, to debate a system that has: inadequate funding allocated for nursing care; a lack of trained and qualified nurses with ‘non-nurses’ attempting to provide very complex nursing care classified as ‘non-nursing’; under a documentation quagmire; and the distant gaze of RNs who are accountable and responsible for the care provided - who are leaving the profession because of the system.

A culture of neglect existed in this facility, despite the funding, accreditation, residents’ rights, and complaint mechanisms in place. The doors were open, but it was beyond these open doors where the nursing practices were exposed as sub-

standard. There are far reaching ethical, epistemological, and political implications for nursing, as well as the upholding of the residents' right to quality nursing care, and hence their quality of life. This also has serious implications for the industry and the federal government. The delivery of evidence based nursing care by 'nurses' and 'non-nurses' providing nursing care ought to be the nursing profession's focus. It may be questioned whether there were 'any' skilled and empathic nurses or non-nurses caring for these three residents in this facility, and in answer to this; any instances of 'good' nurses, empathic and skilled non-nurses, and satisfactory nursing practices were fairly represented in the data chapters and were non-existent in the scheme of things, which only makes this study all the more alarming.

In conclusion, most elderly persons are well off in Western societies such as Australia, so how is it that some marginalised and vulnerable individuals end up in aged care institutions that '*may be questionable and operate under clouds of scandal*' (Foucault 1994i, p380). Foucault states that if it was possible he would set up a voluntary institution where people could have a holiday of hedonism and pure pleasure before dying (Foucault 1994i). The aged care facility in this thesis, far from being an institution of pleasure in Foucault's fantasy, was in reality one of suffering, struggle, and incompetent nursing for the three individuals and their relatives.

What was revealed in this thesis was a cacophony of nursing care provision, controlled by federal government policies that was having a profound negative effect on the nature and quality of residential aged care nursing. This bordered on abuse for the residents and their relatives, and at the very least abuse of their legislated rights. Perhaps the image of aged care and aged care nursing as commonly portrayed is, after all, warranted - whereby the reality behind the open door contradicted government rhetoric, and in essence, fractured nursing to the detriment of the residents' quality of life.

APPENDICES

Appendix 1 - My Impressions after the Observations

Anna

It was absolutely poignant the way Joe spoke to Anna and fed Anna. The amount of effort and concentration that Joe put into getting Anna to take food was astounding. And take it she did – all of it. He was constantly cooing, speaking, touching, and encouraging her – very gently and in soothing, baby-like tones – sometimes in English and other times in Hungarian. Anna did respond to Joe at times but if she stopped chewing and swallowing, he would persist, sitting very close and continually talking, whispering, and cooing until she had taken the whole meal. He added things to her meal and explained to me it was to make them more tasty and nutritious. It took something like 40 minutes for Joe to feed Anna but the CW took more like 3-4 minutes in total giving Irene in the next bed her lunch (Irene from the interview and observation was emaciated, cachexic, and in end stage dementia, did not communicate, and she had severe contractures). Furthermore, Irene was wearing her orange juice when the CW spilt it over her after attempting 2 or 3 dessertspoons full of food. Irene did not get anything else to eat or drink for lunch. Whilst Joe was attending to Anna, the whole time and even when the residents were supposed to be resting, the place was extremely noisy and this noise was constant. There was no sense of peace and quiet in the facility and I did not notice this until the interview and the NPO. Cupboards opening and closing, voices, paper towels being torn off, water running, footsteps, laughter, singing, conversations, and the PA boomed a few times. It was very notable. The TV between Anna and Irene was ‘blaring’ during almost all of the observation but nobody was watching it (except the CW sitting down for a couple of minutes to feed Irene). The residents appeared totally oblivious to the TV. Joe did not watch it and was not interested, and was always concentrating on Anna and focussing on her. Also there was this singing careworker. This singing careworker was unknowingly and ignorantly behaving in an unethical way. I heard her a number of times (up to 20 times) in the corridor and also in the room of Anna and Irene when attending to their needs. She would sing very loudly, one line, and out of tune “I am woman, I am invincible”. She sang this line constantly throughout the NPO singing it at any time – inappropriately. Anna appeared to be unaware, however, and Joe seemed to ignore it. Safety was an issue with unsafe practices observed, brakes off on bed, one CW lifting and not using slippery sam. The number of different people and the public nature of the environment was evident in that there must have been about 10-12 different people over a 2 hour observation that simply walked into Anna and Irene’s room. The mechanistic care that occurred and there were ‘missing’ practices namely oral hygiene, grooming, massage, and exercises. Anna was left to rest with TV blaring, lights on, doors open, and curtains open with many further noisy interruptions. (De Bellis 2001-2005)

Ruby

After this observation I felt that Ruby was more cognitively aware than her husband Ben or staff thought or responded to. Ruby would make sounds like a verbal yawning. This was interpreted by me as clearing her throat after having something to eat or drink; however, this was interpreted by Ben as Ruby being tired or laughing and by staff as resistance. The noise in Ruby's environment was extreme and constant. In the corridor, cupboards were opening and closing, conversations occurring, trolleys going past, and the PA came on once. Whilst the staff were attending to Ruby after lunch, when Ruby sounded an 'oooh' on them moving her, both CWs laughed at this, and one CW had the following statement to Ruby 'I will have to smack you' and later when Ruby moaned one CW said 'Come on Ruby, I'm going to have to tell on you to Ben' and at the same time called her 'sweetie' throughout - infantilisation. The amount of time for hygiene and turning was a matter of 3-4 minutes – only incontinence was checked and she was repositioned – no hygiene to face and hands, no oral hygiene, and no exercises. It was very short and very mechanical. Ben during the meal generally ignored Ruby's verbals but then again didn't, just responded as someone would have a conversation with a person who was not responding. When lunch and care was completed Ruby appeared to sleep despite the noises all around. There was no TV in the room. The door was left open and curtains were open when Ruby was left and she appeared to sleep. (De Bellis 2001-2005)

Cynthia

The mother and visitors very much involved in Cynthia's meal. There was unsafe practice by care workers and the whole nursing care took less than 10 minutes and was very mechanistic and difficult for the CWs. No exercises, no massage, no oral hygiene, or appropriate positioning. How RN did not return during the hygiene and turning of Cynthia to check the rash on Cynthia's right leg as she had promised the mother in discussion during the NPO. Cynthia's needs were not really taken into account by anyone except her mother who was very attentive to her and what was needed. Cynthia needed one on one help with her meal that took about 30 minutes. Also Cynthia's hair washing had to wait another week after five weeks of it not being washed and Betty stated it was beginning to smell and was asking staff to please wash her hair. Little autonomy allowed by staff eg a domestic entered the room and asked if it was alright if she took the chair and had left the room with the chair by the time Cynthia had responded with a clear and loud 'no'. Cynthia later complained to her mother about this as Betty was not present at the time. People made the decisions for Cynthia when the mother was not there. How aware Cynthia was of everything that was going on – she knew what was happening and what conversations were going on but chose to ignore questions or not respond. How her mother totally and consistently advocated for Cynthia. Safety an issue in that the brakes were not on and bedrails not up when they were attending to Cynthia's hygiene and she nearly rolled out of the bed onto me. Cynthia had five visitors at one stage including the

mother (mother's friends) and these visitors were largely ignored by Cynthia who watched TV. Everyone else did all the talking. During the NPO, I dropped my pen and on the way up from picking it up, hit my head on the bedrail and Cynthia immediately turned her head to me and said 'are you alright?' She knew what was going on. She was concerned for me and at one stage she asked her mum if I was still there. I was sitting very close to her but behind her at the head of the bed between the bed and the wall. The corridor was noisy, lots of conversations. Cynthia had the TV on the whole time and was watching it mostly (despite all the visitors). Cynthia ignored their conversations and questions and focused on the television. She was left to sleep with light on, glasses on, curtains closed, and television blaring but because of her positioning -not being able to see it if she wanted to – she gave up trying and appeared to go to sleep for the remainder of NPO. The mother kept a visitor's book for Cynthia. (De Bellis 2001-2005)

Appendix 2 - The Analysis Outline

Level 1 Analysis

The initial analysis involved the reading, conceptualization, and notation of all the transcripts, fieldnotes, and documentation and resulted in the following beginning general themes:

Rhetoric vs Reality Constant Noise Non-autonomy Advocacy Perceptions of Cognition Time Factors, Haste, Tight Ship Safety Aspects Task Orientation Agency Staff Nutrition Baby Talk
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Sleeping Programs, Programs, Programs Embodiment – Trapped No Complaints Have to come in every day! RN Inquiry, CW Task Out of touch Vocal tones – cognition Cheating

Levels 2-4 Analyses

These steps involved the analysis of the sample units as three separate data sets each with five subdata sets. This commenced with the interview transcripts from the RN, CW, and relative regarding each resident's nursing care followed by the incorporation of the NPO field notes and then the documentation. On completion the following themes were in evidence for each of the residents.

Level 4 Themes

Anna	Ruby	Cynthia
Documentation Issues Unsafe Practices Ignorance Ethical/Professional Autonomy and Advocacy Advance Directives Communication and Behaviours Sleeping and Noise Mechanistic Care and Time Poor Agency Staff Relative Doing Care Need to Come in Every Day Nutrition/Meals Skin Care/Hygiene/Non-documentation Continence Program Sham Contractures, Physio, and ROM Exercises Infections Religion/Spirituality	Standard Of Care/Unsafe Practices Caregiver Burden/Responsibility Ignorance/Unethical Practices Documentation Relating Care and Behaviours to Funding Agency/Staffing Autonomy vs Resistance / Aphasia Advance Directives Spirituality/Cognizance /Relationships RN Reliance on CWs Rush Incontinence Issues/Hygiene/Skin Integrity Activity and Exercise/Sleeping Stimulation Nutrition/Hydration Safety Issues, Medication Issues	Ignorance Dangerous/Unsafe Practices Exaggeration of Needs/Non-Recognition of Needs Contradictions in NPO Autonomy Advocacy by Relatives Contradictions/Issues with Documentation Differing Perceptions of Needs Not Enough Time CW Reliance On RNs/RN Reliance on Relatives and CWs Need to come in Things Going Missing Language

Levels 5-6 Analyses

These levels involved conceptualising the sample units into common themes that encompassed all the data subsets of each resident. This involved recoding into the commonalities between the sample units and there were very few differences when conceptualised under the following overriding themes evidenced across all units of analysis.

Level 5 Themes

Resident's likes and dislikes
Inappropriate dementia care
Residents defined by eating habits
Relatives as advocates
Relationships - relatives, staff and residents
Things going missing
Language/communication of staff and residents
CW reliance on RNs, RN reliance on CW, staff reliance on relative
Contradictions between all discourses
Misunderstanding of dementia progression and cancer
Exaggeration of needs
Agency Staff
Documentation out of date and poor standard
Advanced directives
Noise
Sleeping of residents
Relative burden/relative doing care
Need to come in everyday/checking by relative
Continence program problem

ROM passive limb exercises
Skin care/rashes/incontinence pads
Relative struggles
Religious/spiritual issues
CWs judgemental, unethical, denigrating
RNs ignorant/unsafe/scribes
Medication issues/Doctor issues
Nutritional issues
Differences between data sets on nursing care provision
Contradictions in perceived needs
Similarities in the perceived needs between three residents
Unsafe practices observed
Documentation – cheating, fraud, out of date
Exaggerations of time involved and frequency of care
Choice and autonomy
CWs ignorance, education, or misinterpretation
CW's reliance on RN and relatives
RN's reliance on CWs and relative

Level 6 Themes

When a minute is a half hour
When safe is unsafe
When a home is not homelike
When ethical responsibilities are not ethical
When autonomy is not autonomy
When funding drives the rhetoric
When practices and documentation are unprofessional, illegal and fraudulent
When you need to come in - vigilance
When there is increased carer burden and need for advocacy
When continence management systems are a sham

Levels 7-10 Analyses

These final levels in the analysis focused on refining the previous themes through continual deconstruction, construction, and reconstruction until all the data could be explained under one of seven primary themes that related to the nursing care for each resident.

Level 8 Themes

When a minute is a half an hour
When safe is unsafe
When a home is not homelike
When ethical responsibilities are not ethical combined with when autonomy is not autonomy
When funding drives the rhetoric combined with when practices and documentation are unprofessional, illegal, and fraudulent
When you need to come in / vigilance / carer burden / advocacy / when the RN and doctor do not know
When continence management systems are a sham

Level 10 Final Themes

- Indecent Haste - When a Minute is a Half an Hour
- A Risky Existence - When Safe is Unsafe
- A Documentation Quagmire - When Funding Drives Discourse
- Under the Sheets - When Incontinence Becomes Normalised
- Misdirected Stimulation - When a Home is Not Homelike
- Non-Autonomy - When Practices are Unethical
- Vigilance and Advocacy – When You Have to be There

Appendix 3 - The Development of Cynthia's DVT

Documentation extracts from Cynthia's progress notes in relation to the development of a deep vein thrombosis and inappropriate assessment.

DOC: Cynthia complained of ® foot pain. Treatment was flexion and Panadol. (PN p40 29th Dec) Again Cynthia complained of leg pain (PN 31st Dec). Documented that Cynthia had ® foot pain and treatment was repositioning and elevation. (PN 5th Jan) The next day it was stated that Cynthia was hard to settle and was treated with Panadol and that Cynthia rested in bed for the day. (PN 6th Jan) The doctor visited but it was documented he was in a rush and was in to review drug charts and no mention was made of ® leg and foot pain. (PN p43 10th Jan) A week later it was documented that Cynthia was complaining of pain in legs and general discomfort for which the treatment was Panadol. (PN p47 15th 16th Jan)

The following night again it was documented that Cynthia had general discomfort and was given Panadol. (PN p47 16th 17th Jan) The next day the physio assistant noted that Cynthia's ® foot was abducted and a sandbag had been placed (Cynthia's mother stated that Cynthia did not like this). (PN p48 18th Jan) Three days later it was documented that Cynthia was crying in pain when placed on a bedpan and treatment was positioning onto ® side. (PN p49 21st Jan) Later it was documented that Cynthia was offered an exercise program twice weekly but that she often refused especially when she became bed bound. In this program Cynthia's arms are exercised but not her legs (PN p55 25th Jan) Again Cynthia was described as unsettled and treated with Panadol. (PN 4th 5th Feb) And the next day Cynthia again had leg pain and was treated with Panadol. (PN 5th Feb) A DVT was diagnosed on 9th March 01 after consistent complaints of ® leg pain. (MN p7 9th March) (Data Doc Cynthia p25)

Appendix 4 - Cynthia's UTI

Extracts from Cynthia's documentation relating to the development of an ascending urinary tract infection caused by the indwelling catheter remaining in situ and no antibiotic treatment prescribed.

DOC: Haematuria and pathology report (19th 20th Nov) re catheter induced UTI. Doctor doubts effectiveness of AB treatment because IDC in situ and Cynthia would be reviewed if developed a temperature. (MN p3) The nursing notes describe Cynthia having pain, fever and concentrated urine - the pain is not described and no temperature was taken. (PN p32 9th Dec) The next day it is written that Cynthia has a UTI and she was 'told' to drink more water. The next day staff perceived Cynthia has having a behaviour problem. (PN p33) The following day the urine is described as offensive, thick, and cloudy and it was stated that clear fluids were encouraged – no other treatment and doctor not called. Cynthia has been incontinent of faeces during this time.

Twelve days after the fever, the IDC starts leaking and was simply repositioned. (PN p34-5 21st Dec) Cynthia complained of pubic pain and feeling sick. Her pulse was 100 (up from baseline) and her BP was 130/80 (up from baseline) – nothing was done. No temperature was taken or recorded. (PN p37 21st Dec) The IDC again was leaking and the catheter bag was changed only. Cynthia at the time was complaining of back and abdominal pain and it was stated Cynthia was feeling unwell. (PN p37 21st Dec). It was stated the IDC was draining well. (PN 22nd Dec 00) Haematuria was again noted. (PN 27th Dec) Cynthia complained of middle back pain. (PN 27th 28th Dec). Notes state IDC blocked and leaking and a new IDC was inserted with the notes reading 'she has been incontinent of urine long before catheter replacement' (PN p40 28th Dec). As if justifying use of IDC. A locum visiting Cynthia stated that Cynthia wanted the IDC out as it was distressing her – nothing however was done. (MO p6 24th Dec) One week later the locum stated that the IDC had been removed but there is no mention of this in the progress notes. The doctor stated that the IDC was to be left out but would review re-inserting because of what could be described as staff pushing for recatheterisation because of incontinence and difficulty. Cynthia was also complaining of back pain. (PN p41 31st Dec)

The progress notes stated that faeces had been found in Cynthia's 'vulval area despite BO 24 hours ago' - implying in documentation poor hygiene. (PN p41 1st Jan) 1/1-1400 feaces found in vulva area even though Resident has not had BO since AM 31/12! Vulva wash given resident resting in c/chair this am tegaderm applied to ® breastfold. ® axilla needed extra care white odourous crusty substance found. Monitor for breakdown. (PN p42-3 1st Jan) The progress notes then state that Cynthia was wet between the legs but the IDC was draining well. A statement that Cynthia was also confused. (PN p41 2nd Jan) The IDC has either been reinserted or was never removed but nothing documented. The next day it was reported that there was nil leakage from the IDC (PN p42 3rd Jan) The following day it was stated that there was nil urine in the catheter bag and there was leakage onto the Kylie. On night duty the IDC was re-inserted. (PN p42 4th 5th Jan).

One week later it was noted that there was blood in Cynthia's bed and around the IDC tubing and that the RN was notified. No assessment was documented. On night duty it was stated that blood was found on sheet and vaginal area and it was determined that Cynthia was menstruating. It was stated that the IDC had drained 1500mls but not the period of drainage. (PN p44 11th 12th Jan). It was stated a day later that urine output was 250mls and it was very concentrated and offensive. No further assessment or contact with doctor performed. (PN p45 13th Jan) The doctor was contacted about medications being written up but nothing of UTI or IDC. Cynthia was incontinent of faeces. (PN p45 14th Jan) The following day it was stated that Cynthia's urine was dark and concentrated and a flush was unsuccessful. It was stated that the IDC was changed by RN and was draining clear urine. (PN p46-7 15th Jan). Cynthia was complaining of pain in her lower abdomen (PN p47 15th Jan)

Progress notes stated clear fluids were encouraged for chronic UTI. (PN 19th Jan) Cynthia was crying in pain when on pan to have her bowels open. Later the IDC was changed as it was not draining properly. A 14G Foley was used (16G previously) and it was stated that it was draining clearer urine. (PN p49-50 21st Jan) Soon after it was documented that the IDC was leaking. The documentation was all about keeping the two Slippery Sams clean. (PN p50 21st Jan). 21/1 2250 x2 slippery sams removed from residents bed due to contamination from above leaking IDC. Slippery Sams washed hanging in bathroom. When replacing back on residents bed please place s/sams under AC as to prevent soiling and contamination thank you. (PN p50 21st Jan) The next day Cynthia was being encouraged to drink clear fluids. (PN p50 22nd Jan 01) Cynthia complained of lower abdominal discomfort and the IDC drained 400 mls of very concentrated urine. (PN p51 23rd Jan) Cynthia complained of pain in the pubic area. IDC not draining and IDC removed and MSSU collected.

Night RN made request to RN on morning to ask doctor for PRN Valium 5mgs order. No assessment documented. Implies behavioural problem with Cynthia. (PN p52-3 24th Jan) Doctor requested removal of IDC. (MO p6 24th Jan) Documentation that Cynthia was incontinent of urine. Separate documentation that doctor contacted re IDC removal and PRN Valium. Documentation that RN told by surgery to ring back on Saturday as doctor was not available. (PN p53-4 25th Jan) Six days later the doctor came. Meanwhile the statement made that IDC was not re-inserted due to doctor's and family wishes, a continence advisor was contacted to determine the insertion or non-insertion of IDC. Cynthia was put on a continence program but it is not documented anywhere what this program was. Separate documentation states incontinent of faeces and fluid intake good. Incontinent and 'saturated'. Cynthia's monthly observations were taken. This did not include a urinalysis or her temperature. P78 BP100/80 - only one entry (Monthly Observation Chart 25th Jan 01; PN p55-6 25th Jan) The next day the documentation stated that the doctor had been contacted re the catheter and the doctor was going to talk to mother re IDC re-insertion. (PN p56 26th Jan 01) No further entries except to state that Cynthia was incontinent of urine and faeces. (PN p57)

Cynthia complained of pain in her lower back and it is stated to leave IDC out. (PN p59 31st Jan) Doctor visits and states IDC removed and that Cynthia looked

flushed and cushoidoid. Doctor wrote monitor skin integrity (MO p6 31st Jan) Cynthia was feeling tired according to documentation. (PN p62 2nd Feb) No further documentation on IDC or UTI. No MSSU results in records, however, was not commenced on any therapy other than final removal of IDC because of family wishes (over two months following pathology result). Also dependent oedema noted way back on 24th Dec. Also throughout December and January Cynthia had a large urinary output according to measurements made and then it was three ticks a shift when IDC removed and she was incontinent. No incontinence program documented or commented upon. (Data PN Doc Cynthia pp25-7)

Appendix 5 - (Non-)Management of Cynthia's Rashes, Pain, and Positioning

Documentation extracts about Cynthia's development of her various rashes, pain management, and positioning problems.

DOC: Throughout progress notes it was documented that Cynthia had various rashes most notably on her sacrum, ® armpit, and breasts. Various creams were being used and often were not stated and if stated varied as to what they were. The resident care plan stated that moisturiser could be used on Cynthia's skin. In January Cynthia's integument began to break down (this is also the time in which she had a catheter induced UTI and following its removal - incontinence, and was also developing a DVT). On 1st Jan it was documented that: tegaderm applied to ® breastfold. ® axilla needed extra care white odourous crusty substance found. Monitor for breakdown. (PN p42-3 1st Jan). No further documentation for a week. Symptoms indicate thrush and Tegaderm would make this worse. A break was documented on Cynthia's buttocks and the treatment was to keep Cynthia off her back. It was also stating the Cynthia was 'refusing often' to be repositioned. (PN 5th Jan) Cynthia could not watch TV nor eat when she was on her side, therefore preferred to be on her back. About a week later it was documented that there was a reddened area under her ® armpit. The RN was notified but there was no further documentation of any assessment by the RN and nothing was documented in the Resident Care Plan (PN p44 11th Jan) Again it was documented that Cynthia had a break on her sacrum and that cream had been applied. No statement as to what cream. (PN 46 14th Jan)

Two days later it was documented that the doctor had been contacted re skin integrity and also that Cynthia was refusing turns as she liked to be on her back. (PN p47 16th Jan) Two days later the physio assistant documented that sitting and balance exercises had been attempted but it was too painful in the sacral area for Cynthia and they were abandoned. (PN p48 18th Jan) Two days later it was again documented that Cynthia was refusing turns and was on her back to watch TV. (PN p49 20th Jan) Three days later the progress notes stated again that Cynthia's breast and axilla were excoriated and calamine had been applied as well as Ungvita. (PN 23rd Jan) Nothing was written in resident care plan. Again it was documented that Cynthia was RIB and lying on her back mostly but also side to side. A combine had been placed under her ® armpit as it was slightly red. (PN p57 27th Jan)

Then a special wave mattress was trialled that could be rented with an option to buy - \$100 per week. (PN p58 30th Jan) The mother must have decided to have this because Cynthia kept the wave mattress and PAC went to six hourly. On this day it was written in the progress notes (but not on the resident care plan) that Cynthia was to not have soap and water washes but was to have Triple Care Cleanser and Cream. (Product Driven) (PN 31st Jan) The doctor finally visited fifteen days after being contacted and wrote that the IDC was to remain out and Cynthia's skin integrity was to be monitored. (PN 31st Jan) The next day it was stated that the mattress was on and Cynthia was requesting to be on her back. It

was stated that Cynthia's skin was in tact and barrier cream had been applied (PN 1st Feb) The following day it was documented that Cynthia would have six hourly turns but this was not documented in the resident care plan which still had her being transferred into a comfy chair and having a mobile bath. (PN p62 2nd Feb) Sacral skin was stated as being in tack but that it was red under Cynthia's breast and Prantal had been applied. There was also a reddened area in Cynthia's (L) groin and ungvita had been applied. (PN p62-3 2nd Feb) Cynthia throughout requesting to be on her back. It was documented that Cynthia's sacral area had improved despite the last entry that skin was in tact (PN p63 5th Feb). (Data PN Doc Cynthia 27-8)

Appendix 6 - Examples from Cynthia's Documentation

Excerpts from Cynthia's progress notes entered by CWs in the main but countersigned by RNs. All spelling, grammar, and use of capital letters are as was written.

8-12 Yesterday I visited Cynthia at 0930hrs and asked her if she would participate in her theraband exercises, she gave eye contact but would not answer me instead watching television and picking up her magazine, I repeated myself again and she looked at me & sighed, I said if she did not feel up to it we could try again tomorrow, she looked at me then looked away still not responding verbally, later on the physio (name) suggested we could get Cynthia to do her sit/balance exercises she spoke to Cynthia who agreed she would, she was waiting for her hygiene care before the exercises but staff could not meet our time frame for the appointment, Cynthia's mother was not happy that Cynthia did not receive these exercises and (name) explained why, her mother wants Cynthia washed & ready in bed for next Thursday for these exercises. Signed by CW who was physio aide and countersigned RN. (Data DOC Cynthia PN pp30-31)

10/12 2130 Resident refused to go to bed this pm as bed is still broken. RN ... gave permission to swap bed with another resident. Resident gone to bed at 2030 and settled well. Signed by CW and countersigned by RN.

11/12 Resident up in a comfort chair today and in a pleasant mood. Residents mood changed when staffx3 was attending to her and resident ignored staff when being spoken too, rolling her eyes and raising her eyebrows, and speaking abruptly. Signed by CW and countersigned by RN. (Data DOC Cynthia PN pp32-33)

20-12 N/NOTE: 2200: HAS BEEN EXPRESSING CONCERN OVER EVENING MEDICATIONS. ESP. 2100 DOSES. EXPLAINED TABS WITH AID OF MIMS ANNUAL BUT LATER TABS WERE STILL NOT TAKEN AND RESIDENT WAS GIVING NO DEFINITE ANSWER ABOUT TAKING TABS. Signed by an Agency RN. (Data DOC Cynthia PN p36)

1/1 1400 feaces found in vulva area even though Resident has not had BO since AM 31/12! Vulva wash given resident. (Data DOC Cynthia PN p41)

1/02 Resident was turned on her back because she was very demanding saying she was very uncomfortable so we turn her on her back although the memo says 4 hourly. Signed by EN and countersigned by RN. (Data DOC Cynthia PN p59)

6/2 1400 Resident has been nursed on side some of this shift. Unable to move mattress (has slid of onto one side) as it was too heavy to move. R/N notified. Signed by CW and countersigned by RN (Data DOC Cynthia PN p63)

19-01 3) mood swings – she can be very demanding eg wanting bed pan 4-5 times per shift – extra time spent by 2-3 staff for toileting. 4) RNs spend approx 5-10 mins with her whilst she takes medication ... very slow and patient process. (Data DOC Cynthia Monthly Summary p1)

Appendix 7 - The Continence Management System

CONTINENCE MANAGEMENT SYSTEM

- ♦ Check resident's care plans for individual care. They will be updated from time to time.
- * Check the pad you are placing on a resident is the correct pad as indicated on the DAY / NIGHT card in the wardrobe
- ♦ **DON'T** borrow pads from other residents
- ♦ Communicate with staff between shifts i.e. inform oncoming staff which resident requires attention first.
- * Check wetness indicators before removing pads. Pads are to be used to their full capacity in most instances to be cost - effective. The exception is day pads are to be removed by 10:30pm regardless.
- ♦ Use fix stretch pants with the comfort pads to obtain maximum benefit. If stretch pants are not tolerated by resident, firm fitting underpants may be used.
- ♦ Have the seam on the outside of the fix pants and the legs of the pants pulled right up into the groin to prevent skin marking and to act as a seal for the pads.
- ♦ Leave the pad on the resident when putting them back to bed in the afternoon or evening and remove only when wetness indicator is invisible.
- * **DON'T** put on night pads until at least 8:00pm. There are exceptions to this i.e. if a resident has a behavioural problem then the pad can be applied when settling.
- * Have all night pads on by 10:30pm
- ♦ **DON'T** leave day pads on after 10:30pm as this will lead to resident's requiring a bed change in the middle of the night and consequently their sleep is disturbed.
- ♦ Notify the RN in charge if a resident is consistently wet despite wearing a pad. They may need to be reassessed for a more absorbent pad.
- ♦ Update the stickers on the DAY / NIGHT cards in the wardrobes and the master list in the Continence File if pads are changed.
- ♦ DO toilet residents as per their care plans
- ♦ Changes to pads are only to be made by an RN.
- ♦ If pads are removed on the 5:00am round they must be replaced with a day pad and the day staff to be notified. Day staff will then leave these residents until later in the morning and attend those with expired pads first.
- * Night pads only need to be removed on 5:00am round if they are unlikely to keep the resident dry until they are next attended.

- * If a pad is taken from the cupboard, note this on an 'Additional Pads' form.
- * Night staff must check they are giving the right pad to the right resident. Use resident list and check DAY / NIGHT cards when distributing. In particular make sure the resident has the right size and colour pad.
- * Nappy liners may be used if a resident has had suppositories or is experiencing faecal smearing.
- * DO make sure pads are applied correctly. The plastic backing on the pads may cause skin redness or blisters if it comes in contact with the skin.
- * DON'T use creams and talcs if at all possible with the pads. These interfere with the absorption of the urine.
- * DO have two staff apply the slip product. This ensures the product is put in correctly without any unnecessary manual handling and help is at hand if a resident becomes difficult.
- * Please dispose of the pad as per Nursing Home policy.
- * Nighties and Pyjamas can be worn over the night pads.
- * REMEMBER: THE AIM OF THE SYSTEM IS TO ENSURE THE COMFORT AND DIGNITY OF THE RESIDENTS BY KEEPING THEM DRY ALL OF THE TIME.

Appendix 8 - Discourses on Ruby's Incontinence and Rashes

Differing perceptions from the transcripts of the interviews with an RN, CW, and Ben where each described Ruby's bowel management, rashes, and incontinence issues.

CW: She's on a, yeah she's on an incontinence program and we have a (name) link nurse here that they have the pad audits regularly to see what type of pads they need. What type of, what their incontinence is and what type of pad and that's all done and that's all changed throughout the day. The all in one pad. They're in 24 hour pads here. And Ruby's a 24 hour pad and she has them in her top drawer. She has the day pads, the green all in one on days, and like white at night. And they're checked throughout the day, that's with the indicator strip which is returned back to bed. The pad's always checked. They've got a pad chart in their room so we know exactly what time the pad went on and we can look at the capacity to see whether it can stay on longer but usually a pad's not left on for more than 8 hours. If for some reason, because of an UTI or they're urinating more then it gets changed more frequently. We look at the indicator strip, you look at what time it's been on, whether we change it there or then.

Yep every third day suppositories um because of her immobility and we don't get her up because of her poor balance and the structure of her limbs now. One of, like her right leg and hip turned in, so we don't sit her out on the commode but every third day she'll have suppositories for bowel management. For bowel management, every third day. And there's a little bit of oozing and cleaning up afterwards but you know we have a bluey placed under her and she's cleaned up - with the bulk of it's gone - there's still a little bit of oozing afterwards, so a bluey sheet's put under her and she remains in bed the day she has suppositories, we can't have her up in a comfort chair, when she's a full lifter and trying to you know manage her bowels, so we have her in bed on those days, every third day. And suppositories given, cleaned up and then checked throughout the shift. Blueys placed underneath her and her skin integrity attended to. You know, washed down below and creams, ungvita ointment applied so she doesn't get a reddened area, and turned frequently. She's on a turn chart. (Data CW Ruby p113)

Ben: Rashes. Well, not that I can recall, you know, she may have, may have, but I think occasionally she gets chaffing down below, you know, but I think that's probably through pads and that sort of thing. She always wears those now. (Data Rel Ruby p114)

RN: Yes, she gets constipated, mostly due to immobility and the fact that she's got a vitamised diet. There's a regime that seems to work with her where the third night that she hasn't used her bowels, we give her a senekot drink, and then that will soften it enough for suppositories not the next morning but the one after, and that seems to work. It's a very regimented regime, however, it works. Intractably incontinent and she wears an all in one slip maxi - she's a wide one. We check

them every 3 hours but generally the pad the care lies between 6 and 8 hours, and they'll change her when it's necessary. Yeah, they change her first thing in the morning when they wash her and then if she's up she'll be in until half past one 2 o'clock, even half past two, and then they'll change her when they put her back to bed as needed and another change around 10 o'clock that night. (Data RN Ruby p161-2)

Appendix 9 - A CW's Discourse on Ruby's Stimulation, Sleep, and Rest

Transcripts of a CW's discourse about Ruby in relation to her stimulation, sleep, and rest.

CW: Well, that's it - rest. I mean, yeah, there's not much else happening for her. You're going to tend to sleep a lot in the comfort chair. I mean we do, we played, when Ruby's up in the comfort chair and they're in the lounge, we'll either have music on. We have some really nice CD music. You know a variety of music to cater for everyone. And there's usually always music playing. If the music's not playing we have the television on in the morning. Some like to sit and watch Ben Newton show in the morning. So, but we'll always position Ruby where she can at least, if her eyes are open and she's facing the television, at least she's getting some stimulation (sic) in the room. That something's moving, to you know to get her attention, but yeah, her sleep needs. I don't do afternoon shifts but I would imagine she sleeps. I don't hear of any problem of her not sleeping well because you don't really hear her singing out or moaning or anything like that. She's a very quiet person, Ruby, and when she's in bed, most of the time, yeah she would be asleep.

Yeah. And she has her radio in her room and you know a lot of the times we have that on just gently to a nice station for her as well. So while she's in her room, until she's ready to get up for the morning, you know, she's got a radio on and sometimes it might be a talkback show or something, but at least she's getting something there. It's not just nothing all the time and you know, there's always music and something for her to listen to. Yeah.

Oh yeah if there's things like radio, TV yeah, we have like pet therapy. There's a, I don't know what the name of the place is, but they come in every so often and they have pets and these people bring in their, it's like a little farm, like a little nursery, see. It's a place that goes around to different schools, kindergartens, you know nursing homes and they bring in animals. Anything like that, Ruby in the comfort chair will get wheeled out to the courtyard and she might have rabbit or a guinea pig or a cat or something on her lap that they'll place for her to feel and touch. If there's any children come in, which we had last week, we had children from (Name) Primary School come in and they were doing singing in the lounges. So we got everybody that was in comfort chairs and wheeled them down to central and west lounges and the school children. So any activity or group of people that come in, those that are up and out of bed get wheeled down to that lounge area so she can see and hear the children. So we had that last week. Yeah her eyes are open. It just depends, it depends really. You don't really know how much, when I think of Ruby, how much she's taking in but she responds to, she'll respond to music and she'll know if somebody's in the room, you so she'll visualise, she can visualise, and she'll know that somebody's there cause her eyes can follow you around the bed and with touch, she responds to touch. So, if there's you know somebody's come in and we're talking, we touch her arm. She will respond, sometimes she makes a noise, and her eyes will look at you and flicker, or she'll

make a noise. And so she'll know that we're there. Yeah. And she's know if there is, you know, to touch, she'd know if you had an animal on her lap, she may not, it's hard to say she knows it's an animal but she knows something's there. Because you'll get a response from her and she's looking around, her eyes are open, she's looking around, she knows that somebody's there. She does make a noise. She doesn't say words, but you know she'll make a noise, she'll make a little moaning noise, so yeah. (Data CW Ruby pp57-8)

She's, she doesn't comprehend like I said. I mean you don't, you'll never know what's going on. I can't say what's going on inside Ruby's head. Not unless she had a brain scan or a cat scan, to say what's there but, like I said, we do our best for her, we look out, in looking after her and we include her in as much as we can and we look after her needs, and like I said again, you know, if she were to say well what are her needs, what if she, but who knows. You know. But we talk to her, she's in the lounge with other people, there's music playing, there's staff coming in and out all the time, so she's not just like left in her room like they did years ago. So she gets stimulation, like I said, she's in the lounge room, she's got staff coming in and out, and there's always something during the days are very busy in a nursing home. While she's up in the comfort chair, she's out of her room, she's got music on or if the music's not on the TV programs on. She's always faced where she can see it, um, people going in and out, people you know giving her drinks during the day, she has her morning tea, then she has her lunch and so, you know I think by the afternoon, she probably looks forward to maybe when she's back in bed and it's a different position again from sitting up in the comfort chair, where you can't sort of move around a lot. You know, she's got a limited, like I said, so. She probably looks forward to when she does go back into bed and she's lying down flat, and a bit of quiet time, you know. (Data CW Ruby p109)

Appendix 10 - Discourses about Cynthia's Stimulation

Interview transcripts from a CW, RN, the mother, and reflection on the perspectives of getting a computer for Cynthia, her stimulation, an expectation she should be normal, and the attempt to transfer Cynthia to another institution.

CW: Oh lot of things frustrate me, I mean, the frustration is her being in a nursing home for a start. I don't, personally I don't believe that she should be here. I think she needs to be in a place where they have people her own age and they have social activities that are for her. Yeah to just be around younger people really - that's what she needs, I think a nursing home will never really meet the needs that she needs. I mean she's sharing a room with an elderly lady. I mean, to me, I would absolutely hate that. It's just, it's pretty depressing I think. Yeah, if it was up to me I'd you know, I'd want her to do lots and it's just really sad to see that. Yeah and it would be really good, like to have the family to see that, but I believe that they're in a lot of denial and they're finding it very hard themselves to sort of cope with the situation. If you have a child like that, well she's not a child, a lady like that I mean it would be pretty hard to cope with. So you know it would good - like I know that the Chaplain's had a talk with her mum, I mean, there's been times where I've spoken to her and she's just put her arms around me and cried, you know, and then I've just called in the Chaplain. Her mum yeah. I can't remember her mother's name. But yeah. (Data CW Cynthia p62)

CW: But she doesn't really have anything at all to stimulate her, and that's really sad. We have tried to discuss it with the family to maybe bring a computer in for her because she use to work for the ... and she was very clever on the computer, so we have suggested about having a computer and maybe having an internet on there and she can communicate with people like herself, in the same situation, and talk to people and maybe play games, I mean, the stuff they have on computers these days you can do anything really. She could use it, I believe so yes. She might need a little bit of training but I don't think it would take her long. I mean she can still move her hands and her fingers, she might be a bit slow at it but there's other ways that she can be helped, I mean, they have a lot of different things today that can help her. Like she could hold something in her mouth if she needed to press buttons and stuff like that. But that would be really good for her. The only thing she does is watches TV and maybe do some crosswords on her magazines. And if she can do crosswords on her magazine and hold a pen she could press buttons on a keyboard.

Well, I think due to family mainly - they tend to think that if they have a computer in it will upset Cynthia because she can't do what she used to do before, so they feel that it will upset her more than do her good and they just, they don't want to upset her in anyway type of thing, but it's actually doing the opposite. She's not getting anything, all she's getting is the TV and that's it really. It's not really stimulating her mind, at all. I mean you find, you see a lot of quadraplegics and para and you know like people with those sort of illnesses that there are sports days and you know they do all sorts of things like that. It just depends on what kind of stimulation they're getting. I mean I know that she tends to be spoilt a lot.

Yeah so it's really hard. It's hard for us because there's so many things that we'd like to do for her and it's sad for me because if I was in that situation I'd want to be doing things. And I think that just makes them deteriorate more when they haven't got anything. I mean the elderly here do more than what Cynthia does. They go to the community centre and doing a lot of things. She's just stuck in her room - day after day, laying on her back, doing nothing. (Data CW Cynthia p60)

RN: She needs companions her own age for starters and she needs something constructive to do. At the moment she spends most of her time watching television or occasionally you'll see her doing a crossword in a magazine, which is OK for leisure time but at her age most people are either working or they've got a family, or they've got some purpose in life but Cynthia doesn't have one at the moment. Her only purpose is to stay alive - at the moment. Basically I'd be happier to see Cynthia with younger people, someone or people who could stimulate you. She's stagnating here. She's a bright girl with a lot of potential and although her life is likely be limited due to this brain tumour, there's a lot more she can get out of life than what we can give her. I mean, we're geared here for elderly people who don't want to do a lot, they've done a lot in their lives, and they've had enough and just want to rest and someone to take care of them with a bit of fun to keep them going. Whereas Cynthia needs more stimulation - basically she's just a young woman whose really been neglected, is how it feels, because she's just doesn't have the stimulation. I mean we can give her the physical comforts, keep her body nourished and her skin in good condition but what we can't seem to do is stimulate her brain... No, I mean we love having her, we love her dearly but it's not the best place for her, the best place for her is where there's young people and they can give her things to do, she needs to do something for herself. Like even if it's um learning a course on a computer - something that will give her a purpose in life other than just waiting to die - waiting for the next seizure. (Data RN Cynthia p61)

According to the documentation, a senior social worker supported Cynthia not being transferred to another institution because of her need to be with her family and in close proximity to allow visiting by her mother everyday, however, the physiotherapist stated another institution would be the best place for Cynthia. In the documentation there were notes concerning the doctor, RN, and CN who had had a meeting one day and decided that Cynthia needed to be referred to another institution, and it was stated that this was 'not likely to be accepted by family'. The clinical nurse manager contacted the institution for help with equipment but no equipment was available. Two weeks later the institution's Liaison visited Cynthia and I presume nursing staff, and Cynthia was referred to two programs. Nothing further was documented re these programs. In the same meeting of the doctor, RN, and CN it was decided that a laptop would be good for Cynthia (no consultation with family or Cynthia). (Data PN Doc Cynthia p63)

Rel: But they may not continue either, I mean, who knows what's coming down the track. Yes. Cynthia's often asked me 'can I get a room of my own' because sometimes when (name) comes in of a night time to go to bed, Cynthia still wants to watch tele but because (name) in there, she feels that she can't do that, because she doesn't want to upset (name) and keep her awake. But when we first bought Cynthia here, because of her age, (name) in admin said that as soon as there was

an available single room, that they would put Cynthia in it. Whether that will happen or not, I don't know, but it would need to be down West anyhow because I don't really think, down East would be very good because they're all dementia patients and stuff like that and they scream of a night time and I don't really think she'd like that. So yeah, but you've got to wait, and it could be years couldn't it? Yes so. (Cynthia did get a private room). I mean even though a few people have passed away since Cynthia's been in here, they've all been in double rooms so that didn't help at all. Not that you want see anyone pass away just so she can have room, but that would nice I think, because Cynthia's a bit of a loner. She's always enjoyed her own company, even when she lived home, she would be, most of the time she would be out in her two rooms and every now and again she'd come inside like to get her lunch or just to say 'what are doing' and when she knew what I was doing, she would just go back out again. Play with her computers, you see, she used to love her computer. Well I don't think she can even do that now, no. So yeah. (Data Rel Cynthia p63)

Appendix 11 - A CW's Ethical Discourse about Ruby

Excerpt from the interview with a CW when questioned about what she would do in the event of Ruby's deterioration or death, if Ruby aspirated or was choking, and Ruby's advance directives.

CW: I don't think she's (Ruby) for resuscitation. No. I would, well the first I would have to do is to go down and I'd find the RN. I'd find the RN but it's a fine line because a lot of us, the RNs, unless they're down for resuscitation, we don't resuscitate. We don't resuscitate. Yeah. It's not a dilemma. No it's not, because you know, yeah. Yes because I probably from my personal beliefs. Yes, it's hard with Ruby, I mean. I don't know, it's good, because I really don't know. I know I wouldn't resuscitate. I wouldn't resuscitate. I would get the RN, so it's like passing the buck I guess. But then, I would get the RN, that's what we're told to do, so that's what I would do. That's what I would do. I'd pass it on to the registered nurse. But I wouldn't there and then, start CPR or start, I mean the thing is we don't have a three bell system here for an emergency anyway.

Oh we've got an emergency, yeah we've got all that, we've got the oxygen and the suction and I would just, yeah, I would get the RN. Yeah, I would get the registered nurse. That's as far as I know that I have to do, but I wouldn't personally get up there and start, because I couldn't, so I'd get the RN and leave her not breathing, or stay there and get air into her, when still nobody knows I'm in trouble, you know. I mean I could press the button but how long before someone responds. Or is it quicker to leave her and then grab an RN, get somebody straight away in there, but no I wouldn't resuscitate her. Yeah, my belief she die peacefully, yeah. (Data CW Ruby p119-20)

Appendix 12 - Cynthia's Observed Nursing Care

Observation field notes on Cynthia's hygiene, interaction, and repositioning by CWs.

NPO 1331 - Almost immediately two CWs came into the room with some linen and both said hello and left the linen and then walked out again one asking about getting more help with Cynthia. Another CW comes into the room donning gloves and says 'howdy' to Cynthia and asks how her arm is. Cynthia does not answer. Waiting for other staff to come and the second CW dons some gloves and states to Cynthia that they are going to change her Kylie and is this OK? No answer. A third CW enters and puts gloves on. The bed is laid flat by a CW and the overway taken out of the way. The cotsides are put down and the fourth CW enters the room. One CW asks what the bruises on Cynthia's arm are from and whether she had had a fall and another CW answers that it is from the blood tests they are doing on Cynthia. She says all this while she is closing the curtains which face out onto the street.

1335 - All four careworkers are present with two on each side of the bed with the cotsides down and Cynthia laying flat at about waist height of the careworkers. The television is still going and Cynthia has said nothing. The head care worker has a wet flannel and soap and proceeds to wash in between Cynthia's legs and in her groin. She then dries this and together on the head care worker's instructions they roll Cynthia onto her left side. The cot side is not up and the two care workers and me to stop Cynthia falling over and out of the bed. One of the careworkers starts talking about television day time programs and the soaps that are on and others make comments about various TV programs. The head care worker asks Cynthia if she watches Springer and Cynthia does not answer her. One careworker is washing Cynthia's back and cleans up some faeces. The Kylies are then changed and soiled one rolled under Cynthia's back. The care worker looks at Cynthia's rash on the back of her left leg and stated it was getting better but did not know whether they were putting anything on it (it was promised to the mother than an RN would look at this rash at this time but this did not occur). The careworker had a look in Cynthia's drawer and found some ungvita which she applied to the rash area. The careworkers then rolled Cynthia back onto her back and then onto her left side. As this was happening the bed started to move away and a careworker said the breaks were not on and then she put them on - all the while standing and holding Cynthia in the bed along with one other careworker and myself - could have easily rolled out as there was no cotside for extra protection. The Kylies were pulled through on the other side by the careworkers and one care worker asked if Cynthia was OK and which way would she like to face. Cynthia indicated she wanted to face the door and she was rolled over again and a pillow placed behind her back. The careworker asked if she was comfortable and Cynthia said 'no'. A pillow was placed between her legs and the cotsides were put up and the bed head was put up and Cynthia was asked if that was better and Cynthia said 'yes'. Cynthia's top blankets were placed on Cynthia and one care worker asked if they were tucked in at the foot and another careworker said no - that it placed too much pressure on Cynthia's

feet. A care worker asks for a pen and documents on the chart that pressure care had been attended to and by whom and which side she was facing.

1345 -The curtains were closed and careworker asked if Cynthia wanted them open while she was opening them and Cynthia said no and the careworker closed them again. The careworker took Cynthia's overway over to the side of the bed Cynthia was facing and all the careworkers left at once taking their gloves off in the process.

Cynthia is left but cannot see the television which is on very loud. She closes her eyes and appears to be resting. Her glasses are still on. Cynthia opens her eyes and is lifting her head to see the television and stays there for a minute and rests her head back and closes her eyes. After a minute she tries to lift her head and watch television again but again puts in back down on the pillow and faces the doorway. With a huff she closes her eyes and appears to go to sleep.

1430 - Cynthia has gone to sleep, her glasses are on, the light is on, and the television is blaring. I left. No-one entered the room, the TV was on the whole time, her glasses were on, and Cynthia appeared to sleep. (Data Cynthia NPO 1 p5-6)

Appendix 13 - Joe's Discourse on his Vigilance for Anna

Extracts from Joe's interview, whereby he describes his need and intention to come in every day and care for Anna.

Joe: Yeah, yeah. And one lady who work here, everyday, but she doesn't work supper, she give them all, every morning drink, and afternoon, yeah. That's it. But I, she doesn't give (Anna), because I am here, and I give myself all the time. Yeah, well that's it. That's why I feel like I have to be here. Yeah. Yeah, I can't, I just can't sit when it's morning, the time comes I have to go. You know my kids say you don't need to go, if you go at quarter to twelve. I said no I just can't. I go there and give mum drink and I am happy when I am here. But they always say you have to stop this. If you go once a day, but I, no I won't stop it. I won't stop it. It makes me happy. Make me happy. I go home and I see the, I go see Anna, yeah. (Data Rel Anna p95-6)

No normally it's alright. I am happy like it is now. Because I don't mind to come every day and give her food. Well, I say, that what I said, if I didn't come - she wouldn't be here maybe. Yeah. She wouldn't eat. Yeah (crying) so...but because I, I'm here, I give her and I know I give her heaps too much, and yeah, and that's for sure, she wouldn't be here, yeah. From starved, she wouldn't eat from nurses. Nurses told me that, she doesn't eat. When I started, she couldn't eat, and I yeah. Sometimes, some days at night I don't come and the young lady she comes with her husband here, and she said that your wife - the food come all here on the jumper, she didn't eat. She tells, I tell, told her that she not Anna eats. But sometimes they say that she eats, yeah. And now some nurses when I ask who is here on Sundays and now I know them, which ones is alright. Yeah, and they tells me that she eats, yeah, yeah. But that is true she doesn't eat sometimes for the vegetable always, but eat always when I am not here, yeah, yeah. But at my daughters, I take a peace sometimes someday, afternoon, go to my friend and we be sitting there talking. But when I am there with them, but my mind is here. Comes five o'clock I said I don't know if she eats or not, yeah. You see. And when it is five o'clock here, six o'clock I've got to leave the company. At five o'clock. I mean, I don't know. I am very emotional, feel very emotional. I am just. (crying). (Data Rel Anna p97-8)

Sometimes I think she's all, I always like, you know by her foam, when she sometimes sat in the (chair), I don't know, four or five days in the bed. Sometimes got out for a couple of days and then bed, but I actually not against as much when she's in the bed. It's not really different, whether she's in a comfort chair or in the bed. I prefer in bed, even better. Yes, you relax more, you stretch your legs. But in the comfort chair, you can't, when you go your bottom like that, there I try, there's some hard thing underneath. When I touch, there I said, she said put a pillow underneath, pillow underneath. And I tell her, when you tell them they doesn't (do it). But if you don't tell them they doesn't. That's why my wife feel a sore back, and she was up a long time ago. Terrible she was, and screaming and trying to, and I thought, my goodness, what to do with that? I lifted up higher and the howling put down. Yeah, yeah. Screaming out in the pain. Then I lifted her higher up, because once she have got a sore back, even so

that part will not get sore. But it's a little like, I don't know, timber or hard thing, she must be moved up so the place right on there. That's how she got that terrible sore. But I lift her up and when Anna I finished lunch I ask the nurses to put straight away in bed and they did, yes. (Data Rel Anna p98)

Yeah, yes. I feel very good with treatment, I know she's here and good, so I am very pleased with that, yeah. Yeah, I am very happy with that. It's one thing that's a good about these nursing homes. But you have to look after yourself a bit too. Yeah. That is alright yeah. But that, like that lady (Irene). They give her drink but Saturdays and Sundays, it doesn't come so many nurses. And that one nurse, she actually she's not a nurse, but she gives a drink, but on Saturday and Sunday she doesn't get a drink. But I know. Used to be on weekend here, more nurses, they old timers, not any nurse from any agencies. Completely different. Ten o'clock there was all out and about here, when lunch finish, they took them straight away to bed and they was sleeping and they give them drink, the nurses. But now it is different, now it is different. She's good, the lady good. Come another nurse and it's different completely. And they cut nursing, nurses here, and always from agency staff. (Data Rel Anna p17)

Appendix 14 - The Charter of Residents' Rights and Responsibilities

10.13

Note: Below the term 'residential care service' means the same as 'aged care home'

A. Each resident of a residential care service has the right:

- to full and effective use of his or her personal, civil, legal and consumer rights;
- to quality care which is appropriate to his or her needs;
- to full information about his or her own state of health and about available treatments;
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
- to personal privacy;
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
- to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
- to continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination;
- to select and maintain social and personal relationships with any other person without fear, criticism or restriction;
- to freedom of speech;
- to maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions;
- to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions;
- to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;
- to have access to services and activities which are available generally in the community;
- to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;
- to have access to information about his or her rights, care, accommodation, and any other information which relates to him or her personally;
- to complain and to take action to resolve disputes;
- to have access to advocates and other avenues of redress; and
- to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.

B. Each resident of a residential care service has the responsibility:

- to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;
- to respect the rights of staff and the proprietor to work in an environment which is free from harassment;
- to care for his or her own health and well-being, as far as he or she is capable; and
- to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

(DCSH 1987; CofA 1997, 2002b)

Appendix 15 - Ethics Approvals



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ESR 1494

20 December 1999

Ms Anita De Bellis
School of Nursing

Dear Ms De Bellis

Project 1494: The needs of six highly dependent residents of an aged care facility and their care provision

I refer to your application for a modification of the above project which had been approved previously.

I am pleased to inform you that the Chairperson has approved your request for modifications to your project.

Yours sincerely

A handwritten signature in cursive script that reads "Raelene Wildy".

Raelene Wildy
Acting Secretary
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

cc: Dr Carol Grbich
Dr Cathy Hawes

RW:as
for:letter:1494bt

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