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‘ALL IN A DAY’S WORK’

THE LIFEWORLD OF OLDER PEOPLE IN NEW ZEALAND REST HOMES

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in General Practice and Primary Health Care, School of Population Health, The University of Auckland, 2010
ABSTRACT

This doctoral thesis contributes to critical gerontology research by investigating the lived experiences of residents in the everyday world of New Zealand rest homes. There is a need to understand how frail rest home residents experience ‘age’. This study focuses on describing and understanding residents lived experiences. As the New Zealand population is ageing, this phenomenological focus adds clarity to the poorly understood lived experiences about being aged in rest homes. Policy initiatives such as the Positive Ageing Strategy with its emphasis on keeping older people living in the community largely ignore the life practices of the increasing proportions of frail older people who require long-term residential care.

My mixed-methods modified framework approach draws on the lifeworld as understood by Max van Manen (1990) and Alfred Schütz (1972). The lifeworld is made up of thematic strands of lived experience: these being lived space, lived time, lived body and lived relations with others, which are both the source and object of phenomenological research (van Manen, 1990). These strands are temporarily unravelled and considered in-depth for 27 residents who took part in audio-recorded interviews, before being interwoven through a multiple-helix model, into an integrated interpretation of the residents’ lifeworld.

Supplementing and backgrounding the interviews with these residents, are descriptive data including written interview summaries and survey findings about the relationships and pastimes of 352 residents living in 21 rest homes, which are counted and described. The residents day-to-day use of rest home space, mediated temporal order, self-managed bodies and minds, and negotiated relationships are interpreted. The mythology of the misery of rest home life is challenged, and a more constructive critical gerontology approach is offered. Findings of this research reveal how meanings around daily work practices are constructed by the residents. These elders participate in daily rest home life, from the sidelines or not at all, as they choose or are able, and this always involves work for the residents. They continue to actively manage satisfactory and fulfilling pastimes and relationships, because in their ordinary, everyday lifeworld it is “all in a day’s work”.

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1 CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

In this thesis, I offer a contribution to the field of critical gerontology. Critical gerontology challenges the status quo with the intention of stimulating thought and debate in order to keep mainstream gerontology from becoming complacent (Ray, 2008). Significant aspects of ageing lack investigation, such as the meaning of the lived experience of older age (Achenbaum, 1997). Later life resembles a foreign country (Biggs, 2008), so I use social constructionism to critique what is known about older age, to understand and make meaning of older adults ageing and living in a rest home context.

Notions of older age are rightly equated with being in an unfamiliar realm, to a researcher. It is my intention in this thesis to make familiar what is unknown: the everyday world or lifeworld of residents. Biggs (2008) pointed out that “critical gerontology is positioned as a starting point in the discovery of what is usually hidden” (p. 118). However, in seeking out a hidden reality, I aim to interpret constructed meanings of rest home life from the residents’ lived experience.

This research is concerned with ordinary daily life for the residents so that they take centre stage. In seeking to describe and understand what life is like for them in New Zealand rest homes, my phenomenological approach positioned on a social constructionist model recognises their expertise as rest home dwellers. Given the main research question How do older people in New Zealand rest homes experience daily life? I explore in-depth to develop understandings not previously recorded.

For the first time in history, New Zealand has, along with other Organisation for Economic Cooperation and Development (OECD) countries, an ageing population that continues to increase over time. Predictions of increasing proportions of older people, who are living longer, bring with them a need to better understand what it means to grow old. In New Zealand, ‘old age’ begins at the arbitrary age of 65 years, which is the time that residents become eligible for state funded New Zealand Superannuation (NZS), the universal ‘old age’ pension. Currently, 12% of the total population of approximately four million are aged 65 years and older (Statistics New Zealand, 2008).
Census projections estimate that by 2025 one in four people in New Zealand will be aged 65 years and older (Statistics New Zealand, 2004a).

As the older population steadily grows, the numbers of elders requiring long-term residential care will increase. At the time of my study, approximately 46,000 people aged 65 years and older lived in residential care facilities in New Zealand (HealthCare Providers New Zealand, 2006). Of these elders, 55% lived in rest homes (New Zealand Institute of Economic Research (NZIER), 2004). The average age of the residents has increased from 75 years fifteen years ago to 85 years (HealthCare Providers New Zealand, 2006). A recent local study covering 20 years reported that elders living in residential aged care have become older, frailer, and more dependent (Boyd et al., 2009). New Zealand rest homes specifically house elders who experience low-level dependency issues, unlike long-term hospitals and dementia care (secure environment) facilities, which house those with high levels of dependency (Elder Net, 2010). This distinction is similar to the types of nursing home care found in the United States and United Kingdom.

Rest homes are the places frail elders go to live when community living becomes untenable. The terms ‘rest’ and ‘home’ derive from Old English and Proto-Germanic; ‘rest’ means ‘sleep, bed, intermission of labour, mental peace’, while the term ‘home’ denotes a ‘dwelling, house, estate, village’ (Harper, 2001). As a starting point for this thesis, I use contemporary dictionary definitions of these terms which include “relaxation from exertion or labour” to define the term ‘rest’, and “the place where one lives” for the word ‘home’ (McLeod, 1992, pp. 477, 852). Synonyms for the term ‘rest’ include leisure, inactivity or relaxation (McLeod, 1992).

Rest homes in New Zealand provide 24 hour, seven day a week care catering to mainly older people whose dependency levels require some support from others. Residents can be ambulatory and independent in basic ‘Activities of Daily Living’ (ADLs) such as dressing, toileting and bathing (Katz, 1983), although most require care with ‘Instrumental Activities of Daily Living’ (IADLs) such as preparing meals, housekeeping, taking medications, and handling finances (Powell Lawton & Brody, 1969).

For the purposes of this thesis, ‘rest home care’ is defined under the ‘Health and Disability Services Act (2001)’ as residential care provided for three or more people
unrelated by blood or marriage, (civil union or de facto), for the care or support, or to promote independence of frail people, often elders (Ministry of Health, 2001a). In this Act, ‘rest home care’ refers to the care practices and care assistance given to older adults, and will be alluded to during discussion about staff interaction with residents, and to talk about the residential care facilities (Ministry of Health, 2001a). Residential care services take into account the needs and wishes of the individual.

The move from community living to a rest home is an unsettling thought for many people. Little is known about the lived experience of rest home life, so it is important to demystify and document what it is like to be one of the growing numbers of residents, now and in the foreseeable future. Of the role models available few are positive. Accounts highlight negative aspects of being a resident, and are reinforced by elders locally (Ogonowska-Coates, 1993) and in overseas research (Laird, 1979). Anecdotal evidence helps perpetuate pessimistic perceptions.

Neglect by staff members has been reported in the research literature (Daly & Jogerst, 2006; Peri, Fanslow, Hand, & Parsons, 2008a; Ulsperger, 2008). This view is supported by sad tales told to me by many non-residents, and gives an overall opinion that rest homes remain a last resort and places one step removed from funeral homes.

A recurring theme in my many discussions with non-residents occurred whenever talk about my research arose. I found ‘older people in rest homes’ evoked in others what I interpreted as repugnance or fear. Some of the discussions were with people who worked in a rest home, or had a relative living or working in a rest home, while others knew of a friend who was a resident. Most backed their views by citing sensational but negative stories about rest home life commonly found in media reports. Conversations always concluded with an expression of personalised disquiet about the possibility of ending up in a rest home themselves. Fitzgerald and Robertson (2006) echo this uneasiness by thoughtfully posing the question “if so few New Zealanders eventually move into residential care facilities why does the possibility of residential care figure so predominantly in New Zealanders’ concerns for their future?” (p. 48). Why indeed? To address this question, this thesis elucidates the lived experience of rest home life in order to understand what it is like to live in a rest home.

Media accounts about the pitfalls of rest home living tend to reinforce depressing perspectives. One titillating case in recent times involved an older female resident
gagged with duct tape by a rest home employee, as documented on the mobile phone camera of one shocked tradesman at an Auckland rest home. Subsequently, the photograph was given to the media and became headline news (New Zealand Press Association, 2008). The rest home was closed following staff dismissals, (Ministry of Health, 2008) and an investigation into the alleged elder abuse was set up by the Ministry of Health (2008). This sensationalised case highlights a negative daily life that sometimes occurs in rest homes. While acknowledging this awful story, it nevertheless remains important to remember that these stories are not the norm. This research study investigates the little understood phenomenon of normal rest home life, through residents’ ordinary, everyday lived experiences.

My personal and professional background has influenced the way this research has been undertaken. As a New Zealand-born offspring of post-World War II British migrants, I had no available grandparents, and few older substitutes, to give me childhood knowledge of older people. Only more recently, as a middle-ageing grandmother, have I gained personal experience about being old through my relationship with ageing kin, whilst I too grow older. These experiences have helped shape, and have been informed by my own gerontological research.

At a professional level, interest in the topic grew out of my previous research with older people living in rest homes and in the community. In those studies I found that regardless of the locale, the physically and sometimes cognitively frail elders I worked with appeared more interested and involved in the world than the negative ‘old people living in the past while waiting to die’ stereotype I had previously assumed them to be.

Over time, I became increasingly aware that the elders were willing to offer up important information about living as an older person. The older people I worked with had many frailties, disabilities and ill-health so I was equally aware that the information they had to give was available only in the short term. I started to reflect upon how to gain an understanding of the experience of everyday life for an older person. In the mid-2000s I was fortunate enough to be offered the opportunity to work as the administrator of, and undertake doctoral work within, a larger research project conducted in 21 rest homes in two New Zealand cities.

The field of study I was trained in, women’s studies, encourages critical thought, which has a bearing on how I practise social science research. Using a critical
gerontology allows me to reflect critically on, and share in my prior research (Kiata & Kerse, 2004a, 2004b; 2005; 2001), what I have learnt about the lived experiences of residents of rest homes. All too often, life is so wrapped up in the mundane ordinariness of the day-to-day that there seems little point in questioning the taken-for-granted, or seeing the rest home in its wider spatial or social context (Buttimer, 1980). However, for the residents and people outside the rest home, a challenge lies in evoking responsiveness to taken for granted practices within that lifeworld. I welcomed this challenge by engaging with residents as guides and experts of everyday life in a rest home context. A major strength of this study therefore lies in its ability to place the elders lived experiences to the fore to better understand how they live with mainly positive meaning. By illuminating the ordinary lived experiences of the older people taking part in my study, this thesis will inform future planning and provision for those of New Zealand’s ageing population who will move to a rest home.

1.2 A NEW ZEALAND CONTEXT

1.2.1 HISTORY
Older people currently living in New Zealand rest homes share a similar historical context. Their fathers would likely have travelled half way around the world to fight in a world war and, within a few decades, the young men of the 1920s cohort were themselves taking up arms in another war thousands of kilometres from home. Meanwhile, their sisters and girlfriends were picking up jobs in the public sector only to relinquish their employment when the ‘boys came home’. Between the world wars, these young people lived through hard economic times of what became the ‘great depression’ of the 1930s. There dominated in capitalist nations at that time (and still today) a specific set of moral values, including attitudes and behaviour based on hard work, termed the ‘protestant work ethic’. This ethic holds ‘work’, especially paid work, in highest regard (Furnham, 1984).

Attitudes about the work ethic differ over time and place (Lipset, 1992). During the 1930s being in work was not an easy task due to global economic depression which served to emphasise the work ethic. Better economic times followed the depression and WWII, as did the knowledge of a secure lifelong living situation entrenched by the ‘cradle to grave’ policies of the New Zealand ‘welfare state’. These elders were parents of the ‘baby boomers’ who lived on a ‘quarter acre paradise’ (Mitchell, 1972) in
inexpensive housing and had a decent wage (Ministry for Culture and Heritage, 2006). They often worked in a government job and had adequate state funded health and education systems, which contributed to household stability and mass consumption of leisure pursuits (James & Saville-Smith, 1994; Koopman-Boyden, 1985; Phillips, 1996).

These birth cohorts have lived through a policy swing from significant state sponsored support from the 1930s, to a highly privatised market economy in the 2000s. Devolution of the state from the 1980s went hand in hand with user-pay policies, which was according to Kelsey (1993) doomed to fail. Massive social and economic changes included the sale of State Owned Enterprises (SOEs), which started as these older New Zealanders began to retire. One group of New Zealand elders were spoken with in 1993 and 1994 which was a time of substantial upheaval within state policy as it related to older people. For these elderly, ‘home’ was “synonymous with home ownership and reflected deeply held concerns with respect to security, family and continuity” (Dupuis & Thorns, 1996, p. 485). Ekerdt (1986) suggested that this work ethic still applies, and that once retired, older people continue to abide by the ethic. Of use in this study is the idea of this work ethic.

Dependence on state services remains a legacy from the past and is extremely influential. The propensity of public policy to consider an ageing society as an “economic burden, rather than a social and economic triumph, is a strongly enduring one” (Walker, 1999, p. 375). This view is coupled with an important notion that assumes the transfer of older people from “homes to more institutional environments” frequently “to the detriment” of an older person’s “health and against their wishes” (Andrews et al., 2005). A local report (Belgrave & Brown, 1997) produced in tandem with another document based on the proverb ‘home is where the heart is’ as its title (Richmond, Northey, & Moor, 1997) utilised these ideals surrounding ‘home’, and recommended elders be enabled to stay at home in the community for up to six months from initial assessment of care need before placement in rest home care. It was argued that not only was this better for the older person, it was also more economically viable for a rapidly devolving state that was pushing forward into a free market economy (see Kelsey, 1993).
Traditionally, Christian welfare based social service organisations providing care for older people have a long history in New Zealand (Conradson, 2006). However, the transformation from a welfare state into a market economy has changed the landscape of residential care. The introduction of rest home standardisation meant audits and quality improvement across the sector, although compliance has varied. In line with international trends, changes and closures of rest homes in New Zealand have occurred along with policy reforms, (explained in the next section), in conjunction with shortages of care staff, low wages and concerns about the cost implications of new care standards (Netten, Darton, & Williams, 2003).

During this transition of the residential care sector, I started my research in 2004. Over the time of the study, some rest homes cut services and others were sold or closed down. A political cartoon in Auckland’s daily newspaper portrayed the social climate by depicting two older people sitting in ‘wheelie’ rubbish bins waiting to be taken away to the dump (Appendix 1). One local resident offered a succinct negative account of how changes impacted on rest home management and policy and residents as a result of the upheavals (Maclean, 2000), although most remained silent about the impact of yet more changes in their lives. Residents’ lived experiences during repercussions of the transformation of the New Zealand rest home setting are examined in this thesis.

1.2.2 POLICY

**SOCIAL POLICY**

How an older person experiences ‘old age’ depends on a number of factors including who they have contact with, how they interact with other people, how interaction is played out within social contexts, and how socio-cultural meanings resonate through social policy; all these factors influence the process of growing old (Estes, 1986). The ageing experience is shaped by society, but the “aging experience also shapes society” (Ferraro, 1997, p. 137), as a reading of the *Journal of Aging and Social Policy* shows with its overview of ageing policies internationally.

With guidelines aimed at offering older people a choice about where they live, in 2001, the government began promoting the *New Zealand Positive Ageing Strategy* (Minister for Senior Citizens, 2001). This *Strategy* focuses on old age as ‘successful ageing’ and ‘ageing well’, along similar lines to the United Kingdom (Clarke & Warren, 2007; Mayhew, 2005).
The New Zealand government’s policy course aims for older people to be cared for in their own homes (Booth & Mor, 2007), for as long as desirable (Minister for Senior Citizens, 2001, 2008). The implications of population ageing have been addressed in a local context (Boston & Davey, 2006), and have covered demographic trends (Dunstan & Thomson, 2006) including housing for older people (Davey, 2006).

Home ownership legislative amendments to the Social Security Act 1964 have resulted in asset testing changes from eligibility for full subsidy for residential care being reached with a total asset base of $15,000 up to 2005, to a total asset base of $170,000, and rising to $200,000 by 2010 (Ministry of Health, 2006). At the time of writing, legislative changes in the Social Security (Long-term Residential Care) Amendment Acts continued with amendments passed in 2006 (Ministry of Health, 2006). Jorgensen’s (2006) recent New Zealand based work found that asset testing had limited impact on older people entering rest homes.

The New Zealand government’s social strategies are mirrored by health strategies.

**Health Policy**

Health strategies include the New Zealand Health Strategy (Ministry of Health, 2000) and the Health of Older People Strategy (Ministry of Health, 2002). The Health of Older People Strategy (Ministry of Health, 2002) points to the direction of health and disability support services for older people. Recognising the majority of older New Zealanders as independent, and able to make decisions about their health and well-being, these health strategies acknowledge that elders will become more dependent on health care over time. Indeed, a proportion of elders will need long-term support services including rest home care, which will impact on funding and policy.

New Zealand health policy is based on medical models of care, in the form of the Health and Disability Services’ (Safety) Act (Ministry of Health, 2001b); This Act legislates the licensing of low level dependency rest homes (and higher level dependency care hospitals). Registration of rest homes has been replaced with a certification system for the organisations and people providing the services. An estimated 1.3% of the population currently aged 85 and older consume 10% of the government funded Vote Health expenditure on health and disability support services (Ministry of Health, 2004). New Zealand is one of many countries that have assessed disability trends among older people (Organisation for Economic Co-operation and
Development [OECD], 2006) and implemented continuing care policies (Metha, 2002) usually emphasising community-based services (Merlis, 2000).

The New Zealand Health Strategy (Ministry of Health, 2000) and the New Zealand Disability Strategy (Ministry of Health, 2001d) promote population-based care delivered by integrated primary and secondary care organisations. Under state subsidy eligibility criteria an older person can be referred to the District Health Boards (DHBs) for assessment, including for rest home admission. Admission is allocated according to set eligibility criteria based on the older person’s need for care and financial situation. The care provider of a ‘bed’ for a fully subsidised resident receives about NZ$90 a day, ‘Goods and Services’ tax inclusive.

Government initiatives have aimed at supporting cost effective measures euphemistically termed ‘positive ageing’ (Ministry of Health, 2002). The state’s aim has been to realise the “vision, objectives and actions of the strategy” through an integrated continuum of care with older people having ready access to specific care they need in the right place from an appropriate provider (Ministry of Health, 2002). To that end, ‘positive ageing indicators’ (Minister for Senior Citizens, 2007) offer a picture of New Zealand elders’ quality of life in health, housing, income, transport and access to services and facilities.

The call for workable policy in a long-term care context continues (Booth, Miller, & Mor, 2007). The New Zealand Health Research Council (2004), in keeping with government-stated priorities, identified older adults as a high priority group likely to become increasingly reliant on health, disability and social services. Within this context, health-focused rhetoric surrounding ageing has been full of “doomsday language of demographic imperative” (Keeling, 2003).

**Policy: A life course perspective**

As a social Scientist, I have applied a sociological imagination (Mills, 1959) to highlight how social and health policy resonates with general population concerns of an increasingly ageing population becoming dependent on shrinking state funding. ‘Old age’ is constructed in a way that accentuates loss of independence and autonomy which in turn can result in vulnerability and passivity (Boyle, 2008). In reaction to the losses thought to be part of the process of old age, New Zealand follows other OECD countries and United Nations agencies, where in line with health policy, a push to
promote “‘active’, ‘healthy’, ‘successful’ or ‘positive’ ageing, now pervades social policy discourse” (Boston & Davey, 2006, p. 1).

In this policy thrust aimed towards ageing well, older people have been commonly perceived through a ‘life cycle’ or ‘life course’ theory such as that proposed in Erikson’s (1980) model, which positions elders at one end of a linear, developmental life course from infancy through to old age. In New Zealand, this view is prevalent in policy, and is matched by local research. One recent project using an ‘ageing well’ model was the Enhancing Wellbeing in an Ageing Society (EWAS) study of 1680 independently living older New Zealanders aged between 65 and 84 years (Koopman-Boyden & Waldegrave, 2009). The community-based study focused on key determinants of the elders’ well-being. The study was based on a ‘capabilities’ approach which focused on older peoples’ experiencing of a sense of satisfaction, and acquiring capabilities to achieve good quality of life. Koopman-Boyden and Waldegrave’s (2009) study resonates with Sen’s (1999) ‘capabilities’ approach based on individual agency and well-being.

State sanctioned discourse advocates ‘ageing in place’ in the community as a desirable and preferred cost effective measure compared to residential care (Ministry of Social Development, 2004). A framework for successful ageing, ‘Ageing in Place’ impacts on “current and future development of age-related policies” in New Zealand (Schofield, Davey, Keeling, & Parsons, 2006, p. 300). Within this framework, the continuation of living in a private abode is a prerequisite to ageing well, and so to reside in a rest home is thought of as failure of successful ageing (Keeling, 1999; Schofield, et al., 2006). Rest home dwellers are out on a metaphorical limb because they fail to fit the ‘Ageing in place’ model.

In this thesis, I argue for the importance of understanding how ongoing changes impact in the here and now because the residential care sector in general, and rest home living in particular, will be substantially different for upcoming generations of older people, starting with the ‘baby boomers’. It is a surety that a percentage of elders will eventually live in what we currently call a rest home. This study attends to the lived experiences of residents during 2004-2006 to illustrate how everyday life works and what it means now, and potentially in the future. This thesis can inform policy which may sway local and national characteristics of the residential care sector and in turn, an
understanding of these characteristics can inform insightful implementation of reformed social policies in the future (Andrews & Phillips, 2002), as well as health policy.

1.3 RESEARCH SIGNIFICANCE OF CRITICAL GERONTOLOGY
This thesis has as one of its concerns what it means to grow older in an ageing society. To achieve a thorough understanding about what it means to be an older rest home resident I use as a filter, critical gerontology, a subfield of contemporary social gerontology grown from several parallel lines of enquiry (Holstein & Minkler, 2007). Critical gerontology is important because it provides “a critical eye on society and the field of gerontology itself” (Ray, 2008, p. 97). Fundamental to the approach taken by critical gerontology is the notion that ageing is a socially constructed process and experience (Minkler, 1999).

Interestingly, this lens has been utilised by surprisingly few social gerontologists. Exceptions include Gubrium’s (1975, 1993, 1995, 2001) narrative research with elders, which illustrated dementia as socially constructed as well as biologically based. Featherstone and Hepworth’s (1991, 1999) critical gerontology found that society’s changing trends in retirement matched shifting consumer based perceptions. Estes’ (1999, 2000) work on the political economy and later life pointed to supposed problems associated with old age, actually being created by economic and social policies set up to counter the perceived ageing crisis.

de Beauvoir’s (1972) observation of a reticence to explore the meanings of old age may be explained in part by the belief that old age is something that happens to other people but not to ‘us’. This thesis questions this reserve as the first wave of baby boomers have reached the retirement age of 65 years and continue to grow older. Yet, there is still little critical self reflection about old age as de Beauvoir (1972) pointed out four decades ago:

When we look at the image of our own future provided by the old we do not believe it: an absurd inner voice whispers that that will never happen to us – when that happens it will no longer be ourselves that it happens to. Until the moment it is upon us old age is something that only affects other people. So it is understandable that society would manage to prevent us from seeing our own kind, our fellow-man [sic], when we look at the old (p. 5).

Growing old and possibly frail is something that most of ‘us’ will do, yet with few local community-based exceptions (Wright St Clair, 2008), there remains an aversion to
addressing what old age is understood to be (Moody, 1988). In part, this is due to an insidious ‘ism’ termed ageism. Coined by Butler (1963) ageism refers to age discrimination. Ageism operates on various levels to cover over thoughts of ‘our own’ old age. Ageism can include a type of age-blindness where age can be ignored (Calasanti, 2008) as ‘it’ only happens to other people. Ageism also allows for comparison of the elderly with younger people (Calasanti, 2008) at individual and group levels to gauge successful ageing.

An issue with a comparative model is that older people are more often than not found lacking, in line with both health care models and theories of sociology which have shown age-graded transitions to be regarded negatively as role losses (Westerhof, Dittmann-Kohli, & Bode, 2003). As ageism ignores older age or unfavourably compares elder groups with younger cohorts, older people become more marginalised, which perpetuates the stereotype of old age and so the cycle continues. Positive ageing discourses may screen negative stereotypes, but positive rhetoric is also ageist as it falls short of capturing the realities of later life (Dupuis, 2006).

The significance of a critical approach to social gerontology in my research is because it allows me to challenge ageist and negative attitudes about how older rest home dwellers have been theorised. In my research, theory will attempt to explain the social science perspective used (Bengtson, Gans, Putney, & Silverstein, 2009). Using a critical gerontology approach, I question the marginalisation of the archetypal older resident. Of interest in this thesis are issues about the meaning, interpretation and subjective experience of ageing which need to be considered (Ray, 2008). My intellectual tradition in gerontology is rooted in the discipline from which I emerged, according to Bass (2007). As a social scientist grounded in critical theory through a women’s studies programme in the 1990s, I learnt the skills for taking up various socio-cultural positionings. In order to understand everyday experiences, theories of knowledge can be woven together (Thomas, 2006).

In a study about older rest home residents I adopt the position that age “does matter: bodies do change, old age is a social location burdened with the stigma of marginal status, and accumulated experiences do make a difference” (Calasanti, 2008, p. 156). Research about older age in general and frail older age in particular has been in the main positivist, with health focused ‘custody and care’ models concerned with
institutionalised care practices such as in hospital or nursing (including rest) home settings. I acknowledge that a reason for the ascendancy of health related literature is the significant proportion of elders having health related conditions (Bowers, Fibich, & Jacobson, 2001; Wiles, 2005).

Keeping with a health oriented lens, but in a way that differs from positivism, is a challenge to dominant notions about health and illness. It is possible to think about health through what Fox (1998) called ‘arche-health’. In the fields of health and illness, which is pertinent in this study about frail elders, health and ill-health can be deconstructed into a series of possibilities, with the potential to be reconstituted as the arche-health of an individual’s unfolding life where health and ill-health coexist (Fox, 1998, 1999b). However, arche-health cannot be “reduced to language and discourse” because as soon as it becomes a text, it “ceases to be ‘arche-health’” (Fox, 1998, p. 45).

Arche-health has no prior or privileged position, as it is a state of ‘becoming-different’ which resists definition (Fox, 1998). The usefulness of arche-health is in its “pure difference”, where the possibility of diverse notions about health and ill-health can arise (Fox, 1998, p. 45). There is no authentic body (Lupton, 1994). Rather than define ‘health’ in binary terms, arche-health serves as a way to look discursively into any number of likely health (and ill-health) related choices made by the individual.

Health and illness are common to rest home residents. Comparable to rest home living in New Zealand are assisted living facilities in the United States and hostel living in Australia. Residents are commonly ambulatory and independent in eating and grooming but may need assistance with toileting and/or bathing. The residents in my study all live in this type of dwelling colloquially and legally termed ‘rest homes’. Terms used in other research will be designated by their author(s). What these terms have in common is that they each signify dwellings that provide some sort of supported accommodation and care for older people (Ashton, 2000). This thesis uses New Zealand English, including the term ‘ageing’. Direct quotations using United States English, such as ‘aging’ will stay the same.

Meanings taken up by those who live and work in residential care settings, along with those who visit, are usually based on a highly regulated institutional model (Stafford, 2003a). The notion of ‘home’ is problematic, as noted in the United
Kingdom, where there has been an unsuccessful call to replace the term ‘home’ with ‘community’ (National Care Homes Research and Development Forum, 2007). Regardless, the rest home is an institution and so will always be “a contested site of meaning ... caught between the rival discourses of medicine, social care and day-to-day living” (Twigg, 2005, p. 623). Unsurprisingly, ethnographic research about residential care has continued with a health-ill-health focus.

Ethnographies have offered a series of snapshots about how older people go about their lives, and how life is played out by residents (and workers) within residential care settings in the United States (Diamond, 1992; Foner, 1995, 1995a; Gubrium, 1975; Kaufman, 1986). Savishinsky (1991) for example, described relationships among residents, staff and visitors in one nursing home and found contradictory attitudes of a institutional sub-culture. One local ethnography investigated how nursing contributes to the nature of comfort and discomfort in three rest homes, and found that accurate assessment of individualised care is fundamental to the comfort of residents (Bland, 2004).

Phenomenology has proved a useful research technique, particularly in nursing research (Dowling, 2007). A recent Australian account focused on ageing and chronic pain in a residential care context, and found that pain seemed to matter less to the residents than them being useful to other people (Higgins, 2008). Nay’s (1993) account of lived experiences in Australian nursing homes reported that elders were resigned to their life in the home, feeling they had little choice in where they lived. The elders had suffered losses, which included the move into residential care. In the United States, Rippstein (2007) gave an account of the bullying of residential care residents, and urged for change in the ‘culture of care’ facilities, particularly through staff education. These phenomenological interpretations illustrate ‘misery myths’ (Tornstam, 2004) and ‘misery perspectives’ (Oberg, 2003) tied to what have been termed ‘heaven’s waiting rooms’ (Forbes, 2001). ‘Waiting’ is an ambiguous experience (Fujita, 2002), and an activity that residents seem to do a lot.

It is unclear whether residents themselves would subscribe to misery tales if the research focus was on their daily lives, rather than on their frailties, both physical and cognitive. For as Andrews (2005) observed “imagining what everyday life is like” in a residential “home is beyond the capacity of most people [as] they do not know where to
Fortunately, diversity in the study of ageing has been encouraged (Blaikie, 1999), particularly over the past decade, to include ordinary, as well as expert approaches. This shift means that in this thesis I can move beyond an imagining to an exploration of the lived experience of residents in the everyday.

In my work, a phenomenological perspective adds to the literature at the point where attention shifts from a mode of illness, to one of health with illness. As clarified above, Fox’s (1998, 1999a) idea of arche-health takes a deconstructive perspective to explain that ill-health is health in the making rather than simply an absence of health. Similarly, by taking frailty into account as part and parcel of the everyday in the making, instead of a state of being, my study “can be accurately captured and theoretically anchored in phenomenology” (Carel, 2008, p. 76). Rather than use discrete categories devised by experts, I take up the notion of arche-health which Fairhurst (2005) reasoned is a more useful critique that comes out of everyday talk expressed by ordinary people as a “sense-making activity of growing and being older” (p. 36).

I set out to understand the ordinary, mundane day-to-day lifeworld of rest home residents. In Chapter Two, the selected literature along with the conceptual model developed for this thesis depicts a phenomenological approach that illuminates the importance of learning from experience about rest home life as it happens. As approximately 5% of people aged over 65 years, and 25% of the population aged 85 years and older stay in rest homes (Statistics New Zealand, 2004a) gaining knowledge about this lifeworld is essential for future policy and practice.

1.4 SOCIAL CONSTRUCTIONISM: A PHENOMENOLOGICAL APPROACH

The phenomenological approach taken in this thesis assumes that multiple realities are socially constructed to give individual and social meaning (Berger & Luckmann, 1966). Reality is like a mélange of competing standpoints (Arxer, Murphy, & Belgrave, 2007). Social constructionism itself is a social construction that offers a theoretical way to understand the lived world as it is experienced (Gergen & Gergen, 2008). Both the phenomenological and sociological approaches used in my study are discussed in Chapter Three, and are positioned within a broader social constructionism to provide the grounding for this thesis. Cutchin’s (2003) challenge to question negative assumptions means I can use a flexible and attentive social constructionism which adds to current ageing in place contexts, processes, and meanings about the lives of rest home residents.
I have chosen to use the term ‘constructionism’ rather than ‘constructivism’ for two reasons: First, social constructionism operates well through lived phenomenology as constructed-life. Second, what I “take to be real is an outcome of social relationships” rather than a mere mental construction undertaken in the head as is often associated with constructivism (Gergen, 1999, pp. 236-237). Sociological thought holds that a bridge between interpretive and positivist approaches is important in understanding the meanings of people’s lives (Snape & Spencer, 2003). Interpretive social constructionism unsettles the prevalent search within the social sciences for the naturalised life course of innate development and decline of human capacities, tendencies, interests, and desires over the life course (see Holstein & Gubrium, 2000a). In this thesis, interpretation is a term meaning “clarification, explication, or explanation of the meaning of some phenomenon” (Schwandt, 1997, p. 73). Phenomenology has an established tradition in the social sciences, and provides an epistemological underpinning for several social gerontology approaches, including critical theories (Longino & Powell, 2009). In this critical gerontology study, social constructionism will serve as a firm base for phenomenology to be applied to residents’ narratives and interview summaries, to investigate, describe and interpret the phenomenon that is their everyday lived experience.

1.5 ORGANISATION OF THE THESIS
The aim of this research is to understand how ordinary, daily life is experienced by older people living in rest homes located in two New Zealand cities. The residential care literature is located within both positivist and socially orientated health models. I have argued for the significance of undertaking this study. The broad historical and political scene of rest homes in a New Zealand milieu has been set. In this chapter, I have given a broad interpretation of New Zealand’s history and policy regarding rest homes. I have explained the rationale for using critical gerontology, and situated the social constructionist base on which to apply a phenomenological approach in this study.

Chapter Two offers a conceptual map of this thesis, before reviewing selected literature to give direction to how space, time, body and relations with others have been conceptualised. In Chapter Two, I point out the usefulness of a critical gerontology approach is in its insistence that popular socio-cultural assumptions and practices surrounding older age in general and frail older age in particular be rigorously examined
(Ray, 2000). I indicate that the literature about space, time, body and relations with others, contained in separate sections in Chapter Two, correspond with the findings Chapters Five to Eight.

The methods and methodology used in this thesis are explained further in Chapter Three. A mixed-methods approach (Figure 2.1) was used to collect the data (Appendix 2). Audio-recorded interviews with residents are the main data source, supplemented by interview summaries collected by a counterpart researcher and myself (Appendix 3), along with my field-journal notes. Using the specific modified framework approach described in Chapter Three, I identified and developed patterns and themes that I understood as most important to interpret the qualitative study findings.

The research is guided by the methodology detailed in Chapter Three. Social constructs are applied to the lived experiences of the everyday often without being thought about, a point applicable to the researcher as well as participant. As a social scientist, I have long acknowledged the tension between what ‘I know’ and what ‘I assume’. My experience is not (yet) one of being an older rest home resident. At the start of the study, I hold preconceived “beliefs, biases, assumptions, presuppositions, and theories” which I seek to acknowledge overtly (van Manen, 1990, p. 47). Interpretations of the nature of the phenomenon under study are also predisposed by existing bodies of scientific knowledge, assumptions and commonsense (van Manen, 1990), one version of which is described in this chapter, in discussing ‘misery myths’.

Data from a survey as part of a larger study (Kerse et al., 2008; Peri et al., 2008b) carried out in the participating rest homes at the time my study was conducted, have been made available to me to help elucidate the qualitative research (Appendix 4). I have included selected demographic, health and social characteristics of 352 older people living in rest homes in two New Zealand cities. The focus of Chapter Four is to use these data (i) to create a backdrop for the residents; (ii) to identify the residents’ relationships; and (iii) to typify the residents’ regular pastimes in an everyday context. As these residents are not a representative sample, caution is advised in interpreting the quantitative data. Chapter Four is the quantitative precursor to the main focus of my mixed-methods study which is the qualitative component.

The main research question addressed in Chapters Five to Eight, How do older people in New Zealand rest homes experience daily life? draws on Max van Manen’s
(1990) and Alfred Schütz’s (1972, 1970) notions of phenomenology. A phenomenological approach is readily framed within social constructionism to investigate how social reality is understood, and the meanings made by an individual or group. This reality is informed by shared assumptions about what is real in the representation of lived experience. Taking this approach reveals core, socio-cultural patterns and meanings of ageing which in Schütz’s (1972) phenomenological-sociology is a concept termed ‘typification’.

Typification illuminates how meaning is made through a pre-existing stock of knowledge at both individual and societal levels. From a social constructionist viewpoint, Gubrium and Holstein (1999a) describe this typified worldview as containing “the operating frameworks that make what participants do immediately reasonable in their everyday lives [and] to assume that what one and others do in the context of that world makes sense” (p. 295).

Having autonomy over the data collected qualitatively, I was able to consider the appropriateness of various methodologies to my study. Phenomenology had the best fit because it is a philosophical doctrine whose principle is that social worlds are created by people through their experience of everyday life. Phenomenology became the most viable approach following an application to the data of Borkan’s (1999) immersion/crystallisation (I/C) technique. Using the I/C technique meant that I could be immersed in the data, out of which interesting and repeated themes would crystallise over time. Major themes coming out of this highly inductive approach mirrored the deductive overarching phenomenological lifeworld themes that van Manen (1990) suggests are present in all lifeworld research. The advantage of drawing on van Manen (1990) and Schütz’s (1972, 1970) methodological approaches is that they write explicitly about how to use phenomenology.

van Manen (1990) writes that phenomenological research is the study of lived experience that aims at gaining a deeper understanding of the meaning of our everyday experiences. The scientific focus on lived meaning “refers to the way that a person experiences and understands his or her world as real and meaningful” (van Manen, 1990, p. 183). Phenomenological awareness is most successful when the tension between what is unique about, and what is shared of lived experience is made explicit (van Manen, 1997). Detailed explanation about how phenomenology works makes van
Manen (1990) and Schütz’s (1972) work methodologically suitable for this study, and this is presented fully in Chapter Three.

In sum, the residents’ lifeworld has four major themes of lived space, lived time, lived body and lived relations. van Manen (1990) suggests that for research purposes the themes, which I signify metaphorically by invoking the term ‘strands’, can be temporarily unthreaded in order to examine their differentiated characteristics, all the while acknowledging that one theme always calls forward the others. The strands’ sub-themes (threads) are not necessarily those most often woven; rather, they represent my interpretation of the themes that I found held the most meaning for the residents. A phenomenological approach to these strands and threads is the basis of each of the qualitative findings chapters, Chapters Five to Eight. In these chapters, the notion of ‘work’ comes to the fore and will be further developed in Chapter Nine.

The ways in which residents experience their spatial environment in the rest home is examined in Chapter Five through their narratives. That chapter on lived space takes into account how frailty affects the residents’ use of space. Also considered are spaces for specific tasks. I explore the idea that particular space is adapted by residents which takes work, so that they can continue making meaning of lifelong pastimes.

Lived time is covered in Chapter Six. What becomes clear is that temporality has multiple rhythms for the residents. I explain that from the residents’ perspectives, time holds flexible understandings. In the chapter, I illustrate how the residents work in maintaining their temporality in the day-to-day experience of living in the rest home.

The lived body is explored in Chapter Seven. Embodiment is discussed through notions of work, contrasted with concepts around leisure. The elders express the need to work at keeping ‘self’ well. Day-to-day is based on managing lifelong valued activity, and mostly enjoyed. Residents work at adapting to suit current levels of ability.

Chapter Eight considers lived relations with others. Residents consider their relationships with fellow residents, staff, along with family and friends. Social interaction is by nature a reciprocal business. Residents are givers as well as receivers in their relations with others. They practice reciprocity by helping out co-residents, assisting staff in their work, and continuing to maintain their family relations.

Chapter Nine gives a synthesised summation of the overall findings through my interpretation of the elders’ narratives. The main contribution to critical gerontology
research, which aims to challenge current notions about older age and residential care, is that the residents engage everyday in work. In the final chapter, the stereotypical negative misery view of residents’ daily lives in the rest home is demystified. The older people in my study are not sitting around the rest home with nothing to do. I expose an image of the residents’ day-to-day lifeworld as being work.

The term ‘work’ is a fusion from Old English and Proto-Germanic languages which means “something done, deed, action” (Harper, 2001). Internationally, unpaid ‘work’ is categorised into two mutually exclusive categories, ‘productive’ and ‘non-productive’ activities (Statistics New Zealand, 1999). Unpaid work takes up many hours of the average day. Unpaid work is valued in that it is measured in economic statistics of work and production, and frames public policy and business decisions (Statistics New Zealand, 1999). This thesis explores unpaid work carried out by the residents.

The introductory chapter has provided an overview of and rationale for my study. I address what is quiet in the critical gerontology research, with emphasis about how the ordinary, lived experience of rest home dwellers are (mis)understood. This thesis offers an alternative to the way in which older people living in rest homes have been documented. This thesis will inform theory and allow for future planning in policy and practice by providing a perspective that offers a constructive critique to what is already known about New Zealand’s rest home milieu.

In the next chapter, I offer a review of the literature, which follows on from a conceptual model of the way I have chosen to collect, analyse and write up my findings to increase understanding about what it is to be a rest home resident.
2 CHAPTER TWO: A CONCEPTUAL MODEL AND LITERATURE REVIEW

2.1 CONCEPTUAL MODEL

2.1.1 A MODIFIED FRAMEWORK APPROACH

For clarity, in this chapter I first develop and present the conceptual model used (Figure 2.1). To engage in interpretive social constructionism is to throw light on lived experience from the perspective of the people living it (Schwandt, 1994). The purpose of the phenomenological perspective used in this thesis resonates with that of social constructionism, which serves as the cornerstone to this study. Importantly, social constructs of scientific and everyday knowledge have to be taken into account. There will always be tension between scientific and commonsense understandings, because both types are themselves constructs (Schütz, 1962). The model will be followed by deliberations about older people’s residential facility spaces, temporality, embodiment, and relationships, which correspond to findings Chapters Five to Eight.

A mixed-method modified framework approach was used. Employing mixed-method research techniques provided a more in-depth and broad perspective than can be depicted using a single method alone, and illustrates the methodological strengths of the research (Tashakkori & Teddlie, 2003). Communication difficulties experienced by many residents, such as those related to cognitive and physical impairment often made narrative interviews a challenge for both resident and researcher. For this reason, a mixed-methods approach offers confidence that the study data collected contains breadth and depth.

Analysis and interpretation arising from I/C (Borkan, 1999) were inductive and informed my decision to use a deductive phenomenological account derived from van Manen (1990) and Schütz (Schütz, 1972, 1970) as my main methodological approach. Phenomenology and I/C as methodologies will be explained in Chapter Three. I took on board van Manen’s (1990) suggestion that Merleu-Ponty’s (1962) umbrella existentials, made up of lived space, lived time, lived body and lived relations, are useful for the process of phenomenological questioning, reflecting and writing. Once crystallised, the secondary approach I/C (Borkan, 1999) mirrored van Manen’s (1990) umbrella lifeworld themes of space, time, body and relationships as central findings, and affirmed my decision that phenomenology was a relevant approach to use in this thesis.
The range of methods made valid comparison of the data from various sources difficult to achieve, so I chose not to formally triangulate the methods. That is, after themes were identified and text coded, the text related to all data sources was considered together rather than from one source being compared with the next (which may have been considered triangulation). Instead, an alternative method of creating themes, through which the reader could readily understand, was drawn from the four data sources (Koch, Haesler, Tiziani, & Wilson, 2006; Koch, 2006).

In phenomenological research there is ongoing dialogue between the author and the text, so I needed to lead the reader to the way I came about the decisions for my interpretation (Koch, et al., 2006). The themes chosen were not necessarily the most dominant; rather the themes best demonstrating the lived experiences of the elders came from the importance I believe the residents placed on these themes. Decisions made during the study are sign posted throughout the thesis, particularly in Chapter Three (Guba & Lincoln, 1989).

The qualitative data were collected by me in Auckland and a counterpart in Christchurch, using three qualitative collection components: audio-recorded interviews transcribed verbatim were the main data source for interpretation, supplemented by interview summaries and field-journal notes. I was fortunate to have worked alongside a study team conducting a survey as part of a randomised controlled trial in New Zealand rest homes at the time of my study. Data from the quantitative survey is used to elucidate description in this thesis.

A mixed-method modified framework approach allowed material to be analysed in a number of ways. Access to the survey data, which included questions about daily pastimes and relationships along with demographic and health oriented information was shared with the wider study team. Selected descriptive data from the survey will be reported in Chapter Four, which serves as the backcloth to the phenomenological strands and threads which form Chapters Five to Eight. These chapters address the main research question *How do older people in New Zealand rest homes experience daily life?* When woven together these strands make up the lifeworld explicated in Chapter Nine. This lifeworld I conceptualise as the multiple-helix summarised visually in Figure 2.1. This conceptual model illustrates how I went about the research.
The model was produced by first identifying this study as social constructionist in its perception of all reality as socially constructed. The study question, methodology and interpretation of the data gathered each reflected my use of this metatheory. Built upon this foundation was the main phenomenological lifeworld approach whose purpose is to understand lived experience, and as it is immediately experienced, before being reflected upon or conceptualised (Schütz & Luckmann, 1973; van Manen, 1990). The data were examined using a modified framework approach.

Moving deductively from predetermined aims, a framework approach is strongly informed by a priori reasoning before taking inductive account of the narratives and interview summaries of the participants. I modified this approach by originally analysing my data using the highly inductive approach of I/C. Subsequent to this, I checked my findings by applying the phenomenological perspectives of Schütz (1962) and van Manen (1990), which I represented using the multiple-helix. The helix comprises four parts of the lifeworld: lived space, lived time, lived body and lived relationships. It provides a framework in which I temporarily separated my overarching thematic findings, which I term strands, before relating them back to the findings from I/C. Hence, the text moves back and forth in a hermeneutic circle (Gadamer, 2000).

2.2 SELECTED LITERATURE

2.2.1 RESIDENTIAL CARE FACILITY SPACES

Institutionalised spaces

Institutions are systems of common, well-known social rules that structure social interactions (Hodgson, 2006). Historically, institutional care facilities in the United Kingdom (Bond, 1999) and United States (Rowles & High, 2003) were frequently former workhouses and isolation hospitals that evolved into residential homes for frail older people. In contemporary times, research has indicated that even homely residential care facilities remain institutions to some degree (Peace & Holland, 2001). Age segregated institutional settings have the fundamental feature of being “some form of common residence” for older persons (Wilson, 2000, p. 146). The stereotypical institution has been commonly reported in ethnographic studies (for example Kaufman, 1986; Townsend, 1962).

Residential care homes as social and physical places are “constituted by and constitutive of social relations” (Laws, 1997, p. 92). According to Davey (2006), some
kind of institutional housing will always be required in New Zealand, yet understanding
which accommodation types best benefit older people is only just developing. Rest
homes taking part in my study have institutionalised rules and routines as part of the
establishment, so I have chosen to define them as ‘communal’ in that they are shared
institutionalised environments. ‘Teatime’ is one institutionalized routine where
communal (and (semi) private) space is commandeered in a specific structured way

Elders in residential care tend to stay close to home (as it were) due to frailty
(Cutler & Kane, 2005; Holland et al., 2005; Kane, 1991; Rodiek, 2005; Toombs, 1988).
Residential care facilities are often regarded as “self-contained and cut off from the
outside world, usually left undefined” (Shield, 1988, p. 24), and little is known about
how these institutional spaces are used by residents, so in Chapter Five of this thesis I
explore these spaces.

**PUBLIC AND PRIVATE SPACES**

Spatially, rest homes are positioned in ambiguous territory. Willcocks, Peace and
Kellaher (1987) have reported that residents carry out private lives in public places.
Certainly, it remains difficult to determine where resident or staff space begins or ends
(Bermann, 2003). Pinning down the meaning of privacy has proved difficult for
researchers because patterns of interaction vary in terms of privacy (Applegate &
Morse, 1994). For example, one local study reported on the difficulty in discouraging
residents with cognitive impairments from going into co-residents’ bedrooms uninvited
and taking personal belongings (Milligan, 2004). This results in a rest home
environment that defies “normal social conventions surrounding privacy” which “are
seen as inappropriate, impracticable or dangerous” (Boyle, 2004, p. 219). Social
conventions usually observed are unable to be applied in the rest home context. This is
why residents, staff members and visitors:

see and interpret what’s going on through an active process of ‘reading’
the environment and the human interactions within it. The cultural space
does not fully determine meaning, however. No single reading is correct,
although one may be more powerful than another. Rather, the ‘text’ of the
nursing [and rest] home provides a backdrop for interpretation, always
subject to revision and multiple readings (Stafford, 2003a, pp. 8-9).
Metaphorically then, this notion of text (or discourse) grows out of the landscape (Gesler & Kearns, 2002). Interpretations of this type of textual reading result in a “specific geographical location” with the residence holding less importance than the symbolic social organisation of the space (Smyth, 2005).

Space in residential care facilities is based on the needs of frail elders (Horsley, 2008). Andrews (2005) and Stafford (2003a) have pointed to the ambiguity of residential care homes having evolved as medically focused institutions which simultaneously struggle to maintain a home-like quality within the same space. The facility setting is positioned at the boundaries of meanings held about (rest) home and (nursing) hospital (Rowles & High, 2003).

Environments in which health care practices have been undertaken in a way perceived as remedial have been termed ‘therapeutic landscapes’ (Gesler, 1992). Paradoxically, residential care dwellings fail to fit a therapeutic landscapes model because they hold an infamously negative place in the range of long-term care settings built chiefly for frail older people (Sokolovsky, 1997). This failure meant that I was able to cast around for alternative ways to discuss rest home spaces.

**BEYOND-SPACES**

Continuing with the theme of landscapes, residential care facilities have also been termed ‘landscapes of loss’ (Hockey, Penhale, & Sibley, 2001). Space is lived in specific ways when ill-health and disability are part of daily life (Hillyer, 1998; Thomé, Esbensen, Dykes, & Hallberg, 2004). The residential care literature has been dominated by a care and custody model of health care due to illness and disability; one through which old age is thought and talked about (Gubrium & Holstein, 1999b). Older people are said to draw meaning from their ‘social spaces’ which in part encompass their physical, emotional and symbolic experiences (Wiles et al., 2009). Leisure is one such social space, where it is possible for the (embodied) self to develop beyond what is expected (Wearing, 1998).

Rowles (1978) believed there are different ways of relating to space at different life stages. From the perspective of middle-aged values, older people may appear to have a small or shrinking life world. However, elders’ geographical imaginations are also expanding into ‘beyond spaces’ which are both spatial and temporal, and available through reminiscence.
Figure 2.1: Conceptual model used in this thesis
Reminiscence allows the elders to engage with the experiences and events of friends and family members far away over time and space. Whether my participants shift into and out of Rowles’ (1978) notion of beyond-spaces, and if so how they go about this change, will be explored in Chapters Five, Six and Eight.

As I have discussed, the rest home as a space disrupts “distinctions that normally separate the different spheres of life” typified by institutions (Higgs, MacDonald, & Ward, 1992, p. 287). Spaces within the residential care home hold indefinite meaning (Hauge & Kristin, 2008). A focus in my study is the substitution of outdoor spaces for indoor spaces as older residents become more constrained in the space they are able to use (Cutler & Kane, 2005; Rodiek, 2005).

The next section will review literature about the notion of space as it pertains to older people.

**Residents’ Perceptions of Space**

Heller (1984) stated that “everyday life always takes place in and relates to the immediate environment of a person” (p. 6). Environments demarcated on an age-related basis are an important part of the way elders identify who they are, as well as how others view older people, and by definition themselves, in age-specific ways (Carel, 2008; Golant, 2003; Laws, 1997). Agreeing, Percival (2002) suggested addressing how elders use rest home space to aid memory, augment reflection and endow the rest home with meaning important to residents.

In communal environments such as rest homes, in-groups can be important to defining territory (Miner Salari, Brown, & Eaton, 2006), and studies have shown resident exclusion from specific spaces occurs in rest homes (Bland, 2004; Nay, 1993). This negative view on the lived environment illustrates how environment is a significant factor in people’s lives (Bond, 1999). Some care recipients have reported that the rest home is unlike home (Hale, 2006; Twigg, 2000). However, there may be a risk of overstating the role of emotional attachment and the familiarity with place as part of a preferred dwelling (Rowles, 1993). The physical setting, which includes the people within it, is said to be central to contentment when a good fit between these areas occurs (Eales, Keating, & Damsma, 2001). Other research confirms this positive corollary, as some elders making the shift to residential care have found their well-being enhanced (Rowles, 1993; Savishinsky, 1991).
This enhancement echoed Fox’s (1998, 1999a) notion of the arche-health, where residents deconstruct known concepts surrounding health and ill-health, and reconstitute new sets of activities (so-called arche-health) that can enhance the spaces of their lived world, and so increase their well-being. The idea of arche-health and arche-ill-health will be engaged with in this thesis, because these notions allow an alternative to the care and custody models encompassing common binary notions about health/ill health (Gubrium & Holstein, 1999b).

One local study exploring elders’ understandings of the rest homes in which they lived reported that perceptions of physical space differed substantially (Fitzgerald & Robertson, 2006). These differences may be in the nature of residency, because “it is unrealistic to expect that any sort of residential development or older people be viewed or experienced as ‘normal’; age-segregation itself sets such places apart from the norms” (Rubinstein & Parmelee, 1992, p. 154).

As part of the misery perspective of research noted in the previous chapter, Schuster (1996) contended “there is no getting around” the fact that residential homes are institutions for older persons who have experienced “too many losses” and are unable to function independently (p. 57). Wilson (2000) agreed, stating that “life in institutions need not be bad, but it commonly is” because “people go into institutions” as they have nobody to look after them and “cannot...look after themselves” (p. 158). While these sentiments are common, in this study I investigate another line of inquiry about the lived experience of rest home residency, including an exploration of the rest home spaces that the elders employ in their everyday lives. Addressing how spatiality is woven into the fabric of the residents’ lifeworld will be focused on in Chapter Five.

In the next section, I turn to literature on notions of time as I follow Phoenix, Smith and Sparkes’ (2007) observation that time and space are intertwined.

2.2.2 TEMPORALITY FOR RESIDENTS

Reordering past, present and future

Fundamentally, time is meaningless (Adam, 1995). Ambiguously, it is this lack of meaning which provides a way into this study about the lived experiences of rest home residents. This is because the purpose of time remains an abstract category, which allows for a comparison and integration for what would otherwise be processes such as time ‘zones’(Gell, 1992; 1991; Twigg, 2000).
Time can be perceived in culturally specific ways. Metge (1976) pointed out that Māori perceptions of time differ from those of New Zealand European. Traditionally, Māori “order time in terms of sequences of events, both natural and man-made” while for New Zealand European, clock time and calendar time are most important. Contemporarily, the capacity to reflect on lived experience allows an individual to move back and forward temporally (Mattley, 2002). This ability to shift resonates with the Māori perspective of seeing the future through the past (Buetow, 2004a).

Although it is time that “ties our experiences together” (LaCourse, 1999, p. 33), older people have often been viewed as attempting to live in the past, and are perceived to deny living in the present and so are not taken seriously. Further, due to the long time lived, elders’ meaning making through storytelling of life experiences can appear non-linear and non-chronological (Coleman, Ivani-Chalian, & Robinson, 1999), and therefore irrelevant to other people, including gerontologists.

There is an inclination to condense social aspects of ageing to fixed points across the life course that may determine the experience of old age (Gubrium & Holstein, 1995). Using this lens, old age is perceived as primarily a personal experience of adapting to physical and cognitive decline and preparation for death. A consideration of ageing using set stages across the life span is “quite alienating, and people logically flee from this image of senility” (Gubrium & Holstein, 1995, p. 385). Life review models such as Butler’s (1963) model advocate a linear trajectory from birth to death, making this form of review achievable by any individual. Yet, life review can occur at any point in life, not just in old age, because its main tenet is death rather than old age per se (Butler, 1963). For this reason, the life review literature is of limited use in this thesis. In this thesis the focus is on life, in the form of lived experience in older age, rather than death in old age.

Of course, elders do review their past experiences, as do all individuals. Like other people, their focus is not on (their own) death. The past holds particular value because it represents the stories that have already happened in their life. Bad experiences act as lessons to be applied in the present, while good experiences offer memories a safe place (LaCourse, 1999), which resonates with a Māori perspective of time. Older individuals take time to tell their narratives which usually do not surface.
“all at once in a linear, chronological order” but meander, backtrack, jump ahead, or digress (Muller, 1999, p. 228).

Meaning is managed through shifting physiological and cognitive ideas about self health (Jerrome, 1992), and are filtered through various timeframes in an adaptive way (von Faber et al., 2001). Fox’s (1998, 1999a) idea of an arche-health explained earlier allows elders the possibility of deconstructing notions of health and ill-health through which they can continually unfold their changing health (and ill-health) status over time as and when required.

According to Hendricks (2001), “weaving stories is akin to crafting time; doing so provides continuity” (p. 40). Metaphoric weaving proves useful in my study because it allows a threading of a temporal strand back and forth without too much concern about getting lost in time (and space). Exploring temporal aspects of the residents’ lived experiences in my study will illustrate whether (or not) the weaving metaphor is relevant in their lives.

**Adaptive Temporal Paces**

Frail elders have illnesses and disability. Disabled people have a temporal coordination where everything takes longer (Agich, 1995; Iwakuma, 2002). Elders who have exceeded life expectancy have been found to have reduced (Dosman, Fast, Chapman, & Keating, 2006) or adapted productive activity (Fast, 2006). The temporal pace of residents differs from that of staff, whose work time is premised on clock time (Wetle, 1991). Despite tasks taking more time for older people, they can aptly manage their day-to-day through multiple meanings made about life using a subjective timeframe (Walker-Birckhead, 1996). Arxer, Murphy and Belgrave (2007) consider temporality as “connected to meaning making” and so all points of time are valuable (p. 135).

In terms of running out of time, older people have been reported by social gerontologists to experience fear of, and anxiety about death (Tomer, 2000). This viewpoint is clear when time is thought about as a clock, so “fear of dying is a reasonable response, since life is imagined to be on a linear lifetime line where “death is placed at the end” of a time continuum that counts down to a person’s demise” (Arxer, et al., 2007, pp. 128-129).

It is generally known that life expectancy diminishes with increasing age (World Health Organization [WHO], 2010). An individual’s relationship to the future changes
as they get older, and the future grows shorter. The past is observed through the present; a present that is shared with others (Heikkinen, 2004). A temporal definition of time ticking away from birth through old age to death is in reality a social construction because “death is neither near nor far: it is not” because dying “‘soon’ remains as vague at eighty years of age as it was at seventy” (p. 442). Elders are not near death because they are old. Like people of other age groups, older people have a “relationship with life and with nothing else” (de Beauvoir, 1972, p. 442). Life changes over time, but death of self (if not others) remains at some unidentified future point in time.

Notions about time change over a life time, for example Parkins (2004) noted the importance of slowing time to a pace that suits an individual, and termed this an ‘ethics of time’. This ethics is “a re-invention, an inversion even, of temporality” (Parkins, 2004, p. 372). Along similar lines, LaCourse (1999) spoke about the experience of managing the self in time, and suggested that a slower pace is in keeping with managing an ageing body. By changing attitudes to time, posited Carel (2008), the quality of the here and now can be positively altered.

This alteration appears to apply especially to the elderly. Older people have been found by Dittmann-Kohli (2007) and Gubrium (2001) to draw positive narratives from the way they “linked their present lives with their pasts” (p. 27). Older people present themselves to others by weaving narrative and reminiscence into a richly illustrated montage (Keeling, 1998), which is a storied account of “different spheres of meaning in the context of lifelong experiences” (Gubrium, 2001, p. 28).

Concepts of time hold a kind of embeddedness that refers to life as it is known, based in a temporal order that occurred in the past, takes place in the present and will continue into the future (Grosz, 2004; Knipscheer, 2004). This restructuring of an embedded but flexible temporality is a useful notion in my study which will be discussed in Chapter Six.

**Residents’ Reminiscence**

Everyday life is above all a temporal concept (Felski, 2000). Scientists studying social life are expected to “rise above the common-sense and the-taken-for-granted” (Adam, 1995, p. 3) which, I can attest, is far easier said than done. This is because time is such an obvious factor in social science that it is almost invisible. Socially orientated time is often subjective time, and so can be theorised as a series of components consisting of
“the subjective time estimate, the event, and the subjective meanings attached to the event – and how they are related to one another” (Lawton, 1983, p. 41). Subjective time differs from objective time in that its various components do not have to add up; rather, subjective time must merely make sense to the teller of time as reader, narrator or storyteller.

To understand life (and death), people tell stories to pass down facts (Haber, 2006; Webster & Haight, 1995). Stories appear to develop directly from lived experiences and actions at various points of time (Baars, 2007). Knowledge is not dependent on whether the events taken place and reported are true or false. Rather the “criterion is whether they are expressive of the subject’s current assessment of their value and importance in contributing to the episode that is the topic of the story” (Polkinghorne, 1996, p. 95).

Often, humour is used by elders to get through difficult times, and in the telling of the hard times. Humour has been used as one way to talk about life and death (Stroobants, 2009), as noted in the residential care literature (Gubrium, 1993; Makoni & Grainger, 2002; Nay, 1993). In my study about frail elders, I will investigate the lived experiences of the residents relating to death of others, and reflections on their own deaths. Ways in which older people interact through their stories includes humour (Burgener & Dickerson-Putman, 1999; Carty, 2008), especially ‘black humour’ (Stroobants, 2009) which puts together morose or horrifying elements with humorous ones.

**WORK AND LEISURE TIME**

The realm of time for roles such as making plans and scheduling periods spent becomes “activity (actual or fantasized) as allocated over clock time, not time in any abstract sense” (Lawton, 1983, pp. 41-43). The most common dimensions of time in western societies, including New Zealand, include work time, rest time and mealtime (Agahi, Ahacic, & Parker, 2006). These times often prelude what is currently termed leisure time. Leisure time usually has more flexibility than does work time. However, social meanings given to work and its relationship to leisure determine there is no leisure outside the context of work (Carrington, 2008).

Social context is a major factor in the meaning given to the social constructs of work (Grint, 2005) and leisure (Devine, 2004). Leisure takes some working at, as
Mansvelt (1997) found in a local community-based study with older people. Recent research found leisure engaged in by some elders with dementia is used as a form of resistance to stigmatisation (Genoe, 2010). For other older people however, leisure may serve to remind them of the losses they have experienced (Genoe, 2010). Clock time allows meaning to be made about the temporal order of set times, such as work and leisure, in a concrete way. Perceiving time as a mechanical clock results in viewing older people as ‘worn out’ and closer to decline, dysfunction, disengagement and death than are younger cohorts (Arxer, et al., 2007), and so hooks back into the care and custody models mentioned earlier.

In this thesis, I move away from these models, instead I investigate how residents take up the notion of work and leisure time to understand how they make meaning of their everyday. In other studies, leisure has been found to hold minimal meaning for elders (Roadburg, 1981). The commonly expressed rejection of leisure by elders in the literature stems from the depression years when unemployment was not a “voluntary expression of one’s spare time, but rather a consequence of mass, long-term unemployment caused by a global economic recession” (Bailey, 2007, p. 463; Jahoda, 1979; Waters & Moore, 2002). It is not surprising then, that leisure time has been reported by older people as more of a privilege than a right (Hoppes, Wilcox, & Graham, 2001).

Free time on the other hand is discretionary time not involving ‘essential’ pursuits such as work. Pronovost (1989) states that free time is gained out of time spent in work, so only through work time does free time derive its meaning. The notion of paid and unpaid work has taken on specific form in a New Zealand context. For older men, paid work roles ceased suddenly with mandatory retirement as they reached 65 years of age. Forced retirement accompanied a superannuation benefit from the state. Legislation abolishing compulsory retirement came into force in 1999 (Ministry of Health, 2001c), so work and retirement experiences over the past decade will differ substantially from older generations’ experiences.

Older men’s lived experiences of work and retirement differ substantially from how women experience work (Arber, Davidson, & Ginn, 2003). Work that is paid fails to apply to older women because most spent their lives in unpaid work in the home. A woman’s place was in the private domestic sphere of the home, providing unpaid care
for husbands and/or children, managing the household and completing home chores termed ‘housework’ (Johnson & Lloyd, 2004). Women’s labour outside the home was often based around the family, such as children’s sports or men’s organisations, and was voluntary (unpaid) work (Park, 1991). Following retirement from paid work men’s lives altered substantially, while women’s work changed little, remaining on a similar trajectory as always.

Frailty over time resulted in some elders making the move from their own homes to rest homes. Here, a double invisibility occurs as older residents hypothetically ‘rest’ in the rest ‘home’. How older people make meaning of their supposed rest in the home context is unclear. From an outsider perspective, older residents, who are usually long-term retirees, may appear to do little. However, it is not known how they perceive their accomplishments, as they may be busier than is recognised by other people. A temporal context in this thesis will improve understanding about people living in rest homes, and as Morgan (2006) pointed out, provides a richer view than can be offered using a simple snapshot. Chapter Six offers such a viewpoint on time.

To add another dimension to this study, next, the selected literature about the lived body will be reviewed.

2.2.3 EMBODIMENT

PROBLEMATIC OLDER BODIES

In this critical gerontology study, notions of the body have to be at the forefront as the “embodied experience is always socially bound [because] bodies exist in social settings” (Tucker, 2006, p. 433). Yet, I found limited research about the socially lived ageing body in general and the frail ageing body specifically, even though “every understanding of the body” is socially constructed (Hughes, 2004; Longino & Powell, 2004, p. 207). The reason for this deficiency according to Heikkinen (2000), Powell and Wahidin (2007) and Oberg (2003) is a general reluctance of socially trained gerontologists to deal directly with the body. According to Twigg (2004) the focus on older peoples’ physicality is what makes the residential care environment and its regimes so uninviting. Bodies are observed for “signs of dirtiness, sickness, and decline. They are got up, dressed, washed, moved, fed, toileted, arranged in chairs” to generate the “end-product of the institution” (Twigg, 2004, p. 65). Residents’ apparent bodily
inactivity is perpetuated by the ongoing decline in physical and cognitive health (High & Rowles, 1995).

Props such as “stigmatized bodies, posture, demeanour, closed doors and similar barriers to perception, furniture arrangements, lighting, and other bodily or environmental props” can be used to convey meaning about a particular account of the body (Holstein & Gubrium, 2000b, p. 187). In the rest home setting, elders’ bodies as props have been situated as a lifeless creation that Lee-Treweek (1994) called the lounge standard resident. This representation of residents is reinforced through mainstream media (Andrews, 2001; Bonnesen & Burgess, 2004; Featherstone & Hepworth, 1999) often in the “guise of scandal and sensationalism” (Stafford, 2003b, p. 21) as reported in Chapter One. Undoubtedly, this unappealing rendering fits well into negative views of both the rest home environment and its residents in a New Zealand context (Fitzgerald & Robertson, 2006). Older people’s bodies unable to fit so called successful models are by definition ageing unsuccessfully.

Negative meaning has also been socially constructed about disability, so it follows that older people with disabilities are constructed negatively (Oliver, 1990; Roth, 1983). As a social construct, disability is embodied and thus negative social constructions result in the individual body becoming stigmatised (Goffman, 1968). Embodiment in old age becomes especially complicated because the ageing body sits uneasily within socio-cultural meanings. This uneasiness is compounded by the notion of old age being simultaneously perceived as a social category, yet one that is exceedingly difficult to apply to self on an experiential level (Degnen, 2007).

Old age based solely on the elderly body is the “hub not of cultural discourse but of its negation. Rather than generating meanings, even in the form of self adulation, it is marginalized to the extent of symbolic invisibility” (Hazan, 1994, p. 27). Thus, there is constant tension that threatens to unravel which comes about when embodiment is disturbed through disability or frailty. This results in “disruptions to the flow of bodily experience in daily life” (Becker, 1994, pp. 62-63). Occurrences of illness only serve to highlight ageing and its impact on the life world (Thomé, et al., 2004). The notion of old age’s bodily incapacity and disease appears to justify the limited authority associated with older people (Calasanti, 2003; Cuddy, Norton, & Fiske, 2005), and so their viewpoints remain quiet, despite the suggestion that combining ageing research
and disability models could prove useful (Crooks, Chouinard, & Wilton, 2008; Oldman, 2002; Putnam, 2002).

**A CHALLENGE TO THE BODY/MIND DUALISM**

The mind and body are intrinsically linked (Bullington, 2009), which allows a space to develop between the first person ‘I’ and scientific third person ‘him or her’ through which the lived body fits (Leder, 1990). The third person perspective is used in storytelling, and so is appropriate in this study’s focus on older peoples’ narratives. The notion that mind and body are lived offers a non-dualistic way of understanding embodiment (Bullington, 2009). This concept of embodiment links together broadly cultural and circumstantial usages, with the body taking on meaning at the intersection of narrative, culture, and social interaction. In the rest home context, these combined interactions are drawn together in relation to the ageing body. Simultaneously, the body itself acts as both discursive anchor and as an anchor for discourse. The meaning of the body is practical, not simply definitional or cultural. Fortunately, the idea of the body as a discursive endeavour moves beyond the Cartesian notion of the “old body-mind duality” (Shilling, 1993), to a position of meaning made through lived experience (Andrews, 1999; Gubrium & Holstein, 1999b; Kontos, 2003).

Some research has shown that an awareness of embodiment is possible through the elders’ material body which becomes a “mediating feature of everyday life” (Holstein & Gubrium, 2000b, p. 197). Everyday function can no longer be performed in the way they used to, and simple tasks become technical problems to be negotiated (Bullington, 2009). Frailty does not preclude elders from experiencing positive shifts in the ageing process, because “even poor health could open new vistas” (Furstenberg, 2002, p. 9). Research with older persons in residential care has shed light on the strategies used by older people to make meaning of their everyday lives (Nay, 1993). To achieve this, the disabled embodied self can be positioned from invisibility to the forefront of experience (Hayne, 2002; Kliever, 1995).

Black humour is particularly helpful in bed-and-body work where “the ageing body is discursively anchored in direct relation to organisational practices” (Gubrium & Holstein, 1999b, p. 533). Stroobants (2009) found that “humour can resolve tension and improve relationships” and even the incomprehensible can be positioned through humour as it allows for ridiculousness to make sense (p. 11).
ADAPTING EMBODIMENT

Here, the idea of arche-health again comes into play (Fox, 1998, 1999a). Residents make choices concerning their actions regarding both health and illness. One study of nursing home residents found that a need to continue performing activity was imperative (Bryant, Corbett, & Kutner, 2001), while in other research just being in the surroundings may, for elders, accomplish the same need as the actual activity (Ball et al., 2004; Hallam, Hockey, & Howarth, 1999; Phinney & Chesla, 2003, p. 289; Van't Leven & Jonsson, 2002).

It may be difficult for some residents to sustain or adapt pastimes (Mozley et al., 2007; Segal, 2005; World Health Organization [WHO], 2008), so the ability to carry out an activity plays an important role for individuals in their perceptions of capability and wellbeing (Sen, 1993), successful activity (Bergland & Kirkevold, 2006; Moore, 2006), productive activity (Dosman, et al., 2006) and good health (Reed, Stanley, & Clarke, 2004).

Alternatively, embodying adaptations may be a way of not giving up lifelong pastimes altogether as suggested by Bergland and Kirkevold (2006) along with Kahn (1999). This point is backed by Australian research with care facility residents reporting that having no useful activity to do was difficult for them (Nay, 1993). In another study, repetitive activities were likely to be endeavours to place boundaries around the existential world in order to hold in place those activities over which elders still have some control (Gamliel & Hazan, 2006; Hazan, 1987).

Embodying self care or self help takes planning and adaptation of what is known about “bodily signals of health and ill-health” as other phenomenological research suggests (Fex, Ek, & Söderhamn, 2009; Hjaltadóttir & Gústafsdóttir, 2007). Various aspects of well-being are important lay concepts, but these differ between age groups. On one level, emphasis is placed on positive well-being by older people themselves while on another level individuals take up cultural values of ageing (Westerhof, et al., 2003).

For example, food nutrition along with social aspects surrounding food plays a large role in the subjective health and well-being of elders (McCormick, 2008). Food has been linked to elders’ subjective well-being in assisted living (Park, 2009; Savishinsky, 2003; Street, Burge, Quadagno, & Barrett, 2007). Of the few residential
care studies available in this area, weight loss is usually associated with disability and illness (Splett, Roth-Yousey, & Vogelzang, 2003). Furstenberg (2002) found that when observing others who were sick or experiencing ill-health, elders constructed and managed cognitive and social activity through which they retained what they considered as good health for themselves.

The experience of growing old may have contributed to a diminishing ability to undertake everyday tasks, but it does not necessarily undermine individual elders’ self-esteem. Torres (2006) pointed out that this tension could be due to how the experience of old age is talked about rather than what growing old intrinsically involves. Due to silence in the research I offer, in Chapter Seven, to address older residents’ embodiment.

Discourses about ageing bodies need to take account of the ordinary “needs, deeds and relationships” of older people (Clarke & Warren, 2007, p. 465). To this end, the literature about the relevance of older persons’ relations with others will be now drawn upon.

2.2.4 Residents’ Relations with Others
Social interaction, social participation and social involvement have been advocated by the World Health Organisation (WHO) as guiding principles for enhancing the ageing experience (Kalache & Keller, 1999). In a residential care context, empirical evidence of social support interconnects with the provision of health-care, positive well-being and quality of life in old age (Bemis, 2003; Declercq, 2000; Hubbard, Tester, & Downs, 2003; Kiely & Flacker, 2003; Knight & Mellor, 2007; Levasseur, Desrosiers, & Noreau, 2004; National Care Homes Research and Development Forum, 2007; Sasidharan, Payne, Orgsenga-Smith, & Godbey, 2006). Other studies have called for more relationship-centred approaches in the residential care context (Nolan, Brown, Davies, Nolan, & Keady, 2006). Research reflecting on nursing home daily life over a quarter century found a need for “more engaging long-term care facilities” that “promote and support social interaction and meaningful activity throughout the day” for residents (Harper Ice, 2002, p. 345).

Having a good sense of self has been associated with what Kellaher (2000) termed mutuality in resident relationships. Reciprocal relationships that engender mutual exchange have been found important in residential care settings, although these hold
specific challenges for frail older people (Brown Wilson, Davies, & Nolan, 2009). For example, Brink and Stones (2007), identified social engagement as adversely affected by hearing impairment and other communication difficulties for elders in continuing care locations.

Other losses such as death of relational others impact on institutionalised elders (Djivre, 2008; Sidell, 1999), yet available settings for rituals around death are few (Benner, 2000, 2001), and allowances for grief are limited for bereaved people (Gass, 2004; Goodrum, 2008). In residential care, humour has been found a useful compromise response style because it allows residents to convey resistance while simultaneously managing the appearance of competency and good manners (Shumovich, 2000) even in the event of loss.

Recent research examined personal relationships which Brown Wilson (2009) found to be a vital part of living, working and visiting in residential homes. Nevertheless, exchanges between residents and other people “may go unrecognized by passers-by or busy staff, who remain unaware of this interactivity” (Peace, Kellaher, & Willcocks, 1997, p. 48).

My research will examine reciprocal relations within the rest home in Chapter Eight. Residents’ relationships are often conflated, although for the purposes of this thesis, I have reviewed the literature in the categories of co-residents, staff members, and family and friends.

**Co-residents**

Research about the significance of residents’ perceptions of giving assistance to fellow residents is available. One study found that older residents believed they could still contribute in some way and this resulted in continued self worth (Nay, 1993). Perceived ability to ‘give’ to others may be connected to people rating their health as better than others (Suls, Lemos, & Stewart, 2002). In a primary health care setting, Buetow and Kerse (2001) pointed out the value of recognising health within illness, which is tied to the need for reciprocal caring relationships for ill and/or disabled people. As a way of managing, through their narratives individuals may favourably compare their health to co-residents’ ill-health (Buetow, Goodyear-Smith, & Coster, 2001). Wellness includes cognitive as well as physical ability.
Cognitive impairment often becomes noticeable in the residential care setting through socially inappropriate noises such as yelling (Babbage, 2005; Meacher, 1972; Shield, 1988). Carel (2008) stated that observable disability or ill-health is “the elephant in the room. It is seen as something that is not to be commented on or mentioned by polite people” (p. 51). Residents have been found to rationalise co-residents’ behavioural problems associated with cognitive impairment. These elders become empathic and point out that they could be the individual with dementia (Powers, 1991). Potential stigma ties into the older people’s perceptions of use it or lose it, in keeping with other investigations (Corner & Bond, 2004; Graneheim & Jansson, 2006). As already discussed, the notion of arche-health (Fox, 1998, 1999a) would allow an individual to deconstruct the way they view their own health and ill-health, and offers the possibility of constructing a more positive self health outlook compared to co-residents.

Older people living in institutional care settings have reported that residents create social interactions in which activity is entrenched, but only within specific cultural and structural contexts (Hubbard, et al., 2003). Networking with peers has been found to be relevant to older people living in retirement homes (Gubrium, 1975; Powers, 1996). Buys (2001) pointed out that the close proximity of residents in an age-segregated environment of a retirement village facilitates regular contact with co-residents. Social relationships between residents have been found to be connected to well-being, and take precedence over keeping up past relationships or the physical setting in assisted living (Street, et al., 2007). Guse and Masesar (1999) found it noteworthy that frail older residents have remained willing and able to support others, although frailty does impact on this willingness (Clare, Rowlands, Bruce, Surr, & Downs, 2008).

Giving and receiving in social relationships has been found beneficial for community-dwelling elders (Bowling, 2005; Li & Ferraro, 2005; Lum & Lightfoot, 2005; Musick & Wilson, 2003; Narushima, 2005; Thomas, 2010; Warburton & McLaughlin, 2006; Yunqing & Ferraro, 2005), although the effects of taking part in informal volunteer work is not well known for residential care dwellers. One study in assisted living found ability to give to others may lessen with age for frail older persons even though a need to reciprocate continues (Beel-Bates, Ingersoll-Dayton, & Nelson, 2007). Another assisted living study reported that not all elders want to volunteer, especially in household tasks (Ball, et al., 2004).
Despite lack of acknowledgment of informal, volunteer work done by community dwelling elders as a legitimate contribution at individual or societal levels (Dosman, et al., 2006), Rook and Sorkin (2003) indicated that volunteering enhances the opportunity for friendship with age peers. Social engagement and giving back to others were crucial factors for (young) older Australians in one of the first studies to ask elders about their active engagement in life; however, how this was achieved was unclear (Buys & Miller, 2006). Put simply, my research will explore resident reciprocity through volunteerism. This view resonates with other studies about ageing well (Townsend, Godfrey, & Denby, 2006). Guse and Masesar’s (1999) study with residents self-reporting their interactions included helping others, and was tied to the elders successful ageing and quality of life. Another study found residents actively involved in the development of relationships with co-residents (Eales, et al., 2001).

Residential care dwellers’ opinions of fellow residents have been said to vary from keeping to one’s self to considering most co-residents to be friends (Matthews, 2000). As active social lives are most often related to younger people it has been difficult for others to picture older people having rich lives (Reed & MacMillan, 1995). Yet, by acknowledging elders’ interactions, the types of relationships important to them can be glimpsed (Chown, 1981). In a nursing home context Reed, Payton and Bond (1995) argued that it was necessary to look beyond the utility of friendship, in order to take up sociological dialogue about what friendship means. One definition states that friendship, which is central to individuals’ lives, is a specific personal relationship grounded in reciprocal concern by each friend (Helm, 2008). Co-resident relationships are supposedly constrained, yet they have continued reciprocity in the face of facility regulations forbidding residents from “giving each other much help in the form of treatment or therapy” (Diamond, 1992, p. 230). Enforced helplessness towards others may have magnified empathy for co-residents considered less fortunate and has remained an ongoing theme in the literature (Becker, 1994; Nay, 1993), which I will explore in this thesis.

Other studies however, have suggested closeness between residents is rare (Willcocks, et al., 1987). One study found avoidance was an approach used to circumvent disagreement with co-residents (Moremen, 2008). Other research about residents spending time in a communal lounge argued that elders’ relationships are fragile, and that those who could, withdrew from common living areas (Hauge &
The notion that frail residents have to remain in a particular location owing to immobility may be one reason for co-residents spending time together (Hauge & Kristin, 2008). This view fits with the misery perspectives that greying bodies line the lounges of residential homes (Hallam, et al., 1999), where residents spend a great deal of time in one place doing nothing at all (Gottesman & Bourestom, 1974). Whether co-residents’ relations have been documented from their experience, or of researchers’ perceptions of co-relations is not always clear. In Chapter Eight of my study, I take the opportunity to specifically investigate co-resident relations from residents’ lived experience, to increase understanding about living in a rest home.

Reciprocal interaction with staff members is also significant in daily life in the rest home, and will be reviewed next.

**STAFF MEMBERS**

Resident and staff relationships in long-term care have been found critical to residents’ quality of life (Hauge & Kristin, 2008; McGilton & Boscart, 2007) and well-being (Knight & Mellor, 2007) along with quality of care (Tinney, 2008). Residential care dwellers actively interact with, and elicit care from formal and informal caregivers (Russell, 1996). Staff members relationships with residents are often described as ambiguous, with awareness from both parties that this relationship is tension filled (Bergland, 2001; Chou, Boldy, & Lee, 2002; Persson & Wasterfors, 2009; Powers, 1992). The daily life of residents and the staff members who care for them has been studied overseas (Hubbard, et al., 2003; Spencer, Hersch, Aldridge, Anderson, & Urlbrich, 2001), but with the exception of Bland’s (2004) work on residents’ (dis)comfort, little research has been carried out in New Zealand rest homes. Overseas studies have found that for older people conversing is an important activity and staff members are urged to listen out for residents’ need to converse with other people (Andersson, Pettersson, & Sidnevall, 2007; Wadensten, 2005). This may be difficult in the residential care setting however, because

the social relationships of older adults…in private households are maintained thanks to everyday gestures, conversations, offers of help, and attention that demand little time or effort. The institutionalized do not have such scope for contact with others; they are cared for merely in the formal sense (Wagner, Schutze, & Lang, 1999, p. 299).
Studies of relationships between residents and staff members (Eales, et al., 2001; Holloway, 1999; Marini, 1999; Nay, 1993) have pointed to unequal relations that require rigorous resident advocacy (Nelson, 2000). Residents have been found to work with staff as part of their everyday private life that entails most aspects of day-to-day life, including basic activities of the everyday (Agich, 1993). One study differentiated between staff labels and residents’ identity claims in a nursing home, and allowed the residents to portray their lives on their own terms (Paterniti, 2003). In the United States, another study argued that nursing home residents were always at risk of being lonely (Hicks, 2000).

Key pointers for staff to recognise loneliness, and act to counter it, included being aware of residents’ social preference and interaction style (Hicks, 2000). Other research found that a social history intervention to individualise residents did not change staff perceptions about nursing home elders (Hillman, Skoloda, Zander, & Stricker, 1999). Reinforcing this view, Knight and Mellor (2007) found that notions of social inclusion through activity differ between older residents and staff in residential care.

Emotional experiences are shaped by social contexts and in turn shape social contexts (Mattley, 2002). Research findings about emotional support in relationships in residential care ethnographies differ. Bland (1997) was of the opinion that residents emotional and social requirements are met by staff, while Gubrium (1975) reported residents were separated from staff both metaphorically and literally due to the way the physical environment was arranged.

An accrual of loss is considerable for older people (Lloyd & Cameron, 2005). One review of the literature in the United Kingdom found losses and expected losses in bodily terms (National Care Homes Research and Development Forum, 2007). Decreasing ability and deaths of family and friends and co-residents is, for nursing home residents, an ongoing theme not often acknowledged in gerontology research (National Care Homes Research and Development Forum, 2007). Death of resident elders is not uncommon, as studies have shown (Brooke, 1989; Diamond, 1992; Djivre, 2008; Gubrium, 1975; Howarth, 1998; Nay, 1993; Shield, 1988).

The normalising of dying in the residential care context has been called for (Nolan, Featherstone, & Nolan, 2003), although scant literature is available. Research has found death of nursing home residents to be ignored by staff members (Parker-
Oliver, Porock, & Oliver, 2006), while dying and death of others are often concealed and denied by staff and rest home management, although residents have been found to want to be involved when co-residents die (National Care Homes Research and Development Forum, 2007).

In my own previous research, staff ignored visibly distressed residents, explaining upset elders as typical in the residential care setting (Kiata & Kerse, 2004b). This finding reflects a perception that older people are less likely than their younger counterparts to be upset (Komaromy & Hockey, 2001). More recently, Jones and Wright (2008) argued that older residents’ emotional worlds swing between emptiness and fullness in the ways that they impact on care staff. In this thesis, I will investigate the resident and staff relationship from the lived experience of the residents, to understand how they make meaning of their relations with staff members.

Studies have highlighted how residents have been patronised and treated as children, most commonly heard in baby talk used by staff (Biggs, 1993; Nussbaum, Pitts, Huber, Raup Krieger, & Ohs, 2005; Williams, Kemper, & Hummert, 2003). One piece of research found residents were often not taken seriously by some staff who applied stereotypes to the elders (Shield, 1988), such as infantilisation (Kitwood, 1997). This negative type casting is not always the case because residents “adapt, and find meaning in new relationships, new hobbies and new roles” (Rowles & High, 2003, p. 14).

Stigma tends to be “woven into the very fabric of our morality” where it is internalised by individuals (Hendricks, Sheets, & Bradley, 2006, p. 22). This leaves older people having to deal with social and self identities within the confines of stigmatised environments such as the rest home (Gamlil & Hazan, 2006; Goffman, 1968, 1983). Add to the rest home context time measured in years, and a person is marked as “distinctively old, in diametric opposition to the stereotypic youthful scheme of things” resulting in few positive views (Gubrium & Holstein, 2003, pp. 6-7). This results in (s)ageism which reinforces ageism (Minichiello, Browne, & Kendig, 2000).

Ironically “ageism by the non-elder is unique in that it is directed toward a group to which, barring premature death, the perpetrators will one day belong” (Martens, Goldenberg, & Greenberg, 2005, p. 223). Resident and staff respondents in one study reflected this type casting when reporting that neither group were “optimistic about
achieving more resident control and choice which” paradoxically “both groups perceived as desirable” (Kane et al., 1997, p. 45). Others have reported staff members require more training in communicating effectively with residents (Carpiac-Claver & Levy-Storms, 2007; Kennedy, Sylvia, Bani-Issa, Khater, & S., 2005; Wadensten, 2005). An investigation into interpersonal conflicts between residents and staff in assisted living and nursing homes found resident centred care practices resulted in fewer conflicts (Small & Montoro-Rodriguez, 2006). Pleschberger (2007) argued that staff in institutions could match ideas about dignity to those of care residents more often, particularly when the residents were dying.

In the main, literature about resident-staff relations can be one of tension and inequity (Hockey & James, 1993). The scant research about residents’ relations with staff encourages my exploration of this type of relationship in Chapter Eight of my thesis. Relationships of residents and their families and friends are also important, and will now be reviewed.

FAMILY AND FRIENDS
Residents in long-term care have been found to highly value family connections and reminiscence which is tied to social activity (Harmer & Orrell, 2008). For residents, family connections and interactions with friends remain on a similar trajectory as throughout their lives (Rowles & High, 2003; Rubin-Terrado, 1994). One study about assisted living residents’ views on visits by family and friends found that the numbers of visitors and amount of time spent are important to the older person’s life satisfaction (Thompson, Weber, & Juozapavicious, 2001). Other studies have found a shift over time in patterns of altruistic activities taken up by nursing home residents, although activities have remained focused upon family and friends (Bland, 1997; Cipriani, Faig, Ayrer, Brown, & Johnson, 2006; Kaddar, 2001).

Research demonstrating that family members remain involved in the lives of residential care residents (Bond et al., 1999) has “helped debunk the myth that families abandon their relatives in nursing homes or similar settings to die in isolation” (Gaugler, 2005, p. 105). Diamond’s (1992) nursing home ethnography noted that “listening to residents’ everyday conversations about their families…did not lead to the inference that they were abandoned” (p. 70). It is worth bringing attention to the point that:
informal social interaction is generally viewed as an activity that does not have any readily identifiable social value. However, informal networks and relationships form the basis of people’s connections with society, and enhance the likelihood of people acting for mutual benefit (Statistics New Zealand, 2004b, p. 78).

Despite inability in measuring informal social interaction, particularly in residential care (Mor, Branco, Fleishman, Hawes, & al., 1995), these links have long been popular with older people. A local study found social support systems continued to be used by elders in both residential care and the community (Belgrave & Brown, 1997). Promoting meaningful interaction has its difficulties. One Scandinavian survey found that social connections impacted on levels of loneliness in residential care (Drageset, 2004). As previously reviewed, residents have been construed as dependent on others which is associated with passivity and vulnerability. These traits are always viewed as negative, with elders being perceived “as objects of care rather than recognised as active agents or as equal partners in caring relationships generally” (Boyle, 2008, p. 302).

Andrew (2005) cautioned that distressed individuals, such as those recently moved unwillingly into residential care may perceive and report poor social support (see also Kawachi & Berkman, 2000). Further, older people may have stated what they thought researchers wanted to hear. A word of caution notes that long-term care residents in one study were found to be unquestionably conscious of being stereotyped as abandoned elders left in care homes “by uncaring children” and were eager to “allay any perception that they themselves fall into the category of lonely” and dejected old person (Williams & Guendouzi, 2005, p. 458).

The significance of informal contact through telephone contact has been reported to be an important connection for elders in residential care to remain in touch with family and friends (Gueldner et al., 2001). Other research in a geriatric care facility also found maintaining outside ties highly regarded by elders (Gubrium, 1975; Silverstein & Angelelli, 1998). Mystified by how outside information was relayed to residents when they appeared to have few visitors, Gubrium (1975) initially believed staff members’ opinion to take residents’ tales with a grain of salt as possibly imaginary. Gubrium (1975) concluded however, that residents’ access to up to date information was irrespective of the amount of time physically spent with family and friends or in
telephone conversation. In this thesis, I will investigate the importance of this type of information regarding family and friends through the lived experiences of residents.

Older people in adult assisted living facilities, along with elders living with family were found to desire access to long time friends, but this was not achievable for the majority taking part in one study (Eales, et al., 2001). The role of grandparenthood holds specific worth according to other research that included elders in assisted living, because grandchildren added a “positive element to the aging identity” (Williams & Guendouzi, 2005, p. 468). Residents in Williams and Guendouzi’s (2005) study reported pride about grandchildren’s achievements based on honour roll achievements rather than a relationship that “deeper personal intimacy would afford” (p. 468).

Another form of important social contact for residents is animals. It has been reported in residential care studies that animals play an important role in residents lives (Kawamura, Niiyama, & Niiyama, 2009; Lutwack-Bloom, Wijewickrama, & Smith, 2005; Ruckdeschel & Van Haitsma, 2001). I will consider in Chapter Eight the residents connections with others including pets, particularly cats.

The review above has highlighted existing research about older people living in residential facilities in relation to spatiality, temporality, embodiment and relations with others. Largely absent from the research are critical gerontological accounts of the ordinary, day-to-day lived experiences of elders staying in residential care.

2.3 CHAPTER DISCUSSION
When starting this chapter, I set down the conceptual mixed-model modified framework approach used in this thesis. I then reviewed a selection of gerontology literature. The main research question in this critical gerontology study asks How do older people in New Zealand rest homes experience daily life? Readings were chosen for relevance to older people living in residential care facilities such as rest homes or nursing homes, assisted living and residential villages. Most of this literature was based on age-segregated living environments.

The literature above corresponds to four thematic strands of lived experience found in the phenomenological lifeworld approach (van Manen, 1990). This lifeworld is a way of “seeing through which to investigate aspects of aging that may otherwise be overlooked” (Kenyon & Randall, 2001, p. 3), and is the main approach used in this thesis. Lines of inquiry in this chapter serve to illuminate the strengths and weaknesses
of the literature. Selected readings I considered in this chapter investigated the specific environmental context (lived space) of the rest home, where embodied (lived body) narratives of past, present or future (lived time) are intersubjectively intertwined (lived relations with others), and are the means by which biographical lived experiences are given meaning (Phoenix, et al., 2007).

In the next chapter, the methods used and methodological approach of phenomenology taken up in this study will be discussed.
3 CHAPTER THREE: METHODS AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes how this study came about and the methods used, along with my choice of philosophical and methodological approaches for an investigation into the phenomenon of older peoples’ lived experiences of rest home life. Phenomenology is one well established perspective of social constructionism and can be applied in innovative ways as this thesis illustrates. Based on extensive field work, this study offers an interpretive and locally situated critical gerontology of the ways in which rest home residents make meaning of their day-to-day lives.

In this chapter, I explain how a social constructionist approach to phenomenology can produce an interpretive representation of rest home residents’ lived experiences. The term ‘live’ comes from Old English and means to be alive and to pass life while the word ‘experience’ comes from Old French and Latin, and is defined as “knowledge gained by repeated trials” and “to try, test” (Harper, 2001). I draw on van Manen’s (1990, 1997, 1998, 2002) and Schütz’s (1962, 1972, 1970; Schütz & Luckmann, 1973) phenomenological approaches in order to consider the philosophical and methodological issues in seeking perspectives of the lifeworld. Researching the lifeworld will be presented in this chapter in light of the study’s main research question How do older people living in New Zealand rest homes experience daily life?

3.2 MIXED-METHODS

3.2.1 RESEARCH DESIGN

The procedures used to collect and make sense of the data relating to the research questions are the methods undertaken for this study. Mixed-methods include both quantitative and qualitative research techniques (Brannen, 2005; Johnson & Onwuegubuzie, 2004) and generate knowledge not available when undertaking either a qualitative study or quantitative study separately (O’Cathain, Murphy, & Nicholl, 2007). The value and risk of mixing methods in any one study continue to be debated (Bryman, 2004, 2007; Creswell & Tashakkori, 2007; Fry, 2000; Johnson & Onwuegubuzie, 2007) and until very recently most methodological approaches have been either quantitative or qualitative (Creswell, 2003). Now, theorising the application of mixed-methods
research has become more widespread and productive (Murray, 2003; Tashakkori & Creswell, 2007) as illustrated by a dedicated *Journal of Mixed Methods Research.*

A mixed-methods design (Figure 2.1) offered several ways to address the aim of the study, which was to explore the lived experiences of older people living in New Zealand rest homes. Qualitative research methods included interview summaries from these participants and researcher field-journal notes for scope and context. Audio-recorded interviews are from a subset of the participant residents whose voice is pivotal to the study findings. As a mode of enhancing my findings, data from a quantitative survey conducted at the rest homes during my study were included (Appendix 4).

To select a subsample of the participants who were investigated qualitatively, systematic sampling was used because a priori there were no evidence based criteria on which to sample purposively. This method of probability sampling is less efficient than selecting on purpose the most information rich residents. However, it was easy and quick to use and since the sampling frame appeared homogenous and not to conceal any pattern, it permits inferences to all 352 residents from which the sample of 27 was selected. The mixed-methods I chose were each sound and legitimate research approaches in their own right, and offered complementary, potentially layered views of the same phenomena (May, 2007).

### 3.2.2 Recruitment

This doctoral study was located in the control arm of a wider study, a cluster randomised controlled trial entitled ‘Promoting Independence in Residential Care’ (PIRC) (Kerse, et al., 2008; Peri, et al., 2008b).

**The PIRC trial**

The PIRC trial aimed to test the effects of a physical activity intervention on the quality of life and physical function of older people in New Zealand rest homes in two cities, compared with a control group. Rest homes were chosen over aged care hospitals because residents were ambulatory to some degree so it was possible for them to increase their physical ability, and make and remember goal setting tasks. Rest homes were also selected because this level of care is under considerable pressure from increasing disability levels and decreasing government funding. It was hoped that
improving levels of function in this level of care would relieve at least some of the care burden and improve residents’ quality of life.

The New Zealand Ministry of Health supplied the PIRC team with a list of all rest homes in two cities, Auckland and Christchurch. Criteria for rest home inclusion included status as a low level dependency rest home that catered for older people. In random order, using computer generated random numbers, rest homes were chosen and invited to take part until the desired number (determined by the power calculation for the trial) was recruited (Kerse, et al., 2008; Peri, et al., 2008b). Rest home management and staff members within each home identified eligible older residents for the study. Resident eligibility criteria included being aged 65 years or greater and “able to engage in a conversation about a goal, likely to remember the goal, and participate in a programme to achieve the goal” (Kerse, et al., 2008, p. 2).

Ability to participate in a goal setting activity, a proxy designed to exclude those with advanced dementia, was determined by the clinical nurse at the home in consultation with the research recruitment nurse for the PIRC trial. These criteria were set as the participants needed to be able to engage in the activity intervention. The recruitment strategy resulted in 83% of eligible residents agreeing to participate in the trial (Kerse, et al., 2008). Those ineligible numbered approximately 50% of all those in the rest home. The main reason for ineligibility was being unable to participate in a goal setting intervention, thus the recruited sample could be considered the group of residents with better cognitive function (Kerse, et al., 2008).

Once informed consent was received from all of the eligible residents who wished to take part in the study, a survey was conducted with all participating residents (n=682). The active arm was a physical activity programme delivered by a nurse. When all residents participating at a rest home had completed the survey, the rest home was randomly allocated into one of two groups: the intervention (activity) or the control (social) arm. The control (social) visits were designed to control for the social attention given to residents taking part in the intervention (activity) arm in the PIRC trial. As the PIRC trial is discussed elsewhere (Kerse, et al., 2008; Peri, et al., 2008b) conclusions from the activity intervention arm of the trial are not described or reported on in this thesis.
**LIFEWORLD DOCTORAL STUDY**

Survey data for the 352 residents taking part in the control (social) arm of the PIRC trial survey were made available to me by the PIRC study team (Appendix 4). The management at each rest home were introduced to my counterpart and me by a research nurse. Residents were approached and invited into this doctoral study by my counterpart and me. Of those asked, 314 residents agreed and were visited by me in Auckland, and my counterpart in Christchurch. Interview summaries (Appendix 3) along with field-journal notes and data from the survey supplemented audio-recorded interview data. The detail required to describe residents’ day-to-day lives in the rest home came mainly from 27 transcribed audio-recorded interviews. My counterpart and I arranged a second visit with residents to verify information and give back to residents in written form, documentation of the first visits (Appendix 6).

Intellectual input to the overall trial design resides with others (Kerse, et al., 2008). Primarily, I contributed intellectually to the design and application of this doctoral study involving the control (social) group arm with support from the supervisors, one of whom was the PIRC trial Principal Investigator (PI). Design of the data collection tools for this doctoral study was not constrained by PIRC trial methods, and I developed the interview summaries and areas of inquiry for discussion with each resident. I interviewed residents in Auckland. A counterpart interviewed most, and me some of the Christchurch residents. My counterpart and I spent time together training through discussing and practising different interview scenarios, piloting interviews with older friends and comparing notes.

**3.2.3 DATA COLLECTION**

While a fundamental condition of social research is to gather data from people (Fleming & Ward, 2004), the way in which data are gathered remains most important in the research process. Distinctive factors needed in research with older people have started to be addressed as the increasing numbers taking part in research initiatives illustrate (Mountain, 2003). Special consideration should be given by researchers when carrying out research with older people (Butler, 1990). This particularly applies in a rest home context, as elders may be hard of hearing or find communicating difficult due to physical or cognitive impairment as discussed in upcoming chapters. The older people may in some ways be a ‘captive population’, and may feel a strong social expectation to
participate in research. Owing to special characteristics it is important to adhere to a
gold standard such as Gilhooly’s (2002) four principles of good ethics in research: (i)
doing no harm, (ii) doing good, (iii) treating people fairly and (iv) having respect for
people.

**QUANTITATIVE DATA**

**Survey**

Prior to randomisation, all enrolled residents in the PIRC trial were surveyed by trained
research nurses to ascertain baseline features and demographic data (Appendix 4).
During the development of the survey schedule I contributed structured questions
relating to relations to others and patterns of pastimes. These questions were
administered by a research nurse as part of the baseline survey to all 682 PIRC
participants taking part in the intervention and control (social) arms. In this way,
demographic, health related and socially focused data for the 352 older people taking
part in the control (social) group were made available to me by the PIRC team as
background information.

Survey data presented in this thesis were analysed by me using SPSS 14.1 with
some support from a statistician. Demographic and health data from the survey serves
as contextual backdrop for my study and enhances the main findings (Kerse, et al.,
2008; Peri, et al., 2008b). Coding of the social focussed survey questions was built into
a coding schedule of the survey (Appendix 4). Health related data came in part from
self-report and from standard statistical measures. Descriptive statistics were used to
summarise findings of the survey items. Scales were summed to construct a score where
relevant. Each social question was summarised and means or medians presented
depending on the distribution of the data.

Data included in this thesis includes socio-demographic information and health
characteristics. Data chosen for my study is intended as background information to the
residents’ lives. For the wider PIRC trial, rest home medical records elicited
information about the residents’ diagnoses and medications. Cognition was tested using
Hodgkinson’s (1972) Abbreviated Mental Test Score (AMTS). Recording dates and
circumstances of falls within rest homes is compulsory in New Zealand. A fall was
defined as unintentionally coming to rest on the ground, floor or other lower level
(Buchner et al., 1993). Falls onto furniture, into walls and other structures were not
counted. Falls data from three months before the start of the study were collected in line with other New Zealand falls’ data (Butler, Kerse, & Todd, 2004).

A generic self-rated health measure ranging from poor to excellent was used (Ware & Sherbourne, 1992). Adapted from the Life Satisfaction Inventory (Neugarten, Havighurst, & Tobin, 1961), the Life Satisfaction Inventory Z (LSI-Z) (Wood, Wylie, & Sheafor, 1969) measures residents’ self-reported life satisfaction to show how content they are with their lives. Respondents were offered three options, where they could (a) agree or (b) disagree or state (c) not sure in response to 13 statements relating to life satisfaction. The range of possible score was 0-26 with higher scores indicating greater life satisfaction. A 15 scale version of the 30 scale Geriatric Depression Scale (GDS) (Yesavage et al., 1983) is a frequently used measure with yes versus no responses. Residents are less likely to tire while completing it. A score of less than 5 means respondents are not depressed, while a score of 5-15 indicated mild to moderate depression. Any score over 15 correlates with severe depressive symptomatology. Both the LSI Z and the GDS measures point to the impact on participants’ ability to network with other people, and affect the types of activities the older people undertake.

Developed by a multi-disciplinary team, the EuroQol (1990) was used in this study as a way of describing and valuing health related quality of life. Six broad areas are assessed in the EuroQol measure: (i) mobility, (ii) self-care, (iii) activities, (iv) pain, (v) psychological functioning and (vi) self-reported overall health related quality of life. The measure is made up of two parts; the first five questions cover domains of (a) mobility, (b) self-care, (c) usual activities, (d) pain - discomfort and (e) anxiety/depression and each of these dimensions can elicit three responses and has a total possible cut off score of 12. The other part of the EuroQol is the Visual Analogue Scale (VAS), a self-assessed measure of overall health state with a scale range from 100 as best imaginable health, to 0 as worst imaginable health state. Debate continues about the reliability of the measure, although it has been reported to demonstrate test-retest reliability (van Agt, Essink-Bot, Krabbe, & Bonsel, 1994).

Other survey data applicable to this thesis include the residents’ perceptions about living in the rest home, and their families and friends, along with information about the activities they take part in, at the rest homes.
QUALITATIVE DATA

Following recruitment to the PIRC trial, residents took part in the survey described above. Once all surveys for a rest home were completed, the rest home was randomised into the intervention or control (social) group (see section 3.2.2). The 352 residents in the control (social) group were invited by a research nurse to take part in this doctoral study. Ten residents refused, 20 relocated out of the study area, and eight died. The 314 residents remaining agreed to be interviewed as part of this study.

The research nurse introduced my counterpart and me to the management at each rest home. Initiating contact with residents was left to my Christchurch equivalent and me. We interviewed participating residents in each rest home, collecting qualitative data between March 2004 and April 2005. Residents in each rest home were visited twice sequentially. Time spent at rest homes differed, although data collection for this mixed-methods study was always labour intensive. Research visits generally took place between 8.30 a.m. and 5.30 p.m. Some residents welcomed weekend visitors because most rest home based activities were from Monday to Friday. Visits lasted from 15 minutes to two and a half hours with the majority between 30 to 45 minutes duration.

Resident visits and write-up from notes at the interviews, and composing summaries to be returned to each resident totalled at least 600 hours across the two cities. For example, a conservative estimate of time spent for one rest home consisted of two visits with 20 elders, and type up of interviews totalling approximately 37 hours. Audio-recorded interview transcriptions have not been included and travel time to and from rest homes has been excluded from this estimate.

Rest homes with large numbers of residents sometimes took weeks to complete data collection compared to smaller homes. I also had to take into account adequate time to provide both written and verbal information about the study. At times, the older people were away from the rest home for appointments, which meant more time spent there, due to having to return time and again. Becoming a familiar face to residents and staff proved valuable in retaining participants (Kiata & Kerse, 2004a), and in the development of my field-journal. To augment the research experience as a positive one for the elders I had to ascertain appropriate times to visit and how long to stay so as not to tire them.
A summary of an interview outline had been piloted with 10 residents living in two Auckland rest homes in February and March 2004. The pilot showed that this method was feasible and effective in the planned research process (van Teijlingen & Hundley, 2002). Piloting the interview gave me an opportunity to discover obstacles previously not thought about (Miles & Huberman, 1984; Perry, 2001). Concentrating on what was important to the residents meant I was able to modify the interview schedule as I went along (Huberman & Miles, 1994). Attempts to gain information about residents’ lived experiences initially resulted in many saying they had few or no interests. To get around this problem, the older peoples’ experiences of past relationships and pursuits were asked about. Once these conversations began dialogue easily flowed into more current, lived experiences.

As I considered the residents “experiential experts of the topic under investigation” (Eatough & Smith, 2008, p. 188), they were asked to take part in a conversation-type interview consisting of seven semi-structured questions and these were reported onto the resident’s interview summary (Appendix 3). Residents were guaranteed anonymity and confidentiality of information. Their words are italicised in the text of this thesis. To ensure anonymity, pseudonyms are used. Double quote marks are used for direct quotations, while single quote marks are used for discussion of terms. Square brackets of insertions within quotes are to add clarity to the text. Text that has been omitted within a quote will be indicated by three full stops.

My primary focus was to cover individual and shared pastimes defined as physical and/or social leisure, hobbies, interests and pursuits taken part in on a daily or regular basis. A subsample of the resident conversations was audio-taped after additional consenting processes. Following the interviews, my reflections and observations about the resident and staff conversations were noted in a field-journal.

Audio-recorded interviews
The main source of data for this thesis was 27 audio-recorded interviews, as the richest layer for phenomenological analysis is found in the narrative texts. A request to audio-record interviews was asked of every tenth resident taking part from the start of my study. My counterpart and I spent time with them responding to queries and requesting signed consent for the conversation to be audio-recorded (Appendix 5). The few who refused cited privacy or health issues. Refusals resulted in the next older
person visited being asked. Audio-recorded interviews took between 15 minutes and two and a half hours with most lasting between 30 and 45 minutes. Standard-sized cassettes with 60 minutes of total recording time were used. Interviews were transcribed verbatim by me. Fifteen interviews at each site provided more than the 12-20 people typically recommended for qualitative research to give clarity to themes in an interview context (Patton, 1990). Technical problems meant three recordings were not audible, which left me with 27 interviews.

**Interview summaries**

The audio-recorded interviews discussed above were collected from a sub-group of those residents contributing interview summaries. At the first research visit, questions were asked using a conversational form in order to complete an interview summary (Appendix 3). The feedback process involved writing up and returning the information in summary letter format to the older people (Appendix 6). This feedback ideally took place over a period of time no longer than six weeks. Regular telephone and email contact continued between the Christchurch counterpart and me throughout data collection to address queries arising from interviews. We also did some co-interviewing, where a resident was interviewed by my counterpart or me, and later re-interviewed by the other researcher while the first interviewer was present. Co-interviewing was carried out for one researcher to observe the interviewing technique of the other to ensure similar interview methods were used.

A second visit with each interviewed resident followed for ‘member checking’, which is where the elders check as true the details collected at the previous interview (Lincoln & Guba, 1985). My counterpart and I transferred the interview summary into a summarised letter format that I had developed (Appendix 6). Bullet points noted major activities specific to each resident. Large font print was used for people with visual impairment. They were asked to check the data by reading the typewritten letter or having it read to them. At the residents’ request, any changes were noted and updated on my Microsoft Word database.

They were again reassured about anonymity and confidentiality of information. Owing to the meanings of words having multiple definitions over the generational spaces between the elders and my counterpart and me, it was important for us to check the feedback, particularly for clarity of meaning. For example, the elders talked of being
“gay” which meant ‘carefree’ or ‘merry’, while a more recent meaning of the term gay is linked to sexuality. The individuals were given their interview summary letters to keep as a record of their past and present interests and pursuits and as a record of our conversations (Appendix 6).

This giving back of information was novel because few residents had their lived experiences, past or present, acknowledged in written format and specific to them. Collecting information that was both rigorous and able to be related to was important (Tushman & O'Reilly, 2007). The rationale for writing up and offering summary letters (Appendix 6) to the elders meant information shared was correctly recorded as a sign of our respect as researchers. The second visits lasted between 15 minutes and two and a half hours with most lasting between 30 to 45 minutes.

The main data collected for this study is qualitative, and based on 314 interview summaries, with a sub-group of 27 residents taking part in audio-recorded interviews.

**Field-journal notes**

A record of my researcher observations and thoughts was also made throughout the data collection process using a field-journal. An integral component to data collection was thus observation, which has long been a tool in its own right for social researchers (Adler & Adler, 1994; Angrosino & Mays de Perez, 2000). My counterpart and I recorded observational field notes and our reflections after each visit which usually covered the resident’s location, length of time spent with each resident and their overall demeanour before, during and after the visit. Observations from these notes are incorporated into the following chapters to provide environmental context, and add depth of interpretation to the interviews. Residents and staff carried on with their day ‘as if I was not there’ (Kiata & Kerse, 2004a) and I was able to move around the rest home without being challenged. I tended to stop and sit in public areas such as lounges and dining areas to observe goings on or to write up field-journal notes.

Having described the data collection phase of the study, the next sections explain the techniques used to transcribe, code and analyse each component of my study data.

### 3.2.4 TRANSCRIPTION

Audio-recorded interview data were transcribed and became what Elliott (2005) termed a reflective bridge to which the other data sources were connected. I transcribed all
audio-recorded interviews. Background noise and some residents’ speech affected by ill-health resulted in one audio-recording in Auckland and two in Christchurch being inaudible, and so these recordings were unable to be transcribed. I transcribed 27 audio-recorded interviews verbatim into Microsoft Word. On average the transcriptions took four to six hours per tape. The residents speak through anecdotes and stories shared during interviews and these extracts are italicised in the text of this thesis. To ensure the residents’ anonymity pseudonyms are applied.

3.2.5 CODING AND ANALYSIS

Analysis in most qualitative research begins at the time of data collection (Ezzy, 2002) and my study was no exception. Interwoven to position and strengthen the study overall, focus was placed on the 27 audio-recordings as the main data source, complemented by the 314 interview summaries. Both sources were checked for consistency using inter-rater coding and comparisons in coding as reviewed with my supervisors. Ambiguities in the accounts were clarified with the residents when visited for a second time.

In developing themes for the interpretation I read and reread the transcripts looking for common patterns and themes. After immersion in the data themes were reviewed considering those that were most important to the older participants, that is the participant talked in detail and appeared to gain clarity for themselves during our conversations. Subthemes were developed. Coding began manually first to try out the themes and subthemes. Constant crystallisation of the themes continued throughout analysis until saturation and clarity were achieved. Then data previously recorded in Microsoft Word were converted to N6 format to enhance the findings. Assisted by the N6 software I continued to work with the qualitative and narrative data (Weitzman, 2000). Using this software provided fast “access to the data and a way of writing” and gave me a “paper trail that increased the credibility of the analysis process” which is key to good research practice (Meadows & Dodendorf, 1999, p. 199). Notes from the field-journal were coded manually. The use of a field-journal meant that I had an ongoing, audited record of the decisions made along the way, and developments in my thinking over the duration of the study. The large amounts of written data were deductively and inductively coded manually for themes and patterns (Adler & Adler, 1994) through several iterations.
All data material was coded and reorganised so that field journal, taped and interview summary material were considered alongside one another within each theme. Thus each source was not compared. This was to enable meaning making from each of the sources to be informed directly by the other sources, rather than triangulating. In reporting it is the participant’s perspectives that are conveyed and my interpretation is explicit.

The next section will be an in-depth discussion of the methodological stance taken in this study.

3.3 A PHENOMENOLOGICAL APPROACH

Phenomenology is coined from the Greek words ‘phainomenon’ meaning that which appears or is seen (Harper, 2001), and ‘logos’ which means ‘word, speech, discourse’ and ‘reason’. The concept of the lifeworld derives from the German term ‘lebenswelt’, and translates into English as meaning “the world of lived experience” (van Manen, 1990, p. 182). Challenging dominant views on the nature and origin of truth, in early twentieth century Germany, phenomenology gained popularity as a philosophy. Its philosophies have included the pure or transcendental phenomenology of Husserl (1970), who is the so called father of phenomenology (Racher & Robinson, 2002) and Heidegger’s (1996) existential phenomenology, with its interpretivist view.

Further phenomenologies include Gadamer’s (2000) constructivist hermeneutics, Foucault’s (1977) phenomenology, Levinas’ (1998) use of ethical phenomenology and of most interest to me Schütz’s (1962) phenomenological sociology and van Manen’s (1990) hermeneutic phenomenology. Each of the above approaches develops as the research that engages with it progresses (Moran, 2000). These traditional phenomenologies developed in Europe have been called the German, French and Dutch schools (Dowling, 2007).

The phenomenological approach used in my study begins by drawing on interpretations of Husserl’s philosophical idea of lifeworld research. Major contributors to phenomenology in the German tradition include Husserl (1970) whose ideas were taken up by phenomenologists such as Schütz (1962) and van Manen (1990) from whose writings I have borrowed for this study.
3.3.1 **Alfred Schütz**

A contemporary of Husserl’s, Schütz (1962) worked at the “frontier between philosophy and social science” and developed a phenomenological sociology (Schütz & Luckmann, 1973). While Husserl remained working in Germany during the 1930s, Schütz, like many Jewish intellectuals fleeing Nazism, emigrated to the United States. Schütz believed that the work of phenomenologist Husserl (1970) and sociologist Weber (1991) were intimately related and could be synthesised (Ferguson, 2006). In response to Husserl, Schütz established both a philosophy and a research method in a shift away from traditional phenomenology to what has been called a hybrid, or American phenomenology (Ferguson, 2006).

Schütz’s (1972) attention to pre-existing social contexts of meaning fits with Husserl’s view because the “social world is a world of shared meanings” found in the idea of lebenswelt (Rasmussen, 1984, p. 130). Schütz (1972) stratifies the lifeworld into spatial, temporal, embodied and social dimensions through what he terms phenomenological sociology. Historically, sociology and phenomenology have not been positioned together, although both disciplines hold a “shared interest in clarifying the nature of intersubjectivity” which is an actively regenerated social construction (Ferguson, 2006, p. 83). An intersubjective world is experienced as moving beyond the field of immediate contact because it acts as a container to its own past and future (Ferguson, 2006).

Sociologically, it is practical to include interactive exchanges between the past and present, which includes the living and dead (Turner, 1984). These interactions with self and relational others, dead or alive, are embodied through spatial and temporal dimensions positioned in the notion of phenomenological intersubjectivity. These dimensions, which are integral to this thesis, are found in Schütz’s (1962, 1972, 1970) phenomenological sociology which gives social processes priority when investigating the lifeworld.

Social processes are twofold and distinguishing between direct interaction and indirect action with predecessors, successors and contemporaries where the “dividing line between the world of contemporaries and predecessors is not sharp” (Schütz & Luckmann, 1973, p. 88). On one level, meaning making occurs in interaction between individuals through Schutz’s (1951, 1953) notion of biography where meaning is made.
On another level, the constitutive characteristics of life experiences become preserved in memory within a person’s lived world of meaning making. This intersubjectivity is what Schütz (1972) termed “growing old together” and involves both subjective and objective temporality.

Schütz’s (2002) notion of ideal-types shows the usefulness of his phenomenology for a critical gerontology, which is fluid rather than fixed (May & Powell, 2008). Longino and Powell (2009) agree that Schütz’s phenomenology contradicts the notion of a fixed standpoint of life stages. Normative life stages across the life course, such as that posited by Erikson (1980), appear to establish the experience of old age. In such models, old age is presented:

as primarily a private experience of adaptation to inevitable physical and mental decline and preparation for this. This common understanding of aging is quite alienating, and people logically flee from this image of senility (Longino & Powell, 2009, p. 382).

I follow the lead of other recent research using phenomenological approaches of lifeworld research “applied to the study of other people’s experience”, to seek and understand the “reality of individual’s experience as they engage with the phenomenon” (Dowling, 2007, p. 137).

### 3.3.2 MAX VAN MANEN

A more recent phenomenologist also borrowing Husserl’s ideas is van Manen (1990) who remains in the traditional European camp, and has become a major thinker of the Dutch school of phenomenology (Caelli, 2000; Holloway & Wheeler, 1996). His phenomenology sets out to describe how people are oriented to lived experience: “descriptions of prereflective experience, as it was lived” are “solicited as a means of accessing real descriptions of phenomena” (Caelli, 2000, p. 369). van Manen’s (1990) view is that “phenomenology is the study of the lifeworld” that “aims at gaining a deeper understanding of the nature or meaning of our everyday experiences” (p. 9).

van Manen (1990) continues to pursue Husserl’s point that a lifeworld has no need for a conclusion or summary because it tells its own embodied notion of itself. Lived experience is in phenomenological terms a lifeworld approach which acts as an “operating framework” to allow for contextual interpretation of “a world that makes sense” (Gubrium & Holstein, 1999a, p. 295). To elucidate the phenomenon in question,
van Manen (1990) suggests employing lived experience as “the starting point and end point of phenomenological research” (p. 36).

The context for my beginning an interpretive study of the lived experiences of the residents was based on questions and observations made early in the developmental phase with the research team and work colleagues about shared meanings of rest home life. Examination of the phenomenology literature was also necessary and will now be discussed.

van Manen (1997) argues that “a good phenomenological text has the effect of making us suddenly see something in a manner that enriches our understanding of everyday life experience” (p. 345). Aiming for clarity, phenomenology applied in this thesis follows a blend of description and interpretation. van Manen’s (1990, 1998, 2002) writings are of particular relevance because lifeworld structures of older people are central to my research interests. The experience of lived time, lived space, lived body, and lived relations are central themes in van Manen’s (1990) lifeworld approach.

The methodological processes used in this lifeworld study will be considered in the next section.

3.4 INTERPRETIVE AND DESCRIPTIVE METHODOLOGY: A PHENOMENOLOGICAL APPROACH

Engaging with a range of phenomenological perspectives (1972, 1970; Schütz & Luckmann, 1973; van Manen, 1990) allowed me to work from a unique position within a broader social constructionism. Philosophical perspectives with phenomenological leanings such as those of Husserl (1970), from whom both Schütz (1972, 1970; Schütz & Luckmann, 1973) and van Manen (1990) drew heavily, were not originally intended for methodological use (Dowling, 2007). Yet, researchers have adapted these methods to their own research, particularly in psychology (for example, Giorgi, 2005) and nursing (such as Dowling, 2007).

A phenomenological perspective depends on the interpretive legitimacy of the researcher (Crotty, 1998). According to van Manen (2007), an individual (researcher) with empathy can arbitrate a viable space in which to work, between the people who live in places (residents) and the people who want to plan for those places (management and policy makers). With its purpose of interpreting and understanding the meaning of
In the lifeworld, phenomenological research is interdisciplinary which makes it ideal for a study in critical gerontology.

The term ‘description’ is used to include both the interpretive hermeneutic and descriptive facets of other components of the study. van Manen (1990) defines phenomenology as the science of phenomena and hermeneutics as the practice and theory of interpretation. Rejecting the view that his phenomenological technique is a methodology, van Manen (1990) argues that the researcher’s presence influences the phenomenon under study.

Westerhof and colleagues (2003) pointed out that “methodology is an age-sensitive issue”. Certainly, phenomenology as lived experience of elderly people has proved valuable in other health related research exemplified in local studies about the comfort of older people ageing in the rest home (Bland, 2004) and well being of community dwelling oldest-old (Wright St Clair, 2008), and internationally with studies about older people and loneliness (Abas, 2007), and ageing men and disability (Fleming, 2001). These studies offer “good phenomenological description” that has been “collected by lived experience and recollects lived experience – is validated by lived experience and it validates lived experience” (van Manen, 1990, p. 27).

[T]he aim of phenomenology is to transform lived experience…in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful; a notion by which a reader is powerfully animated in his or her own lived experience (van Manen, 1990, p. 36).

Descriptive interpretive research succeeds when an aspect of the lifeworld is illuminated and seems credible to the reader, who then gives it a phenomenological ‘nod’. The nod is one of understanding, in recognition of having had, or potentially having, the experience described and interpreted.

The fundamental lifeworld has umbrella themes comprised of lived space, lived time, lived body and lived relations with others (1972, 1970; Schütz & Luckmann, 1973; van Manen, 1990). These themes belong to the structure of the lifeworld, known as ‘existentials’ in phenomenological research. I will use the term ‘lifeworld’ because it is in keeping with most of phenomenological research. While aware that there is no single, ideal type of approach (Buetow, 2004a), I employed a lifeworld approach in this
study because it “is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience” (van Manen, 1990, p. 10).

These four existentials of lived body, lived space, lived time, and lived relation to the other can be differentiated but not separated. They all form an intricate unity which we call the lifeworld – our lived world (van Manen, 1990, p. 105).

To be dependable a study’s theoretical, methodological and analytical decisions must be crystal clear to the reader by the author whose job it is to point out to the reasons for the particular interpretation held in a study (Koch, et al., 2006; Koch, 2006). My choice of methodological approaches grew as they related to the research question. As the validity of using triangulation in mixed-methods research, especially qualitative research, has been questioned (Koch, 2006) I chose the approach of setting out different constituent parts (of a whole) to illuminate both the depth and breadth of data that offered richness to the study otherwise not available. In keeping with the mixed-methods used is a modified framework approach that I describe later. I bridged the audio-recorded interviews and the other data sources of interview summaries and my field-journal along with the survey data in a way that brought depth to the descriptive and interpretive aspects of my study.

**Research Principles**

I developed the overall research process with a series of research activities or principles advocated by van Manen (1990). The steps of these principles offer flexible guides and recommendations that enable me as a researcher “to select or invent appropriate research methods, techniques, and procedures for a particular problem or question” (van Manen, 1990, p. 30). These principles are primarily from van Manen’s work, although I have combined other phenomenological perspectives such as Schütz (1962, 1972, 1970) and Schütz and Luckmann (1973). van Manen (1990) recommends six principles to serve as a map to chart other phenomenological signposts. What follows is a description of this mapping exercise.

Principles:

I. Turn to a phenomenon of serious interest

II. Investigate experience as it is lived rather than conceptualised

III. Reflect on essential themes, which characterise the phenomenon

IV. Describe the phenomenon through the art of writing and rewriting
V. Maintain a strong and oriented relation to the phenomenon
VI. Balance the research context by considering parts and the whole

**Principle I: Phenomenon - Lived experiences of older people in rest homes**

As interpreter, I used a phenomenological sociological concept to make meaning through the Weberian concept of ‘Verstehen’. A sociological term, verstehen translates from German into English as the notion of understanding “what it means to comprehend the meaning of something” because “what is understood is meaningful” (Schütz, 1970, p. 323). The starting point of interaction is understanding, which allows individuals to interact but only to the extent that they share understanding of each other’s intentions and motives applicable to their purposes at the time. Making meaning of an experience retrospectively occurs through interpretation.

Lived experiences and the structures of meanings are multifaceted. I aimed to understand the meaning of the lifeworld of residents through the themes of space, time, body and relational others. Subjective meaning is defined by van Manen (1990) as the meaning that people ascribe to their own actions and experiences. Objective meaning is meaning imputed to the conduct of another person by an observer. For Schütz (1970) phenomenological “sociological understanding is the result of a sociologist’s subjective interpretation of the phenomena” of a person’s conduct being considered, and “as such, it belongs to the objective realm of sociological method and interpretative theory” (p. 323). van Manen (1990) similarly suggests that phenomenology is interpretive because it “redefines the meaning of the concepts of objectivity and subjectivity, and it does not make unbridgeable distinctions between fact and value, the empirical and the normative” and so allows for lived experience accounts of the lifeworld (p. 16).

Phenomenological research begins with a researcher questioning a phenomenon in-depth. Lived experience cannot be reflected on while living through the experience so phenomenological reflection is retrospective (van Manen, 1990). Reflecting on the phenomenon of the lifeworld of residents I employed my personal investments as part of an observational act which “are not only recognised but become a subject of the research” (Gergen & Gergen, 2003, p. 580). Investing in what is going on while researching meant keeping a field-journal (Koch & Harrington, 1998). Field notes in the journal depicted my thoughts at the time of interviews and add depth of meaning to the data. I also noted observations and conversations with the older people who were in the
“process of theorising their own lives” and I made sense of their theories in terms of my own (Williams, 2004, p. xviii).

As I am a person located in the context of individual, social, and a historical set of circumstances, the research did not begin or progress in a disembodied manner. Rather I set “out to make sense of a certain aspect of human existence” (van Manen, 1990, p. 31). At a personal level, what I knew about rest home life at the start of my study was limited. During infrequent visits with family members who managed rest homes in the Auckland area for a number of years I observed, but seldom interacted with, older residents. A one off visit to a great-aunt and great-uncle in 1970s England and a visit to a friend’s grandfather living in a west Auckland rest home in the 1990s were my only direct experiences of having family members or friends as residents. Becoming a rest home dweller is possible for me in the future, as it may be for members of my family, friends and colleagues so it is important for me to know more about everyday lived experience in rest homes in contemporary times, to gauge what rest home life might be like in the future. Literally, I would be interpreting the narratives and interview summaries of the elders’ lived experience in a meaning making exercise. In a metaphorical sense, I could attempt to ‘stand in another individual’s shoes’ by imagining what it would be like to be that other person (Messer, 2004).

My professional development as a researcher over the past decade has been added to within an academic primary health care setting. At a professional level, previous health research in a residential care context provided a steep learning curve into the rest home world. I was a researcher in a study about negotiating reciprocity of care in one Auckland rest home conducted with Pacific Islands caregivers and New Zealand European care recipients (Kiata & Kerse, 2004a, 2004b). While working in a large rest home, I found that the physical environment required my constant orientation due to becoming lost in its vast corridors. My senses were initially overwhelmed by sights such as incredibly frail elders confined to beds or chairs, the sounds of residents calling out, and in particular the smell from combined odours of overcooked food, urine and other discharges from older bodies in ill-health. Both staff and residents positioned me as a temporary member of their daily world, and I was more than once mistaken for a rest home employee. Most staff seemed unconcerned about my presence, while the residents expressed interest and were keen to participate in that study. I was surprised by the high levels of interest and willingness of the frail elders to take part in the study.
It was while engaged in research for that previous study that a wish to work with older people unexpectedly arose. From that initial study to the time of this doctoral research, I have worked hard at questioning my prior understandings about the experiences of residents and what I expected their experiences to be. Those expectations included loneliness and frailty among elders ‘making the best of it’ after finding themselves ‘dumped’ in rest homes. On the contrary, in the main residents have continued to express considerable knowledge about the goings on in the rest home, and have reported ongoing interactions with family and friends living outside the rest home. My initial expectations before the study, which may well have prevented me from coming to terms with the phenomenon as lived, were quickly negated through conversations with residents. These older people’s experiences were mainly positive and they were open to taking an active role in research about their lives.

**Principle II: Investigate the experience as it is lived**

One problem with phenomenological inquiry is not that a researcher may know too little about the phenomenon under investigation but rather too much (van Manen, 1990). Predisposition to knowing too much consists of pre-understandings that come about through commonsense notions and assumptions, and that, alongside existing scientific knowledge, become how the world is understood (van Manen, 1990). On one level I had to get past my personal feelings, inclinations, preferences and beliefs about how the experience must be for those living in the rest homes, so I needed to hold up to the light my pre-understandings (van Manen, 1990). On another level, I had to remain aware that by disregarding prior knowledge my presuppositions could creep back into my researcher reflections. Further, it was important to remain aware that for older adults talking about their lives depended in part on the relationship established (Randall, Prior, & Skarborn, 2006) between them and my counterpart and me.

Different phenomenological processes could adequately manage my presuppositions including bracketing (Husserl, 1970), eidetic reduction to the essence or essential process of the phenomenon (van Manen, 1990) and typification (Schütz, 1972). While van Manen offers a starting point with a phenomenological essence, I chose to use typification for two reasons. First, despite attempts to facilitate bracketing (for example, Ahern, 1999), and reduction (Merleau-Ponty, 1962), these processes remain extremely difficult to put into practice. Typification is attractive because its
point of difference lays in its “coherence and meaningfulness of the world in general” as consequence of a sedimentation constituted by past and present reflections (Ferguson, 2006, p. 92). Typification occurs through a “store of ready-made meanings” consisting of a pre-existing “stock of knowledge and frames of relevance” through which individuals “explicate their own and others’ meaningfulness” (Ferguson, 2006, p. 93). These typified reflections include “scientific and metaphysical discourse” located “in the mundane reality of everyday life (Ferguson, 2006, p. 92).

Phenomenological sociology holds that lived experience is understandable through social interchanges that are typifications of mutual socio-cultural ways of general meaning making implanted through language (Gergen, 1999).

Intertwined with typification is a premise used in interpretive phenomenological analysis (IPA) (Smith, 1996) where narrative shows “how the world is experienced – and not simply that we are tellers of stories” (Eatough & Smith, 2008, p. 185). As language is learnt the world is experienced “in ways that effectively ‘blind’” the individual to the nuances that give meaning to language and “experiences are inevitably colored by the social – and most directly – the linguistic world in which we are immersed” (Gergen, 1999, p. 128). I appealed to where the basic experience meets the patterned structures of the lived world, where meaning is constructed as lived interaction, through language (Merleau-Ponty, 2000).

Language is central in Gadamer’s (2000) notion of the dialectic, which is rooted in the term dialogue and means to move back and forth as conversations do. The usual way for conversations to come into being is through having a chat (van Manen, 1990). van Manen (1990) suggests that interviewing for personal life stories through recollection and biography is one such “means for exploring and gathering experiential narrative material” which serves as dialectic “resource for developing a richer and deeper understanding” of the phenomenon under study (p.66).

Dialectics are based in the everyday practice of dialogue that is the sharing of different ideas between people. van Manen (1990) argues that “dialogically constructed texts allow us to recognise our lives in the mimicry of stories and conversational anecdotes” (p.144). Thus dialogic texts allow for a certain space, a voice, which teaches by its textuality what the sheer content of the text only manages to make problematic” (van Manen, 1990, p. 144). The way dialogue moves backwards and forwards is in
Gadamerian terms through the hermeneutical circle that I envision as more of a helix than a circle, as discussed below. The helix illustrates the interconnectedness of the dialectical hermeneutic or what I term interpretive dialogue.

The constructionist technique applied in this thesis is a hermeneutic (interpretive) methodology, and offers an ongoing iterative dialectic. It is not obligatory to agree with all the assumptions since they are what Gergen (2001) terms “entries into conversations, insinuations into relationships” (p. 47).

**Principle III: Reflect on essential themes**

The intent of phenomenological reflection is to attempt to “grasp the essential meaning of something” (van Manen, 1990, p. 77). The word essence is derived from the Greek term ‘ousia’, meaning the inner essential nature, the true being of a thing, while the Latin ‘essentia’, from ‘esse’ means ‘to be’ (van Manen, 1990). The eidetic approach is the main level of phenomenological inquiry (Schütz, 1970). Features of this eidetic approach are comprised of broad meanings as “constituted by cognitive processes” (Schütz, 1970, p. 317). Contained within the eidetic approach is the ‘eidos’, which carries the “essential” general characteristics of any perceivable objects” (Schütz, 1970, p. 317). Schütz and Luckmann (1973) consider these essences components of an individual’s ‘stock of knowledge’ with understanding occurring at differing levels of meaning. While phenomenology is the study of the essences of objects as they appear in consciousness, the term essence needs to be demystified because “essence belongs to the everyday world, the everyday experiencing of the world” (Dahlberg, Dahlberg, & Nystrom, 2008, p. 246). van Manen states that phenomenological themes can be understand as the structure of experience (p. 79). As the overarching essential themes of lived experiences are central to lifeworld accounts of the residents, I searched out possible structural dynamics where it was possible to make meaning.

To reveal a phenomenon’s essential themes of meaning, van Manen (1990) unravels a lifeworld consisting of four thematic overarching strands, these being ‘spatiality’ of the lived space, ‘temporality’ of lived time, ‘embodiment of the lived body and the ‘sociality’ of lived relations. To get to the essence of the phenomena I had to use an imaginative variation which is a “free play of fancy; any perspective is a possibility and is permitted to enter into consciousness” (Moustakas, 1994, p. 98). In my imagination, I could subtract one feature, and then another, in order to reveal which
features of themes was essential or not. Using this imaginative variation, I continuously worked on my reflexivity, which in MerleauPonty’s (1962) logic is where “the world is revealed as ready-made and already ‘there’” (van Manen, 1990, p. 182).

To conduct lived phenomenology is to question the way the world is experienced, and is a way of theorising a connection to the lived world called ‘intentionality’ (Schütz, 1970; van Manen, 1990). Pivotal to phenomenology, intentionality refers to the relation between an individual’s attitude and what the individual is thinking about. Consciousness therefore is always consciousness of something. Phenomenology’s aim is to “slacken the intentional strands which attach us to the world and thus” bring “them to our notice” (Merleau-Ponty, 1962, p. xiii). This unravelling of strands is necessary because individuals “are not reflexively conscious of their intentional relation to the lived world” as intentionality is only available retrospectively (van Manen, 1990, p. 182).

As a researcher, I worked on self-reflection and self-awareness, which are features of ordinary human ability to reflect back one’s own perceptions, consciousness and experience. These features are where meaning making comes to ‘be’ (Dahlberg, et al., 2008). Applying these features to the lifeworld, my position was to further elucidate the empirical essence of the actual experience of an individual ‘rest home resident’ as well as a fundamental, ideal essence of the universal experience of the ‘Rest Home Resident’ (van Manen, 1990). As a researcher, I needed sensitivity and subtlety to develop a nuanced understanding of the residents lived experiences, preverbal, verbal and nonverbal - along with systematic research techniques.

In Chapters Five to Eight I will apply phenomenology to gain understanding about the lifeworld of older rest home residents.

Principle IV: Describe the lifeworld of residents through art of writing and rewriting
The art of writing and rewriting is integral to phenomenology (van Manen, 1990). Language is fundamental to phenomenology because “response-reflective writing is the very activity of doing phenomenology” (van Manen, 1990, p. 132). Writing allows possible meanings to grow into language. van Manen (1990) points out that the art of phenomenological method is the ability to listen carefully “to the subtle undertones of language” as well as speak through text (p. 111). The common rhetorical device in phenomenological writing is the use of story (van Manen, 1990). In the interpretive
methodology used, my priority was to honour the lived experiences that residents shared
with me as stories. I was open to and engaged in the participants oral tales, and in
listening, let them influence me to new ways of knowing (Koch, 1996). The other forms
of data, described in the methods sections, enhance and enrich the telling of these lived
experiences.

Understanding came about through my own writing (Schulz, 2006). The ability to
listen allowed me to get in to the hermeneutic helix explained later in this chapter. I
listened by reading and writing and rewriting. The writing process in phenomenology is
about maintaining a constant tension (van Manen, 1990). While writing separates me as
the writer from what I know, at the same time it unites me with what I know. Writing
distances me from the lifeworld, while simultaneously drawing me to that world. My
phenomenological approach entails describing what the older people’s lifeworld
consists of, what the structures of their experiences are, and the concepts and principles
that give shape and meaning to the lifeworld (Schwandt, 1997).

Writing a phenomenological text is the challenge to build systematically on
narrative to illuminate experiences of rest home life as texts, while simultaneously
staying true to the universal essence of the residents’ particular kind of lived experience
(van Manen, 1990). While speech is important, so too are other communication cues
including silence (Buetow, 2009). Silences, which are part of the hermeneutic
endeavour, include pauses and what is not said. In addition, epistemological silence is
present when an individual “knows more than they can tell” but is unable to speak about
that knowledge; and an ontological silence occurs at a moment of a meaningful,
reflexive experience (van Manen, 1990).

Drawing on considerations about reflexivity in Principle III, I engaged in what
Finlay (2002) suggested is self-aware examination. My role in the research was to
strengthen and stay true to the study’s findings (Lietz, Langer, & Furman, 2006). All
constructionist investigations need to consider criteria that authenticate the research.
The criteria are the so called trustworthiness (parallel) and authenticity criteria, along
with a dialectical hermeneutics (Guba & Lincoln, 1989). The first two of these criteria
were “developed as counterparts paralleling those usually specified for positivist
inquiries, which are generated from the basic belief system” of the model of
constructionism itself (Guba & Lincoln, 1989 p. 19). This thesis emphasises the
‘hermeneutic dialectic’ criterion because it acts as “its own quality control” (Guba & Lincoln, 1989 p. 19) aligned to my phenomenological endeavor.

Self-awareness was advocated by Crotty (1998), who along with van Manen (1990) observed that traditional phenomenology must be critiqued using pre-reflective experience in order to achieve a balanced reflexive analysis. This meant that I avoided navel gazing while keeping the elders’ voices to the fore (Finlay, 2002). I kept an open mind through reflection on the existing research, and thinking about how literature could be re-read. My task was full of ambiguity owing to the risk of claiming a self-conscious, unproblematic access to subjectivity which itself is socially constructed (Finlay, 2002). Reflexivity helped “unravel the richness, contradictions, and complexities of inter-subjective dynamics” (Finlay, 2002, p. 542).

While reflexivity did not eliminate prejudice or preconceptions it was a valuable way for me to gain more enhanced insight (Finlay, 2002) into the lifeworld of the residents. I continued to manage the process of reflexivenes, which influenced how, as a researcher, I pre-reflectively observed, wrote and thought during the data collection, analysis and write up. Qualitative inquiry holds that reflexivity occurs throughout the research process and is self-acknowledgement of the researcher’s standpoint (Lietz, et al., 2006). This process is difficult due to the tension caused by ensuring a balance between purposeful, rather than self-indulgent analysis (Finlay, 2002). Through writing and rewriting, I retained this tension by illuminating the research findings through the examples I used, to support my analysis and interpretation along with my management of disconfirming cases, and my use of sceptical peer review through team meetings and supervision.

**Principle V: Maintain strong oriented relation to residents’ lifeworld**

Being oriented is important for attentiveness to aspects of a person’s life that have continued to be taken for granted or glossed over. This orientation then means being able to critically speak up and speak out (van Manen, 1990) about elders’ lived experiences in rest homes. van Manen (1990) states that the text needs to have layers of depth so the reader can orientate towards understanding, and richness in order to become involved in making meaning on many levels. There are various ways narrative is employed when working with older people.
Everyday life experiences that are recorded are termed narrative, which serve as a powerful form of communicative language (Dahlberg, et al., 2008). This thesis uses van Manen’s (1990) definition of narrative, as a short account of a biographical incident; a private or secret unpublished narrative or details of history, or a minute passage of private life. Along similar lines, Schütz (1972) advocates for a biographical approach to allow narrative to move back and forth in a fluid way.

**Principle VI: Balance research context by considering parts and the whole**

van Manen (1990) argues that a frankness is necessary in phenomenology because it allows for a choice of “directions and exploring techniques, procedures and sources” often not known about at the start of a research study (p. 162). To balance the research context by considering its parts and the whole, I needed to construct a workable textual surface that revealed the essence of the phenomenon. I employed a variation of the metaphoric ‘hermeneutic circle’, which is the experience of shifting dialectically between the part and the whole. It was relatively straightforward to make a conceptual shift from the shape of a hermeneutic circle to one of a spiral multiple-helix as shown in Figure 3.1, and developed throughout the thesis.

My use of van Manen and Schütz’s works consists of developing four lived strands of experience, which together weave the fabric of the lifeworld. The whole comprises the parts, and the parts constitute the whole lifeworld. van Manen (1990) argues that in reconstructing life stories it is important to highlight only the theme, as themes become the tool through which the phenomenon can be meaningfully understood. By moving the focus from one theme to another, each part of lived space, lived time, lived body and lived relations with others can be drawn out temporarily for study, even while the helix retains its shape of wholeness. While it is possible temporarily to examine each strand, the four individual components continue to interlace with the other strands; for example, lived time intertwines with lived space, and lived space is woven into lived body and so on. Most dimensional strands of this constructionist process also serve as methods because the multiple-helix is capable of creating a hermeneutic dialectic.
3.5 A MODIFIED FRAMEWORK APPROACH

To organise the qualitative material, I employed a modified framework approach to the data (Miles & Huberman, 1984). As illustrated in Chapter Two, this modified framework allows for quantitative and qualitative mixed-methods and for deductive and inductive approaches to be used within the same study. The standard framework approach was developed in Britain and designed specifically for applied or policy relevant qualitative research to account for a funding agency’s requirements (Pope, Ziebland, & Mays, 2000). This approach resonates with my research experience, can readily connect qualitative and quantitative findings (Miles & Huberman, 1984; Pope, et al., 2000) and is intellectually honest.

For the purpose of this thesis I modified the standard framework approach of looking in the data for expected patterns and themes. Usually, when using a framework approach in qualitative research, an inductive technique follows a deductive approach. In my research however, I chose to modify the framework by starting out with an inductive approach, before applying a deductive approach. In the initial analytic process used in this study, immersion/crystallisation (I/C) (Borkan, 1999), described later in this chapter, was the inductive approach chosen. It involved analyzing my main data source of audio-recorded interviews, which I supplemented with interview summaries, my field-journal notes and the survey findings.

On the basis of feedback from reviewers and my supervisors, a decision was made to use phenomenology as the main approach for this thesis. More specifically, phenomenology was used to test deductively the integrity of the main themes that I had earlier identified and crystallised from the data through immersion/crystallisation (I/C) (Borkan, 1999) described later in this chapter. I chose to use the writings of van Manen (1990, 1998, 2002) and Schütz (1972, 1970; Schütz & Luckmann, 1973), whose deductive approaches hold exemplars of four main themes that can be found in all phenomenological research. This approach starts with a ready-made framework which advocates space, time, body, and relations with others as the constitutive parts of the whole lifeworld. My inductive application of the phenomenological approach yielded themes that fit well with those earlier generated through I/C, and as I discuss in Chapter Nine, these findings support the framework within which I was working. The following sections discuss these approaches.
Phenomenological lifeworld research consists of four overarching thematic strands that according to van Manen (1990) arise in phenomenological research. Matching the themes found through I/C, the deductive lifeworld strands of the main themes are ordered in the following way:

**LIVED SPACE**

The setting and its surroundings are the initial point of interest when entering the rest home so spatiality becomes the first of the four lifeworld themes in this study. van Manen (1990) maintains that spatiality is ‘felt space’ most often perceived as physical dimensions such as height, depth and length as discussed in everyday terms. Common ideas about space include distances, as when talking about kilometres between one place and another. Lived space is more difficult to define because it is not often reflected on. The space in which a person is located is understood in socio-cultural ways. This allows a person to feel a certain way; for example in a cityscape one individual’s feelings will differ (from another) depending on whether they are in an elevator, a large, crowded shopping mall, a city park, at the beach, or at home.

The place in which individuals reside in the lived world is the point from which they take their position in space, declares Schütz (1962). Being at home, states van Manen (1990), “reserves a very special space experience which has something to do with the fundamental sense of our being” (p. 102). The meaning of lived experience will be impacted on by the space in which it took place. The space(s) of the rest homes are full of ambiguity. Lived space holds various and differing meanings in the rest home.
context and is an important aspect of the residents’ lifeworld. Lived space is the central theme of Chapter Five.

**Lived Time**

Once a researcher is familiar within the locale, the temporal rhythms in the rest home begin to surface. Temporality is closely tied to the spaces in which time is passed and is the second theme of this lifeworld study. Drawing on Heidegger’s (1996) study of time in the everyday, van Manen (1990) asserts that lived experience has a temporal structure and is manifested only reflectively as past presence. Schütz’s (1976) idea of typification also connects past, present and future.

Clock time is often thought about as objective time. Lived time on the other hand is perceived as subjective time and can go slowly if an individual is bored, or rush by when they are having an enjoyable time. Time is pertinent to health care contexts (see for example Buetow, 2004b). In the milieu of the rest home, time management is experienced differently by residents than staff. Past, present and future are also temporal dimensions that constitute a person’s lived world horizon (van Manen, 1990). Time is experienced in specific and unique ways in the lifeworld of the residents and is the focus of Chapter Six.

**Lived Body**

Embodiment is the way in which the older people experience their bodies within time and space. Strategies are used to manage bodily health, so embodiment becomes the third lifeworld theme. Tied to the notion of the lived body, a phenomenological embodiment means it is possible to explore lived experiences as told by residents through stories about their lifeworld. The body is not ordinarily noticed in everyday life while health is good, however ill-health means a focus on the body (van Manen, 1998). van Manen (1998) suggests that the body is usually experienced in silent mode.

Older people do not necessarily feel old, unless they are ill (Longino & Powell, 2009). This changes when the body becomes disturbed by ill-health. When illness has “manifested itself then it is clear that the sick person cannot...forget his or her body” (van Manen, 1998, p. 8). van Manen (2002) points out that “we have learned to see through our bodies as it were. We have learned to look at ourselves with the eye of science” (p.179).
Embodiment is about the meaning structure of the body as lived through a relationship between the body as unconsciously seen by self, and the body as others perceive it. In health related contexts this notion engenders a bodily empathy (Rudebeck, 2001). On one level, interconnection is achieved through reflection about the subjective self. On another level, how others respond objectively to self in interaction is primary. A third level agrees with Merleau-Ponty’s (1962) position that the body is interwoven with a sense of self in the lifeworld.

The “body discloses the world just as the world discloses itself through the body” in an intertwining of body and the world (Finlay, 2006, p. 19). This layered lifeworld is what Schütz (1962, 1972, 1970) names inter-subjectivity. The older residents’ embodiment is fundamental to discussion in Chapter Seven.

**LIVED RELATIONS TO OTHERS**

Interaction comes to the fore only after I become accustomed to the setting and tempo of the rest home, and the resident and I are comfortable in each other’s company. The residents’ set of lived relations to others is the fourth and final theme in this lifeworld study. Multiple layers are required for meaning making and include lived relations maintained in interpersonal shared space (van Manen, 1990). Initial meeting with others is at once relational and is achieved in a bodily or physical way such as with a handshake or more intimately with a hug. Relationality is full of interpersonal significance that has two levels.

At one level, observing another’s embodied being, such as observing an older person sitting in a rest home lounge, is my experience of that elder’s body and is by simple proximity the point at which I read possibly (negative) meaning into that experience. In the rest home context social contact with elders who have disabled bodies is most obvious and so to the fore. This serves to override the normal interaction such as I might experience with a friend, colleague or family member, and this priority results in my dis-ease. In a transitory sense, conversational relations are affected because the shift in priority replaces the bodily transcendence that usually occurs. Instead, the older person’s embodiment, rather than the transcendence of self-forgetful bodies, becomes the focus (van Manen, 1998). At another level, in a larger, existential sense an individual searches, within relational experience of the other individual, for the communal by looking for an understanding of the social body (van Manen, 1990).
Relational others are “always approached in a bodily way through the gaining of an impression of the ‘other’ in the way that he or she is present through a physical impression, allowing the individual to develop a conversational relation which means the individual can transcend to the experience of the other (van Manen, 2002). Schütz (1962) argues that these relational experiences are inter-subjective. van Manen, (2002) points out that these are “phenomenologically remarkable because they are so un-remarkable”. Yet, van Manen (2002) also warns against taking these practices for granted, because often they can be ambiguous (p. 10). The residents’ relations with others are considered in Chapter Eight.

These mixed-methods inform the findings chapters starting with the quantitative findings chapter next. Complemented by the survey data in Chapter Four, Chapters Five to Eight discuss the qualitative findings using a lifeworld phenomenology supported by the I/C technique. Chapter Nine synthesizes the findings chapters.

3.5.2 INDUCTIVE APPROACH: I/C

**Immersion/Crystallisation (I/C) Technique**

Borkan’s (1999) I/C technique was an initial research approach used in this study, and was later employed as a way to test the thoroughness of the main phenomenological approach. A highly inductive technique, I/C has been recently used in primary health care research with older people (for example Eastwood & Jaye, 2006; Elder et al., 2008). Borkan’s (1999) metaphorical play on the term I/C is an acronym of the term ‘immersion/crystallisation’ which I imagined as a ‘eureka’ moment inherent in the term I/C which reads as ‘I see’. The play on words fits with the central premise of I/C, which holds that data analysis remains an ongoing practice that occurs before, during and after the collection of data and continues through the writing up process.

Employing I/C, I made horizontal passes which entailed reading a whole body of text to look for various types of evidence with each pass. Meanwhile, vertical passes focused on analysing one section of the data before I moved on (Borkan, 1999). These passes interwove during individual and group data analyses to identify patterns. Immersion in the material was followed by the crystallisation of the data which is one “means of establishing a completeness” in socially focused research (Koch, 2006). Applying I/C to the research data I found that these major themes of space, time, body and relationships crystallised as significant findings, thus resonating with the main
themes from the phenomenological lifeworld approach, which is the approach further developed in this thesis.

3.6 Ethical Approval
Multi-centred ethics approval was obtained for the PIRC trial (Auckland Ethics Committees, AKX/03/08/217 and Canterbury Ethics Committee CTR/03/08/132). Additional consent was obtained, through an amendment to the PIRC trial ethics, in order to conduct audio-recorded interviews (V#2, 03/02/2004). The elders read my supplementary information and consent forms for this doctoral study, as shown in Appendix 5, before signing approval. The information sheet was given to the older person to keep for their reference. As confidentiality was important, particularly as I was using verbatim quotations (Corden & Sainsbury, 2006), pseudonyms were used to ensure anonymity. All audio-recorded interview tapes and transcripts along with other details were kept in a locked cabinet and on password protected computers. Access was restricted to the research team for confidentiality reasons. All information shared by residents remains confidential.

3.7 Chapter Discussion
This chapter has mapped out the mixed-methods and methodology used in this thesis. The quantitative measures chosen for this study belonged to the whole PIRC study team, although I had input into the control (social) and intervention (activity) domains of the baseline survey. I considered how the intellectual property of the research design, construction of social data collection instruments and rationale for using the data instruments rested with me. I have explained the methodological model applied in this study through the lifeworld multiple-helix. I have considered the lifeworld phenomenology to be applied in this thesis. In the next chapter, the quantitative research component will set the scene with its demographic and participant characteristic information.
4 CHAPTER FOUR: THE REST HOME RESIDENTS

4.1 INTRODUCTION
The primary aim of this chapter is to provide a contextual backdrop for this thesis about older people living in New Zealand rest homes. My study was conducted within a larger randomised controlled trial (RCT). From that study, 352 rest home dwellers were eligible for inclusion in my research. Specific survey questions (Appendix 4) were adapted for the study from the Australian Health Status of Older People project (Kendig et al., 1996) and the local Mosgiel Longitudinal Study of Ageing (MLSA) which focused on the social relationships and activities of older people (Keeling, 2001). Survey findings from these 352 residents taking part in a larger study, in which my study was nestled, serve as the backdrop to this thesis.

This chapter describes demographic and health characteristics along with social relations and pastimes from a survey conducted with these rest home dwellers, at baseline in the trial. I offer responses to the following research queries: (i) who are the 352 rest home residents? (ii) what kind of relationships do these residents have with other people? (iii) what are the residents’ pastimes? A discussion section at the end of this chapter compares my findings with the relevant literature outlined in Chapter Two.

The data presented in this chapter was chosen because it relates to the lived, day-to-day experiences of the residents. The strength of this chapter as a backdrop is in the breadth of information it offers my mixed-methods study as explained in Chapter Three. The quantitative data described in this chapter have not been exhaustively examined as systematic analysis of the survey data belongs to the wider PIRC team. This descriptive chapter is intended as a prequel to the interpretive findings chapters that come later. When referring to the older people taking part in this survey, I have chosen to use a variety of terms: ‘residents’, ‘dwellers’, ‘older people’ and ‘elders’.

4.2 BACKDROP

4.2.1 DEMOGRAPHICS
This demographics section responds to the first of three initial research questions raised in Chapter One, which asks about who lives in a New Zealand rest home?

Last landfall before Antarctica, New Zealand is an island nation situated in the South Pacific (Appendix 7). The composition of the total population of over four
million is changing as New Zealand becomes increasingly ethnically diverse through growth in the proportions self-identifying as Maori, Pacific peoples and/or Asian, although the population is predominately of European descent. Ethnically based beliefs about ageing can influence health and must be taken into consideration (Gallant, Sptize, & Grove, 2010).

There were two study sites in my research. Auckland, in the North Island, is the nation’s largest city with a population of over one million. Located 760 kilometres away across land and sea, Christchurch is located in the Canterbury region of the South Island, and has a population of 520,000, half that of Auckland (Statistics New Zealand, 2008).

It has been calculated that by 2051, one in four New Zealanders will be aged 65 years and over (Statistics New Zealand, 2007). This population has doubled since 1970 and totalled nearly half a million in 2005 (Dunstan & Thomson, 2006). The population aged 85 to 89 years at the 2005 census was 35,000, while the over 90s totalled 15,000 (Statistics New Zealand, 2005). These populations have trebled since 1978 and are likely to increase. Most of these older people live in urban areas (Statistics New Zealand, 2004b).

Residents in my study live in 12 Auckland and nine Christchurch rest homes. Half this study population live in Auckland and half in Christchurch. All residents are aged 65 years and over and have a mean age of 84 years. Nearly all have European ancestry as shown in Table 4.1. There are 36 years time span between the youngest and oldest residents who were born between 1903 and 1939.

Over their long lives they have come from diverse backgrounds and have very different life experiences. What they have in common is that they now live in a rest home. These elders are all of an age where, in their youth, free primary school education in New Zealand was compulsory and continued until standard six, about age 12 years. Over half the residents (58%) had a high school education. Two thirds (67%) are widows or widowers while 11% never married.

Around 20% of the older people have lived in the rest home for six months or less, with a similar percentage staying four years and more (21%). Five percent of these elders live in small rest homes with 10 or fewer co-residents. Forty three percent live in
medium sized homes of 10 to 20 fellow residents while the remaining half (52%) stay in large rest homes along with 21 or more co-residents.

Table 4.1. Socio-demographic information of residents (n=352)

<table>
<thead>
<tr>
<th></th>
<th>Men n=90</th>
<th>Men %</th>
<th>Women n=262</th>
<th>Women %</th>
<th>Total n=352</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tr>
<tr>
<td>Auckland</td>
<td>49</td>
<td>54</td>
<td>126</td>
<td>48</td>
<td>175</td>
<td>50</td>
</tr>
<tr>
<td>Christchurch</td>
<td>41</td>
<td>46</td>
<td>136</td>
<td>52</td>
<td>177</td>
<td>50</td>
</tr>
<tr>
<td>Age range in years</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>65-74</td>
<td>15</td>
<td>17</td>
<td>21</td>
<td>8</td>
<td>36</td>
<td>10</td>
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<tr>
<td>75-84</td>
<td>43</td>
<td>48</td>
<td>100</td>
<td>38</td>
<td>143</td>
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<td>85-94</td>
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<td>34</td>
<td>125</td>
<td>48</td>
<td>156</td>
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<td>95+</td>
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<td>1</td>
<td>16</td>
<td>6</td>
<td>17</td>
<td>5</td>
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<td>Ethnicity (self-defined)</td>
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<tr>
<td>NZ Europeans, British, White South</td>
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<td></td>
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<tr>
<td>Africans and Other ‘whites’</td>
<td>83</td>
<td>93</td>
<td>257</td>
<td>99</td>
<td>340</td>
<td>97</td>
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<td>Māori</td>
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<td>3</td>
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<td>-</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Pacific</td>
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<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
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<td>4</td>
<td>1</td>
<td>7</td>
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<td>Education (self-reported)</td>
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<td>Primary school</td>
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<td>36</td>
<td>75</td>
<td>29</td>
<td>107</td>
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</tr>
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<td>High school</td>
<td>49</td>
<td>55</td>
<td>157</td>
<td>59</td>
<td>206</td>
<td>58</td>
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<tr>
<td>Polytechnic or University</td>
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<td>9</td>
<td>31</td>
<td>12</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>Current marital status</td>
<td></td>
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</tr>
<tr>
<td>Widowed</td>
<td>39</td>
<td>44</td>
<td>196</td>
<td>75</td>
<td>235</td>
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</tr>
<tr>
<td>Never married</td>
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<td>19</td>
<td>24</td>
<td>9</td>
<td>41</td>
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<tr>
<td>Married or de facto</td>
<td>19</td>
<td>21</td>
<td>19</td>
<td>7</td>
<td>38</td>
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<tr>
<td>Separated or divorced</td>
<td>15</td>
<td>16</td>
<td>23</td>
<td>9</td>
<td>38</td>
<td>11</td>
</tr>
<tr>
<td>Participants in each rest home</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Less than 10</td>
<td>10</td>
<td>11</td>
<td>8</td>
<td>4</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>10 to 20</td>
<td>44</td>
<td>49</td>
<td>106</td>
<td>40</td>
<td>150</td>
<td>43</td>
</tr>
<tr>
<td>21 and over</td>
<td>36</td>
<td>40</td>
<td>148</td>
<td>56</td>
<td>184</td>
<td>52</td>
</tr>
<tr>
<td>Rest home funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner operated</td>
<td>39</td>
<td>43</td>
<td>90</td>
<td>34</td>
<td>129</td>
<td>37</td>
</tr>
<tr>
<td>Church and welfare charitable trust</td>
<td>13</td>
<td>14</td>
<td>36</td>
<td>14</td>
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<td>Multi-national chain</td>
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<td>43</td>
<td>136</td>
<td>52</td>
<td>174</td>
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</tr>
<tr>
<td>Time lived in rest home</td>
<td></td>
<td></td>
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<tr>
<td>0-6 months</td>
<td>23</td>
<td>26</td>
<td>46</td>
<td>18</td>
<td>69</td>
<td>20</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>14</td>
<td>15</td>
<td>44</td>
<td>17</td>
<td>50</td>
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<td>1-2 years</td>
<td>18</td>
<td>20</td>
<td>55</td>
<td>21</td>
<td>73</td>
<td>21</td>
</tr>
<tr>
<td>2-4 years</td>
<td>16</td>
<td>18</td>
<td>54</td>
<td>24</td>
<td>80</td>
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<td>4 years and over</td>
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<td>21</td>
<td>53</td>
<td>20</td>
<td>72</td>
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</tr>
<tr>
<td>Residential fees paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government subsided</td>
<td>56</td>
<td>62</td>
<td>143</td>
<td>55</td>
<td>199</td>
<td>57</td>
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<tr>
<td>Private</td>
<td>34</td>
<td>38</td>
<td>119</td>
<td>45</td>
<td>153</td>
<td>43</td>
</tr>
</tbody>
</table>

Rest homes’ governance or ownership are owner operated (37%), church and welfare charitable trusts (14%) and multinational chains (49%). The large multinational chains are the most prevalent in this study. Rest homes receive funding directly from the
residents (43%) and a government subsidy is supplied for those whose assets meet the subsidy threshold (57%) as shown in Table 4.1.

Table 4.2 reports on how the residents are well aware of the unlikelihood of moving out of the rest home with the majority (84%) of respondents expecting to stay more than one year or indefinitely. The same percentage (84%), are somewhat satisfied or extremely satisfied with their stay at the rest home. More than half (57%) agree with the statement that they are financially ‘comfortable’, compared to over one third (39%) who report having ‘just enough [money] to get along on’.

Table 4.2. Residents’ perceptions about living in the rest home (n=352)

<table>
<thead>
<tr>
<th>How long do you expect to stay in the rest home?</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>12</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>&gt; 1 year - indefinitely</td>
<td>69</td>
<td>225</td>
<td>294</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In general, how satisfied have you been with your stay in the rest home?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat or extremely satisfied</td>
</tr>
<tr>
<td>Neutral or dissatisfied</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Money situation right now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfortable</td>
</tr>
<tr>
<td>Have just enough to get along on</td>
</tr>
<tr>
<td>Can’t make ends meet</td>
</tr>
</tbody>
</table>

*Percentages do not sum to 100% due to multiple responses.

Having offered a demographic overview of the residents taking part in my study, I will now report on the residents’ health status, using data from the baseline survey.

4.2.2 Health characteristics

Table 4.3 represents a summary of the health characteristics, tabulated from the survey. As might be expected, given that assessed health need for 24 hour care is a prerequisite to rest home admission in New Zealand, most of the residents have multiple diagnoses (mean 5.0 sec standard deviation (SD) 2.5) for which they take various medications (mean 7.2 standard deviation (SD) 3.1). Over one third (38%) use antidepressants and one quarter (26%) are prescribed benzodiazepines. Depressive symptoms were measured on the Geriatric Depression Scale (GDS) (Yesavage, et al., 1983). A score of greater than 5 was found in 42% indicating some level of depression. One third (33%) of the residents have some form of cognitive impairment as measured by the
Abbreviated Mental Test Score (AMTS) (Hodgkinson, 1972). Over half (59%) of the residents report that they have some degree of fatigue.

The elders were asked to self-rate their general health and although objective measures describe health limitations, two thirds (70%) consider their general health to be good to excellent. Worthy of note, this finding is reinforced through use of a visual analogue scale to record their current health status, where most residents report between midrange and the best imaginable health (80% of maximal health), in keeping with the selected literature as discussed in Chapter Two. Fatigue was self-reported as seen in Table 4.3. Men were less likely to report any fatigue than women. Over half (51%) of the men reported no fatigue, versus one third (37%) of women.

Using the LSI-Z (Neugarten, et al., 1961), one third (33%) of the respondents report being ‘somewhat to totally content’ while 27% are ‘somewhat to totally discontent’. There is no correlation (Spearman’s correlation coefficient 0.11) between life satisfaction and the time they have spent at the rest home. The EuroQol (The EuroQol Group, 1990) scored half (48%) of the residents as having some health related quality of life problems compared with half (51%) who have no problems. This finding is in keeping with the 52% who report their health as the best it could possibly be (EuroQol VAS). In the following section, I offer a description of the residents’ relationships, based on the survey data, and their ‘lived relations with others’ will be further examined in Chapter Eight. The way that the residents manage their ‘lived’ health and ill-health will be discussed in detail in Chapter Seven.

**FAMILY RELATIONS**

This section draws on the survey data to address the second initial question: *what types of relationships do residents have with others?* Two thirds of the elders who have had children report having borne or raised sons, and a similar percentage report having borne or raised daughters. Similar percentages have sons and daughters who are still living. Of the residents with living children, over half have at least one son and a similar percentage of respondents have at least one daughter.

As Table 4.4 reports, residents were asked whether any of their children live in the same city, and if at least one child lives overseas. More of the seniors reported having daughters than sons living in the same city, while fewer have daughters living elsewhere including overseas than sons.
Table 4.3. Health characteristics of the residents from the survey (n=352)  
(n and % presented unless otherwise specified)

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=90</td>
<td>n=262</td>
<td>n=352</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>(%)</td>
<td>%</td>
</tr>
<tr>
<td>Total number of diagnoses, mean (SD)</td>
<td>4.6 1.8</td>
<td>5.1 2.4</td>
<td>5.0 2.5</td>
</tr>
<tr>
<td>Total number of medications, mean (SD)</td>
<td>0.8 3.2</td>
<td>7.4 3.0</td>
<td>7.2 3.1</td>
</tr>
<tr>
<td>Taking antidepressants</td>
<td>36 40</td>
<td>97 37</td>
<td>133 38</td>
</tr>
<tr>
<td>Taking short acting sedatives (Benzodiazepines)</td>
<td>13 14</td>
<td>80 30</td>
<td>93 26</td>
</tr>
<tr>
<td>Cognitive impairment, AMTS &lt;7</td>
<td>22 24</td>
<td>94 36</td>
<td>116 33</td>
</tr>
<tr>
<td>Falls 3 months prior to enrolment in PIRC trial</td>
<td>- -</td>
<td>- -</td>
<td>277 79</td>
</tr>
<tr>
<td>No falls</td>
<td>- -</td>
<td>- -</td>
<td>277 79</td>
</tr>
<tr>
<td>1 or more falls</td>
<td>- -</td>
<td>- -</td>
<td>57 16</td>
</tr>
<tr>
<td>Self-rated health (SF36). In general would you say your health is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very good to excellent</td>
<td>30 32</td>
<td>72 27</td>
<td>102 29</td>
</tr>
<tr>
<td>Good</td>
<td>33 36</td>
<td>112 43</td>
<td>145 41</td>
</tr>
<tr>
<td>Poor to fair</td>
<td>27 32</td>
<td>78 30</td>
<td>105 30</td>
</tr>
<tr>
<td>Life Satisfaction Index (LSI-Z)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat to totally content</td>
<td>30 33</td>
<td>64 24</td>
<td>94 33</td>
</tr>
<tr>
<td>Neutral</td>
<td>30 34</td>
<td>107 42</td>
<td>137 40</td>
</tr>
<tr>
<td>Somewhat to totally discontent</td>
<td>30 33</td>
<td>64 24</td>
<td>94 27</td>
</tr>
<tr>
<td>Non-respondents</td>
<td>- -</td>
<td>27 10</td>
<td>27 8</td>
</tr>
<tr>
<td>Geriatric Depression Scale (GDS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No depression &lt;5</td>
<td>56 62</td>
<td>147 56</td>
<td>203 58</td>
</tr>
<tr>
<td>Mild/Moderate depressive symptoms 5-1</td>
<td>27 30</td>
<td>94 36</td>
<td>121 34</td>
</tr>
<tr>
<td>Major depressive symptoms &gt;15</td>
<td>7 8</td>
<td>21 8</td>
<td>28 8</td>
</tr>
<tr>
<td>Participants' health related quality of life, time of interview (EuroQol)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No problems, &lt;7</td>
<td>52 59</td>
<td>129 49</td>
<td>181 51</td>
</tr>
<tr>
<td>Some problems, 8-11</td>
<td>36 40</td>
<td>130 50</td>
<td>166 48</td>
</tr>
<tr>
<td>Extreme problems, 12-18</td>
<td>2 1</td>
<td>3 1</td>
<td>5 1</td>
</tr>
<tr>
<td>Self-rated health / EuroQol vertical Visual Analogue Scale (VAS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best imaginable self-rated health, 76-100</td>
<td>55 62</td>
<td>128 49</td>
<td>183 52</td>
</tr>
<tr>
<td>Mid-range self-rated health, 51-75</td>
<td>22 24</td>
<td>75 29</td>
<td>97 28</td>
</tr>
<tr>
<td>Worst imaginable self-rated health, 1-50</td>
<td>13 14</td>
<td>59 22</td>
<td>72 20</td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No fatigue</td>
<td>46 51</td>
<td>96 37</td>
<td>142 41</td>
</tr>
<tr>
<td>Mild fatigue</td>
<td>20 22</td>
<td>88 34</td>
<td>108 31</td>
</tr>
<tr>
<td>Moderate – severe fatigue</td>
<td>24 27</td>
<td>74 29</td>
<td>98 28</td>
</tr>
</tbody>
</table>
Table 4.4. Residents with and without sons and daughters (n=352)

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th></th>
<th>Women</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants with no children</td>
<td></td>
<td>n=90</td>
<td></td>
<td>n=262</td>
</tr>
<tr>
<td>born or raised</td>
<td></td>
<td>%</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>23</td>
<td>53</td>
<td>20</td>
</tr>
<tr>
<td>Participants with children</td>
<td></td>
<td>n=352</td>
<td></td>
<td>n=352</td>
</tr>
<tr>
<td>born or raised</td>
<td></td>
<td>%</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Children still living</td>
<td>231</td>
<td>66</td>
<td>242</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>221</td>
<td>63</td>
<td>227</td>
<td>64</td>
</tr>
<tr>
<td>Same city as participants</td>
<td>155</td>
<td>44</td>
<td>180</td>
<td>51</td>
</tr>
<tr>
<td>Someplace else</td>
<td>66</td>
<td>19</td>
<td>47</td>
<td>13</td>
</tr>
</tbody>
</table>

* Percentages do not sum to 100% due to multiple responses

Figure 4.1 reports the primary contact person recorded in the rest home records. The most common contact is a daughter (43%) followed by a son (26%), compared with 20% of residents having other relatives as first contact. Seven percent of first primary contacts are a non-related support person, while 5% are living spouses. Daughters and sons make up two thirds (69%) of the primary contact person cited in the records, compared to 20% of contacts who are other relatives. Those with children were asked how often have you seen or visited with one or more of your children? and could give a 1-5 score response ranging from (4) Daily to (0) Never.

Figure 4.1: Primary contact sourced from residents’ records (n=352)

In relation to a question about local or long distance contact with their children, participants could give the same zero (never) to four (daily) score response above. Figure
4.2 reports that over two thirds (70%) with children spend time with them on a weekly basis. Of these, over half (59%) report spending time only on a weekly basis while 10% spent time with their children on a daily basis. Nearly one third (30%) report occasional or monthly visits and 17% report occasional visits with their children. Only 1% of the elders report spending no time at all with their children. Time residents spend interacting with their families is central to the discussion and findings in Chapter Six. Figure 4.2 reports two thirds (65%) having face-to-face, telephone or written contact with their children on at least a weekly basis. Of these, 39% report weekly telephone or written contact while 26% report daily contact. Occasional contact between residents and their children either face-to-face, by telephone or in writing was reported by 20% of the residents. Six percent report contact on a monthly basis while 9% report no contact of this type with their children at all.

![Contact with Children](image)

Figure 4.2: Residents with children who report frequency of face-to-face visits, telephone and/or written contact with offspring (n=352)

One third of the residents have face-to-face contact with relatives and friends. Adding a prompt to define close friends as ‘people that you feel at ease with, can talk to about private matters and can call on for help’, they were asked about close relatives and close friends seen face-to-face in the last month. In a similar manner to relatives seen in the last month, over half (56%) reported seeing up to five close friends during that time. Residents are more likely to have spent time with close relatives than with close friends. Figure 4.3 reports numbers of the older people who have seen close relatives over the past month compared with close friends.

Residents report spending time with one or two relatives (30%) monthly, which follows the same pattern of seeing one or two friends (30%) over the same timeframe.
More elders spent time with three or four relatives (24%), compared to the same number of friends (13%). Residents have monthly visits with five or more relatives (35%) compared to the same number of friends (10%). Most elders have spent time with between one and 10 relatives and friends over the last month.

![Close Relatives/Friends Seen in the Last Month](chart.png)

Figure 4.3: Face-to-face contact: Numbers of close relatives/close friends living outside rest home that the residents have seen in last month (n=352)

**LOCAL OR LONG DISTANCE CONNECTIONS**

Figure 4.4 shows residents have telephone or written contact with close relatives and close friends. They enjoy passing time talking with relatives and friends on the telephone on a regular basis while others stay in contact using written correspondence. In relation to a question about local or long distance contact, they could give the same 0 (never) to 4 (daily) response mentioned above. Two thirds (65%) have local or long distance contact with their children on at least a weekly basis. Of these, 39% of the elders report weekly telephone or written contact while 26% report daily contact.

Occasional or monthly non-face-to-face contact between the residents and their children was reported by 26%. Nine percent report no contact of this type with their children at all.

Forty percent of respondents have no written or phone contact with close friends at all compared with (29%) of respondents reporting no such contact with close relatives a few times a year. One third of respondents (34%) report having written or telephone contact with one or two close relatives, while one quarter (25%) have contact in these ways with one or two close friends a few times annually. Similar percentages, 36% and 35%, remain in telephone or mail contact with three or more close relatives and close friends (respectively).
Figure 4.4: Local or long distance contact: Number of close relatives and close friends living outside the home with whom letters, telephone calls or email are exchanged a few times a year (n=352)

Seventy nine percent of the elders answering a question about where close friends live, report having no close friends living in the rest home compared to 27% with no close friends living elsewhere as illustrated in Figure 4.5. Residents with one friend living elsewhere (18%) are double those reporting one close friend living in the rest home (9%).

Figure 4.5: Numbers of close friends living in and living outside the rest home (n=352)

The elders report have more ‘close friends’ living some place other than the rest home, than those reporting close friends as co-residents. It is possible that co-residents are classified in some other implicit, unnamed way. Ambiguity surrounds relationships between co-residents, especially when discussed in terms of reciprocal support. It is unclear whether living nearby as neighbours, necessarily involves ‘close friendship’ as
defined by either the study or the residents themselves. Lived relations with others will be discussed in detail in Chapter Eight.

Figure 4.6: Residents report having emotional supporters (n=352)

**EMOTIONAL SUPPORT**

The residents were asked *Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision?)* The majority (85%) report having an emotional support person as Figure 4.6 illustrates. Resident responses to a question about who had been the person most helpful in providing them with emotional support over the past month is reported in Figure 4.7.

Of those with children, one third (33%) report their daughters as the most likely to provide emotional support, compared to 13% citing sons. Friends living outside the rest home (14%) are also emotional supporters for those with and without children, compared to 8% who report a rest home care staff member as emotional support person. Other close relatives and close friends make up a quarter (23%) of reported emotional supporters. Nine percent of the elders report no emotional support. Emotional support is investigated in further depth in Chapter Eight.

Having surveyed residents’ relations with others, I now describe the patterns of activities residents report enjoying, again drawing on the baseline survey data.
4.2.3 ACTIVITIES

The following is a response to the last of three initial queries raised in Chapter One: what types of activities do residents take part in? One survey question inquired of all the things that you do either as a pastime or as part of your daily life, what things do you like to do the most? (e.g., reading, being with friends, walking)? and was intended to highlight activities that the residents most enjoyed. They could report up to three regular pastimes. Reporting of this question was not quantified, but rather was recorded in word form which was coded by me. From this, I identified main patterns in the reporting of activities most liked by the residents as shown in Figure 4.8.

Pastimes reported most frequently by far are reading the daily newspaper, magazines and books. Taking part in crossword puzzles, alone or with others is also highly regarded. More social occasions are regular musical events hosted by a musician, and dancing (standing or sitting) occurs. Extremely popular is happy hour where alcohol
is usually served in a mix and mingle session, within most of the rest homes. Regular religious gatherings are also well liked.

Other pastimes include playing card games such as Patience or Solitaire and games with other residents and staff including Housie (Bingo), Bridge, Gin rummy, Mah-jong and Scrabble were noted as popular. Watching television alone or with others, and listening to the radio, usually alone, are other regular pastimes.

<table>
<thead>
<tr>
<th>Reading</th>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>newspapers</td>
<td>walking</td>
</tr>
<tr>
<td>magazines</td>
<td>bowls</td>
</tr>
<tr>
<td>books</td>
<td>exercise programmes</td>
</tr>
<tr>
<td>Social events</td>
<td>Games</td>
</tr>
<tr>
<td>musical events</td>
<td>crossword puzzles</td>
</tr>
<tr>
<td>'happy hour'/televenses</td>
<td>card/box games (house; scrabble)</td>
</tr>
<tr>
<td>religious gatherings</td>
<td>multiple types of indoor games</td>
</tr>
<tr>
<td>Volunteer work</td>
<td>Broadcasting media</td>
</tr>
<tr>
<td>helping out around the</td>
<td>Television</td>
</tr>
<tr>
<td>rest home</td>
<td>Radio</td>
</tr>
<tr>
<td>supporting co-residents</td>
<td></td>
</tr>
<tr>
<td>for outside organisations</td>
<td></td>
</tr>
</tbody>
</table>

Figure 4.8: Patterns of pastimes/part of daily life that residents like to do the most

The residents report the most important form of exercise and/or social event taken part in is walking. Rest home organised physical activities including indoor bowls and exercise programmes such as for stroke rehabilitation are also reported as well liked. Work, particularly informal work is reported by many and takes the form of ‘helping out’ around the rest home. For some, support of less able bodied residents, or doing ‘jobs’ around the rest home are willingly undertaken as worthwhile and enjoyable tasks. For the women, informal volunteer work such as knitting or crocheting peggy squares for blankets intended for refugees or premature babies is considered important volunteer activity.

Well liked pastimes are undertaken regularly as Table 4.5 shows, with most residents reporting at least one of the above activities on a daily basis (62%) or a few times a week (29%).

Enjoyable pastimes and information about the elders’ family and friends has been described. The next section will discuss the findings in this chapter in relation to the literature reviewed in Chapter Two.
Table 4.5. Residents’ reported pastimes really enjoyed (n = 352)

<table>
<thead>
<tr>
<th>Pastime</th>
<th>Men (n=90)</th>
<th>%</th>
<th>Women (n=262)</th>
<th>%</th>
<th>Total (n=352)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how often do you do pastimes or activities that you really enjoy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than once a day; every day, or most days</td>
<td>50</td>
<td>57</td>
<td>163</td>
<td>64</td>
<td>213</td>
<td>62</td>
</tr>
<tr>
<td>A few times a week or about once a week</td>
<td>26</td>
<td>30</td>
<td>73</td>
<td>29</td>
<td>99</td>
<td>29</td>
</tr>
<tr>
<td>Less than once a week or not at all</td>
<td>12</td>
<td>13</td>
<td>19</td>
<td>7</td>
<td>31</td>
<td>9</td>
</tr>
</tbody>
</table>

4.3 CHAPTER DISCUSSION

The descriptive demographic, health related and social and pastime based characteristics of residents in this chapter are background to this interpretive study. I discuss the findings in this chapter in light of the existing literature laid out in Chapter Two.

DEMOGRAPHIC INFORMATION

The majority of residents are aged over 85 years which is in line with residential care elders in the United States (Morgan, et al., 2006). All residents had compulsory schooling to about 12 years of age. There are two women for every one man which is in keeping with all residents living in long term care in New Zealand (Ministry of Health, 2007). Widows or widowers make up two thirds of participants which is also similar to the United States context (Moen, 2001). Those who never married (12%) , mainly women, exceeds the national average of approximately 5% (Statistics New Zealand, 2001), although this is in keeping with research showing that older women with no children are more likely to move to residential care facilities (Rowland, 1998). The feminisation of rest home life supports the view that men die relatively younger than women, leaving ageing and disability as women’s problems as others have suggested (Arber & Cooper, 1999; Gamliel & Hazan, 2006; Olson, 1988).

Half the residents live in large multinational chain rest homes with at least 21 co-residents. Length of residency ranges from less than six months to over four years, illustrating that residents constitute an ever-changing population. The services that the residents receive are standard, although nearly half of the residents pay their own fees, while the other half have their fees subsidised by the government. Nearly all the elders (96%) report that they are financially comfortable or have just enough to get along on.
**HEALTH ISSUES**

The residents self-define their health and life satisfaction in positive terms despite having multiple diagnoses for which they take medication, and receive other forms of care, as provided by the rest home. Self-rated general health responses are in keeping with other research which has found that elders who stay in age specific communities re-define their health status to fit current health levels even if frail (Gergen & Gergen, 2002). Various types of reported disabilities are likely to escalate as the residents grow older (Statistics New Zealand, 2004b), along with the New Zealand population at large. The elders are aware that (ill) health means they are unlikely to make the shift back to independent living and most report their stay as ‘indefinite’.

One-third of the residents take medication. Side effects from medications such as benzodiazepines are often responsible for increased mobility related disability which lessens activity (Fortin et al., 2007). Some residents may be undertreated medicinally for mental-health related issues such as depression. According to the World Health Organisation (2008) depression is a mental disorder whose symptoms include depressed mood and loss of interest or pleasure. Depressive symptoms negatively affect well-being and relationships and have increased prevalence among elders with disability (Ferreiro & Sherman, 2006) and in those in residential care (Lin, Wang, & Huang, 2007).

The elders with depressive symptoms (42%) or those taking medication for depression (38%) may be unable to function well socially in the rest home to some degree, and this possibly impacts on their interaction with others, or ability to take part in activities. These rates of depressive symptoms were higher than with older people in community-based studies, including a comparable study of Australians and elderly Americans which found that one third (37%) of the older Australians, and 28% of their United States contemporaries reported experiencing depressive symptoms (Buys, Roberto, Miller, & Blieszner, 2008).

Fall rates for residents are said to be three times those of community-dwelling elders (Rubenstein, Josephson, Schulman, & Osterveil, 1996), however the majority of the residents had not fallen in the three months prior to the study.

Although significant cognitive impairment noted by rest home staff was an exclusion criterion in the study, one third of the residents have some form of cognitive
impairment, as measured in the baseline survey. This percentage of dementia rates is similar to findings in a local study (Boyd, et al., 2009). Recruitment criteria were applied by the nurse manager in each rest home. While reasons for inclusion of demented residents are unknown, staff members could have a high threshold to recognising significant cognitive impairment, and systematic testing may not be standard in the rest homes. In Chapter Eight, residents’ perceptions about being infantilised by staff will be explored.

One third of the residents report contentment and satisfaction with their stay in the rest home. Satisfaction has been the focus of studies in the United States (Levy-Storms et al., 2005), Hong Kong (Lee, Lee, & Woo, 2005), Croatia (Ljubic, 2003) and New Zealand, where Jorgensen (2006) found the health of the elders impacted on their thinking about their lived environment, whether at home or in a rest home. Jorgensen (2006) did find that rest home residents were less satisfied than community dwellers. In keeping with other research (Davidson & O’Connor, 1990; Jorgensen, 2006) relocation to residential care for most elders is satisfactory and acceptable, even though it may be perceived as negative by the general population and even rest home staff. It is possible that high percentages of reported satisfaction could be due to unequal power relations between residents and staff, management and the research team. These perceptions had no correlation with the length of time that residents have lived in the rest homes (ANOVA F statistic 0.89 p = 0.47).

The older people report some problems with health related quality of life in some activities of daily living such as self-care. Measuring quality of life has resulted in a number of community-based models being developed that are relevant to social gerontology (Bowling, 1995; Farquhar, 1995; Gabriel & Bowling, 2004; WHOQoL Group, 1993). These various models have proved problematic (Birren, Lubben, Rowe, & Deutchman, 1991; Kahn & Juster, 2002) so a well-validated measure, the EuroQol (1990) was used.

**Co-residents**

The elders seldom counted co-residents as friends which is in keeping with earlier studies (Willcocks, et al., 1987), although other research (Eales, et al., 2001) has found residential care dwelling elders do form friendships with co-residents. A common pattern grew out of the question about regular, enjoyable pastimes that the residents take
part in, expressed as helping out and supporting other residents. This help given
co-residents underpins Harel’s (1982) claim that the support of others is significant to
the residents’ sense of quality of life. Informally volunteering to help co-residents is a
way of being useful and has been found to enhance empathy for others in residential
aged care (Nay, 1993). These relations with co-residents will be explored further in
Chapter Eight.

**Staff**

For the residents, staff members are important to the day-to-day. Examples of how staff
members are integral can be found during housekeeping, in intimate activities such as
bathing and toileting, and at meal times. Research on the types of communication
regarding care practices between residents and staff is multifaceted in other research
(Carpiac-Claver & Levy-Storms, 2007; Foner, 1995; Kennedy, et al., 2005; Kiata &
Kerse, 2004b; Wadensten, 2005). Rest home employees are reported by the elders to be
emotional supporters by a small proportion, even though information about day-to-day
contact with rest home staff was not specifically sought in this survey. The types of
interaction that staff have with residents is said to be crucial to residents’ quality of life
(McGilton & Boscart, 2007; Nay, 1993) so these relationships will be investigated in
Chapter Eight.

**Family and friends**

The importance of children in the residents’ lives resonates with international research
(Lowenstein & Daatland, 2006), and contact with children has been found important in
residential care studies (Dupuis & Norris, 2001). Having no offspring is said to be an
important risk factor for entry into residential care institutions (Rowland, 1998).

The elders report spending time with between one and 10 close relatives and
friends in the last month, and this is possibly related to gatherings at times of
celebration and commiseration. Close friends, like family, live outside the rest home.
That most residents with close friends reside elsewhere is a finding in keeping with
international studies reporting that social networks tend to stay stable over the life
course (Kellaher, 2000; Staudinger & Fleeson, 1996). The smaller numbers of
participants claiming few and no close friends may be a peer and cohort effect owing to
geographical moves and deaths of close friends as Bauman and colleagues (2001) have
proposed. For some residents, staying in touch may be a case of ‘out of sight, out of mind’, as contact may have been lost when they or their friends moved.

Local or long distance interaction, especially telephone contact, is well reported by the elders. This is in line with one United States study which established that patterns of telephone use in a nursing home helped elders in long-term care remain connected with friends and family (Gueldner, et al., 2001). Where telephone calls are minimal, health related factors including deafness or cognitive impairment may be the reason. Alternatively, some residents may be content with little contact with others because not all relationships are positive (Adams & Blieszner, 1995).

Emotional support is relative to both close proximal and distant kinship and friendship ties (Seeman & Berkman, 1988), although in my study the distinction between emotional support being face-to-face, local or long distance was not made explicit. Close friends living outside the rest home are the main emotional supporters after daughters and sons, and support may be offered via the telephone, which is discussed in Chapter Eight.

My study followed standard practice in social gerontological research, and investigated emotional support roles played by the family and friends of older people as did the local community-based Mosgiel Longitudinal Study of Ageing (MLSA) (Keeling, 1998). The elders in my study reported slightly lower levels of support than community-dwelling peers in Keeling’s (1998) research. Some residents report that emotional support is given to them by staff members. Ongoing emotional support for the elders is a finding that resonates with research showing composition of social support changes over time, although levels of emotional support received are not affected by this change (Due, Holstein, Lund, Modvig, & Avlund, 1999). Questions were not asked about the giving of support to other people.

**Pastimes**

Most pastimes appear to need little ongoing interaction with or reliance on other people in order to be undertaken. Residents can choose to take part (or not) in many of the activities they report enjoying on an everyday or regular basis. These reports match previous findings where any activity that is meaningful and achieves some purpose is important to older residents (Nay, 1993). In my study, the 352 residents’ pursuits are similar to those reported in an Australian community-based study where daily pastimes and interests of older people were mainly sedentary (Kendig, et al., 1996). Reading and
television watching are popular pursuits in the rest home, especially television watching for the men, which echoes findings from community studies (Scraton & Holland, 2006).

To sum up, I have in this chapter described the demographic, health and socially orientated information of the 352 residents which serves as a backdrop for my study. I have responded to the three initial research questions about (i) the elders who live in a rest home, (ii) the residents’ relationships, and (iii) the types of activities in which the elders take part. To achieve a depth and richness not possible with this level of description alone, I employ in the next chapters the main component of phenomenology as discussed in Chapter Three.

In Chapters Five through Eight, I will offer an interpretation of the lived experiences of rest home life for the residents which builds on this descriptive chapter. As the sequel to this chapter, the next chapter (Chapter Five) will focus on lived space for the residents. Chapter Six has lived time at its centre, Chapter Seven discusses the older lived body and Chapter Eight considers residents’ lived relations with others. In the upcoming interpretive chapters I apply a phenomenological lifeworld approach to address the main research question, *How do older people in New Zealand rest homes experience daily life?*
5 Chapter Five: Lived Space

5.1 Introduction

The purpose of this chapter is to interpret the residents’ lived experiences of some of the spaces they use within the rest homes. As discussed in Chapter Two, the literature surrounding space is well documented, and offers a viable way through which to explore the residents’ lived experiences of rest home space. In this chapter, I examine the residents’ lived space as one of van Manen’s (1990) four overarching themes, which I have termed strands. These strands make up the phenomenological lifeworld explained in Chapter Three. This chapter builds on the descriptive backdrop reported in Chapter Four, where the focus was on identifying and documenting the residents’ relationships and pastimes. The breadth of information in that chapter serves as a contextual backdrop for the interpretive findings discussed in this chapter and the three chapters that follow. In this chapter and the chapters that follow, the narratives of a few residents will speak for many.

The primary grounding in our world is spatial according to Schütz (1962). Lived space is “the existential theme that refers us to the world or landscape in which human beings move and find themselves at home” (van Manen, 1990, p. 102). While space is an important concept in the person-place relationship, lived space is difficult to put into words because it is not usually reflected upon (van Manen, 1990). van Manen (1990) argues that an inquiry into the nature of lived space is helpful because it imubes the “particular experience” with “its quality of meaning” (p. 103). The meanings of places permeate with shared feelings, and Schütz’s (1962) idea of typification suggests how individuals take for granted that they can understand another person’s conduct (and vice versa) and that communication is possible (Fairhurst, 2000). These typified meanings are how space is experienced by the residents.

In this chapter, I consider rest home spaces, based on the ways in which spaces are referred to in the residents’ interviews. The way in which a lived environment is structured impacts on how events are experienced by individuals (van Manen, 1990). Rest home spaces are configured in specific ways that enable a group living environment for residents and a work space for employees. This chapter focuses on the lived experience of the residents. I employ the residents’ narratives and interview
summaries as a kind of reflective bridge (Elliott, 2005) through which I interpret my findings using the phenomenological approach explained in Chapter Three.

The ways in which space is experienced by the residents will be followed by a discussion section, as will the findings in Chapters Six, Seven and Eight. I will address the research question, *How do older people in New Zealand rest homes experience daily life?*, and explore residents’ meaning making of their lives within the rest home milieu. First, spatiality in the light of the main research question will be addressed. Phenomenological analysis comes out of audio-recorded interview narratives with 27 residents, which is the main source of data for this mixed-methods study, and is fully supported by the wider body of over 300 interviews. Appendix 8 provides further information about 27 residents. The phenomenological characteristics used in this chapter will be legitimate only to the degree “that they inform, confirm, value and validate one’s own possible experiences” from the standpoint of the lifeworld of the subject (van Manen, 1998, p. 3).

In analysing the interviews, I noticed that the older people’s narratives commonly exhibited variation in their responses. These responses defined evolving themes for each of the thematic strands. To represent the tension produced by this variation. Figure 5.1 illustrates a multiple-helix depicting a strand of lived space, where the meanings of the lived experience of spatiality for the older people relate to threads of ‘communal-(semi) private spaces’ and ‘expanding-restricting spaces’.

![Figure 5.1: Threads of a lived space strand using a multiple-helix model](image)

Figure 5.1: Threads of a lived space strand using a multiple-helix model
5.2 COMMUNAL – (SEMI) PRIVATE

The first of the threads woven into the lived space strand is one of communal and (semi) private space. In the initial section, I will discuss environments including the hairdressing salon, smoking areas and gardens which are communal spaces located on the thread. Then, a move towards the (semi) private spaces at another point along the thread will be considered in a discussion about the residents’ bedrooms.

COMMUNAL SPACES

Hairdressing salon

Lived space is the direct and subjective experience of space. Spatiality is more than a physical location; it is a spatiality of situation. One specific communal space within the rest home is communal, as exemplified by the place of the hairdressing salon. Most rest homes have a regular hairdresser who usually works at the rest home in a dedicated space. As these places are contained within the rest home, frailties such as immobility need not be overcome for residents to have their hair “done” as Lena suggests, since they remain seated throughout. The hairdresser’s arena is open to all as Jean reports: “I can go and get my hair set, which will be tomorrow. There is a place in the building where a lady does it. That makes you feel good”. The importance of this experience is made clear during many interviews, particularly by the women residents. The older people have spent regular times throughout their adult lives going to “the hairdresser” which has traditionally been one of the few public spaces specially geared towards women of their generation(s).

The space encompassing the salon acts as a conduit for information both given and received for the residents and continues to be greatly valued. Residents report ongoing arrangements that, depending on ability to pay, range from attending once a week to monthly. They look forward to their “appointment”, which highlights the importance of ongoing routine. Some like Lillian are lucky enough to have their “hair done once a week” which she expresses is “a lovely day”. Receiving a hair “wash and set” provides a pleasurable form of close physical contact that results in the older person feeling special. As an ongoing social institution, the hairdresser offers spatial physicality in the form of touch, which functions as intimacy along with the interaction of conversation that occurs.
Enjoyment of the hairdressers continues to be communicated in other communal rest home spaces. Sitting in a lounge room one afternoon, Lena and a co-resident share a laugh following their visit to the hairdresser that morning. The women’s easy banter is in a teasing tone as they tell one another how “beautiful” they look, and how they will have to watch each other around the male residents. Lena jokingly states that they “are too old” to do anything about it, and the men “too senile” to notice.

**Smoking places**

Terence requests that we move to a communal outside space to sit at a large wooden barbeque table on a covered veranda so we can talk while he smokes. As a cigarette smoker, Terence can only “have a smoke” if accompanied outside the rest home building by a staff member or visitor. A taciturn man, his interview is filled with long silences as he slowly hand rolls and smokes three cigarettes in succession. He crushes the butts in a full used ashtray sitting on the table before immediately rolling the next cigarette. I too sit quietly, looking back through large glass doors at the goings on of the residents sitting inside the communal lounge while Terence sits beside me enjoying his “smoke”.

Quite a few older people have been smokers at one time mainly because they started smoking when it was a fashionable social activity. As a sign of contemporary times, and the health risks and costs associated with smoking, only a small number now smoke cigarettes. Yet, enough residents still smoke to ensure that most of the rest homes set aside an outdoor space for smoking, typically for residents and staff. The older people are clear in their opinions that a smoking area serves an important social function as Lillian points out.

*I go down there [to the smoking area]...after morning tea, after dinner, I sometimes go down after afternoon tea time. After tea I might if I’m lonely. I’ll go down at supper time. I just smoke a mild cigarette but I’m not really enjoying them, I’m enjoying the company, even though I don’t say that. I like to laugh and joke, I mean laughter is the best medicine of all (laughs).*

As recent law changes in New Zealand have resulted in banning smoking in a number of public places, Lillian’s claim of “enjoying” the company covers over the fact that smoking places are stigmatised spaces. Residents’ bedrooms are staff members’ working spaces and smoking in bedrooms is banned. My interviews with smokers took
place outside, and in one case inside, in clearly designated and demarcated smoking spaces.

Rest homes in contemporary times allow smoking areas where residents can congregate. The addictiveness of cigarette smoking is compounded by the long time that the elders have smoked, in some cases sixty-plus years, and the habitual social interactions that occur when smoking. The health risks are reflected on by Mary who overall feels that the risk is worth her taking since smoking has yet to “kill me, and I’m in my 80s”. The rest homes have ambiguous spaces such as smoking areas which are loosely classified as public places.

**Gardens**

New Zealand has a temperate climate that encourages the use of outdoor spaces. From the outside, most of the rest homes are aesthetically pleasing, being well maintained and often with established, tended gardens that may be communally used. Gardens have played a large part in most of the older peoples’ lives in the context of the ideal New Zealand home with its quarter acre section, an ideal obtained by many elders. A number of rest homes hire a gardener to tend the grounds and older people report that this pleases them. Some mention that the rest home gardens are less well tended than in past times which many astutely suggest is a sign of the economic times.

Residents’ talk about the outside spaces of the rest home results in reminiscences about their gardens of the past. Lillian speaks fondly of her previous own home where she spent many enjoyable hours gardening in her “quarter acre section”, while Daphne recalls her husband’s vegetable garden and her flower garden on their “full section”. Indeed, most residents speak about tending their own gardens in the past. Echoed by many are Bill and Bessie’s experiences, in recalling their personal garden spaces of the past, acknowledging the shared gardens of their current experiences in the rest home.

*I had a vege[etable] garden when I was in my own place...The[bean] wires went right across the back of the section. I used to grow my white icicle radishes...and...runner beans...I kept my own seed of those ...they were lovely big long ones....and tomatoes of course, I grew...enough for...a meal all the time.*

*I just loved my garden... I had a big bed of asters; the giant ones and I’m picking bunches of asters, beautiful. Daffodils...and coloured freesias. Those were my specialities really. I was a school teacher and of course, every school had an established garden.*
Some residents continue to garden around the rest home, using strategies such as potted plants and raised beds. Available space may be much less than in the past, however this parallels their decreased physical and cognitive abilities. With support, gardening can work well in the rest home setting.

One keen gardener is Catherine whom I find outside tending pot plants at a waist height bench the (short) length of her bedroom. Acknowledging me, she slowly removes her gardening gloves, placing them on top of a small stack of plastic flower pots. Rubbing her hands together, she moves back inside through the ranch slider doorway to sit on her bed. I follow and upon her prompt sit on the only (easy) chair in the bedroom. Catherine explains how she “loves the garden” and the planted pots have become substitutes for, and extensions of, her own precious garden. Gardening her numerous pots of indoor and outdoor plants that spill out of the room onto a shared cobbled courtyard, Catherine continues a lifelong enjoyable pursuit. Not all the older people have enjoyed gardening as immobile Norman adamantly states, “no, to hell with the garden. I don’t like digging gardens”.

While many speak about their enjoyment of gardens, seldom do I see a resident sitting outside and those who do are accompanied by younger, more able people in the form of a staff or family member. Residents often mention that they are discouraged by staff from going outside unattended. Increasing frailty constricts available physical space and requires residents to spend more of their time inside the rest home. The inability to access diminishing outdoor spaces is compounded by the often expansive and attractive gardens being extremely difficult to access by residents with walking aids and unsteady legs or low vision. The changeable New Zealand weather also limits residents’ use of the gardens, which are seldom covered from the sun, rain and wind.

Often, I find the older people looking out of large windows and doors common to both communal areas and bedrooms. When I comment on the view, the elders express their contentment of being able to enjoy the vista of courtyards full of flower beds, well kept lawns, or bush (wood) settings from the inside. From inside the rest home they are safely encased behind large glassed windows. The long time enjoyment of gardening as a pastime for many has been reconstituted from within, and remains the same as always. Physically gardening, sitting or walking in the garden; and gardening in the mind’s eye of memory allow the residents to continue to enjoy outside spaces.
Positioned at another point on the communal-(semi) private thread are the residents’ bedroom spaces. These spaces are rarely private domains, which they would likely be if located outside the rest home context. One of the reasons that residents’ bedrooms are (semi) private is due to being work spaces for staff. Fellow residents also enter co-resident bedroom spaces without invitation. Residents are able to regain some sense of private space through visual aids including photographs. Invisible boundaries are created by residents around bedroom space by ignoring or incorporating sounds and odours as part of rest home life, when these senses threaten to intrude on the residents’ (semi) private spaces. While shoring up their own bedroom space, other resident’s bedroom spaces hold more ambiguous meaning. Uncertainty surrounding the sudden disappearance of fellow residents in (semi) privacy will now be considered.

Residents’ bedroom space
Residents’ bedrooms are work places for staff members and professionals and visiting areas for family and friends. Despite bedrooms being the residents’ living and sleeping spaces, these rooms are only ever (semi) private spaces for the residents, because others can access them at will. During interviews with doors closed, staff members often give a cursory knock before entering residents’ bedrooms to complete jobs like cleaning bathrooms, changing towels or bringing tea. Family members or friends sometimes pop in with magazines or clean washing for the residents.

Owing to lack of privacy in the semi-personal space of the bedroom, being away from co-residents has, for a number of older persons, become problematic at the most basic level. Alice discourages fellow residents from entering what she considers should be the private space of her bedroom.

*I think one has to be very careful in a place like this and not have somebody special who is always in and out of your room. A lot of people think a [rest] home is like that, but it’s not, not this place here.*

Alice makes an implicit distinction between co-residents and staff members, who are routinely “in and out” of residents’ bedrooms in the course of their work day. Alice relays at length how she actively discourages one co-resident from coming into her bedroom and reinforces her view by stating that “people don’t socialise here, and I think that’s rather a good thing”.

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Daniel discourages co-residents and staff from encroaching on his space with a hand written sign taped to the closed door of his bedroom stating in large black, block letters “DO NOT DISTURB”. I knock on the firmly closed door tentatively and am relieved when Daniel calls out for me to “enter”. Once settled for our interview he explains that he thinks little of the company of others which in a rest home setting necessitates spending a great deal of time alone in his bedroom. “It’s not that I don’t like other company, but I’m more at home if there’s no one around me, yeah”. Daniel prefers to remain quietly within the spatial confines of the bedroom, which offers a degree of sanctuary where he can feel relatively safe in his own company.

While not explicitly stated, staff members appear exempt from attempts to manage spatial boundaries that Daniel and Alice have determinedly erected to keep co-residents out of the (semi) private spaces of their bedrooms.

Locking bedroom doors is discouraged in the rest homes as staff must be able to enter bedrooms in an emergency, and resident surveillance by staff may be part of residents’ care plans. The effect of these policies, Norman sourly remarks, is that “there’s no privacy in a place like this”. The elders’ experience of personalised space is diminished in the knowledge that interruptions by others can occur at any time. In an attempt to keep others out of their vacant bedrooms, some elders use a crude alarm system.

Barbara uses a makeshift alarm to ascertain whether her bedroom has been entered while she is otherwise engaged elsewhere in the rest home environs. The rationale is to safeguard items of jewellery and food, which she says are being taken from her bedroom. The alarm system is simply a dressing gown cord placed halfway up the doorframe before the door is closed. When the door is opened, the cord falls to the ground alerting Barbara to an intrusion when she returns to her room. This alarm is only likely to work if the intruder does not notice the (obvious) cord and this gives a clue to those responsible, who are likely to be confused co-residents.

An example of an intrusion occurs when an agitated resident bowls into Barbara’s room without knocking and lurches across the room incoherently shouting and waving her arms excitedly. Through the now open door way I hear a Mr Whippy ice cream truck playing the familiar Green sleeves tune over its loud speakers. Although I am startled, Barbara remains calm and tells her intruding friend that she will come see her
soon and they will go for ice cream together. The woman wanders off leaving the door open. Almost simultaneously, an intercom located next to Barbara’s bed crackles and a staff member loudly announces the arrival of the ice cream truck.

The disruptions to her (semi) private space do not appear problematic for Barbara. Offering to illustrate how her alarm system works, she moves us out of the bedroom before quickly closing her bedroom door on the dressing gown cord. Hurriedly taking her leave in search of her friend, she leaves me standing bemused and watching her rapidly retreating back disappear down the corridor. Despite intrusions by her co-resident and the intercom announcement, Barbara successfully retains a sense of privacy.

**Visualizing (semi) private space: Spatial aids**

Mainly due to being staff members’ workplace, coupled with the possibility of intrusions by co-residents, the residents’ bedrooms are (semi) private spaces. Within these spaces however, the residents maintain a more personalised ‘space’ in the form of spatial aids such as photographs and other paper-based mementoes. Often, these keepsakes are readily brought to the fore for discussion, and act as another buffering layer to the (semi) private space of the bedroom.

Entering Clifford’s bedroom after knocking on the open door, I receive his firm handshake in welcome. He turns to sit in the only relatively paper free space on his bed and motions to the only chair, which resides in the corner of the room. Moving papers from the chair I place them precariously on top of another pile on the floor. I lower myself gingerly into the impractically low seat while wondering how I’ll later manage to get upright without toppling the paper tower beside me. Looking around the room from my low perch, I note that from bed to armchair to floor, mementoes including photos of family and friends fill every available space.

While I wonder how Clifford can find anything in the mass of paper strewn around his bedroom, he deftly illustrates that the spatial layout is organised in a way that puts at hand everything he requires. Numerous birthday cards, newspapers, magazines, piles of books, opened envelopes with letters; accounts, flyers and other miscellaneous paperwork take up all the flat surfaces including the chair I have commandeered. Despite this clutter, he easily lays his hand on a funeral order of service, and we talk about his recent experience meeting with people he has long known
at a friend’s funeral. The photo on the front of the ‘order of service’ offers us a visual cue into his story.

As a visual tool, photos (and other paperwork) hold significant meaning and in almost all interviews provide a talking point. Individual personal space is reflected through the possessions of the residents, despite the sameness of the bedroom spaces commonly containing a single bed, a chair of some sort, drawers and a cupboard(s). Personal biographies are interwoven through the objects within the resident’s bedrooms. The (semi) private spaces of the bedrooms are arranged in a way that gives meaning to the present by connecting it with the past. This meaningfulness is most often achieved using prompts such as photographs as Clifford illustrates.

Robert is a dejected looking man of small stature. Until recently, Robert has been physically active, but his rapidly declining visual acuity coupled with the recent death of his wife have negatively impacted on his life. Robert waves to a wall mounted photograph of his wife as a young and attractive woman, and begins to speak about how much he misses her. The photograph is a kind of visual prop (for me) through which Robert can bring his “lovely lady” into the room with us. The space between Robert and me is bridged by my acknowledgement of their life together, and so he finds a valid space in which to talk about his current sadness since her recent death. His story is more than merely memories of living in the past; his few possessions, including his photos, colour his life as he currently experiences it. The way the space within the bedroom is set up is highly meaningful for Robert. Poignantly, the rapid decline of his physical and emotional health compounds his grief as his world continues to shrink through his rapid loss of vision, which is reducing ability to “see” his wife’s picture.

To aid discussion about her grandchildren, Maura points out a framed portrait of her granddaughter that sits next to a vase of fresh flowers on a tidy, Queen Anne sideboard. Maura gives a detailed account of her grandchild’s professional work and upcoming marriage. Maura travels through temporal space, arriving at a place where she can muse over her own life experiences, and speak about how different her experiences were from her granddaughter’s world today.

Rummaging around her paper strewn side table for a few minutes Vera finds a letter she very recently received from a granddaughter living overseas who she has never met. I express surprise that the letter is in email form. Vera tells me that she
writes out in long-hand her communication and gives it to a rest home employee who types the letter into an email message. Despite the vast geographical space that separates Vera and her granddaughter, email provides a current and constant link to her family, and her own younger life, and in this way she maintains a strong connection with her granddaughter. It is important to highlight here that the (unstated) support of a staff member willing to help is necessary for Vera to stay connected with her family overseas.

Using Maura’s photo and Vera’s email as props, visual cues are provided for me to locate myself in these residents’ differing spatial timeframes as I listen to their stories. As the receiver of Maura and Vera’s narratives, I draw on my own experiences as a middle generation female (researcher), which bridges their life experiences across time and space and those of their granddaughters.

Photographs and other paper-based items such as email transform the smallish space of the stock standard rest home bedroom into a highly personalised, meaningful space for the residents (and me). The space of the bedrooms are small, and the geographic distance of their granddaughters vast, yet unbroken connections draw these older women’s descendents into the bedroom with us. Visual cues allow the residents to discuss their relations with others, the theme of Chapter Eight, as indicated through Clifford’s tale, Maura and Vera’s comparison and Robert’s sad reminisce. These stories also illustrate the interconnectedness of spatiality along with temporality, the major theme of Chapter Six.

**Creating Boundaries for the Senses: Odours and Sounds**

All societies have culturally prescribed and proscribed spatial boundaries that are in the main observed. Markers of contempt for others can include encroaching into another individual’s personal, (semi) private space. In mainstream New Zealand European culture, displaying excessive noise such as shouting and swearing, or emitting unpleasant sounds and odours such as flatulence are perceived as signs of disrespect towards others. In the rest home context however, these spatial boundaries become easily blurred. Most often the socio-cultural rules governing bodily odours and noise are ignored in lived spaces; these sensory secretions become transformed into signs of illness and disability rather than deliberate contempt of other peoples’ spatial boundaries.
Recorded in the interviews and my research notes are accounts of odours from some residents’ leaking bodies, sometimes accompanied by the sounds of screaming, yelling, and swearing. At times these smells and sounds overtake my senses.

Incontinence in many older frail bodies in a confined space can be overpowering. The practicability of residents crossing substantive spaces to reach the bathroom, whether en suite or communal, in good time is clearly unknown. Unsurprising then that odours associated with incontinence are present in most rest homes, to some degree, and encroach on what I perceive, but must acquiesce, as personal space; my senses.

Although I ponder over the residents’ experiences of what I find unpleasant odours, this topic remains quiet with the exception of Maura, one of the few residents who shares a room with a co-resident. Maura is content to “bunk in” with a female fellow resident. She tells me that other residents sometimes complain to her about the odour that wafts into the corridor due to her roommate being incontinent, however Maura has “lost her sense of smell” so does not mind a bit. Incontinence is a subject avoided by me, and out of a sense of courtesy I (dishonestly) claim that the smell is not too noticeable.

It is difficult to cope with other assaults on the senses, particularly in the form of excessive noise, a topic spoken about by the residents. At times it is hard to concentrate, let alone hold a conversation over intrusive sounds. Interestingly, interviews take on a surreal quality as screaming, pleading, moaning, and shouting suddenly erupt, but are politely ignored. The older people have become desensitised to the sounds and smells, which become to them background noise. A few however, do bring attention to the invasion of noise in the (semi) privacy of the resident’s bedrooms. Clifford is one who pauses early on and asks me “hear that?” as a woman’s ear-piercing shrieks of terror fill the space of his bedroom. “That’s the lady next door being showered” he laconically states. We sit quietly listening for a few moments before recommencing the interview, raising our voices to quell the disruptiveness of his co-resident.

A few residents do experience distress including Simone who points out that some fellow residents suddenly “scream and frighten me to death”. Simone is disturbed that her aural space is periodically threatened by co-residents’ yelling. Her fear reflects the negative aspects of living in residential care and backs up derogatory anecdotal comments of media accounts that inform mainstream ideas about rest home life. In the
main however, I observe that most residents (and staff) ignore and tolerate noises and odours periodically invading bedroom (along with communal) spaces.

**Co-resident bedrooms**

Nancy’s relationship with a co-resident living in the room next door offers a glimpse of the ambiguity of supposed (semi) private space in the rest home setting. Nancy asks if I have seen the woman from the next room because she thinks the woman has died. Surprised, I respond that I have not seen her co-resident. Nancy reports that even though she and the woman were “friendly” staff members have not explicitly told her that the woman is dead. Nancy has observed none of the signs usually involved in a death and so remains unsure of the situation. She is of the opinion that the woman’s body must have been whisked off quickly and quietly sometime during the night before.

Nancy says she does not want to act inappropriately by asking staff members about the vanished co-resident. She is unsure whether or not there will be a funeral and if so, if any of the staff will be attending. As Nancy has multiple health problems including loss of hearing and cognition, she has difficulty communicating with staff, especially over such a sensitive subject as death. The flurry of quiet activity by staff over the previous days cumulating in the sudden disappearance of Nancy’s co-resident remains contained by silence by the staff, and compounded by her hearing loss, leaves Nancy perplexed. An unknown space lies behind the neighbouring room’s firmly closed door.

Like Nancy, I experience perplexity when returning a summary letter to Eric, an interesting older man always ready to have a “yarn”. Knocking and entering his bedroom I find all trace of him has disappeared. Suspecting that I am in the wrong bedroom, I check with a staff member who informs me that Eric died a couple of days back. I find it eerily bizarre that the space which a week ago had been so full of the older man, his energy, his belongings and his wit has in such a short space of time been completely wiped clean leaving no trace. It was as if he never lived, or died there. The space Eric inhabited is empty. Within days the barren space of Eric’s bedroom will be filled by another resident.

Specific (semi) private space is often full of a co-resident, and then frequently, suddenly and quietly emptied of that resident and their belongings. Perhaps occurring many times over during an elder’s residency, this phenomenon may help to account for
the tendency of residents to protect themselves by perceiving co-residents as acquaintances rather than friends and is a theme discussed further in Chapter Eight, in the context of experienced relations with others.

5.3 EXPANDING - RESTRICTING

While physical space remains the same, rest home lived space is used in ways that allows for activities to be undertaken by the residents that the original space had not intended. Lived spaces used by the residents tend to be staff orientated, rather than resident focused. For these reasons, rest home spaces are ‘expanding’ or ‘restricting’ along sundry points of the spatial strand for the residents. These spaces continue to expand and restrict depending on where (and when) that space is required by residents. I will first discuss expanding spaces that occurs in corridors, informal, volunteer work spaces and staff-oriented work spaces. I will then consider the residents’ use of restricted lived spaces.

EXPANDING SPACE

Corridors

While serving as a space that connects other spaces, corridors act as important spaces in their own right. Corridors can be spaces that unfold to meet the residents need to adapt long-term activity, such as exercise and socialising, so that they can continue these pastimes within a safe and accessible environment.

Smiling a greeting to a mobile older woman as she passes me in the long, wide corridor, I walk to a resident’s bedroom to ask for an interview. The room is empty, so I turn back the way I came. The woman I passed reaches the other end and turns. As we walk closer towards each other, I ask if she knows my missing participant. We laugh together as she tells me she is my missing participant, Lena. This scene is a common one as I observe residents walking along corridors. Often, I observe the same resident going back and forth many times along a corridor, which could be a busy place when the space is filled with older persons, some with and others without walking aids.

Initially, I wonder if some of the residents are lost or perhaps aimlessly wandering around the rest home (as was I, sometimes). Lena confirms my observations that the hallway setting offers adequate socially orientated space allowing the opportunity to interact with peers.
I just like to get my walk every day because people are so friendly when you are walking in a place like this, people are walking in [walkers and scooters] and get to know you and so forth.

Corridors connect with other communal spaces. Often, residents state that they are discouraged from walking outside the rest home by management and staff, in the main due to previous falls. In the previous chapter, falls in the rest homes were recorded as few, even though falls in rest homes are three times the rate of those in the community. Bessie is one such resident who says she is no longer “allowed” by management to walk outside the rest home unattended by a staff member as “I’ve got to go with an escort out of here. I walk” to the local town centre and “back, which” she laughingly remarks “is an achievement”. More often than not, Bessie is confined to the “four walls” of the rest home because busy staff members have little spare time to go walking with residents. Yet, confinement is turned into a positive attribute as corridors are converted to important spaces for social and physical activity to take place. Many residents utilise the corridors in their daily fitness routine and as an opportunity to engage with others in their lived environment.

I note that while most residents are present at collective events in specific spaces such as lounges, a few are absent from card games, group readings and happy hour events that take place in communal areas on a regular basis. I ask the friendly and outgoing Vera why she does not attend the Housie (Bingo) session at the rest home in which she lives. Vera explains that the sloping ramp in the corridor that paves the way from her bedroom to the communal area is an insurmountable obstacle she is unable to overcome owing to her physical impairment. Explaining that she “had to give up” attending following a “fall, you see” in which she injured her leg, Vera has been immobile and mainly confined to her bedroom for an extensive period. Now that her leg has started to heal,

lately I’ve decided I’ll try going up [to the communal lounge] but due to the sloped corridor I can’t because it’s slanted, not on the flat here. I call it Mt Everest that I have to go up.

Despite having a walking aid Vera remains unable to negotiate the sloped ramp which she likens to “climbing a mountain”. This means inability to access some communal areas in the rest home without help from others. Constrained by her immobility, Vera has become confined to a smaller lived environment than previously. Ongoing encouragement by rest home staff to get mobile unaided is treated by Vera
with frosty silence because, she tells me with a tone of annoyance, the staff do not understand her difficulty with mobility. She continues to use a walking frame because she feels safer and believes she is less likely to have another fall. Having incorporated the walker as part of her spatial sensory awareness, Vera’s reluctance to stop using the walking aid is a logical choice. While Vera’s mountain metaphor may seem excessive, the importance of being able to get around the rest home unimpeded cannot be overstated.

Residents confined to wheelchairs and other walking supports can usually find a willing able bodied fellow resident to wheel them to rest home events and communal meals. The loss of basic mobility (walking) is not so easily adapted to by those without aids who would like to be able to “walk more” but are physically unable because they have no support. Harry, who is becoming increasingly immobile, but has no walking aid, is philosophical when he understates “oh yeah, I loved the walking. After five strokes it’s just a wee bit much now”. Like Vera, Harry now spends more time confined to his bedroom.

**Informal work spaces**

In their role as informal, (unpaid) volunteer workers, some residents have more access to rest home space than their co-residents. Their work spaces expand. For example, “working” to help staff and fellow residents by doing maintenance jobs holds enormous value for Clifford who believes that he is an “asset” to the rest home. Although stooped and frail-looking in appearance he is surprisingly agile and continues as always to volunteer for general handy work around the rest home as I witness at various times during my visits. Rest home management approves of Clifford’s help by requesting he complete odd jobs. Holding a privileged position, he moves easily through all areas of the rest home without being challenged; changing light bulbs, hammering nails into walls for hanging pictures, photos and clocks and helping out with various small tasks at the rest home.

Importantly, residents working on a voluntary basis in specific rest home spaces make space for staff to move on to other work spaces. Some residents work alongside staff members at specific tasks. Folding serviettes for the evening meal tables or setting the table with cutlery for lunch/dinner are daily routines in collective areas. Residents’ preparedness to miss group pursuits in order to complete tasks in other common areas
illustrates the high regard in which daily work routines are held in the rest home context.

Jobs in everyday spaces flow from a lifetime of similar tasks in the residents own homes and continue to be considered essential work. Barbara offers an example of the importance of having, and then losing, a work activity. Over the past decade, her work space has been in the main dining area where she has made breakfast toast. Recently however, she was devastated to learn that management were dispensing with her services, giving her “job” to a staff member instead.

Lena offers a clue to the rest home management’s rationale for residents being no longer able to help out with everyday jobs, including Barbara having her long valued space restricted.

_The organisation in this place is absolutely wonderful. That’s why you can’t do anything, because it’s all done for you... You see, this is too big a place. You would hold [staff] up between the first sitting [of meals] and the second sitting. There’s lots of space between the tables and that, and if [residents] fall, well you see [rest home management] are responsible._

**Staff-orientated work spaces**

Utility areas designed for, and hence restricted to staff use, such as rest home laundries, can be appropriated by residents through a spatial overlap and consequent expansion of space. Lillian is one who spends time in the laundry as she washes her own clothes which she believes reduces the chance of having her garments go missing “in the wash”. She has come up with this strategy following lack of action by staff and management over previous losses. Lillian claims the laundry is an appropriate place to be outside of “working hours” which is when the residents are “allowed” to use utility rooms.

_At night time, I can go down, like I wash my own jerseys now. I hang the cardigans up [in my room]. I can only do one at a time you see. I hang them up on a coat hanger at night and they dry overnight because I leave both my windows open all night._

The space Lillian requires for her laundry spills over from the rest home communal laundry to her (semi) private bedroom. For Daphne, washing the floor and changing the towel in her bed-cum-bathroom is done because in her view, staff members do not properly complete their cleaning tasks. Believing she has little choice but to do the work herself, she wipes the bathroom floor and walks down to the laundry
to collect a clean towel. Daphne feels she is taking “liberties” by claiming the staff orientated space, but justifies this by stating

*I just go in and I think ’well, I've been here so long...you get so used to the place...Mind you, I suppose I’ve got nerve...but nobody knows, nobody sees me, I just go quietly down, hm. I don’t tell anyone.*

On the one hand, Daphne feels she has the courage to encroach on staff orientated space, yet on the other hand she does not inform management about work being left unattended in her room by staff as “you see, I don’t want to make waves” because “I’ve got to live here”. Daphne suggests that being offside with staff members could result in them making her life in the rest home unpleasant and she makes it clear that she actively avoids complaining.

The laundry and other staff designated places are always vacant when appropriated by residents. While co-residents may be using the facilities at the same time, Daphne and Lillian’s point that no staff members are present contributes to their use of the staff based space as this manages resident/staff relations, a topic discussed further in Chapter Eight.

**Restricting Space**

Other spaces have more restricted use. The perception that informal resident volunteers hold up staff routines in the rest home that Barbara resides in, illustrates the different values placed on the perception of work space (and time) versus resident space. Lena’s viewpoint that residents are perceived by rest home management and staff as a health and safety issue could have contributed to Barbara’s job loss. Changes in the rest home sector including the sale of the rest home in which Barbara resides precipitated the loss of her role in a kind of ripple effect from the top (management) down. She tearfully reports being aware that managerial changes resulted in the loss of what was for her a useful role within the milieu of the rest home. Barbara’s space has become more restricted as she spends longer periods in her bedroom.

Suitable, safe and restricted space means that the elders can take up informal work which ensures continued participation in meaningful lifelong pursuits. Requiring little space or interruption to rest home routine, as well as having a low risk of injury, knitting is a common group (and individual) activity undertaken using limited space such as an armchair. Often, a seated row of women, situated in shared lounges, focus busily on knitting or crocheting. Knitting is reminiscent of a prior home based pastime
and able to be practiced in relatively restricted spaces. Upon asking what the knitting is
for I am told that the women are making knitted squares to be sewn into blankets for
premature hospitalised babies or refugee children. The older people often talk about
“helping out” so continuing lifelong unpaid work holds intense meaning and the
pleasure of giving. Iris, who knits for charity, is typical.

Now I do knitting… If you’re having a baby or anything [I knit] you
know. I’ve done a lot of [knitted] patches and make them in to blankets
for the children’s hospital… They wrote back to me [to thank me].

For the women of Iris’s generation, and those either side of it, volunteer work
such as knitting for the “war effort” and later “for the family” has been an integral part
of their lived experiences. They are able to manage this work for a good cause in
multiple sites in the rest home due to the small amount of space and cost required for
the task.

5.4 CHAPTER DISCUSSION

COMMUNAL – (SEMI) PRIVATE SPACES

The spaces used by the residents encompass communal and (semi) private spaces.
Illness and frailty impact on how these spaces are ‘lived’ in the day-to-day as the
residents’ narratives illustrate, and other studies have noted (Thomé, et al., 2004).
Spatiality takes on a particular significance for the residents with chronic illness
because it restricts the ordinary space of day-to-day life as noted by Hillyer (1998). The
most popular spaces are those that allow for frailty, without it becoming the focus of
meaning.

Cigarette smoking fits such a space. The smokers in my study make the most of a
clearly defined space for their habit. For most of the long-term smokers the space
provided is necessary due to their addiction far outweighing any potential harm. While
other research report that long-term care and community-dwelling older smokers do not
perceive smoking to be a serious threat to their health (Carosella, Ossip-Klein, Watt, &
Podgorski, 2002; Wolfsen, Barker, & Mitteness, 2001), there is little research on the
space required by smokers for this activity in an increasingly regulated non-smoking
society.

Indoor spaces become a ready substitute for outdoor spaces. Visual use of the rest
home grounds especially are used by the residents as a mnemonic device through which
they share memories of being outside, a finding in line with other research (Bermann, 2003). Gardens feature large in most of the residents’ lives in the context of the New Zealand quarter acre paradise (Mitchell, 1972). The exchange of one type of space for another is especially useful for those who use aids, including walkers, sticks and wheelchairs. Substituting outdoors for indoor space means that the residents are relatively safe walking on the level without worrying about the weather or personal safety as they would be when outside. This swap, similar to mall walking in North America where it is advocated as a form of exercise for elders (Culos-Reed, Stephenson, Doyle-Baker, & Dickinson, 2008), is adapted by the residents themselves, who use it to maintain social and physical activity. Similarly, there is a substitution of precious personal indoor and outdoor spaces, for rest home spaces situated at a communal or shared point on this thread.

How lived space is experienced in the rest homes highlights a transformation of what in community living serves as privacy. The elders are ambivalent about the concept of privacy, particularly in their bedrooms. A definition of a bedroom used in this thesis is of a room inside a dwelling, or a room intended as a place for sleeping (Statistics New Zealand, 2010).

Private space is routinely compromised by staff and sometimes co-residents. Private papers such as letters or accounts are likely to be sighted by staff as they work in residents’ bedrooms. Although located in the public domain, email is a form of correspondence considered by the residents to be a (semi) private correspondence. Email is sent and delivered for the residents through staff members, and as news is shared in this way, may serve to enhance resident and staff relationships, a topic of Chapter Eight. Discussing Giddens’ work, Cassell (1993) states that at a societal level, telecommunications have been successful in the attempt to dissolve space and time restraints. New Zealand is isolated from the rest of the western world, and this has resulted in verbal (telephone) and written correspondence becoming commonplace. Email may increase and become popular as a form of remaining connected in space (and time) as the population of computer literate elders grows.

Taken into account a discussion about odours and sounds is essential because these senses are to the fore of the spatial context of the rest homes. Aspects of space should be considered part of the research milieu. Gesler and Kearns (2002) agree that
the notion of space should include senses such as smell as these add to the character of place. For those living, working and visiting the rest homes unpleasant smells are so much a part of the environment that they tend to be ignored.

For the residents, death is perceived as part of their life experiences of being older people who have outlived many of their contemporaries. Rest home space is a historic repository of old and frail bodies (Horsley, 2008) and residents often die. Death is a relatively common happening, and it is often a topic of conversation among the residents in my study, as also found in local community-based research (Wiles, et al., 2009). Within a clinical context when a death occurs without the rituals of preparing a social space and setting of time for death, it is usually experienced by clinicians as a human failure in care (Benner, 2001) and lack of dignity (Pleschberger, 2007). Perhaps for these reasons rest home staff members deal with dying and dead residents behind closed doors.

Rituals of death are similarly required by the residents, yet death tends to be hushed and dealt with in secrecy by rest home employees, which has been found in other research (Brooke, 1989; Diamond, 1992; Djivre, 2008; Nay, 1993), as expressed a decade ago when Howarth (1998) pointed out the scant literature tackling the subject of death in old age. My findings are in keeping with two of the few exceptions including Djivre’s (2008) writing about the meaning of living and dying, and Pleschberger’s (2007) work on dignity and dying from the perspectives of the older people themselves. These standpoints need to be matched with those of institutional places in which frail elders live and die.

When a death occurs, the elders’ expand their horizons by moving into what was described in Chapter Two as ‘beyond spaces’ (Rowles, 1978). Beyond spaces allow the residents to make meaning of their loss within the realm of their own, often vast life experiences using reminiscence. Without acknowledgment and ceremony usually involved in death, such as a funeral, space (along with time) shifts, literally leaving an empty space seemingly suspended in time as other studies have observed (Shield, 1988). This indeterminate state can be compounded by the negation of staff to older persons’ grief, which is often perceived as less important than younger people’s as other studies have reported (Hallam, et al., 1999).
EXPANDING – RESTRICTING SPACES

Corridors can expand and restrict so these are threaded across the expanding-restricting space theme. Corridors expand to become a substitute for getting outside, and are spaces used for walking as others note (Cutler & Kane, 2005; Rodiek, 2005). The more meaning the elders attach to an activity within a specific environment, such as walking, the more the self is enhanced and thus enjoyed as others indicate (Kusenbach, 2003), which illustrates the importance of expanding space.

This type of affirmative meaning-making is in keeping with Fox’s (1998, 1999a) notion of arche-health, which is at the same time arche-illness, where health and ill-health are deconstructed and reconstituted in more positive ways. Corridor walking is an ideal way to exercise in order to stay healthy for some and for others is tied to social aspects of meeting with co-residents. Elders who walk for multiple reasons including exercise and the social aspects have a well rounded sense of (self) satisfaction.

Importantly, walking aids are incorporated into the available space, and removing these props leaves frail elders feeling vulnerable (Toombs, 1988). The rest home environment enables these types of spaces with wide corridors and doorways. Walking sticks and walkers used by other residents in effect normalises the use of mobility aids. Contemplating a point outlined by other researchers (2005), the residents express the need to stay close to the rest home in case of falls. Indeed, venturing into outdoor spaces such as gardens is discouraged owing to difficulty of access or bad weather as other studies have established (Cutler & Kane, 2005; Kane, 1991; Rodiek, 2005).

For ill and disabled individuals, lived spatiality changes such as a sloping corridor or a set of stairs become insurmountable obstacles that restrict space use as others have illustrated (Toombs, 1988). Rather than give up on their walking as exercise, the residents in my study have adapted to more straightforward tasks in relation to increasing physical requirements and cognitive decline as Heikkinnen (2000) also reported. This is not just a local disturbance of the ill elders’ activity, but a fundamental alteration of their way of engaging with their spatial world as Carel (2008) points out.

The residents are able to maintain jobs such as washing and cleaning by utilising staff allocated areas. Staff-centred spaces such as rest home laundries and dining areas outside of set meal and activity times are not intended for resident use but the elders expand their space to take in these staff dominated areas. This commandeering is what
Bermann (2003) terms spatial overlaps between residents specific spaces and those usually reserved for staff, such as the laundry room, and are commonly taken up by the elders. This expansion of space is discussed in more detail in Chapters Seven and Eight, linking work to embodiment and relations with others.

The examples given in this chapter illustrate how the elders experience daily life extending along a stand encompassing threads of ‘communal-(semi) private spaces’ and ‘expanding-restricting spaces’ as illustrated on the multiple-helix in Figure 5.1. How the older people experience space is closely intertwined with time, which is examined next in Chapter Six, as a way to understand the residents’ lived experience of spatiality and temporality in daily life.
6   CHAPTER SIX: LIVED TIME

6.1   INTRODUCTION

A phenomenology of rest home residents’ everyday lives necessarily takes the concept of time into account (van Manen, 1990). In this chapter, I investigate the lived experience of time for the residents. As time is everywhere (Adam, 2004), as suggested in Chapter Two, I will navigate through the residents’ narratives and interview summaries to locate specific social constructs of lived time that act as points of entry for understanding how the residents experience time. I subscribe to van Manen’s (1990) viewpoint that lived experience can only be perceived reflectively through time.

A phenomenological lifeworld approach differs from other sciences because “it attempts to gain insightful descriptions of the way” the world is experienced pre-reflectively, without taxonomizing, classifying, or abstracting it” (p. 9). A lifeworld approach is interested in understanding what the experience itself is like. A phenomenological Husserlian (1964) viewpoint that van Manen (1990) draws from subscribes to the passing of time needing to be addressed as ongoing modification of lived experience, rather than in the perpetual motion found in clock time. When time is viewed as experiential, the temporal view of older people can be expanded. Through a few examples the observations and conversations in this chapter present the residents lived experience as evidence of the residents’ use of time that fits differing temporal constructs to address the main research question *How do older people in New Zealand rest homes experience daily life?*

The idea that life is experienced by the residents, as I theorise it, becomes achievable through Schütz’s (1976) typification processes which tie the past and the future. By going one step further and drawing from van Manen (1990), I can examine my pre-understandings and presuppositions (typifications) to reveal that for the older people the notion of time holds different meanings and values than those originally held by my research counterpart and me. One reason for the different meanings of time among the residents was pointed out in Chapter Two. It was noted there that temporal experiences are altered by chronic illness over time (Agich, 1995). Here, the overlapping of threads on a temporal strand of the lifeworld becomes apparent.
The temporal structure of the experience of the embodied self (discussed in Chapter Seven) and relational others (Chapter Eight’s focus) along with spatial elements (explored in Chapter Five) are impacted on because choices and decisions become distorted owing to pain or disability. An arche-health (Fox, 1998, 1999a) is made possible as bodily movements slow down in a way that is evident to others, who need to decipher health time in to another rhythm where more time can be given to the activity at hand (Carel, 2008). Activities are not necessarily health related, but the time needed to complete an activity can depend on individual health and illness.

This chapter brings lived time, as it is experienced by the residents, under examination. I explore how time is understood by older rest home residents, and differs from that found in the selected literature. I make use of the narratives and interview summaries of the residents, which act as a conduit (Elliott, 2005) to that research, which will again be summarised in the final section of the chapter. Temporal lived experiences for the residents will be discussed using the themes of ‘timeless-bounded in time’ and ‘present-future’ as illustrated by the multi-helix Figure 6.1.

Figure 6.1: Essential threads of a lived time strand unwoven from a multiple-helix

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6.2 Timeless – Bounded in Time

In the next section of this chapter on lived time, I discuss notions of ‘timelessness’ in the lived experiences of the residents, along with the elders being ‘bounded in time’.

**Timeless**

At an early point in the study, it becomes apparent that time works for the residents in a way that differs from my understandings of time. The asking of common opening questions such as “how long have you been ...?” along with other requests for timeframes of past events, was intended to help the elders make sense of their experiences. However, interviews then take on stilted tones as the residents’ telling of their experiences initially appears sequentially disconnected and some interviews are non-linear, disjointed and non-sensical. Often, the residents’ narratives took on a timeless quality.

Imposing timelines with a chronological order with a beginning, middle and end fail me time and again and complicate my interpretation. Using chronology gives the impression that the elders are muddled and confused, and which adds to the commonsense view that they are living in the past. Deliberation with my counterpart in Christchurch confirms that we are assuming some sort of logical (i.e. read chronological) order to the stories shared by the older people. Questioning my pre-understandings and assumptions as van Manen (1990) suggests initially serves little purpose as it fails to clarify why our pre-supposition is problematic.

It is only after meeting Jack that my ongoing perplexity about alternative time as a main theme becomes clearer. Jack is a large man of intimidating presence despite (or due to) being confined to a wheelchair. He wheels himself along the rest home’s driveway as we pass the time of day. We chat for a few minutes before moving to outdoor seating for the interview. Before sitting, I am unnerved as Jack wheels back and forth in close proximity to me, in what I perceive is a threatening way. Being aware that if Jack chooses he can easily knock me off my feet with his chair makes me feel uneasy. As I consider myself physically under threat by Jack, I do not question the tense of his narrative and allow him to verbally vent anger about his tough life.

Jack conflates past and present when relating his activities over the years. Bitterly unhappy about his life he speaks in the present tense about the physical and emotional abuse inflicted upon him by his father. If alive, his father would be physically incapable
of beating Jack who is aged in his seventies. Jack does not measure time in clock or calendar time. Instead he tells his story of an abusive father in the here and now. For Jack, the threat of abuse is still real as he relives painful memories of maltreatment at the hands of his parent. This incident with Jack is a turning point for me. It heightened my awareness that residents often interweave the past, present and future in making sense of their lived experiences. They are always bounded in time, but may experience time as qualitatively timeless.

I frequently observe that the memory of historical events that occurred many years ago remains undimmed by the passage of time for many residents. Residents’ narratives often fail to fit into a storyline formula with a beginning, middle and an end. Even small talk such as asking the length of time an elder has been living in the rest home proves unpredictably problematic. Terence shows how these conversations are anything but straightforward, when I question him about how a typical day might begin for him at the rest home.

_I don’t know, I don’t wonder about that. I don’t know, there’s no alarm clock. If it’s the amount of daylight or the brilliance of the light which wakes me up, I don’t know._

Terence seems puzzled temporarily by my question, suggesting that he is awoken by the light but does not really know or seem bothered. With a similar response, Norman briefly ponders over his attempt to measure time in past, present and future tenses.

_I’m trying to think now, I can’t remember. Ah, little things slip my memory. Yeah, but I never think of time, I just go from A to B. The weather, the sky at the time defines that, not me._

Time for these men is non-linear which highlights a sense of timelessness within the rest home context. As Terence notes, he has no clock, and even if he did, it would serve little purpose because it is the light that serves to wake him for the day. Norman does not think in temporal terms at all because he simply moves from one point to another. The rest home routine he follows is left to others (staff) to organise, which works well for Norman, who has little sense of countable clock time. Hence, it is confounding for Norman and Terence that I attempt to order their stories chronologically. Once I stop searching for time sequences, quite a few pleasant conversations take place in a kind of time warp. Irrespective of timeframes used to
contain lived experiences in an ordered way, pastimes are retained in essence and so the meaning-making process remains intact for the older people.

The degree of chaos characterising the tenses in conversations varies from subtle to obvious. In conversations with some of the elders, simple arithmetic informs me that they are sometimes eagerly awaiting long deceased family members to visit or take them on outings. At times, the impending visitors would be aged in their hundreds. It is likely that the older residents’ parents and siblings have become muddled with their children in the telling of stories. Other times, events rather than people from the past are talked about in the present tense.

When questioned about how long she has been at the rest home, Maura responds in a similar vein to her male counterparts. Maura explains that time in the rest home is an elusive construct. However, she is less puzzled than her peers and attempts to rationalise what she suggests is the loss of a lifelong structured timeframe.

I seem to have lost bits somehow. I don’t exactly remember. That’s a point... Somebody recently said to me ‘how long have you been there now?’ and I said ‘oh, darned if I know’. I’m not taking it in, what do I need to know how long I’ve been here for? (laughs). Sometimes I wish I wasn’t here.

Black humour expresses Maura’s ambiguity about the unaccountable lost bits of her life through a kind of timelessness. It is of little consequence to Maura how long she has been staying in the rest home. The point that despite her wishes she is still here is most important to her. It is unclear whether Maura’s poignant response is about a wish that she was not alive per se or that she regrets living in the rest home. Although she laughs, I remain silent as I am unsure whether she is serious or joking.

**BOUNDED IN TIME**

Often, residents spend a lot of time waiting around for staff to attend to their daily needs such as dressing or toileting. For Alice, getting through the morning takes a great deal of time. Alice’s enforced wait on staff to issue medication leaves her no time to attend morning teatime. This loss of time is compounded by difficulties of simply getting ready for the day.

*By the time I make my bed it might be quarter to nine that I go in to shower. Well, [staff] have taken the trolley with the wet towels so I march down with my walker and put my wet towels down there [in the laundry]... Half the time I get my own dry towels... The other day the one
[employee] who should be doing it was sitting reading the paper in the lounge! (laughs).

Alice is unable to make the staff do their job and feels she has to complete tasks for them, a situation about which she expresses annoyance. Alice’s “march” to the laundry room and back to her bedroom along with making her bed take a great deal of time and energy owing to her ill-health and necessitates a need “to rest”. Alice’s whole morning has passed and it is nearly lunchtime before she is ready to face the day. She responds to the question “how would you describe a typical day here for you at the rest home... from the time you get up?” as a time consuming business that takes all morning.

Well, I don’t even have time for morning tea, it takes me until [then], by the time you get up and have your shower and I might have to iron [clothes] before I can put them on. I get down on the floor with my iron.

Others miss out due to staff support allocated to activities of daily living that coincides with a set pastime in the rest home. For Freda this means “a bit of waiting around”. The narratives above debunk the stereotypical rest home resident discussed in Chapter Two who sits in a chair all day doing very little. Filtered through social constructs of temporality these residents illustrate that managing everyday tasks once achieved in minutes now involve ever increasing, but importantly, still manageable amounts of time.

While some residents have a degree of autonomy in completing tasks, others are entirely dependent on staff availability as my time with Simone shows. Very frail with a soft voice and ill-fitting false teeth, communication is difficult in the noisy dining area where Simone and I first meet. Our conversation is stilted and I continually ask Simone to repeat herself which is tiring for us both. Although difficult to understand, she is cognitively astute and says she enjoys taking part in activities. Indeed, she reports being an active member of the rest home until recent times.

When I meet her for the second time, Simone has been waiting in her bedroom for staff to hoist her from bed to wheelchair so she can be taken down to the communal lounge to watch an old black and white movie put on by the rest home. I offer to go in search of an employee to help and find staff having a meeting. I catch the attention of a staff member who loudly whispers to me that Simone will have to wait because staff meetings take priority. Simone is philosophical about having to wait although my notes reveal that I feel frustrated. I sit with her for a while longer and when leaving, express
the hope that she will get to watch at least part of the film. Prioritised staff tasks leave Simone no other choice but to bide time as her everyday revolves around staff timetables and rest home routines. I observe the older people with physical impairments spending a great deal of time waiting uncomplainingly for often quite basic support from staff members.

Time has taken its toll. Over time, frailty increases and new symptoms develop which means the residents continually have to renegotiate their disabilities in their day-to-day experience. This includes how much additional time they must allow to complete daily routines, what further allowances they must make, and what special allowances they will need to follow. All these measures are incredibly time and energy consuming for the residents who become bounded in time.

The notion of being bounded in time differs from the concept of having leisure time. It is inappropriate to talk to the residents about leisure as meaningful activity. Time for leisure is scorned by the elders because it is not considered to be productive time. The residents' perceive pastimes, hobbies, interests or activities as more suitable terms to use. One written question for this study asked; “Recently, what sorts of physical or leisure pursuits, hobbies, or interests have you done, or what sort of pursuits would you like to do?” Residents responses are very clear about leisure time having no place in their lives; ever. Perhaps this is tied to the depression years of the 1930s, where leisure was a euphemism for being out of work and therefore was not valued, and that view remains with the older people. Negative connotations about leisure have long been part of their understandings and expressed attitudes and are reinforced by their contemptuousness. Besides, for these elders, everyday tasks have become hard work leaving little time for leisurely pursuits.

Bill is a large framed man of unassuming nature and few words. He is in the main philosophical about his continuing loss of mobility when he states that “prior to” moving “here things were winding down a bit. It’s a bit frustrating…but still it’s part of it”, the ageing process, “you know?” Bill’s metaphoric use of the term “winding down” is symbolic of his slowing down, and becoming bound in time. Bill is dissatisfied at not being “able to do more”. Bessie too states that although day-to-day she stays active her once busy life has “slowed down in every way, slowed to just about a stop”. Being
‘able’ is, for Bill and Bessie, the ability to continue to undertake ordinary everyday tasks no longer taken for granted.

6.3 Present – future

In this second section of this chapter about lived time, the thread of the ‘present’ here and now is discussed. The thread concerned with the residents ‘future’ is interwoven with the thread of the lived experience of being in the present for the residents. Current routines, which are established and regular, serve as one way for the residents to make meaning of everyday life. While living in the present, simultaneously, the residents anticipate what has yet to occur, and this illustrates how their lived experiences can be located concurrently on a present-future thread.

Present

Teatime and happy hour

Established routines are important scheduled times of the day where all residents taking part know the rules. Of well-known anticipated current routines in daily rest home life the most obvious is teatime which takes place in the morning, afternoon and evening in most rest homes. Teatimes are often group activities, although a few rest homes have a policy that tea, and sometimes a biscuit or small slice of cake, can be taken in residents bedrooms. At multiple times, taking tea is an ordinary routine that structures the everyday into recognisable and achievable sections. Lena says she always has “morning tea first” before setting off on a walk around the rest home corridors, which is a part of many residents’ daily routine.

However, teatime illustrates a well known type of hospitality that some residents lament they can no longer offer. The routine of their former lives has become disrupted since, unable to take up the hostess role they long held in their own homes, the mainly female residents wistfully echo Vera, who states as we settle down to talk, “I wish I could offer you a cup of tea”. The desire to continue a lifetime of hospitality is particularly noticeable when interviews coincide with morning or afternoon teatime in the rest homes as they frequently do. As staff serve up the tea, the residents often carefully negotiate the offer of a cup of tea to their visitor (me or my research counterpart) with the staff member on tea duty.
Happy hour is another commonly enjoyed pastime in many of the rest homes. The term happy hour alludes to a set amount of pleasurable time allocated in a specific space where residents can spend some socially orientated time mingling with co-residents and sometimes staff. Refreshments in the form of an alcoholic or non-alcoholic drink are available and conversation is shared with others as Freda says.

_I must say I love the happy hour (laughs). It isn’t a very happy hour really because so many people sit and say nothing. But I have a special lady that I sit with...and she can laugh, we laugh [at] ourselves and how [pauses]. She’s much more helpless than I am but she can walk better you know. But she has the same values or something and few people have (laughs). We think the same things are hilarious. So, it’s not a very articulate conversation but it’s fun (laughs)._ 

Freda is merrily positive anticipating happy hour as linked to quality time spent in the company of a particular co-resident. Bill too likes happy hour very much. Bill is up for an interview although he informs me that he has set the alarm on a small windup travel clock placed on a bedside table in order to get to happy hour “on time”. When the alarm goes off Bill ushers me quickly out of the room and follows close behind. As we stand in the corridor a short, sharp bell rings through a sound-system and a staff member’s disembodied voice alerts everyone that happy hour is approaching.

Bill calls out to a woman resident further along the corridor and she stops and waits. Ignoring me, Bill moves away and hurries slowly to his companion. Taking her elbow, they make their way to a communal lounge where recorded music is playing loudly and other residents are beginning to gather. I follow in their wake to find one staff member moving among the mingling older people handing out what I assume are alcoholic cold drinks in plastic glasses. As a set routine happy hour has a similar format to other mix and mingle events of previous times which are aspects that appeal to the residents. In a similar way to teatimes held at the rest homes the happy hour ritual has specific rules and a set weekly or monthly timeframe of usually one to two hours. Other rituals are also regular events such as musical events, Housie (Bingo), church services, bell ringing, board games, cards, quizzes and newspaper readings. More active pastimes such as indoor bowls or quoits are on offer on a daily or weekly basis at set times, which are anticipated and enjoyed with pleasure by the elders.
**Reading and crosswords**

Reading is a pastime evidently woven throughout mundane, contemporary everyday life. Many of the older people have the time to spend reading as one way of staying actively involved in the world and abreast of current world events. The newspaper provides an important source of reading material for many residents. Mary reads the “spots off” the newspaper and Bill does “a lot of reading. *I read the paper for the sports… I get that [newspaper] every morning. It’s good to know everything by reading*”. Like Mary, being knowledgeable and up with the times is important to Bill, who feels that reading keeps his mind sharp, a common theme in the residents narratives. Asked if she attends the rest home newspaper readings by staff members, Freda asserts “no, no! I read the paper myself, every page in the paper (laughs). Yes, front to back. I like history and I’m interested in politics too”. Catherine is also explicit about how reading is a strategy to manage cognitive agility at the present time.

*I read all the funny bits first (laughs). I read it right through, whether I’m interested or not, I just sit down and read them…I’d rather read because you watch TV and the next day you’ve forgotten…So apart from you watching the news…I read to keep my brain active, moving.*

These residents stress that they are able to read coherently and without support of others. For some, reading becomes a more time consuming task, such as when Catherine has “to use a magnifying glass”, even through this laborious pastime is justified by her matter of fact comment that “I can’t sit here and be idle”. Others are unable to read due either to physical or to cognitive impairment. Reading sessions, usually lead by a staff member, take place in communal lounges in some rest homes at specific times of the day. These sessions emphasise a loss of autonomy that these residents face even though they allow residents to retain a pastime and stay up to date with current events.

The older people determine their cognitive health through maintaining the ability to read. Minimising the stigma of being labelled mentally deficient takes a great deal of time. In a similar way to reading experiences, Alice completes crosswords because they help her to “improve memory”. Others cite similar reasons for taking part in memory games such as general knowledge quizzes. The amount of time spent doing crossword puzzles is talked about by Freda as an enjoyable experience, particularly as “it makes me think”, thus emphasising her cognitive astuteness in the ‘here and now’.
The pursuit that I enjoy is...the crossword that you’ve never seen before. They do quite moderately difficult ones as a group [activity in the rest home]. There aren’t many of us who try those, mostly they sit in silence...That’s two, three days [a week]. The crossword in the Listener, we do it on Saturdays. It’s real hard, it takes me all day. It comes at lunchtime and I usually spend the rest of day mulling it [over].

It takes half a day for Freda to complete her difficult crossword. However, this time is enjoyable as it is usefully spent. It comes with the pleasurable knowledge that she will share the completed crossword with a “special fellow” resident, a theme followed up on in Chapter Eight where I explore the residents’ relations with others.

**Future**

Although discussion about the future was not explicitly included in my study, the residents speak about future times. Some residents use humour to speak about what are taboo subjects, in particular the timing of their own deaths in the future. One is Jean, whom I find lying on her bed, as she is “not feeling too well today” and is prepared to be interviewed only if she can continue to lie down. Although she is feeling ill Jean reports being content enough although she muses with what I strongly suspect is tongue-in-cheek humour that she is “happy to die but I don’t know how to go about it”.

With matter of fact flippancy Jean reflects on the timing of her own death.

*I’ll be really pleased to [die]. I mean I’m not trying to go, but I’m really looking forward to joining my mum and dad.*

Jean may be feeling morose because she is not well the day we speak. Thoughts of being again with family members and friends who have euphemistically been a long time gone comfort her. In the day-to-day of the rest home, dying is a reasonably common occurrence as pointed to in Chapter Five. Death is simply a future point in time for the residents who speak about their own demise in a matter of fact way, for as Jean suggests, she is not trying to die. The residents ensure they make the topic sound less bleak to others through the use of black humour.

However, not all have a frame of mind in which to utilise humour when discussing their future. A few are gloomy, like Tom. His sadness is obvious and attributed by staff, when I ask, to the demise of his wife of many years. At our first meeting, Tom is walking slowly under his own steam in the corridor. With what will turn out to be irony, he is on his way to another male resident’s room to ask about affixing a clock to his bedroom wall. After a short conversation, I arrange a time to
meet in Tom’s room later in the day. I find him lying across his bed with feet dangling near the floor and eyes closed although he is not sleeping. Stating that he is too lethargic to sit upright, Tom completes his interview by saying that his days now at the rest home hold little interest for him. Tom’s distinct lack of enthusiasm for life is clear.

Well, evenings are a bit zero. I’m filling in time now. That’s how I feel...It wouldn’t worry me if I didn’t wake tomorrow morning, not in the slightest. I’ve got no interests... (voice trails off into silence).

It is clear from Tom’s talk that he is deeply unhappy and likely to be suffering from grief and may be depressed. His lack of “motivation” has reached a point where he no longer has any interest in his life. Tom’s sadness serves as an effective conversation stopper, and interviews with residents like him tend to be short affairs. Tom is merely waiting on his departure from the rest home and probably life itself. I leave Tom with his misery soon after. Within a few weeks of our short conversation, Tom’s physical and mental health deteriorates. When I ask after him, a staff member tells me that owing to him becoming physically violent he has been placed in public hospital care. Inside a fortnight, Tom is dead.

Although despondency makes for uncomfortable interviewing and reading, Tom’s experience is important because it resonates through both the research literature and commonsense accounts about rest home dwellers. However, negative aspects of time in the rest homes for some are countered by the positive stories told by the majority. It is important to stress that very few of the residents are simply filling in time like Tom. Others talk about being happy to die, and in so doing express the opinion that their own death holds little fear for them, as Jean illustrates.

Some residents discuss changes occurring over time in the rest homes, despite a perception of timelessness. Legislative changes in the rest home environment described in Chapter One have resulted in increased and frequent staff turnover and changes in management in a number of rest homes. Some residents have been living at the rest home for a long time and various staff members have worked at the homes for years. Long time social contact between staff and residents ceases as staff turnover increases and employees leave the rest home. These increasing changes at the time of this study mean that the older people and staff live in a climate of speculation and some residents have a real fear that they will be moved on to other rest homes or to the homes of family in the future.
Most expect that changes in management will result in disruptions for them. Rather than passively accepting these changes, some residents intend to make active choices about where they will live in the future. The impact that policy changes have on the elders is distressing for many. Yet, they work hard to keep up with the changing times at the rest homes. Many reflect on shifts in management over the time they have lived at the rest home as Vera suggests that over recent times “things have changed”. Having lived in the rest home for many years, she says that to stay abreast of what is happening it is necessary to “read between the lines”. Vera discusses proposed managerial changes and the impact it will have including her worry about moving. Within a short time, Vera does make the shift to another rest home.

While most of the residents adapt well to changes a few are not so successful in finding strategies to cope with the changing times. Sitting in an armchair facing the door Flo asks if I am there to help her “pack up” her belongings for her imminent move “today” out of the rest home. I observe no signs of packing in the room and Flo, who is edgy and vague, is unsure about where she is going. She does know however that due to major structural changes in rest home management, she is shifting to another “place”. She stresses that she has moved house many times in her life so she should be able again to make the transition. A quick chat with the nurse manager confirms that the extremely anxious Flo has not made plans to go to another rest home despite her insistence to the contrary. She remains living at the rest home at the time the interviews are complete.

Even though Flo’s cognitive impairment could account for her agitation it must be noted that she was aware of, and unsettled by, changes around her in the rest home. Despite impairment, Flo’s response to the changes is as it has always been; the need to prepare herself for a shift to another place. A few residents fret because they are unsure about what will become of them, although most are stoic and adapt to the changes over time as Vera illustrates in her move to another rest home.

Next, I will summarise this chapter by comparing the findings with the selected literature considered in Chapter Two.
6.4 CHAPTER DISCUSSION

TIMELESS - BOUNDED IN TIME

Although time is everywhere, time is elusive because it often goes unrecognised. Timelessness and being bounded in time are temporal elements in the rest homes. Timeframes differ for the older people in my study from how time is usually considered as having a beginning, middle and end as I found in my encounter with Jack. Due to its timeless quality, the passing of time becomes problematic when trying to gauge pastimes in sequential chronology. It is possible “to read time backwards”, where the story can be followed from the present back into the past as Baars (2007) has suggested. For the residents in my study, temporality means more than reading time backwards or forwards. These elders simultaneously use past and present life experiences which hold valid meaning for them. Having broad points of reference based on lived experience (already) allows them to give an account that involves a wide temporal orientation as other researchers have suggested (Grosz, 2004).

It is necessary to look beyond the stories and theories about time, to view the practices and temporal relations to see how the residents are involved with the everyday. I acknowledge Metge’s (1976) point that time is perceived in varying terms depending on cultural norms. Time is threaded throughout the elders’ narratives as a way to make past and present meaningful as other researchers have noted (Dittmann-Kohli, 2007; Gubrium, 2001). It is possible to “weave in and out of a wide variety of times” and spaces “without giving the matter much conscious consideration” (Adam, 1995, p. 3). Included are the spatio-temporal beyond-spaces of the lived experiences of the past, in which meaning is made by the residents through their reminiscences (Rowles, 1978).

Temporality takes on an ethereal quality as highlighted by Terence’s and Norman’s talk about time being defined by the light. Elusiveness of time includes Nancy’s lost bits which are spoken about by some residents. Ironically, these elders’ narratives are crystal clear in their meaning about how they experience (subjective) time.

Humour is often employed by residents as a way of making sense of, and giving a lighter perspective to a long lifetime. For the elders taking part in this study, black humour is one way to deal with the taboo subject of death. Humour is useful in this
context because it is reflective and reflexive of life (and death) as Stroobants (2009) suggests, and is especially helpful in the lives of institutionalised older people (Makoni & Grainger, 2002; Nay, 1993). Some of the residents talk about their own future deaths, so a fluid rather than static approach to temporal dimensions (past, present and future) would give elders more scope to talk about death and dying without these considerations appearing morbid or morose (to younger people). Only a few residents share thoughts about their deaths, and this is nicely summed up by Catherine who uses black humour to raise discussion about not being sure how to go about the dying process. My findings are in keeping with Howarth (1998), who suggests that an unproblematic death in older age is a construct of younger adults.

Yet, residents are also bounded in time in specific ways. The ‘ethics of time’ that Parkins (2004) wrote about offers the opportunity to slow time. Using at a more sedate tempo, the elders are mostly content enough with their lives in the rest homes as discussed in Chapter Four, a perspective others have noted (LaCourse, 1999). For the residents, regular day-to-day pastimes are so mundane and habitual that they remain unrecognised as important activities. Time spent by the older people in these regular routines is as it has always been, albeit with tasks taking longer due to decreasing energy levels. While the concept of time management sounds simple enough, managing time in an independent way is often hard work due in part to the amount of time it takes to achieve what were once easy, everyday tasks. Daily work supposedly to be completed by staff may lead to residents being erroneously thought of by others as a passive, constrained, and homogeneous group as others have suggested (Gamliel & Hazan, 2006).

For the residents, the amount of time a task takes to complete is not about competing against the clock; rather it is racing against the task itself. The task simply cannot be done any faster as Iwakuma (2002) noted. Waiting for staff members often requires inordinate amounts of time and energy for the residents, which provides opportunity to rest up for the work it will take. Lack of staff support for residents echoes other studies showing that staff sometimes trivialise residents’ issues (Persson & Wasterfors, 2009). Wetle (1991) has pointed out that the way staff interact with the outside world reinforces a faster temporal pace based on clock (and paid) time, and staff apply this pace while at work. As the residents work at a slower pace, they have to work
hard at complementing the staffs’ pace in order that daily activity is completed. This work time means little free time for the elders (McLeod, 1992; Pronovost, 1989).

Time is taken up in staff orientated tasks based on mealtimes and bed time and these tasks sometimes are used as a form of control over residents (Hockey & James, 1993). What is important here is that while residents mostly work hard at staying at the same pace as staff members in order to implicitly help with the jobs, some tasks undertaken by staff are resisted by the elders. As the residents are dependent on staff support to varying degrees, they do not complain about the ongoing changes in pace and time scale. For those who are very dependent, the result may be mistreatment through neglect by staff members as cited in other research (Daly & Jogerst, 2006; Peri, et al., 2008a; Ulsperger, 2008).

Regular routines are significant as they convey for the older people a sense of security. Teatimes are based on shared drinking patterns and are pursuits performed in an accepted social context, which have been the focus of other studies (Douglas, 1987). Teatime is one example of how the residents structure their day as other research has noted (Johnson & Barer, 2003; Park, 1991). All residents and staff know the rules surrounding teatime as a long standing routine that remains essentially unaltered. Happy hour follows a similar pattern. That these temporal interactions are significant is backed by other studies highlighting the non-linear nature of time (Hazan, 1987). In other words, teatime and happy hour are ways to make sense of the lived world ‘now’ through the rituals and routine involved in preparation and consumption of beverages.

Meaningful, active and productive daily routine attainable by the residents has been found to be central to the well-being of older people in other residential care studies (Kaufman, 1986). In the everyday, ordinary routines such as mealtimes and teatime do not usually involve a sense of urgency and because of this, day-to-day encounters are less dramatic but continue to be important. This serves to reiterate the view that the elders know the rules and meanings around rituals such as teatime and happy hour and these are utilised to enhance social contact time.

Residents’ believe that their experiences of reading and completing crosswords helps improve their minds. Pastimes hold a positive meaning for most and are in the main experienced as enjoyable ways of passing time. They take part in activity that Hoppes and colleagues (2001) suggested has a temporal structure, along with
continuity, completion and a sense of belonging. Reading is a pastime that offers a distinctive marker of who is, and who is not, impaired. Residents are at pains to state that the way they use time to stay well illustrates they have all their cognitive faculties (compared to others).

**Present - Future**

While questions about the future were not specifically asked, the older people were well aware of current changes of management and staff in the rest homes. Most discussion about these changes is initiated by the residents, and although usually I remained uninformed, I was often asked if I knew what was afoot. Irrespective of the cognitive ability of the older people, the goings on at the rest home to some degree are known by most elders whose lifetime experiences are brought to the fore to cope with the changes.

The few sad stories fit well with the scenario that rest homes are heaven’s waiting rooms (Forbes, 2001) where frail older people go to die. These tales reinforce the misery perspectives of residential care for the aged and are important to record. Some of the residents like Tom appear to fit into an old age scenario of the misery perspective where time can be conceptualised as a filler of remaining lifetime which is a finding in keeping with some other research focusing on time (LaCourse, 1999). Contrary to LaCourse’s (1999) research, I found limited narratives of the residents’ experiences of time as running out for them to the point that they will die.

Despite commonsense assumptions portrayed in Chapter Two, where older people were said to resign themselves to their own limited mortality, the elders in my study defy this notion by continuing to focus on managing their overall arche-health (Fox, 1999a) as good health, a topic further developed in Chapters Seven and Eight, as part of embodied and relational worlds (respectively).

The impact of dementia for the residents is an important aspect of life in the rest homes as reported in other research (Corner & Bond, 2004; Graneheim & Jansson, 2006). Often, I observe a hint of fundamental “fear that the speakers might succumb” to dementia and so lose independence and autonomy, as has been suggested by others (Townsend, et al., 2006, p. 898). They continually compare themselves favourably to their more cognitively impaired counterparts who can be readily identifiable because they are no longer able to read. Comparison with co-residents is discussed, through relations with others, in Chapter Eight.
To sum up, a focus on time is a social construct that disrupts the perception that the residents have little valuable (or valued) time in their daily lives. These elders exemplify how age affects the experience of time. Although speaking about historical events that have occurred during the past half century or more, lived experiences at any point of time in the past remain also very much in the ‘here and now’ for the residents. The present is made sense of by filtering time through the past (Buetow, 2004b), and what has yet to happen in the future, and is comparable to other studies centring on the unique way that older people experience their everyday (Walker-Birckhead, 1996).

This chapter has focused on lived temporality through ‘timeless-bounded in time’, and ‘present-future’ threads symbolised in the multiple-helix model in Figure 6.1. The residents’ experiences of time permeate through themes of work identified in this chapter, and throughout the thesis as a whole. A focus on lived time is one of four strands, along with lived space, lived body and lived relations with others, that van Manen (1990) suggests are part of all phenomenological studies.

The next chapter will explore how the residents’ lived experience is embodied in the rest home context.
7 CHAPTER SEVEN: LIVED BODY

7.1 INTRODUCTION

The thematic strand central to this chapter is the residents’ embodied lived experience in addressing the research question *How do older people in New Zealand rest homes experience daily life?* As in the previous chapters, a few residents will speak for the many. The experience of being bodily present in the world is termed embodiment, which is expressed through the lived body (van Manen, 1990). For a lifeworld approach used in this thesis, phenomenology starts with experiences or the awareness of the individual. “Indeed, the body is the material basis of everybody’s experience” (Hughes, 2004, p. 66). Chapter Two considered the notion of the body as a discursive enterprise that transcends the Cartesian body-mind binary (Shilling, 1993) to a point of understanding made through lived experience (Andrews, 1999; Gubrium & Holstein, 1999b). When viewing lived experience phenomenologically, there is no separate body-mind split, rather the body and mind are intrinsically connected as “there is mind in the body and body in the mind” (Bullington, 2009, p. 103).

A space is created between the first and third person, and is what Bullington (2009) termed the mind-body-world where the individual lives within a bodily absent-presence (Leder, 1990). Individuals cannot fully control their lived bodies in everyday life and so “regularly must be able to forget” their “bodies in order to be attentive to the things of the world in which” they are involved (van Manen, 1998, p. 16). This forgetfulness of body is termed an absent-presence which is explicable as “experiencing the body…in the mode of near self forgetfulness” (van Manen, 1998, p. 5). This means not that individuals are unaware of their own bodies, but rather that their primary occupation is in the world and with the world (van Manen, 1998). As a consequence individuals are more than their bodies.

The problem with existing discourses making sense of how old age is embodied (Longino & Powell, 2004) is brought to the fore in this chapter. An additional facet is to the dimension of how old bodies are viewed in residential care, in a way that informs what Holstein and Miller (2006) phrased “relationships with individuals and with institutions” (p. 315). As embodied beings “we are always bodily in the world” which, argues van Manen (1990), is a phenomenological fact (p. 103). Furstenberg’s (2002) work with elders illuminated the notion of typification which, as explained in Chapters
One and Three, reveals the nucleus of socio-cultural patterns and meanings of ageing through a pre-existing stock of knowledge, at individual and societal levels (Schütz, 1972). Embodiment embraces a set of typified beliefs, values and commitments that people enact and uphold (Furstenberg, 2002).

The body inhabits time in similar ways as it does space (Merleau-Ponty, 1962). In this chapter, Carel’s (2008) notion of a health with illness is most telling. In the case of illness, a notable feature to emerge is the adjustment to a change, not within the environment, but within one’s body. In the face of a diminished bodily capacity, which is disembodiment, ill people must find or invent physical solutions to unusual problems and challenges (Carel, 2008).

One reason for bodily disparities results from chronic illness over time (Agich, 1995). The body inhabits space (and time) (Merleau-Ponty, 1962). Residents’ embodiment means that they spend a great deal of time waiting, a finding in keeping with the temporal experiences discussed in Chapter Six. The experience of waiting is a familiar topic that most individuals feel they “know only too well what the meaning of waiting is. And yet we would have difficulty describing the experience of waiting in a particular situation” (Fujita, 2002, p. 126).

As meaning making and human agency are embodied experiences, in this chapter a shift is needed that allows the lived bodily experiences of the residents to be illuminated and understood. As residents’ frailty provides a constant reminder of their embodiment in the everyday, to achieve a shift, transforming the absent-presence through shift-shaping permits discussion of the lived body in a more meaningful, upfront way.

To this end, I follow van Manen (1998), who pointed out that an individual’s liveable relation to their own body is particularly pertinent and to the fore during or after a bout of ill-health. The frail body becomes what van Manen (1998) suggests is rebellious and unreliable, meaning that embodiment for the rest home dwellers takes on a specific form. To achieve a suitable solution, an arche-health (Fox, 1998, 1999a) that considers negative and positive aspects of health and ill-health, are appraised by the resident and the best fit chosen.

Illness experience is often discussed as part of recapturing a sense of being whole and incorporated into the lived world (Benner, 2000). Through illness experiences
individuals become aware of and attentive to their body (Hayne, 2002). Most residents in my study are frail with disability or impairment as a result of illness of some kind, yet how bodily considerations are achieved by older adults in residential care is unknown.

Using as a start point the older peoples’ frailty I will investigate how they embody particular bodily styles such as limps or lethargy that may be “scarcely noticeable to an onlooker” like me, but which represent what Toombs (1988) suggested is a fundamental change in body style as a lived body. I endeavour to call to mind the lived experiences of the resident body-person that the reader could recognise by using text to enhance understanding of everyday lived experience (van Manen, 1997). For it is not the physical act itself that is meaningful; rather it is the meaning the activity acquires in the day-to-day that holds importance (van Manen, 1998).

This chapter aims to bring the lived body to the fore through everyday language in a way that illustrates what is seemingly inherent. I explore an alternative way of understanding embodiment for the residents to that found in the existing literature. The residents’ responses fall across a multiple-helix strand comprising ‘embodiment-disembodiment’ and ‘consuming-abstaining’ threads as Figure 7.1 illustrates. Their narratives and interview summaries serve as a channel (Elliott, 2005) to the selected research considered in Chapter Two, and will be summarised in the final section of this chapter.

Figure 7.1: Threads of a lived body strand from a multiple-helix model
7.2 EMBODIMENT - DISEMBODIMENT

In this section, a thread tracing embodiment to disembodiment will be discussed as it relates to the lived body. Initially, I will explore how the residents are mainly concerned with their lived experiences as they are embodied. I will then investigate how disembodiment is considered by the elders more as a loss of cognitive awareness or aural difficulty, rather than any physical disability. The ability to make positive meaning of their lived experiences, that is being ‘embodied’, appears to hold more importance for the elders than being able-bodied. Disembodiment will be considered through the residents’ lost cognition and ‘senses’: sight, hearing and smell.

EMBODIMENT

Sitting straight backed on the edge of her raised bed, Bessie is philosophical about the way her body has aged into frailty over a long period of time. Seriously underweight, legally blind and requiring a lot of medication for a number of chronic illnesses she casually points out that “it’s a bugger” but “I have an acceptance of getting old”. Bessie’s keen mind and zest for life override “the ageing business and all the bits and pieces that go with it”, a euphemism I understand to refer to her decreasing physical abilities. The significance of what Bessie calls her “routine” as a form of positive embodied activity becomes clear as she insists on showing me her exercise routine while stressing the importance of staying lithe and healthy

by stretching your arm, and then I’ve got some special ones [exercises] I do, it’s like a ballet, you know, you hold on to your foot and put one foot forward and back, then forward. Get your muscles right, yep, I do all that. It’s very important. You’ve got to get out in the fresh air [too].

I fail in my attempt to hide anxiety that being so frail Bessie may fall, although she manages to stay upright. She is dismissive of my concern and links it to staff members’ discouragement of her exercise regime, which appears sound advice (to me). Bessie insists “I am very fit” and she is determined to continue looking after her body as always, which includes “doing” her exercises daily despite increasing bodily deterioration and others’ unease regarding her physical safety. As weight, function and mobility continue to diminish Bessie carries on with long held personalised exercise and so can remain healthy in her subjective constructions of her own embodied well-being. However, Bessie’s experience of attempts by others (staff and me) to limit her exercise may be discouraging and serve as a deterrent.
Unlike Bessie whose health has been in slow decline, Walter is one resident who lost a great deal of bodily movement abruptly. Like other residents who have lost function suddenly, such as after stroke, Walter works at repossessing previous bodily function. He mulls over the practicalities of living with a suddenly impaired body. Walter is determined in his attempts to improve eye/hand coordination. Disclosing the experience of “getting on with it”, he talks about regaining lost bodily capacity.

> Well, I’m still weak on the left side. It takes me a long time to do that button up there (points to neck of shirt), a very long time. In fact I’ve stayed here for half an hour sometimes just twiddling around trying to get it in. I’ve got to beat it.

Walter has lost the ability to act in certain established ways as he struggles to button up his shirt. Despite this fissure in what was a lifetime activity, he continues to believe it possible to overcome bodily limitations imposed by his stroke, and to regain a sense of self-controlled fluidity of embodied movement in his effort to “beat” loss of function. By continuing to work hard he sees himself overcoming bodily weakness and relearning long-acquired skills including the relatively simple task (for the able-bodied) of doing up buttons. Walter considers my comment that “there’s always Velcro to make it easy”, and after a pause laughingly responds “yes, that’s right, never thought of that”. His positive response to my suggestion that Velcro be used as a substitute for a shirt’s top buttonhole points to Walter’s willingness to adapt new strategies for old so he does not have to compromise his high standard of dress.

Although the probability of successfully pursuing rest home management to arrange for shirt alteration is doubtful, this does not undermine Walter’s determination to continue doing the small but important lifelong tasks that allow him to perceive himself, and be seen by others, as the smartly dressed dapper man he wishes to remain. The task of dressing is not simply achieved for Walter, it is always based on consciousness and remaining alert in order to complete the task himself.

Bessie and Walter cannot forget their bodies, due to disability and illness resulting in frailty, which elicits responses that highlight the way these elders are embodied. Alice is one of many who further discusses how daily tasks which were once easy but are now more difficult to accomplish owing to disability and frailty. Alice tells how one “arm is paralysed except for” her hand. Despite this restriction she too focuses on the
positive, and because she is able to “work my hand I can cope”. More of a problem than loss of arm movement for Alice is fatigue, due to

the heart problem. I had a pacemaker put in and I get very breathless. That’s the problem, that rules my whole day. I get up and as I say I make the bed; you don’t, you pull it up…Five minutes, or seven at the most I just tidy my bed and pull it up. And I shower myself still so, you know, I cope. That keeps me busy. By the time I’m dressed I need a rest.

Daily chores have to be completed before Alice runs out of energy and has to rest. Suffering from breathlessness, which “rules” the day Alice like her counterparts is unable to go about her daily business in a way forgetful of her body. Alice’s body overrides productiveness of even simple tasks such as bed making. The experience of pulling up the bedclothes becomes a costly chore that in a healthy body can be completed without much thought or energy. Although expressing the difficulty of completing day-to-day activities, Alice is clear about her ability to manage despite having little energy, as frailty has become part of her daily lived experience.

A pleasant and welcoming woman, Iris talks about how she would rather do things for herself than ask for help from staff or fellow residents which can result in lengthy waits. Iris keeps busy, often knitting while waiting. She has long-term complications from chronic illness which severely restricts her mobility, and she is wheelchair bound. Rather than adapting to disability, Iris has instead altered the image of her embodied self through reconfiguration of her body. She has re-learnt to toilet herself from the wheelchair because while “I can’t do much, it’s something I can do by myself”. Iris gets around having to rely on staff support for toileting by flushing her prescribed diuretics “down the sink” although rest home management remains apparently unaware of this fact. While Iris is bodily constrained by her wheelchair use she has incorporated (embodied) the chair into daily tasks such as toileting for as she emphatically states “while I can do things I do them” as “I can’t sit and do nothing all day”. Her bodily self-reliance allows for a sense of being able bodied. Iris has approached management with an idea about adapting her wheelchair so she can also shower herself, but no feedback has been forthcoming.

Walking is by far the most common form of activity managed to some degree by most residents with or without mobility aids. Perceived as an important pursuit that needs to be managed relative to frailty, walking is a common topic of conversation.
Issues about the importance of mobility and how to work around disability and illness are spoken about as part and parcel of managing an active daily life as Nancy states “of course I like to be busy. I do go out walking a lot, trying to keep fit”. Nancy manages her sense of embodiment because she has remained physically able to walk each day and thus is able to control a level of fitness over her embodied self.

Other residents are less fortunate using what Harry terms “shanks pony” (legs). A sportsman in past years, he muses over his increasingly limited mobility. Until recently, Harry could easily do a daily walk from the rest home

*in a circle right around [the block], about a mile. I used to do a lot of walking, or I did do...every day...couldn't do it now...I should do more walking but I'm too lazy.*

He further reports that replacement by sedate pursuits over physical exercise has made him lazy. Harry “was so active” although he stresses that he has replaced walking with another meaningful activity. Reading books has for him become a viable substitution for physical workouts. It has become an expression of his body, since he muses that his increasing immobility has restricted his “freedom to do what you want to do, now you can’t” and so for Harry this has become a “lonely life in many ways”.

Reading is a solitary activity compared with walking in the neighbourhood where Harry was likely to meet other people and take a lively role in the world outside the rest home context.

Like other residents, Harry managed to improve embodied wellness over a period of months following a major health crisis only to find his improvement slipping back into ever decreasing function. Rather than attribute escalating immobility to advancing age and bodily decline, including a series of strokes, Harry suggests that his “weak legs” were the result of being “blown up in the war”. Bessie too talks about having “no legs at all to walk on” which proved “a bit of a problem” and she says this resulted in her move into the rest home. Norman’s legs too have “gone” due to a lifetime of use. Norman is not one to take loss of mobility lying down.

*I’ve got my legs gone on me because I’d run around like a bloody rat at one time, but now it’s a bit of an effort you know. It’s alright when I get up first thing in the morning but it seems during the day that you get tired you know.*
These residents highlight factors that impact significantly on daily routines achieved by others with little conscious thought. With increasing ill-health, residents’ bodies have come more to the fore as activity levels shift. With the exception of Iris, who is an amputee, the residents’ legs have not physically “gone”, yet they have become of little functional use. They must always take their bodies into account, and (dis)embodying loss of legs now requires others’ support for the simplest of tasks. Most residents take part in rest home organised group activities. However, not all are able to play group games such as bowls or quoits. Some play infrequently or not at all owing to physical impairment limiting their involvement. Robert reports that he “used to love bowls but they” are becoming “too heavy for me” to hold. As Robert now does, others literally take up arm chair sports. They include Simone who like Iris is confined to a wheelchair. Simone says that although she does not play bowls she finds it “interesting to watch”. When I ask how she continues to take part in pastimes she tells me the games “are done in my head”. Unable to complete most physical pursuits, Simone substitutes with mental images in a kind of (dis)embodied participation. While over time disability has precipitated changes in Simone’s ability to play she has adapted the sport to fit her bodily (dis)ability.

For others, retaining lifelong pursuits through health related practices has been possible. Freda believes innovative strategies to improve her health following a stroke have resulted in a successful endeavour to recover mobility. The lived body is always in and of the world as Freda illustrates when discussing her capacity to regain the ability to walk.

One leg is at least half an inch shorter than the other, and everybody said ‘oh it won’t make any difference if you build one shoe up’. But the longer I walked on it the more I was going down on that side and it became so tiring to walk, even pushing a [walker]. So I tried, when I first came in…I said ‘one leg is shorter than the other’ and so they sent me to the physio[therapist] from the hospital…I was here for about a year or two and suddenly I thought ‘oh, it’s really down in that leg, it’s not longer, it’s shorter’. I began to ask around, anybody who knew anything told me it didn’t make any difference with half pads to have their shoes built up.

The experience of professional examinations of her leg effectively removed Freda’s control over her body, but unfortunately did not solve the problem and she continued to experience pain when walking. Along similar lines to many residents Freda
illustrates how she is not one to give up. She continues with an embodied perception that she could walk easily again.

After thinking about it and feeling it, it got so I could hardly walk with the pain and the twisting of the muscles. So I thought ‘well, I’ll get it [raised] just a tiny bit…there’s a little cobbler down in [town] and I asked him if he would put something in pretty permanent. I just had an eighth of an inch at first and I walked…I couldn’t believe it…You’ve got to get your leg used to it for a week or two because the muscle changes…it’s just a matter of time. It’s great. It’s just made such a difference to my life.

Regaining the ability to walk is for Freda an experience she claims improved her “life”. Coping with mobility illustrates how the residents are doing for themselves. This action signifies that their failing bodies have not got the better of them. As reported in Chapter Four, over half the residents self-report good to excellent health and as illustrated by the elders above, this is backed by the qualitative findings. These residents are aware of the limited and limiting physicality of their lived bodies, yet they continue to strive to manage current ability of good health in an embodied way. Impairment is adapted to suit activity levels rather than the other way round. Using a walking aid to slowly walk along the corridor and back again twice a day is perceived as a pursuit, and more importantly as a form of exercise that is beneficial to their health.

Many times I find a resident dressed for the day, sitting or lying on their single bed reading, listening to music, watching television, resting and sometimes sleeping. Multiple interviews are conducted with me balanced over the high edge of a resident’s bed, legs dangling. Residents spend a lot of time in or on their bed. Beds seem to offer the residents a space of safety and relaxation. Bed making plays a major role in the lives of the residents (and staff). Most residents are of the belief that this is a job for the staff, mainly because they are no longer up to the task. For Simone, a staff member’s failure to complete the job to her high standard is frustrating.

It’s only made once a week here when [staff] change [the sheets]. They just simply don’t even straighten the underneath sheet or under-blanket.

Simone is “unable to sleep” in the bed unless she remakes it to her high expectations. The bed as a comforting refuge is transformed for Alice into a labour intensive chore. For many, understaffing is increasingly becoming a problem in the rest homes as staff members have more work to do but less time to do their jobs. Some residents suggest this is the reason that jobs remain undone, especially lack of bed
making which is a common theme. Rest home routines override Norman’s wish to have his bed made first thing in the morning.

*It’s very good here, but see, my bed’s not made you know [until just prior to lunch time] and things like that. Four times last week, it wasn’t made.*

For Norman, having an unmade bed leaves the place a “mess” and proves an annoyance. Residents require support for day-to-day tasks such as bed making, which are completed according to staff timetables. A great deal of time, which was the theme central to Chapter Six, is spent waiting for staff to complete the relatively simple task of bed making.

As the older people above illustrate, altered body image is experiential. Keeping watch over their older bodies is done by the elders themselves. They are attentive to their own embodiment. Constrained by physical and/or cognitive disabilities, activities that were accomplished without conscious thought for most of their lives are now concentrated on in fragmented detail in order to complete tasks.

**Disembodiment**

The traditional Aristotelian five senses are sight, hearing, smell, touch and taste. For many of these residents, some of these senses are impaired and this can lead to a disembodied dis-ease. Extreme deafness sometimes impedes the interview process and I am acutely aware that other residents are listening in to my conversation with hearing impaired residents, who in the main appear unworried and happily chat away to my shouted prompts. For some residents, games are no longer viable pastimes due to vision and hearing loss and bodily dysfunction. Impairment such as sight loss serves as an exclusory factor in some activities. As Simone explains, inability to play “rummy” cards owing to failing eyesight is frustrating which she expresses as “the devil, oh, it’s dreadful”. Sight loss means Simone is unable to continue taking part in pastimes such as cards and that

*sort of routine stuff here in the home...because I can’t see now that they’re playing rummy, some are fascinating. I used to play rummy with cards but now they have it different because they have a stand on the table and the cards are on it, it’s a little bit elaborate. I’ve watched it but I can’t see the figures on them, I can’t see whether they’re black and white or purple or whatever so I can’t do that.*

Former routine social activities such as card playing are now impossible for Simone. In disability, her bodily intentionality is disrupted by her failing lived body.
Owing to her blindness, objects previously utilised through a silent body without conscious thought, such as card playing, are no longer accessible. Embodiment is dislocated as visual impairment caused by ill-health forces her to focus on her dysfunctional body.

Audio-impairment acts as a bodily limitation for some residents. Deafness is common and speaking loudly becomes the norm for me. Few request that I lower my voice and only Harry scathingly tells me not to “talk so loud”. Some no longer take part in pastimes such as Housie because they are aware that having the numbers repeated loudly for their benefit is disruptive to other players. This courtesy of being unwilling to upset others is often extended towards co-residents and staff.

Others find hearing loss a positive aspect of self as very hard of hearing Norman wryly observes. Impairment appears unproblematic at times, as Norman dryly notes when talking about the rest home entertainment: “they have a joker [man] on a bit, or an organ and people singing and that you know. I’m deaf in one ear, sometimes it pays to be deaf”. Norman points out that the combination of his own and other peoples’ deafness make it very difficult to converse but the effort required for conversation does not appear to “bother” him. Elders with adequate hearing may also be loath to share information with hard of hearing residents, like Norman, due to lack of conversational privacy.

For others avoiding rest home group activity has more to do with dealing with current health status as Freda explains. While her aural health is fairly good, Freda refuses to attend video showings put on by the rest home because she finds the high noise levels disturbing. Freda is clear about not risking loss of the bodily abilities she retains including her hearing.

Yes, we have activities here each day except the weekends and they have a video then. But I can’t watch videos here because they have to have them so loud and my hearing is well, it’s slightly impaired, [but] the sound worries me, it’s so loud that I fear for what hearing I have. I don’t like it so I never go to a video [showing] now.

Through other bodily losses resulting from stroke Freda’s body is now of primary concern to her, and she is aware of the ever present possibility of future losses which will result in having to reform, yet again, her embodiment. Freda’s approach to preserving hearing can be perceived as a passive giving up, a loss of enjoyable activity.
To the contrary, of the options available, which are few, Freda makes an intentional decision to forego one activity in order to preserve healthy audio function. Little account of adapting organised pursuits for sight or hearing impaired residents appears to be taken by rest home management and staff. Other residents have become physically unable to speak up and in some interviews my interaction with them proves difficult as recorded in earlier chapters. Speech loss is a disabling barrier to communication. In some cases, interaction is impacted on through the residents ill fitting false teeth or having no teeth, in others, neurological diseases affect the power of speech and in turn, my interpretation of the elders’ narratives.

Disruption to the lived body includes cognitive ability. Cognitive impairment was an exclusion criterion of recruitment. However, in part owing to time lapse between recruitment and visits, and in part due to residents being selected by rest home staff rather than on the basis of a standardised screening tool (later used in the PIRC trial), one third of the older people had mild to moderate cognitive impairment as reported in Chapter Four.

Dementia becomes apparent during interviews as cognitively frail residents are repetitive and have difficulty tracking the interview conversation. Reading transcripts of my interaction with these residents seems non-sensical at times because I initially miss signs denoting cognitive impairment. After my probes, some appear to follow the conversation while others act with suspicion including Norman who accusingly sniffs, and tells me “you’ve got me bloody talking, haven’t you?” Other residents are vague, and difficult to engage in conversation.

Ironically, most residents remember that they forget as Maura illustrates when showing how disruption to her embodied self is most telling in her difficulty with language. Following a series of strokes Maura finds her conversations keep “tangling” up which she often finds “frustrating”. Many residents are aware that they have this type of impairment. Nancy, like Maura, contemplates the difficulty of putting thoughts and words together and states that at times this disconnection is exasperating.

At the moment I can’t correlate thought and if I have a decision to make instead of saying ‘oh, but that’s the solution I’d like’ I mull it over, you know. I just can’t put things together somehow…I forget everything now (laughs).
Some problems staying focused and remembering particulars are borne out in quite a few interviews. Many residents are sometimes uncannily, and momentarily lucid about their decreasing cognitive health. Flo talks about how frustrating memory loss can be.

*I'm not really helpful [to you] because, as you see, I'm not. When I was younger I was bright mentally, but I'm not very good now...Yes, it's certainly the memory, yes the memory loss. No, see that's what I'm like now, [what was I going to say?], it's gone now. Later on I'll think 'oh, you goat'.*

These women are vexed by their forgetfulness. The effortless way of being in the world in an (dis)embodied way is for them challenged by cognitive impairment. Yet, dementia is experiential as my interaction with Flo illustrates. Flo’s insight above regarding her memory loss is fluid as one magic moment shows later in our interview. As talk moves away from the issue of moving elsewhere, Flo speaks about the pleasure she finds in singing. She suddenly disrupts social codes normally embodied and typified in socially appropriate conversational behaviour. Flo demonstrates her love of music by breaking unannounced into full bodied and very loud song. Oblivious to the apparent social faux pas and unable to remember the words or tune, she continues to hum loudly with gusto. This cacophony is accompanied by vigorous hand and head movements resembling an orchestra conductor. With fascinated dismay I watch while lapsing into embarrassed silence.

Shared sense of humour allows for a discussion about ailing, failing bodies in ways that are deemed socio culturally appropriate. Sometimes, the older people engage a humorous tack to cover over the confusion caused by cognitive impairment. When asked about day-to-day activities at the rest home Nancy giggles in an apparently light hearted way and states “since I’ve had my stroke of course not a thought comes through my mind”. What appears on the surface to be humour does not equate with mirth however. On the contrary, Nancy’s laugh serves as punctuation in a kind of apologetic full stop at the end of her sometimes vague sentences. Using laughter as a conversational tool to appear flippant means she can cover over embarrassment or concern about her increasing memory loss.

With tongue-in-cheek, others like Bessie share “funny” stories about their frail bodies. Yet, laughter is used in self-disparaging ways. Presented as humorous
interactions, the literal meanings of the residents stories lead into discussions about strategies they believe help them take charge of their physical health. Like many, Bessie feels that the ability to laugh “at myself” is an important trait. She explains how “I wear [leggings] now to protect my skinny legs. Yeah, my legs are so skinny that the [leggings] fall down (laughs)”. Offering an exaggerated mock slapstick demonstration of pulling up her leggings Bessie jokes about having “one” legging “down, I keep on pulling them up. I have to eh, because I’ve got very dry skin and it’s breaking out in sores”.

Bessie brings humour to discussion around her physical health, in particular the severity of a skin condition badly affecting her legs. She feels she has to be extremely “careful” to avoid more ulcers developing. Using humour as a way into the story allows her to discuss one of her many medical conditions without appearing to be preoccupied with her health. Use of wit also gives her a socially acceptable way to talk about how she first got “sore legs”. According to Bessie she caught a “hospital bug” as a patient following hip replacement surgery after a fall. She feels the fall was because of untreated low blood pressure that her local doctor should have “picked up”. Like similar tales of the move from own home to rest home Bessie uses a little embodied comic relief when disclosing that that time was “dreadful. So here’s me without a leg to walk on! (laughs)”.

What is not spoken about is that Bessie’s ill-health may be at least in part, due to advanced age. Like many of her peers, she does not perceive her ailing, failing body as old. Rather than being disengaged from a meaningful life, she continues to work hard in her belief that control over her own bodily being through exercise and diet, along with a good dose of humour, will ensure she manages current health status.

7.3 CONSUMING – ABSTAINING
Food is routine and food consumption central to embodiment. ‘Consuming’ and ‘abstaining’ fall across a band, and will be considered in this section relative to the lived body. The elders are careful about what they consume and abstain from, as they manage their own health.

CONSUMING
At a basic biological level food is necessary for life. At a socio-cultural level, the importance of food lies in rituals and habitual activities carried out in daily situations
and special occasions. Residents’ experiences with food are an integral component of ongoing health needs which must be continually negotiated with other people. Maintenance or loss of ability to control food intake is fundamental to notions of embodiment. Food and nourishment are areas of ongoing tension and negotiation for the residents. Bodily demands point to the need to be attentive to diet-related ways in which to handle physical well-being. Some of the elders suggest that food served up by the rest homes is inadequate and lacks nutrition.

Those who state they have chronic health problems spend a great deal of time considering what they can and cannot eat. Jean converses about strategic attempts to receive what she feels is appropriate food, and so deal with current health by keeping under control what she refers to as “my diabetes”. Jean states that the meals are

*wonderful, I’ve got no complaints in any way... except one thing. [At] breakfast you can’t get the brown bread. I wrote a note and left it in the kitchen, ‘please give me brown toast’...I still got white toast this morning. I didn’t eat it. You see, that means that you are losing weight through not eating. I can’t even get sandwiches at night; they won’t give them to me. I only get water biscuits for supper whereas the diabetic centre ordered four brown sandwiches every night.*

Jean is ambivalent because she talks about the food being “wonderful” in the same breath as she expresses frustration over not receiving a specific food type which she claims would improve her (ill) health. She embodies and expresses health consciousness about what good nutrition means for her well-being. Having no input into an adequate diet, she believes, compromises her health. The importance of her bodily being is to the fore as she unsuccessfully attempts to negotiate a specific eating regime with rest home staff.

**ABSTAINING**

Familiar and liked foods are not always available and for some including Norman the rest home food is often inedible. Comparing food served up in the rest home to that given to animals, in this case “pigs” that eat most things, Norman’s contempt of his dietary intake is apparent. While nutrition is of high priority, Norman touches on the lack of control over consuming certain foods established in a pattern extending back to the way he “was brought up” from childhood. Strategies for coping with his current health state, which focuses on food requirements, is spoken about and woven into narratives about past situations. In his opinion, Norman’s “row” with rest home
management has done little to improve or increase rest home food. Norman also appears underweight and readily complains:

I’m suffering with the food here. I hope this doesn’t get too far [back to management] but I’m going to tell you anyway. I wouldn’t give it to a pig…I don’t like cabbage [and] I was brought up on bugger all vegetables because I didn’t like them…The thing I can’t understand here is…they give you half a scone, half a bloody scone. They give you a bit of butter, a little sachet of butter… one for two people. You put it on that half of scone and half a muffin. You know what I mean? I had a row with them here and they didn’t like it. I told them ‘they were running the place on the smell of an oily rag’ and things like that. A lot of the food I turn away. No wonder I can’t put on any condition [weight].

Others like Norman report that a number of their health problems could be easily managed through adaptations in their diet. However, as Norman and Jean suggest, they consider their ability to supervise their own dietary needs in consuming or abstaining is compromised by the quality and quantity of the rest home meals. Attempts to control their health become complicated by what they believe are inappropriate types of food served. Managing dietary health, indeed health overall, is not an easy task although attempts are ongoing through decisions such as taking responsibility for what they can and will (or not) eat.

To supplement rest home meals many residents have food such as packaged biscuits and fruit brought in by family, friends and staff. Residents explain that rest home meals are supplemented by food brought in to the rest home. Jean’s visitors bring in “extra food. I buy cream cheese and tomatoes”, while Vera buys in “honey” and cracker biscuits through a staff member. These extra items are thought by the elders to be good supplements necessary to maximise their dietary needs. It should be noted that some residents’ weight loss could be due less to inadequate diet or abstaining from food and more to appetite loss due to ill-health such as depression or diseases.

7.4 CHAPTER DISCUSSION

**EMBODIMENT – DISEMBODIMENT**

For the elders, a sense of self-identity forms through the experience of embodiment, in other words, living as a body in the world. The older people are in various stages of ill-health and resulting frailty so a focus on the body becomes, for them, of primary concern. Their lived bodies in illness are engaged in particular ways when experienced bodily as van Manen (1998) points out. The residents live out a set of embodied
activities through what Fox (1999a) named the arche-health, where they can construct how they make sense of their own health and ill-health.

What is important here is the body of self which is experienced by the elders as encumbered (van Manen, 1998). Illness disrupts the lived body which holds different meanings for the residents owing to other age-related conditions they may have, and this is in keeping with other research (Thomé, et al., 2004). Chronic illness takes place over time, and effects the ways the elders experience themselves in the day-to-day (Agich, 1995). Being chronically ill does not however undermine their attempts to manage their current health experientially due to the notion of arche-health (Fox, 1999a), where they deconstruct health and ill-health, in order to reconstitute what they consider good health. Despite illness most remain relatively active and involved in their world, as noted in other studies (Bauman, et al., 2001).

The residents use self-help practices to manage (ill) health levels. The findings in my study match phenomenological research that found self-management is about handling daily life activities, involves planning and comprises knowledge about personal bodily signals of health and illness (Fex, et al., 2009; Hjaltadóttir & Gústafsdóttir, 2007). Lived experiences of later life focuses not on the body itself, but on the meaning-making aspects of an individual self which enable embodiment, a finding others have also reported (Kontos, 2003).

For the non-playing players for instance, it is the choice to take part in a long practised activity that is as beneficial as doing the activity for its own sake. Interestingly, rather than doing activity to enhance health, for the residents, embodying the doing of activity is regarded as good health as other research found (Bryant, et al., 2001). For some, the fact that they are situated in an area where an activity is happening, whether or not they take an active part, meets the same need as participation, again reinforcing a finding observed by others (Ball, et al., 2004; Van't Leven & Jonsson, 2002), which is an example of how the residents take up an arche-health mode of health (Fox, 1999a).

The residents are ambivalent in their talk about how their chronic illnesses impact on everyday life. They may perceive illness as a failing, so are eager to downplay ill-health. Further, illness as such is not the most significant aspect for them when thinking about health in relation to day-to-day activity. Rather, it is reduction of the
ability to do things that leads to subjective feelings of declining health. This finding from my study reinforces other research and extends what is known about rest home residents in other care settings (Reed, et al., 2004). Using Fox’s (1999a) arche-health model to deconstruct ideas about health and ill-health means the residents can perceive their health in positive terms.

Keeping the mind active by socialising, engaging in good conversation and reading were essential to the good things in life as other research found (Moore, 2006). The elders in my study are aware of the personal benefits of pastimes as the many who take part attest. However, it may be difficult for some to sustain or adapt pastimes as existing literature indicates (Mozley, et al., 2007; Segal, 2005).

Walking aids including wheelchairs are embodied and become extensions of the body (Merleau-Ponty, 1962). Although many residents cannot literally “just step forward into activity” (Phinney & Chesla, 2003, p. 289), they adapt new and existing strategies to get on with their lives. They achieve that through use of a technique of evaluation in which they differentiate between being sick, which constitutes such acute illnesses as colds and influenza, compared to being chronically ill or disabled. This means that illnesses such as heart failure, diabetes and stroke are literally incorporated through embodiment into their day-to-day. These definitional distinctions around health and well-being are narrated as an extension of how life has always been for them as other research attests (Gubrium, 1993).

Being in command of how their activities are adapted, despite chronic disability or illness affecting what were simple tasks, is pivotal to self-management (Bullington, 2009). Loss of function in one activity merely means it is adapted to suit alternative functional levels. Redefining abilities to match decreased capacities leaves the residents feeling enabled, which is backed by other studies (Ball, et al., 2004; Hallam, et al., 1999). The residents attribute their current physical and cognitive (good) health to self-supervision, and this is arche-health (Fox, 1999a). This finding is in keeping with other reports that older people’s good health is perceived to be due to heeding cues expressed by their embodied selves through what Jerrome (1992) stated as “sensible routines and positive attitudes” (p. 103).

The residents perceive their good health subjectively as most people do. They clearly demonstrate a continuation of meaning-making in their everyday lives.
Strategies have been adapted to sustain diverse activity such as bed making, dressing and exercise and are intended to sustain activity levels. They perceive themselves as managing their own activity, to some degree at least, and are therefore successful in their quest, which is in keeping with other research (Bergland & Kirkevold, 2006). This makes transition into increasing immobility less drastic and dramatic over time for the residents. Managing through adaptation could be a form of active resistance against having to give up lifetime activity (Bergland & Kirkevold, 2006; Kahn, 1999).

**Consuming - Abstaining**

Consumption and abstinence are aligned closely to health for the elders. Food related topics are often considered by the residents and have long been a subject of study in residential care research (Gass, 2004; Gubrium, 1993; Savishinsky, 2003). However, with few exceptions (McCormick, 2008) there is scant literature about older people and their lived experiences surrounding food, even though this topic is central to the experience of embodiment (Lupton, 1996). Perceived obstacles to dietary regimes are common with the residents although they continue their attempts to adapt their diet and medication (where possible) in order to stay healthy.

Despite their best efforts, the residents have little control over their food consumption supplied through the rest home. This sometimes results in further weight loss which is of concern to them and a major point of discussion. This finding echoes other research which found well-being tied to residents’ satisfaction with food quality (Park, 2009; Street, et al., 2007). Other residential care studies cite weight loss as usually associated with disability and illness (Splett, et al., 2003). Having some control over the types and preparation of food is important in controlling current health for the residents.

The older people negotiate shame avoidance in part by employing humour, reiterating that they are in better health than co-residents, and this is echoed through expressions of direct responsibility for their own health needs. For the residents, shared humour is a useful mode of expressing embodied being because it is introspective and reflexive of life (and death) as similarly reported by other studies (Hubbard, et al., 2003; Stroobants, 2009). Laughter as a social phenomenon allows a sharing of sense of humour central to understanding and meaning-making. This finding mirrors other research where humour has been said to be especially helpful in the lives of
institutionalised older persons (Makoni & Grainger, 2002; Nay, 1993). Humour is used by the elders in cases of marginalisation to deflect being stigmatised, a finding backed by Carty and Musharbash (2008).

As displayed in Figure 7.1, the lived body strand focuses on ‘embodiment-disembodiment’ and ‘consuming-abstaining’ threads in this chapter. These threads have been woven to illustrate the way embodiment impacts the residents’ lifeworld dimensions, including lived space and lived time, as the previous two chapters have demonstrated. In this way, an insight is gained into how the residents’ experience daily life. Embodiment is further entwined with the elders’ lived social relations with others, which is the focus of the next chapter.
8 Chapter Eight: Lived relations

8.1 Introduction
As I was interested in finding out from the residents about their relationships with others, a series of questions in both the survey outlined in Chapter Four, and in the narrative and interview summaries, were asked of residents about face-to-face and local or long distance encounters with other people. The meaning of lived relations with other people as experienced by the residents is the focus of this chapter. Relationships between co-residents, residents and staff connections, and that of residents and their friends and family will be explored to address the research question How do older people in New Zealand rest homes experience daily life?

Relationships are central to this chapter. van Manen (1990) and Schütz (1962; Schütz & Luckmann, 1973) argue that relations with others are of greatest importance in the lived world. As discussed in Chapter Three, relations with others are typified by subconsciously drawing upon our lived experience, in the context of group norms, to give interactions shared meaning. In this chapter, where a few residents speak for the majority, I discuss validation of relationships and reciprocity, which are made possible because people grow a conversational relation which allows the individual to transcend self. Transcendence allows the individual to encompass what van Manen (1990) suggests are communal meaningful “grounds for living” (p. 105); as Schütz (1951) headlines, this is seen as ‘making music together’. This principal reality or the world of shared social experience (Schütz, 1962) is only possible in the ambience of everyday life (Agich, 1995).

Similar to the previous three chapters, this findings chapter investigates experiences of residents’ relationships as they are positioned on a multiple-helix strand as threads comprised of ‘validating-invalidating’ and ‘mutual-non-reciprocal’ relations (Figure 8.1). I then integrate the summary section with the literature discussed in Chapter Two.
Figure 8.1: Threads of lived relations with others from a multiple-helix model

8.2 VALIDATING – INVALIDATING
The thread chosen for discussion in this section concerns the residents validating and invalidating lived relationships. The older peoples’ relations with other residents are not a binary, rather these terms are located as distinct threads coming out from a strand representing the residents relations with others. The elders’ relations with co-residents will be considered for a discussion of the thread that illustrates how relationships with co-residents work.

VALIDATING

Comparisons of resident-self to others
Most residents speak about co-residents as being less bodily and/or cognitively able than themselves and this is a reason they offer support. As explored in the previous chapter, the residents share an understanding of the manner in which their body is positioned as frail through illness, and is the reason for them residing at the rest home. Their experiences of illness are universally typified to the degree that frailty has become lived. Being perceived as frail means they are at risk of stigmatisation. One way to avoid stigma is to validate self in relation to others. Bessie deflects the stigma of being classed as cognitively impaired by euphemistically negating the view that “you come in here and you’re classed as mad but I haven’t lost my marbles yet… and my mind is sound, thank God”. Alice agrees, believing that “there’s very few of us that are what shall I say, still ‘with it’, if you know what I mean by that”. Similarly, Norman
authenticates his and another man’s greater cognitive coherence compared to other co-residents.

“You see the whole trouble is that I’ve got my faculties and that...But there’s hardly anybody you can talk to here, intelligently. There’s one joker [man] along from me...he’s intelligent and everything and nice to talk to but he talks to himself [because I can’t hear him]. I should put my hearing aid on you know.

Residents often tell me that it is “nice” or “good” to have someone “sensible” to talk with. These oft repeated statements I take to mean that I have what Bessie euphemistically terms “all my marbles”. Being of “sound mind” is a topic brought up by many residents and is a way of confirming their presence of mind. The thought of “lost” cognitive ability is a deeply embodied notion that the older people refute for themselves as I discussed in the previous chapter. Comparison occurs as Alice feels pity for co-residents who are demented. She states “I can put up with that” because “it could easily be me”. This is affirmed as Alice discusses the unusual heart-rending behaviour of some co-residents.

One’s going home to her mother and she hears a baby cry and (long pause). You know, it’s different, there’s something different... memory loss, hearing loss, hm. [Another resident] she’s got her clothes packed and she’s going home. It’s sad isn’t it? I think ‘well, it could be me’. I don’t know how I’m going to go (silence).

In the rest home context frailty due to infirmity and illness is usually visible and seldom goes unnoticed. While the older peoples’ bodies are central to their sense of embodiment as discussed in Chapter Seven, the experience of relational others’ bodies is also encumbered by their physical and cognitive frailty. The residents interpret and give meaning to their self through comparison with co-residents which authenticates self. What is always present in their evaluation is the likelihood that in the future, further dis-ease may occur to self. Many, like Mary, explain how others are infirm and these comparisons cover cognitive as well as physiological aspects of health.

I mean there’s a lot of people [here], and I’m not being horrible or anything, but you walk around and you know it’s hard [for other residents] to walk and everything, and they don’t talk to you.

Physical and cognitive self is judged favourably by comparison to co-residents as Mary who is physically mobile suggests that “you know I’m not doing too badly”. Even
those who are severely physically impaired sanction themselves as being more able than their co-residents which is confirming as Bessie states.

_A lot of things that you can’t do, that you’d like to do, and you can’t. In here, you see people are much worse off than yourself. That helps a lot... There is always somebody worse off than yourself. I’ve got a lady over here [points to a room across the corridor] ....She has a terrible time, she’s got a sore right across her [body] somewhere, I don’t know, she’s got that and she has to go to hospital every so often to get topped up with blood. Now she’s coughing it up, the blood coming up with mucus in the lungs. I don’t think she’s got that long to go actually. Terrible (long silence)._  

Bessie’s point that her co-resident has not “got that long” to live serves as a positive comparative measure which validates the quality of her own life as she views her physical condition as superior to the state of the other woman’s health. This comparison with a co-resident’s disabilities is common and may be used as a way the elders manage their own ill-health.

Residents spend a major part of their current lives with others also living at the rest home. Yet, the more I reflected on the relationships between co-residents, the more I found a pattern of strong relationships with others did not fit usual categories. Naming the relationship that residents have with others is a difficult task as the terms friend or neighbour are reserved for non-residents, community dwellers, people from their former lives who reside outside the rest home.

As discussed above, residents do not associate themselves as friends of their co-residents, whom they may consider worse off than themselves and may harm their self-image. To avoid this negative self-rendering, they use impersonal labels for co-residents which serve to legitimate themselves. Bessie is one of many who quash any notion of friendship when she talks about one seemingly close relationship using the phrase the “lady in the room opposite” rather than using terms such as friend or neighbour.

Residents choose to be involved (or not) in the shared pursuits going on at the rest home. Lillian self-authorises her difference from a co-resident by confirming the type of distant relationships she prefers, and states that “people pop in but I’m not one for going into their [bed]rooms”. Similarly, fraternising with co-residents is “not on” as far as Jean is concerned:
No, I don’t encourage that. The point is that I think if you’re intuitive you can understand people, you know where they’re coming from don’t you? I’ve been here long enough to know foibles of quite a lot of [co-residents] here. You either avoid them or encourage them don’t you, really?

For some residents, the set mealtimes are important in sustaining contact. Others choose to avoid contact as a way to demarcate themselves from co-residents. Jean reports going to the combined dining and living room only for meals because she is not keen on the company. Self-validation becomes difficult when sharing food with fellow residents as she reveals when talking about one woman she has known for years but does not particularly like.

She wasn’t really a great friend at all. She is here and I hadn’t seen her for years. But I knew her at school and she used to belong to the [same] club…She was asked which table she would sit at and…as soon as she heard my name she chose to sit with me. Now I listen to her little problems every day.

Jean’s need to remain aloof is one way to authenticate herself as less needy than her co-resident, with whom she is “friendly, but not too friendly”, and proves a difficult task. She speaks about the strain of spending further unwanted social contact with the co-resident, whom she claims is a “nuisance”.

We have a meal together and I say ‘well, I’ll see you tomorrow’ … What else can one do? They bring me breakfast here [in the bedroom] so it’s only twice a day really so I could put up with that.

Despite being “almost rude” to the other woman she finds herself “giving all the time” which proves tiring for Jean as she seeks to validate her self as distinct from the other woman. A perceived expectation to support the other woman means that Jean continues to interact in a “kind” manner despite the relationship making her feel uneasy. She explains the difficulty in managing a positive relationship with this long time acquaintance.

She has anxiety…she never comes in here [to my room], I couldn’t put up with it. But I’m kind and I listen to her…Sometimes she’ll knock on my door and come and tell me something that’s upset her, but I tell her not to worry and off she goes. She says ‘you’re my dearest friend’, she tells me [that] every day. But we’re not, you know, we really haven’t grown up together or know that much about each other but we both came from [the same town].
Always polite, Jean does manage to deflect further contact with this acquaintance, and avoids having to re-evaluate her sense of self. Not all interactions with others long known are negatively reported. Indeed, Bill’s interaction with a fellow male resident that he has “known for years” prior to living in the rest home is reported as very positive as it confirms his sense of self. Evidence of both positive and negatively perceived social contact between residents belies commonsense perceptions that rest homes are lonely, barren places. The residents are able to retain some command over self-authentication in their interactions with co-residents.

Importantly, past associations are individually determined. There are many instances where social contact between residents is not viewed as necessary. As Jean states, little social contact allows her and others to “please themselves during the day” which suits her because she is a “private person”. Rather than alienation from others, these residents validate their preference for being alone, and justify this inclination as continuation of a lifetime of being “a loner” as Terence calls himself. He further adds that “that’s another one of my failures, if a lot of people are doing something I usually go the other way. I can’t handle that you see”. It is possible that at least some of these stated preferences for being alone result from not having a close relational other, such as partner, sibling, or close friend with whom they would want to spend time. It is also possible that remaining detached by limiting social relations with others, along with reserving the term ‘friend’ for people living outside the rest home, may be an attempt by the elders to retain some sense of choice in their relationships.

Keeping to one self is said by residents to be perceived as a negative trait by others, an attribute that requires justifying and amending. While Jean states that she values her privacy, she reflects on negative comments made by staff and other residents about her reserved nature as “they tell me that I’m very private but I don’t think I’m private. I don’t listen to gossip, there’s a lot here, but I don’t”. A distinct set of unwritten rules seems to apply and the message is clear; rest homes are communal dwellings and residents should be prepared to join in. Taking part as an active member of a group pursuit is considered socially acceptable behaviour and thus valid, while being a loner is reportedly frowned upon as being socially irresponsible.
INVALIDATING

Being alone by choice differs from being alone through public proscription. Exclusion is failure to be considered by co-residents as belonging in the rest home. For some residents, segregation is reportedly reinforced by inadvertently breaking invisible and unknown rules set by groups of co-residents. In-groups and the unwritten codes that residents refer to as “rules” are abided by, and are just as important to older people as they are to other age groups. Daphne explains that she has become socially isolated. She does not go to the communal lounge because there are “cliques” that she feels excluded from joining. Speaking specifically about one of these groups she relates a story about being publicly humiliated by another female resident who ordered her out of a chair in which she was sitting in the communal lounge because another resident supposedly had prior claim.

Following up this theme, a conversation with a staff member affirmed that residents are not supposed to claim particular seating. However, in most rest homes specific chairs are informally claimed for personal use despite rest home policy to the contrary. This can be difficult for relatively new residents like Daphne who is unsure of the “ins and outs” of rest home rules and speaks about “adjusting to life” although she states that she still “can’t settle to things”. Conditions of confirming group membership are also unclear although residents like Daphne could be excluded because of their reserved nature. Length of stay and whether co-residents were known prior to moving to the rest home may be additional factors in gaining acceptance, or not, from others. In-group exclusion is embarrassing and hurtful, whereas inclusion into a group means a resident is validated by co-residents to be watched out for and looked after.

Unravelling notions of dependency

Policies set by the rest home around the elders being unable to “help out” when co-residents are clearly in distress are highly problematic. Knowing and abiding by rest home rules is an important but frustrating factor for Bessie who invalidates rest home policy in order to be able to assist her peers.

I like helping people but you can’t do much for them; if you’re a resident here, you must not touch. You know, you’ve got to be careful. People learn to do so much but you know the rules and you just abide by them. You have to. There’s [sic] ladies that are falling over and I hear them fall. I’m out of my bed and I’m out there like a shot. I use the emergency caller [bell] here which I’m allowed to use. The girls [staff] come
running...But I can only say ‘help is on the way’ to them and pacify them as best as I can you know. I just try. I like to help as much as I can.

While a hands-off policy in most rest homes means residents are helpless to attend to co-residents who are injured or ill, assistance continues to be consistently offered. Owing to Bessie’s frailty it is unlikely that she could physically assist or move fellow residents. Yet, she has been explicitly informed by rest home management to stop helping up co-residents who have fallen. This rule “you must not touch” is in place to minimise further potential breakage to brittle bones that many frail elders have. Bessie manages to nullify the regulations and still “help” her co-residents. Her strategy is practical as she uses the emergency bell and placates the stricken resident while waiting for staff members to “come running” from elsewhere in the rest home.

A number of residents take up practical tasks to help out fellow residents despite regulations to the contrary. Bill disregards the rules to help a co-resident, who uses a wheelchair, by taking him to meals, morning and afternoon tea and other set pursuits. Confined to a wheelchair herself, Iris considers she is “lucky compared to some” and so “offers to help” other residents by sewing ripped or frayed seams and hemming dressing gowns. She reports that until recently she helped with daily routines of personal assistance for a female co-resident with an advanced, debilitating disease until the woman left the rest home for hospital level care. Routines such as sorting, folding and choosing clothes to wear, hair brushing, and helping with teeth cleaning are daily personal chores that are said to be a “help” to co-residents directly, and indirectly to staff because they lessen work routines. Unnoticed and undocumented, the older people help out staff and other residents, and continue a lifetime of giving to others. This informal volunteer work is perceived as such by the resident as assistance to others that enhances their feelings of being useful, which increases a sense of agency.

Work undertaken by the residents may also be a form of resistance as it serves to explicitly counter the notion of residents as dependent. Helping fellow residents means the elders can effectively overthrow the idea of being ‘takers’ rather than ‘givers’. Some of the residents speak about listening to others’ problems as one way they give support to co-residents, particularly if the other elder appears “down” as Lena points out: “I feel I’m well enough to help others that I see, to talk with them, as they are just depressed or something”. Similarly, the men in my study perceive themselves as supporters of co-residents as illustrated by Bill whose narrative is fairly typical.
Just recently a lady came in and she sat down beside me very depressed, and I listened. I always listen to them...When she gets a bit depressed I notice that she comes to me and I'll laugh about. She pours everything out and goes away a little bit happier.

At the start of my study it did not occur to me that the residents might perceive themselves to be emotional supporters of other people. Their contributions to others well-being is a main theme that cancels out the idea that all residents are highly dependent. They cite numerous examples of acts of helping others, and both men and women appear comfortable talking about their “support” of co-residents.

The rest home environment fails to take resident relationships into account, and this is reflected through some resident’s narratives. Clifford’s actions highlight the issue of countering the perspective that rest home dwellers are dependent on others in the day-to-day. He also “looks in” on another male resident each day to remind him to come to the dining room for meals. Clifford also has relationships with female residents. He talks about the perplexing situation with a female co-resident “along the hall”. He states that an attempt to be equally friendly has inadvertently resulted in a falling out with this woman. Clifford’s sharing is at the root of the problem. Growing vegetables in a small outdoor garden plot he gives seedling plants such as tomato to fellow residents. A co-resident whom he “liked well enough” has taken umbrage because he first offered one of his tomato plants to another woman resident. He remains unsure how his behaviour resulted in the woman becoming upset and is puzzled now by her stand offish behaviour toward him. Living in close proximity to others in an environment that does not cater for co-residents relationships means “upsets” such as Clifford expresses are unable to be avoided. Despite the trouble, Clifford remains “friendly” because he “still likes company”. Mutual – non-reciprocal

In this section, I discuss the thread of ‘mutual’ and ‘non-reciprocal’ relations with others as I interpret the relationships taken up by the residents. Relationships with people living outside the rest home are most often generational and tend to be mutual, as the first part of this section indicates. Alternatively, there are relationships with family and friends that are non-reciprocal. Relationships between the residents and staff members are care focused and due to this are based on care given to residents, and while these tend to be non-reciprocal relationships, they are carefully managed by the residents.
**Mutual**

**Mutual support**

Support that older people receive from others, and give to people around them, is a topic of discussion in the literature discussed in Chapter Two. I reported in Chapter Four that nearly all the residents claim to have an emotional support person (Figure 4.6), and these are most often family members, and daughters in particular (Figure 4.7). Central to this section is the mutual (reciprocal) support of residents and their friends and family. On many occasions I observed family and friends’ comings and goings in the rest home (Figure 4.3). Often, visits appeared casual and of brief duration with little in the way of conversation. When speaking with residents, often following these short visits, detailed and up to date accounts about day-to-day events in their families’ lives are revealed.

Social contact from people living outside the rest home is not confined to visits from family and friends. For many residents a combination of visits, written correspondence and telephone communications are means by which they can remain in touch with the daily goings on of relational others outside the rest home (Figure 4.4). Telephone contact is one-on-one interaction and acts as a vehicle through which to continue connected mutuality.

At the start of our time together, Lena makes it clear that she is waiting for her daughter to telephone and that our interview will be on hold while they speak. Lena has a landline connected to a telephone in her bedroom as her main mode of keeping in touch with the family who call, as she laughingly puts it “to make sure that the old girl is still breathing”. The phone duly rings and I sit politely pretending not to listen, while Lena and her daughter speak together for ten minutes before ringing off. Their conversation I note consists of mundane, everyday matters including current news about a grandchild and an upcoming outing they are planning. When we continue with our interview Lena shares details of the telephone conversation which we go on to discuss at length. Mary too stays in constant contact with her children, in this case by mobile telephone.

*Oh, they are all very good to me. They keep in touch with me all the time, that’s why the [mobile] phone is here and they all ring me.*
Robert offers another example of reciprocity. He has no telephone of his own, but has a co-resident “mate” who is “happy” for him to use his personal phone although Robert points out that he “doesn’t make a habit of it”. The older people speak about telephone connections being arranged, and paid for, mostly by family members, as an accessible way to stay in touch. Personal telephones are often adapted to take into account residents’ visual or memory impairments. Speed dial or large numbered keypads on phones are common, as are magnifying glasses and large print telephone directories on side tables or walls in residents’ bedrooms.

The telephone serves as a link in dealing with concern as Harry’s situation reveals. During our interview he twice expresses his anxiety over the well-being of his sister, who lives overseas, with whom he has long had twice weekly telephone give and take type contact. He tells me she has recently been hospitalised for a routine operation. Although told by his sister that the hospital stay would be no longer than a few days, Harry’s calls made from the rest home office have remained unanswered for nearly two weeks. At the time of our interview, he has decided to phone his sister’s friend to “see what the story is”. At our second meeting, I ask after his sister and am quietly informed by Harry that she died in the hospital.

There appears little difference in contact rates between residents with and those without children. Phone use practices vary between rest homes, ranging from some residents having their own landline or mobile phones in their rooms to others having to use card or coin operated telephones in busy communal areas, to telephones located in rest home offices. Most rest homes have multiple types of telephone. Residents frequently have difficulty using the phone as Robert highlights when expressing his concern about an old friend living outside the rest home.

He’s got trouble with his leg now. I don’t know quite what it is but apparently it’s swollen and all.../...He hasn’t been in [to visit]. He’s home all the time. He can’t walk far or anything like that. I ring him up on the telephone [but] half the time you can’t get out on it. It’s engaged, engaged (laughs).

Robert’s narrative is followed by laughter, however this is not an attempt at mirth, rather it is an (unsuccessful) effort to hide annoyance over the difficulty of controlling contact with his “mate”. His worry about his friend means the continued attempt to share the line is often thwarted, and Robert gets the engaged tone.
For those with deafness or cognitive impairment, the telephone is of little use in retaining social contact. While managing reciprocal relations remains dependent on the elders being able to mobilise and communicate, the majority do continue to interact with family and friends living outside the rest home. The telephone permits the residents to have relations with others in places beyond the rest home, at different times.

These older people are well aware of changes in social relations within the family from the time they were young people in the early to mid-twentieth century, to the way of life of youth of early twenty-first century New Zealand. Assumed isolation of rest home life away from the everyday world of family relations is contrary to the lived reality for many residents. Iris, for example, is busy knitting a pair of bootees for her granddaughter’s baby due anytime now. She speaks about the close relationship she has with her granddaughter who lived with her “for a while” prior to Iris’s move to the rest home. As she sits and knits, she talks of the support offered to her pregnant granddaughter over the past months. She tells me about coming to understand the generational differences concerning the younger woman “keeping the baby”, and about the de facto relationship with the baby’s father. Iris suggests this closeness is possible because their rapport skips one generation so she can be more objective and less judgemental then her granddaughter’s mother. In this way, Iris is able to show concerned support for her granddaughter.

*Other forms of mutuality*

Daphne is sitting on the end of her bed with an open can of cat food in her hand. The bedroom is sun drenched, overly warm and smells of tinned meat. Daphne states she is waiting for her cat to come in through her open window. She explains that the cat had belonged to another resident who moved to hospital care and has since died. Daphne has “adopted” the cat, which she says keeps her company. She sadly adds that the cat helps lessen the pain of grief surrounding the recent death of the second of Daphne’s daughters. Caring for the cat means she actively employs a coping mechanism to better manage recent loss(es).

The cat also offers a connection to past relationships as Daphne reminisces about the enjoyment she and her late husband got out of their pet cats. The cat acts as a common topic of conversation between Daphne and family or staff members who purchase and bring cat-related items for her. Cats return to the residents’ bedrooms for
food and shelter, along with companionship, so the residents who care for the cats have a shared relationship that could be considered mutual.

For residents caring for pets, considerable effort is spent in organising saucers of food, milk and even cat beds made up from blankets, and windows are left ajar in bedrooms for cats to come and go as they please. Most rest homes have one resident cat or more and when asked, many elders mention that they take pleasure in having an animal around the place. Animals do not feature significantly in the majority of narratives but for those who do talk about their (resident house) cat, this kind of companionship is extremely important.

NON-RECIPROCAL

Lost connections
Losses include death of friends and family. Death is a frequent topic talked about by the majority of older people. Grief over the death of others may not be recent as the elders illustrate in the many conversations that include their experiences of loss of partners, parents, siblings, children and friends over their long lifetimes. Successfully working through grief, even after many years, is possible. Lamenting the death of her child who died decades ago, Barbara goes on to muse that the opportunity to grieve was denied at that time. In recent years however she has openly grieved and reflects on the importance of friends caring enough about her having a “a good laugh or a good cry” when thinking about the loss of her child.

Funeral orders of service in the bedrooms point to a valued topic of conversation about deceased family and friends. Clifford reports in a matter of fact way, “oh yeah, they are all dead except for me”. He shows me two recent orders of service pinned to a cork board on his bedroom wall. Holding one such order, Clifford shakes his head and states he is “sad to have lost a couple of friends” who recently died. Clifford does not seem to expect a response, so I simply nod and we sit silently for a few moments. Death of others is very much a reality in the elders’ lives and many residents mention deceased family and friends as we talk. Ironically, relationships with others no longer able to reciprocate continue beyond death as discussed in Chapters Two and Five. Clifford himself dies during the study, and his death is mentioned by a couple of co-residents in a similar way.
Relationships to the dead are acknowledged as part of conversation, and are a reminder of the residents’ own mortality. Jean’s narrative about death appeared in Chapter Six, where she speaks about her own death, of which she states “I am looking forward to that…Now I just think – ‘oh, gosh you’ve gone and woken up!’ (laughs)”. Jean is merely pondering over her long lifetime, and death holds little fear. Jean’s talk about death is conversational and followed by laughter, her black humour suggesting that a response is not required of the listener.

Living a long time means that there have been many deaths of friends and family for Vera who has “lost all” her “dearest friends because they are dying”. Talking about how she stays in written postal contact with a friend overseas she ponders why there has been no response to her last letter so “I don’t know, I think she must be dead” but “nobody’s let me know, told me that’s she’s dead, I’ve had no reply”. Vera’s loss of contact is concerning for her, and she has asked her son to find out about her friend and expects news when her son next visits.

Unlike Vera, who awaits her son’s visit, some residents may not have family living close by and due to geographic distance, they see them less often than they would like making these relationships non-reciprocal. This is the case for Lillian, a dignified and reserved woman. She reports that after suffering major health problems her children felt it would be best that she move from the place she lived for most of her adult life in order to live in the same neighbourhood as her daughter. However, since moving to the rest home Lillian’s daughter has relocated to a far away suburb. She excuses her daughter’s continued absence by pointing out that her daughter has “to go to work.” She expects that they will see little of one another because she is “busy working about seven days a week …so I don’t see as much of her as we both would like really”.

Mary reiterates some residents’ stated rationale for family visits being few and far between. Interestingly, Mary fails to mention that continued interaction with family, including her own, is predominately through telephone contact.

*They make excuses for their families not coming, ‘oh they’re very busy’, their daughters are working, you know. Life is different today isn’t it? ... So I hear the same story.*

Some residents strongly insist that they intentionally keep some geographical distance between themselves and their children as Vera emphasises “I would never go and live with family” because she says they have their own lives to lead. There is an oft
repeated view that they do not wish to be a “burden” on their children. For other residents, strained family relationships are long-term and there is no reason why these situations should change simply because they now live in the rest home. A few talk scathingly about family members (but not friends) from whom they are estranged. Catherine explains how she lost contact with a sibling.

*I’ve got one sister and she won’t come here. She came here once for dinner and she said ‘well, I’m not coming back here. It just depresses me’. So I never saw her again.*

Further familial tension resulting in non-reciprocation is bitterly expressed by Catherine when she tells me that her son has been “banned” by Catherine’s daughter-in-law from visiting although the reasons for this bar remain unclear to me. Daniel has not seen his grandchildren for some time, although he too is vague about the reasons for a falling out with his children.

*I haven’t seen them [grandchildren] for oh, twelve or eighteen months. I don’t know what happened there. There was some sort of upset with their parents, they took off one night.*

Cognitive impairment may account for part of the reason that Daniel and Catherine appear unable or unwilling to discuss the reasons behind no longer having mutual contact with family members. Other residents, however, have more obvious difficulty communicating such as speech impairment, which results in inability to interact successfully. It follows that the loss of adequate communication factors in shared relationships with family and friends results in diminishing reciprocity.

**Negotiated care**

The practical assistance offered by staff members to residents makes this relationship one of the most important in the older peoples’ lives. Interactions include instrumental and personal care in events which are organised by rest home staff, usually women, and take up a large part of the day. Owing to the intimacy of some tasks involved in day-to-day life in the rest home, such as toileting, bathing or dressing, I initially assume that interaction between residents and workers would be informally mutual, bordering on intimate. Despite my prompting, little specific discussion with residents about this seemingly important relationship ensued. As rest home staff turnover is high and staffing levels are low, long-term relations between staff and residents may be of fleeting duration and thus relationships could be seen as more casual and non-reciprocal.
in nature. It is also possible that residents erroneously believe that I may feed back their comments to rest home management.

I observe employees as a major presence in the residents’ day-to-day lives. Often, my conversation with a resident is halted as a staff member enters the elder’s bedroom with morning or afternoon tea, the call for lunch or to bring a clean towel. Yet, the value of employees is rarely a point of discussion despite my questions about their role in the everyday of rest home life. Relations between the older people and staff regarding practical, daily, health related tasks are overlain by socially orientated tasks featuring workers other than staff employed to assist with activities of daily living, as Bill’s comment suggests. “It’s quite a full day for us” because the “doctor calls, the hairdresser’s here, the band they have now is entertainment, the music”. Daily carers who provide services such as help with dressing, toileting and meal provision remain unmentioned by the residents, suggesting that this relationship is not representative of mutuality.

In the main, my observations confirm that residents interact with the rest home staff in a light-hearted, non-reciprocated way irrespective of the elders’ mood or frame of mind at that time. Humour plays a large part in these weighted relationships. Bessie speaks about the value of enjoying “a bit of a joke” with others working (and living) at the rest home. She says that when staff members sight her they teasingly address her with the comment “here comes trouble”. This form of humour is laced with irony because in a similar way to her co-residents, Bessie is quick to report that she is “no problem” to staff. She makes a point of being pleasant and accommodating in her dealings with all rest home employees. Residents ensure their self directed black humour is appreciated as this is a strategy used to stay onside with staff members. Although small talk takes place between residents and various workers numerous times during each day, there is little reciprocity in the relationship. A short exchange between Bessie and a staff member is typical when the woman enters Bessie’s bedroom and asks if she wants afternoon tea.

*I’m going to have a cup of milk please dear. What have you got to eat...Cake? No, I don’t eat cake love. Just a cup of milk please, [takes cup and sips from it]. Nice thank you.*

Seemingly a quick, undemanding and polite monologue, in actuality a great deal of effort is exerted by Bessie for a specific purpose as explained to me following the
employee’s departure. Bessie tells me that the cup of hot, sweet, milky tea she enjoyed early each morning for most of her adult life is not available at the rest home. To avoid interaction with staff, she uses a strategy that allows her to continue with a lifelong pattern that begins with “saving” her cup of milk from afternoon tea. With minimum staff onsite before morning shift starts at the rest home, Bessie takes the milk, along with a teabag and sugar supplied by her daughter, and moves quietly to a small kitchenette located close to her bedroom. She makes herself a morning “cuppa” using boiled water from the “Zip” and drinks the tea before returning to her room. Bessie remains little (or no) bother to staff while continuing to cope with some autonomy.

Iris is one of the few to speak about having a close relationship with a female staff member, until recently, when she found the relationship had been one sided. Usually a cheerful woman despite multiple impairments, Iris tearfully discusses at length her distress over the employee she had considered a “friend”. Casual conversations with staff members and residents during my time at the rest home confirm that the worker was let go under a dark cloud of whispered insinuations, by other staff and residents, of misappropriated funds. While Iris and I do not discuss the “gossip” surrounding the ex-worker, Iris does wonder whether the rift she had with the employee was in some way connected to the woman leaving the rest home. Iris may have misinterpreted the situation, but feels extremely upset about misreading the relationship, and so feels unable to approach rest home management for clarification.

Robert is a resident who says he is no trouble to staff members. Robert sits in an armchair while I perch on the end of the bed. Softly weeping he says “you’ll have to excuse me…I get like this very often” because “I lost my wife…a year ago Sunday”. I murmur a heartfelt “I’m sorry to hear that” and lean forward to offer him some tissues from a travel pack I keep in my bag. As I sit back and quietly wait for Robert to finish crying, a staff member knocks and without waiting for a response enters the room. Placing clean linen on a dresser by the door she tells Robert “I’ve just brought some clean hand towels for you, see you later”. He sniffs and responds, “oh, thanks sweetheart, thanks for that, bye-bye”. He blows his nose noisily on the tissues. The woman does not react to Robert’s distressed state when addressing him, and does not attempt to make eye contact with either of us before leaving the room. Robert takes a few minutes to compose himself and we continue with our conversation. His obvious sorrow is apparently overlooked or ignored by the staff member, perhaps due to
embarrassment, or Robert may often be in tears so this seems normal. Robert himself appears not to expect a reaction from the staff member about his sadness.

Some residents do cry a lot of the time, and this is perceived by the staff with whom I spoke as a usual occurrence for these elders. Often, the older people are thought by staff to be suffering from dementia and living in the past. Relations with rest home staff can prove hard work for the residents because they feel they have to prove their cognitive astuteness to the employees. One bugbear for Catherine is the tendency of some staff members to infantilise residents including her and she gets “grumpy when people treat me like a child just because I’m old and in here” at the rest home. She tries to remain as coherent and clear in her dealings with all staff members, particularly those who have recently started work at the rest home. Catherine believes that despite her efforts to illustrate her competence some employees continue to think she is “mad with dementia”.

Lillian, who in Chapter Five discusses her use of the rest home laundry at night in order to wash her own “woollies”, offers an example of continued independence. Nancy is similarly careful to avoid holding up, or otherwise bothering, staff members. “Well, I try and get on with everybody…I think it’s better for peace of mind isn’t it?” On the surface, the elders’ little pleasant exchanges appear cordial informalities of little consequence. Nonetheless, they rely heavily on staff members’ practical care in order to dress, toilet and take meals. To express dissatisfaction may mean jeopardising their small independences, and so they actively work at avoiding even the slightest disruption to staff routine. To achieve what they need, residents’ relationships with staff are carefully negotiated as non-reciprocated work by the elders.

8.3 CHAPTER DISCUSSION

VALIDATING - INVALIDATING

Co-residents
The residents rate their health as better off than their counterparts as illustrated by applying Fox’s (1999a) model of arche-health. Rather than the experience of health, it is important to ask about health within illness (Buetow & Kerse, 2001), where chronically ill or disabled people talk of the need for relationships and of their commitment to helping others. The older people downplay their illness narratives by comparing their own health to co-residents’ ill-health. Thus, their own health is validated as good when
compared to others. Presenting their health as better than co-residents may be an attempt to cope with their own (ill) health as local researchers suggest (Buetow, et al., 2001). The experience of other peoples’ bodies is similar to the experience of self in that the focus is on the task at hand rather than the other individual or their own body. This is an excellent example of the absent-presence discussed through van Manen’s (1998) writings, and resonates with my findings in Chapter Seven, where the main activities of the residents concern making meaning of the world in which they live.

The lived shared world has facets called health, which the residents are able to deconstruct before reconstructing a more optimistic arche-health (Fox, 1999a). As frail older people, particularly in a residential care context, they are aware of being socially constructed as needy, and so they attempt to deflect the label of being burdensome. Most are at pains to explain that even if they are cognitively impaired such as from stroke, their own ill-health and resulting disabilities are not dementia related. Problems resulting from impairment are spoken about in terms of what they are able, rather than unable, to achieve.

The residents compare themselves favourably to peers who are viewed as failing at ageing well, reinforcing findings from other studies (Townsend, et al., 2006). The residents respond to co-residents’ frailty using understated techniques. These elders emphasise that they mix only with fellow residents who are cognitively astute which fits well with the view that older people have to consciously deal with self identities within the confines of stigmatised institutionalised environments (Gamliel & Hazan, 2006; Goffman, 1968). Cognitive impairment could have a bearing on the temperament of some of the elders (Declercq, 2000). Residents with dementia and those with extreme physical frailty may use humour to cover over conversations where they feel unable to keep up with the talk as reported in other research (Burgener & Dickerson-Putman, 1999).

Most consider a number of their peers to be what Townsend (2006) termed “victims of old age par excellence” because this echoes a “constant, underlying fear” that they may become demented themselves (p. 898) (see also Powers, 1991). Often during interviews I observe disturbances such as singing and regression to childhood including anticipation of seeing mother expressed by other residents, which is also noted by other researchers (Babbage, 2005; Carel, 2008; Meacher, 1972; Shield, 1988).
Ever polite, it is only when the noise becomes obtrusive that I find the older people acknowledge and sometimes excuse seemingly inappropriate behaviour of co-residents.

Potential stigma ties into the elders perceptions of ‘use it or lose it’ and is in keeping with other investigations (Graneheim & Jansson, 2006). Many quietly rationalise behavioural problems displayed by fellow residents as being associated with cognitive impairment.

Pursuits are undertaken by groups of residents, a finding that supports engagement in meaningful pursuits as central to rest home life (Knight & Mellor, 2007; National Care Homes Research and Development Forum, 2007). All relationships are reciprocal, according to Schütz and Luckmann (1973). However, I found the residents’ relations with others are reciprocal only when the possibility of mutual care is involved. Other researchers finding co-resident reciprocity have been surprised (Guse & Masesar, 1999; Wagner, et al., 1999). This may be because, as onlookers, the staff, family and friends (and researchers) have been unaware of the type and meaning of interaction between residents (Peace, et al., 1997), which has remained undocumented.

The elders often talk about helping out or taking part in voluntary work, which is a give and take activity, in relation to daily chores. While there is a gap in the residential care literature about reciprocity through informal volunteer work, my findings about the residents’ active support of others resonate with results from community-based studies (Musick & Wilson, 2003; Narushima, 2005; Thomas, 2010; Warburton & McLaughlin, 2006; Yunqing & Ferraro, 2005). Volunteering means the elders are free to offer support to others less able than themselves.

Informal work such as volunteering is likely tied to lifetime pursuits, particularly for the women working in (rest) home orientated areas and for the men who do odd jobs around the place. The image of older people as managers of their lives is rare but not new, as local community-dwelling research has shown (Keeling, 1998; Wright St Clair, 2008). While not naming the work that they do as management per se, meaningful active and productive daily routine that is achievable for the residents has been found central to other residential care research (Kaufman, 1986). Volunteer work is often modified to enable physical work to become less strenuous than previously engaged in, a point also discussed in Chapter Seven.
For many, support for co-residents takes more energy and effort than in the past, and has become hard work (Blaikie, 1999; Clare, et al., 2008; Hallam, et al., 1999; Phinney & Chesla, 2003). Additionally, there is a lack of spontaneity because all tasks have to be planned in order to be carried out as disability researchers have indicated (Iwakuma, 2002). It is important to note that not all the residents want to volunteer as they believe that rest home employees are there to do the work, a finding also backed by other studies (Ball, et al., 2004).

I observed many interactions between co-residents which are in line with research identifying that living in close proximity to other residents encourages regular contact to be managed (see Buys, 2001; Eales, et al., 2001; Gubrium, 1975; Street, et al., 2007). Despite some studies suggesting that close relationships between older residents are rare (Willcocks, et al., 1987), my difficulty was more to do with naming the relationships between co-residents. Contrasting the survey findings in Chapter Four, where few of the elders reported having co-residents as friends (Figure 4.5), the findings in this chapter make clear that friend-like relationships are common.

Some of the older people express frustration at their inability to help support co-residents owing to rest home rules and this is reflected in research showing hands off practices are common (Becker, 1994; Nay, 1993). It is not clear where helping out ends and informal work such as volunteering begins. Some have ceased volunteering due to frailty which is a finding reverberating with community-based research with elders which found problems with functional health are significant barriers to volunteer work (Li & Ferraro, 2005; Lum & Lightfoot, 2005). The arche-health (Fox, 1999a) fails only when the residents’ are unable to keep up with demands of informal work. The need of these residents to continue with the volunteering role, through the delivery of some form of reciprocated support is made explicit in my findings.

Shared understanding leads to responsive relationships for many, yet for some residents close contact is intolerable as other authors have described (Hubbard, et al., 2003). Disliking the company of co-residents does not depend on whether that individual is a new or old acquaintance. Some residents actively avoid disagreement rather than openly face up to their peers when they feel displeased, which is echoed in others research findings (Moremen, 2008). The effort to be polite can be distressing and time consuming for residents living in close quarters with others, which is also in line
with other reports (Powers, 1996). My findings point to the residents’ inability to control acceptable levels of social contact at an individual level, and suggest this makes for hard work for the residents. This work can lead to isolation or feelings of overexposure to others. These findings may be generalisable to wider groups of residents.

**Mutual - non-reciprocal**

**Family and friends**
The residents strongly refute any suggestion that they may be a burden to their families and this finding is in keeping with other local community-based studies (Keeling, 1998). While loath to live with family, one way that the elders have countered lack of social contact has been to move closer to their children, which resonates with international community-based research (Silverstein & Angelelli, 1998). Some residents report a mismatch between previous social patterns and their present reality, which results in less social contact than is desired, a view that echoes other residential care studies (Eales, et al., 2001; Nay, 1993). Nonetheless, the residents actively contribute to their relational others by giving as well as receiving emotional support through their social networks, a finding backed by other research with older people in different living situations (Beel-Bates, et al., 2007; Buys & Miller, 2006; Phillipson, 2004). Yet, it is unclear how these reciprocal interactions work (Buys & Miller, 2006; Reed, et al., 2004).

Reasons for lower visit rates than wanted by residents are in the main geographic distance, which a local community-based study has also established (Keeling, 2001). Some report receiving less social contact than they would like. It could be assumed, and often is, that they are expressing a lack of adequate social contact. However, the elders are prepared to accept less frequent interaction and differing forms of communication to ensure good, ongoing reciprocal relationships with their families. One way of getting around geographical isolation may be through Rowles’ (1978) idea of beyond-spaces, where experiences with relational others are part of reminiscences that include emotional significance, and which are brought to mind to be enjoyed again (and again) through time and space as discussed in the previous findings chapters.

One significant way that residents handle contact with close family and friends is via telephone communication, a finding in keeping with other studies with care home
residents (Gueldner, et al., 2001; Hjaltadóttir & Gústafsdóttir, 2007) and community dwellers (Bowling, 2005). An expected increase of internet availability will lead to more elders using Internet Technology (IT). Increases in technology will result in greater numbers of older people become more computer literate. Video software such as Skype may add to or even replace telephone technology and serve as an important form of communication to manage interactive contact with family and friends. While uncommon at present, IT use by older people, particularly those living in institutionalised settings may become a growth area and requires further research, particularly in the New Zealand context due to geographic isolation from the rest of the western world. In the future, video communication may prove useful in a residential care milieu as suggested by Hensel and colleagues (2007).

One element to reciprocity is the companionship of animals, especially cats. Rest home cats serve as significant social substitutions for some residents which fits with existing research recognising the company of animals as a positive one with residential care elders (Kawamura, et al., 2009; Lutwack-Bloom, et al., 2005; Ruckdeschel & Van Haitsma, 2001) and older community dwellers (Abas, 2007; Bowling, 2005).

The meanings of friendship or companionship for older persons are complicated (Chown, 1981; Reed & MacMillan, 1995). It is clear however that assistance and attention gained from informal friendships with non-relatives are crucial to the residents' connectedness with relational others. They speak about these close relationships in ways that point to the positive influence on well-being noted by McKee and colleagues (1999). Informal social contacts are interchangeable and can be added to or quit as required, usually as confidants move away or die.

When speaking about death of others, which is a relatively common event, black humour is used by the residents. They are no strangers to what Hockey, Penhale and Sibley (2001) earlier termed a landscape of loss. The older in age the residents become the more losses they will experience (Sidell, 1999). Demise of a cherished person is a traumatic occurrence irrespective of the time passed since the death occurred.

**Staff**

It is likely that the residents refrain from talking in-depth with me about their care requirements precisely because it draws attention to the neediness they are unwilling to acknowledge. While they are actively involved with, and obtain necessary care from
staff, the residents are very clear that their own role in meeting their daily needs is primary. They are vulnerable and so employ tactics to keep staff members onside, which is in keeping with other investigations (Diamond, 1992; Foner, 1995; Powers, 1992; Savishinsky, 1991). Many brief communications are exchanged that may appear (to the staff member) time wasting. However, these interactions provide a way for residents to work in unity with staff as carers and are essential to meeting the needs of the residents.

While the importance of staff members to the social inclusion of residents is ambiguous in the literature (see for example Bergland, 2001; Chou, et al., 2002), both parties know that the employee has the potential to refuse the residents’ requests. This is rationalised by the notion that staff schedules take precedence over residents’ timetables (Agahi, et al., 2006; Shield, 1988).

As discussed in Chapters Six and Seven and this chapter, the older people actively employ strategies including humour to avoid demands on staff members. Wit is used by residents (and staff) to make light of the extreme physical intimacies involved in care practices. Shared humour is at a superficial level. Staff joking with residents is not due to the formation of close bonds. Rather, humour is short and sweet and covers over the realities of the heavy workloads of the staff and the enforced dependency of residents, and so humour mediates the interactive care relationship as other research has noted (Makoni & Grainger, 2002).

Humour may also be used by residents with dementia to blur conversations where the elders feel unable to keep up. Joking is also used to deflect stigma. Staff members who infantilise residents by using baby talk can be denounced using tongue in cheek humour. Other studies too have found that infantilisation of older people occurs, particularly with, but not exclusive to, those with dementia (Graneheim & Jansson, 2006). In my observations, several instances of staff members babying residents occurred although in the main, staff members appear respectful and polite in their interactions.

My findings illuminate the fact that death goes largely unacknowledged by staff members as other research has found (Parker-Oliver, et al., 2006). Despite residents being visibly distressed at times, staff members explain this away as a symptom of old age and so ignore their anguish, as my previous research illustrated (Kiata & Kerse,
Other studies have found that staff members tend to view older people as less likely to be distraught by death than are younger people (Komaromy & Hockey, 2001).

The mismatch between the resident as griever and the potential care role of the staff member results in the bereaved elder completely withholding their grief in public to spare staff from their pain, and damages the potential for furthering social relationships, as research on grief management in everyday life has illustrated (Goodrum, 2008).

Reciprocity appears to me diminished by those staff simply doing the job but ignoring the distressed behaviour of residents. Employees may behave as they do in response to having a heavy workload, or staff may perceive residents as cognitively impaired. That some residents often become upset when evoking their life experiences, as other research has found (Haber, 2006), may account for staff members treating residents in a detached way. These frail elders with ill-health or those recently bereaved may benefit when encouraged to remember and reminisce through space (and time).

The residents’ lived relations strand of the multiple-helix model has had pulled the fore threads representing ‘validating-invalidating’ and ‘mutual-non-reciprocal’ (Figure 8.1). The findings from this chapter and the previous findings chapters will be consolidated into an overall discussion and conclusion in the next and final chapter. The resulting synthesis, my contribution to the critical gerontology literature, will increase understanding about the lived experience of being a rest home resident.
9 Chapter Nine: Discussion and Conclusion

9.1 Introduction

This chapter offers a concluding discussion about the lived experience of rest home life in a New Zealand context. The characteristics and demographic description in Chapter Four considered the initial research queries: (i) who lives in a rest home; (ii) their types of relationships with others along with (iii) the sorts of activities in which they take part. For a more in-depth exploration of rest home life, in the following four chapters I then addressed the main research question *How do older people in New Zealand rest homes experience daily life?* A phenomenological lifeworld approach underpinned by a social constructionist perspective was taken in this thesis to answer the main research question.

I drew on van Manen (1990) and Schütz’s (1972) phenomenological writings to position the lifeworld as paramount as explained in Chapter Three. From initial I/C analysis I found four overarching thematic strands for my interpretation which were consistent with these writings: these were lived space, lived time, lived body and lived relations with others. Subthemes were then unthreaded from those strands in Chapters Five to Eight. The findings were discussed through each of the interpretive chapters as represented in Figure 5.1, Figure 6.1, Figure 7.1 and Figure 8.1. In those chapters, I considered the strands and threads of the themes, and then compared my findings with relevant literature about spatiality, temporality, embodiment and relationships, which had been previously discussed in Chapter Two.

In Chapter One, a definition was offered of the term ‘rest’, meaning relaxation from exertion, with synonyms including leisure and inactivity (McLeod, 1992). The findings in this thesis contradict the meaning of ‘rest’ in relation to the term ‘rest home’. In contrast, this thesis identifies the residents’ lived experiences as ‘work’ in the rest home context. Applying a phenomenological lifeworld approach demonstrates that the residents’ activities take place in specific spaces that cater for them, but only to a point. Often, residents adapt their daily practices in order to continue taking part in everyday tasks, while the performance of other jobs becomes untenable. Relationships with co-residents and staff, family and friends are maintained through specific, self-initiated practices by the residents. Day-to-day life entails management of the body and mind. As
a consequence, it becomes much more time consuming than previously to maintain a positively constructed self. Combined, these strands and threads of lived experiences culminate in the residents’ (whole) lifeworld. In this thesis, this lifeworld is illuminated through work.

Chapters Five to Eight resonate with, and expand on, the descriptive data in Chapter Four. The residents are aware that their rest home stay will be indefinite, and are mainly satisfied and reasonably content (Table 4.2). They take part in regular activity (Figure 4.5) and common pastime patterns are enjoyed by the residents, which include exercise, social events and informal, volunteer work (Figure 4.8). The findings from Chapter Four supplement Chapters Five to Eight and together provide an affirmative perspective of the residents’ daily lives at work. Having applied a phenomenological approach to the multiple-helix model, I now reweave thematic threads into the pre-existing strands to reveal a rich, layered fabric of the residents’ daily lifeworld.

The key findings of this study are termed ‘self-maintenance work’ and ‘reciprocal support work’, and are depicted in Figure 9.1. Core elements of these key themes in the residents’ lives can be found in the work in which the elders take part. They manage in the day-to-day despite having frail bodies, which require careful use of time. Employing time at particular paces is not inactivity. Rather, activity often involves embodied intensity. Rest home spaces can prove difficult to negotiate, as residents’ narratives demonstrate, and prove hard work. The residents’ relationships with co-residents and staff in the rest home, and family and friends outside the rest home, have to be carefully and constantly renegotiated. Applying the four thematic strands that make up the lifeworld, the residents lived experiences illustrate how they remain busy at work.

A central finding in each of the four lifeworld chapters of this thesis is that the older people make clear that they direct their own work activity. Associating work with residents is seen as anomalous because ‘work’ and ‘leisure’ or ‘rest’ are often juxtaposed. Ironically, ‘work’ for the ‘rest’ home residents is a central component of these elders’ lived experiences. Being engaged in the work of daily life gives meaning. The residents do not view strategic adaptations in the day-to-day world as problematic because they are merely working at getting on with life. They participate in rest home life actively, from the sidelines or not at all, as they choose or are able.
Figure 9.1: Multiple-helix: Applied phenomenological lifeworld approach developed from van Manen (1990) and Schütz (1972).
9.2 SYNTHESIS OF FINDINGS: EU-WORK IN THE RESIDENTS’ LIFEWORLD

9.2.1 EU-WORK AS SELF-MAINTENANCE

At the start of this study, the notion of the residents ‘actively working’ was outside my frame of reference. At completion of this thesis, ‘work’ has become a key construal in this lifeworld study of rest home residents. Work was defined in Chapter One as an action, deed, or task (Harper, 2001), with synonyms including effort, chore, manage, perform and accomplish. Work was discussed in contradistinction to rest and leisure in Chapters One and Two. The meaning of work (and leisure) is always socially constructed and reconstructed. As suggested in Chapter Two, there is no enduring “or objective thing called work, there are aspects of social activities which we construe as work” and this represents social organisation (Grint, 2005, p. 11).

As the notion of work goes unrecognised so does the concept of leisure. Yet, my findings illustrate that to be a rest home resident takes work. A specific social construction of work is required at this point. Rather than being at ‘leisure’ or ‘rest’ the residents are instead participating in ‘informal work’. The idea of informal work serves to re-emphasise that the residents are indeed at ‘work’. Informal work includes volunteer and domestic work, both dominant forms of labour carried out by the residents at the rest home as the previous findings chapters have elucidated.

With connotations of undervalued or unimportant work, I replace the term ‘informal work’ with a key contribution to critical gerontology research: that is, residents engage everyday in what I term ‘eu-work’, through ‘self-maintenance work’ and ‘reciprocal support work’ as illustrated in Figure 9.1. Originating in the combined Greek terms ‘eus’ (good) and ‘eu’ (well) (Harper, 2001), the term ‘eu-’ is a prefix that means “well, pleasant, or good” (McLeod, 1992). In a similar way to arche-health (Fox, 1998), eu-work is always in the process of transforming into ‘becoming-different’.

Applied in this chapter as both a noun and a verb, ‘eu-work’ is a homonym with ‘you work’, a metaphoric play on words which denotes how daily life is full of good work and worked well (eu-work) by the residents.

A multi-dimensional concept, eu-work also allows for pleasant pastimes to be engaged in, although as I discuss in this thesis, even pastimes can constitute work. Noting the positive angle on the notion of eu-work, which is the affirmative approach I have used in this thesis, the stereotypical negative misery view of residents’ daily lives
in the rest home is contradicted. My findings contribute to the critique of what Lee-Treweek (1994) coined the ‘lounge standard resident’.

Residents cannot be evaluated through measures of younger people or older community dwellers because they will always fail at ageing when assessed against those models. Residents’ responses about their health, quality of life and life satisfaction as reported in Chapter Four (Table 4.3), implies that they have unrealistic health expectations. On the contrary, these elders understand that they are frailer than in the past. They self-rate their health and well-being through a process which Fox (1998, 1999b) termed arche-health, where differences and diversities are used to generate transformative ideas about ‘health’ and ‘illness’ as outlined in Chapters One and Two, and incorporated into Chapters Five to Eight.

As documented in this thesis, the residents employ unique modes of lived experience including eu-work to understand their own lifeworld. Eu-work is multi-dimensional ordinary, normal, everyday work. In this study, I have chosen to focus on mainly self-affirming aspects of the types of eu-work in which the elders engage, including regular pastimes of daily life that they enjoy, as reported in Figure 4.8. Their lived experience is based on how well they manage their time (Chapter Six) and their bodies (Chapter Seven) within and outside the rest home with their relational others (Chapter Eight), including the ‘beyond’ spaces (Chapter Five) they navigate through their day-to-day.

The residents’ success at eu-work depends on continuing the same determination and agency they have always had. In line with policy discussed in Chapter One, the residents are ‘ageing well’ through their life course as they travel through their older age. The findings of this study have similarities with Koopman-Boyden and Waldegrave’s (2009) recent community based study, which in turn resonates with Sen’s (1999) ‘capabilities’ approach of agency and well-being.

Well-being, for the residents, is possible through the application of Fox’s (1998, 1999b) notion of arche-health, where the elders construct their own health narratives through their lived experiences of eu-work. These eu-work practices are in the main confirmatory accounts. The residents self-measure their daily work as highly meaningful even though the tasks completed are often evaluated unfavourably or dismissed by others such as staff, as depicted in Chapter Eight. Regardless, the elders
continue with the job in hand which is linked to their work ethic as put forward in Chapter One. These elders were brought up to adhere to the work ethic, so the idea of not working at life remains personally and socially unacceptable to them.

Most of the elders are clear about how hard they work, and express contempt of leisure as dialogue in Chapter Six illustrates. Any suggestion (including mine) that they may be at leisure is quickly countered. Free time is only gratis when it is compared to work time. Most residents report having little free time because they are busy adapting and compensating for the eu-work they need to get on in daily life as highlighted in Chapters Five to Eight. To discontinue a long ingrained work ethic successfully achieved all their lives, simply because they now live in a rest home, makes little sense to them. They perceive themselves as having always been workers and this will continue.

At the same time, everything about the residents highlights their experience of frailty. Failing sight, paralysis, arthritis and lack of concentration resulting from stroke and dementia combine with numerous other forms of ill-health as reported in Chapter Four (Table 4.3). A few older people do have a negative frame of mind towards managing even passive forms of day-to-day work. Some less positively minded residents have probably always been that way. However, most meet the challenges resulting from these frailties head on. When challenged by lack of capacity and difficulty they devise their own solutions, through arche-health (and arche-ill-health), for example by replacing fitness routines and social events no longer possible with exercise and/or socialising by walking the rest home corridors. The four lived strands of the lifeworld interweave as the elders take up enjoyable activity as reported in Chapter Four to utilise corridor spaces as put forward in Chapter Five, in their own temporal paces considered in Chapter Six, according to their embodiment, the focus of Chapter Seven, as a way to manage their relationships with co-residents and staff as discussed in Chapter Eight.

Revisiting activities could include identifying ordinary, everyday tasks which have become difficult but remain highly meaningful for the residents, and additional or alternative strategies for adaptation may prove useful. Some activity will decrease and may eventually cease due to frailty. However, even cessation gives the opportunity to rework activity to achievable levels. These elders are realistic about what they can
accomplish. Strategies such as taking part in their minds rather than physically are employed through embodiment by some residents, to accommodate gradual and sometimes sudden bodily or cognitive changes as deliberated in Chapter Seven. Often without requiring support, they rearrange their own resources over space and time as illustrated in Chapters Five and Six. Almost all residents in this study undertake pleasurable pastimes at least twice a week. Pastimes sustain and enhance constructive feelings about working the ordinary, everyday as part and parcel of getting on with life.

Self-management is a key to coping with changing circumstances for the elders. Having chronic illness or disability does not deter from supervising their own health in specific embodied ways, including adaptation, to engage in their lifeworld through the arche-health. They believe their health is positively influenced by how they look after themselves. In general, they evaluate their health status as good, or very good despite poor objective measures of health. The elders do not represent the stereotypical rest home dweller, that resident is rare. Age does impact on the day-to-day as the residents talk about exerting themselves at tasks that once took less time, space and embodied energy: and which now often require the care or support of other people. While these day-to-day tasks hold similar meaning today as always, the way in which the jobs are achieved differs and so the tasks take on new forms. Undaunted, the elders take up the challenge of getting on with life.

In the interpretive chapters of my research, I explained how the residents are a group of individuals who articulate positive attributes of their old age within the context of their own lives. For the elders, living in a rest home is neither here nor there, because the lifeworld continues in much the same way as always. Rest home life is not all bad as the older people in this study illustrate. They continue to manage long-term pastimes, which are adapted to suit increasing frailty levels. For the residents, inhospitable terrain such as corridor ramps that become metaphoric impassable mountains, serve to make ordinary lived experiences truly extraordinary. Little attention has been paid to date to how these forms of work, in a sense, work.

The long lived experience that residents possess means that they have plenty of knowledge from which to choose in making meaning of their current experiences. Managing ailing bodies and minds in time and space in a way that caters not only for themselves but for fellow residents, staff, and family and friends comes out of their
lifetime of possible meanings. Yet, too often the residents’ considerable knowledge base, used to make sense of a given set of circumstances, can appear to other people as elders living in the past.

Older people manage their losses by using knowledge acquired through previous loss, and adapt to growing older by spending more time and energy managing or changing pastimes to stabilize or continue physical and cognitive function. Loss and death are dealt with by the residents in the same way as in their pre-rest home lives. Death of relational others is a relatively common occurrence as these people age, and death and grief need to be appropriately managed, which can take a great deal of emotional work, although the residents report having emotional support in Figure 4.6 and Figure 4.7. Even so, the residents are sometimes unable to take part in or attend funerals to say goodbye. Open information about death would encourage recognition of the need to mourn.

Embodied loss can be adapted to, and is compensated for through variation on past ways of working activity. As they continue to age, acute illness and symptoms appear alongside chronic conditions and place an increasing emphasis on frailty as Table 4.3 shows. However, the residents tend to minimise their impairments and carry on with everyday life as usual as their narratives illustrate. Despite chronic illnesses and/or disability, they construct comprehensive (if fragmented) stories of lived experience to compare with the present situation. In this way, contemplating their many daily lives serves to inform them about possible ways of ‘doing’. Strategies used to decide on a course of action to be taken, along with successfully executing that choice, hold great meaning for the residents, and will continue to do so.

9.2.2 Reciprocal support as eu-work

Co-residents

This thesis reveals the importance of fellow residents in the elders’ day-to-day lives. Relationships between the residents are difficult to define, and fit uncomfortably into either a friendship role or neighbour model. One reason for this failure may be that residents are of differing ages and life experiences to date. They come from diverse backgrounds and interests and there is no reason for this to change simply because they have moved residence. Indicated in the heading themes of the previous chapters was a sample of the variety of life experiences of the residents.
Some residents make clear their inclination to be alone as considered in Chapter Eight. Perhaps due to the communal nature of rest homes, even self-styled loners have to work at avoiding interaction with others. Each resident has individual needs for social interaction (or not). Matching of residents’ needs is important for a sense of meaning (Chapter Seven), yet it is necessary to keep in mind that not all contact is positive. For some, any interaction with specific co-residents is unwanted and avoided where possible. That residents who are content with their own company feel the need to justify their desire to be alone is eu-work, and testament to aloneness being negatively perceived by others as un-rest-home-like.

Residents ignore or discount inappropriate behaviours, such as screaming, that are usually considered unacceptable in other settings. Situations that include intrusive sounds including yelling and shows that the residents practise empathic tolerance as illuminated in Chapter Five. When acknowledging sudden outbursts, eu-work comes to the fore and they accept the situation as part of everyday rest home life. Empathic offerings include practical help, such as comforting upset co-residents, or helping a wheelchair bound fellow-resident to the dinner table. There are many common day-to-day tasks where residents take great care in supporting co-residents whom they see as less fortunate than themselves.

Empathy may give rise to a kind of reserved restraint which impacts on how relationships appear to be more acquaintance-like than friendship-based. This is reinforced by being unable to offer practical assistance to other residents due to their own frailty or rest home regulations (or both). As reciprocity is the main component of friendship, the way residents interact with fellow dwellers takes on a new mode of interaction in which reciprocity becomes conditional. Contributing to the support of other residents (along with staff) is an important aspect of eu-work for the elders. As reciprocal concern is always dependent on levels of frailty of self and others, the older people have to actively manage their relationships with fellow residents.

Residents’ ability to compare favourably their own health status as better than their fellow residents, (even if this may not be the case) is made possible through an arche-health (Fox, 1999a). This ensures an understanding of themselves as givers in the relationship. To give is crucial in the friend-type role. By offering co-residents empathy, it then becomes acceptable to receive often needed support in return. There is a fine
balance to how reciprocity is played out in co-resident relationships. For the residents, reciprocity is ongoing eu-work.

Additionally, an accumulation of losses for residents must be negotiated as discussed in the previous section of this chapter. Frailty results in loss, and impacts on the ability of residents to eu-work at forming and maintaining relationships in the rest home. The risk to co-resident relationships is death. Often, death of a co-resident remains unacknowledged by staff, which leaves the elders with an uncanny feeling of relational loss, especially when a fellow resident suddenly disappears, or leaves for a hospital trip and never returns. Making meaning of these losses in the context of their current lifeworld takes eu-work by the residents.

**Staff**

Evident in my findings is Schütz and Luckmann’s (1973) proposition that relying on others for support is a type of reciprocal remedial work. Residents are givers as well as receivers in their relationships. For the older people, synchronising their bodies with a staff member’s is necessary, as body eu-work takes longer and is more difficult to achieve than in the past. A great deal of residents’ time is taken up in energy spent avoiding holding up staff. Residents’ bodies move slowly, while staff members work quickly through their allocated jobs. Residents spend a good deal of effort in avoiding being seen as needy and actively eu-work to reduce the possibility of pain or injury. What is most obvious, but seldom noted in these intimate, physical relationships is how much synchronous behaviour is required from the elders to help staff complete bodily focused care tasks.

Positive connections between pastimes and eu-work have revolved firmly around notions of home, so a rest home type setting is an appropriate environment for continuing domestic life as the residents have known it. For these elders, post-WWII peace encouraged family home life where home based pursuits were central. In their free time, that is unpaid time, men worked in the garden or tinkered in the shed, and women grew and prepared food and made clothing for the family. As an extension of those times, the residents keep themselves busy doing similar meaningful work in the rest home alongside staff.

Volunteer work, that is informal and unpaid work, remains a valuable pastime. Working by definition is being useful and the elders continue with activity that they
consider work, such as knitting or helping out with jobs around the rest home. Chores such as setting tables or doing odd jobs are reported as important eu-work and serve to enhance reciprocity with co-residents and staff. Residents also eu-work around staff members to utilise staff space, such as laundries to do their own washing, at times when staff are not working in those spaces. Residents are aware that they are doing staff tasks, and are helping out with work.

The residents willingly take up or adapt to pursuits that are highly meaningful to them, even if unrecognised as important by others such as staff. Social interaction is managed, and adaptation possible as the residents in my study illustrate. Staff may not discern loneliness and could get to know residents life stories in order to counteract some forms of loneliness.

My findings confirm that the elders are sometimes stigmatised, and infantilisation does occur. Despite being marginalised as old residents, the elders are scornful of what can be humiliating experiences, and can deflect any attempts to baby them. Ironically, stigma often occurs as others’ response to the residents’ practice of moving back and forth through a range of their life experiences, which can be perceived as these elders conflating past and present.

Paradoxically, it is this practice of sense making in the day-to-day through their narratives that gives residents the ability to continue to construct positive meaning from their overall life experiences in relation to the present. When this occurs, the archetypal resident as assumed by others, is deflected through residents’ use of humour, albeit in self-disparaging ways. Humour is a vehicle through which they can discuss failing bodies and minds. Typical of this type of joking around is black humour, as noted in Chapters Six, Seven and Eight.

**FAMILY AND FRIENDS**

From the residents perspectives, family and friends play an important role in their daily lives. Over half the residents have weekly visits with family and friends (Figure 4.2 and Figure 4.3). More friends of the residents live outside than stay in the rest home (Figure 4.5). The importance of friends and family is from the residents’ perspective and is unrelated to the time these people actually spend with the elders, which is implied through the residents’ ties with family and friends surveyed in Chapter Four. While acknowledging that some residents have minimum contact with family and friends, my
interpretation of the way the residents refer to this contact is that the connections they do have allow these relationships to stay intact. The residents continue their relations with others living outside the rest home along comparable lifelong lines, as discussed in Chapter Eight.

Interestingly, the elders in my study do not necessarily require face-to-face interaction for quality meaning to be found in their relationships with family and friends (Figure 4.4). While reflecting on the importance of remaining independent of the family, sustaining contact continues to be finely balanced eu-work for the residents. They would like to spend more time with family members, especially children, but are aware that this desire cannot always be met (Table 4.4). Those residents with children are clear that dependency on family is not a viable proposition.

The one generation removed relationships that residents have with grandchildren has been discussed in this thesis through observation of photographs and other tokens which provide excellent examples of how the older people maintain familial links with young people. The grandparent-grandchild link requires little eu-work compared to the parent-child role. Grandchildren can be admired from afar. Grandchildren are also used as a touchstone for the elders to reflect on their own lives. Although there have been many changes over their lifetimes, their connection with the much younger generation keeps the family relationship strong. Ironically, these links are kept in place via Rowles’ (1978) beyond-spaces of the past, selected and reminisced through personal mementoes such as photographs, which are highly meaningful.

Animals can also play an important role for the residents who care for them. Pets, especially cats provide emotional and physical comfort to residents.

The blending of the threads and strands of lived experiences results in a lifeworld in which the residents continue to eu-work, as they have always done, in their day-to-day lives. Understood through an arche-health model (Fox, 1998), throughout this thesis the actions and interactions of the residents are shown to add purpose to their lives. For the residents, life carries on in much the same way as always.

Yet, as a note of caution, it is important not to equate the rest home residents with their less frail, community-dwelling contemporaries. Although more dependent than elders outside the rest home, the residents maintain a lifeworld that continues to include
eu-work; the continuity of this eu-work over time distinguishes their lifeworld as extraordinary.

9.3 STRENGTHS OF THE STUDY
This study complemented a large randomised controlled trial (PIRC). As such, having the sample identified and recruited created efficiency for me. The gathering of the quantitative and summary information of 352 residents as part of a larger study meant that comprehensive information was available to add contextual breadth to the depth provided in the qualitative inquiry with 27 residents, thus producing a more holistic view. This research has a high response rate with few of those eligible declining the invitation to participate.

This critical gerontology study adds to existing research perspectives about New Zealand rest home residents. The mixed-model used offers a breadth and depth of analysis not possible using single research methods. A framework approach typically moves from a deductive to an inductive approach. What is different in this study is the way I modified the framework, by first employing an inductive approach (I/C) then starting from a deductive technique, developed and a (phenomenological) lifeworld multiple-helix to test the robustness of the themes.

A strong point of this thesis is found in the comparison of the lifeworld themes to those from I/C, which illustrate the similarly between two methodological approaches used. Prior to using a ready-made (deductive) phenomenological technique, I engaged with an (inductive) I/C approach in a previous version of this study. Using I/C, I was immersed in the data, from which themes crystallised. Methodologically, my study varies from other research due to the sequential order of the approaches used. From the I/C technique, main themes crystallised around ‘time’ necessary to do the ‘embodied’ work in which the residents participate, along with their interactions with ‘relational others’ in the ‘space’ of the rest home.

The residents use flexible time zones of past and present experiences in ways that continue to hold valid meaning for them. The elders have little time for leisure. Despite their experiences of frailty and disability they remain no less active than in past times but moderate their activity time, and what that means to them, to suit their present abilities. No strangers to loss, they work hard at managing and maintaining their current social contacts and activities. Applying meaningful strategies, they adapt their social
and physical activity, and time and again adopt new ways to continue to participate in
everyday life. In the I/C reading, the elders offer a mostly positive representation of
their day-do-day rest home lives, where time ticks over in mainly constructive ways.

Following the I/C induced findings, a deductive phenomenological lifeworld
technique was then applied to this final iteration of my study. The lifeworld approach,
which involves four overarching themes described by van Manen (1990) as part of all
phenomenological research, proved similar in their thematic makeup to those growing
out of I/C. I found that the four set lived themes of space, time, body and relations with
others, which have been applied to the eu-work discussed in this thesis, resonate with
those from the I/C approach. Similarity between the deductive and inductive thematic
components in this study serves to validate each of the approaches, and strengthens the
main lifeworld findings in this thesis.

Another key contribution this research offers is the way that a phenomenological
perspective has been used in the residential care milieu. The findings are reflective and
positioned to the fore so that interpretation of the meanings imbued by the residents
become explicit. The daily world may appear so mundane and ordinary that most people
seldom think about their lived experiences. This thesis has sought to make clear how the
rest home residents’ make meaning of their lived experiences, which make up their
lifeworld.

9.4 STUDY LIMITATIONS
In terms of study design, the rest homes were recruited through management and
eligible residents within each rest home were identified by management and staff. A key
limitation of this study was the nature of the exclusion criteria. While a random
clustered sample of rest homes was recruited, within each rest home there was a limited
sample selection with only the most cognitively active residents being eligible. The
systematic sampling of resident participants to identify the sub-group whose interviews
were audio-taped was less efficient than would have been achieved through purposive
sampling. The multiple data sources were laid side by side and compared together,
rather than triangulated. The most interesting findings were chosen by me, and were not
necessarily dominant themes, but rather those which were emphasised by the elders as
important. While not claiming to have a representative sample, my study findings
nevertheless are applicable to general rest homes in New Zealand, recognising that
specific dementia care homes are likely to have special characteristics, which calls for future studies.

Problems were encountered owing to communicative inability caused by residents’ cognitive and physical impairment. Lack of communication meant relying on professional or staff assessment of resident functioning. Qualitative research relies on rich, intensive narrative, and due to communication difficulties, my skills as a researcher were required.

Further, rest homes from only two cities have been recruited so this study is not representative of the lived experience of the residents in the everyday of rest homes in all New Zealand cities. In the future, differences between the two cities such as population size and composition, geographical location and climate may change residency makeup. Residents in rural areas may hold differing views and different experiences yielding quite dissimilar results.

The approach used in this thesis complements the clarity of in-depth discussion available in other phenomenological New Zealand based research with elders living in the community (Wright St Clair, 2008), and ethnographic work in residential care (Bland, 2004; Schofield, 1996) and the community (Hale, 2006; Keeling, 1998). The older people in my study were aware of changes of management, staff and co-residents in the rest home. Questions about the future were not considered in this thesis however, future research could include circumstances that shape thinking about the future.

New Zealand has growing populations of Maori, Pacific peoples and Asians. The participants in this study are nearly all of European descent. However, ethnic diversity in New Zealand is rapidly increasing and must be taken into consideration as a study limitation, in relation to future projected changes to rest home populations in New Zealand.

9.5 Research, policy and practice
van Manen (2007) argued that the empathetic person is proficient at mediating the gap between people who live in places - in this thesis the residents - and the people who wish to plan for those residents’ places, that is the policy makers and rest home management. In that gap, I position this study of descriptive and interpretive understanding of residents’ experiences of daily life. Using phenomenology as a research approach in this thesis adds to the existing critical gerontology research.
**RESEARCH**

**Future implications**

This study considers what it is to be in old age. Research about the lived experiences of rest home residents is important because New Zealand is one of many countries whose population is ageing. Increasing proportions of the population are elders who will require rest home living even if community-based care continues to expand. Research with, rather than on or about, rest home residents remains scant. For example, research could further examine the unnamed social relationships between the co-residents. Although my study explored co-resident relations, more intensive research within their overall social worlds would advance knowledge about older people living in rest homes. Gendered analysis based on the work that residents undertake would provide further detail about the lives of residents.

Staff members are integral to the ordinary day-to-day of rest home life. Yet, residents’ talk about staff in this study was limited. The significance of staff in the everyday is glossed over by the elders for a number of reasons. On one level, residents’ perceptions about give and take in relationships become disrupted if patient-nurse rhetoric is taken up. On another level, the power differential shifts if staff members are talked (gossiped) about by the residents, potentially making interaction between resident and staff member problematic. How the staff-resident relationship works out from the residents’ perspective could be focused on in further research.

This critical gerontology study has brought to the fore residents’ lived experiences of ordinary daily life not documented elsewhere. There is no guidebook on what it is like to live in a rest home. These older people have to figure it out as they go along, becoming socialised to the culture of care. Although misery perspectives can be found throughout the literature and in mainstream media as discussed earlier, the majority of residents in my study actively and effectively get on with their daily lives. Despite ambiguity, frail bodies were worked through the arche-health in order to remain inscribed as healthy (Fox, 1998, 1999a). Residents have no difficulty constructing meaning from their ordinary lives which are made up of eu-work. They engage in relations with others and take part in activities in much the same way as they have done over the years. Having choices and being able to act on them is a basic part of daily life,
and the decisions of the older people need to be viewed within the everyday situations in which they are made.

In the future, cohorts of baby-boomer residents are likely to embrace the concept of leisure, in contradistinction to the residents taking part in this study, who actively dismiss the notion of leisure as being part of their everyday lives. Leisure may in the future become a key component in the lifeworld of residential care. Leisure has been conceptualised as a ‘space’ for marginalised groups to practice resistance to social norms such as ageism (Genoe, 2010; Minichiello, et al., 2000), and so lends itself well within a residential care context.

The strength of a mixed-methodology offers both breadth and depth to this study. There remains significant scope for continuing analysis of the PIRC trial data from both arms. However, my study centred on the (social) control arm of that data. Further analysis of the survey will add to what is known about those in New Zealand residential aged care facilities. Future research could include an investigation about residents’ perspectives about the future of residential care in New Zealand.

**Policy**

A framework is needed for future development and understanding that moves beyond the frail, dependent rest home resident. Policy makers need to appreciate the positive aspects of residents’ everyday lives. Further social research on ageing issues both at a local and national level, and in a variety of settings, could increase understanding and better prepare policy makers and health professionals to plan strategies and implement policy for an ageing population. This thesis can enlighten policy by highlighting residents’ lifeworld. Implementation of social reform for the future requires documenting what life is like today before irreversible changes are made to public policy, which can potentially change both the political landscape, and the lifeworld of the rest home.

Policy has struggled to keep up with the size and complexity of New Zealand’s ageing population. As pointed out in this thesis, the ageing experience is both created by, and creates society, and this means ageing-related issues can and must be attended to through social policy. The current health and social policy regarding this country’s older people continues to be shaped by doomsday rhetoric and misery myths, despite the core messages of the *Positive Ageing Strategy* (Ministry for Senior Citizens, 2008).
The elders’ narratives illuminate the need for policy makers to take their considerations into account.

Policy must be responsive to the increasing proportions of the total population who will require long-term aged residential care. My study provides evidence that the residents are willing and able to have input into policy making. The current care and custody models could have more balance if residents did provide input. The subjective measures used in this thesis were of mixed-method design, and this type of research could be drawn on to broaden understanding for policy making.

The findings in this thesis could also inform education in policy about residential care. Access to resources outside the rest home for the residents is needed. Policy could be amended to allow the elders opportunity to connect with individual and collective resources.

Local and national policy could ensure that older people have ready access to avenues of communication with other people outside the rest home. This could include transport to attend community-based events such as funeral services.

**Practice**

It is possible to consider practical applications of my findings. This study is about residents’ everyday lives in the rest homes. While in this thesis I do not focus on care practices or staff education, there are important implications for rest home management and staff. Since residency is about the care of residents, the importance of the findings of this study is in its understanding what the elders are doing in their everyday. Common notions about frail older people have been broadened from the usual care and custody model applied to residents.

The diversity of the elders in terms of age and life experiences must be taken into account. For staff, understanding an elder’s experience should be on-going. Staff working with residents could interact with the older people using a teamwork approach. The residents could be considered more a part of the team delivering ‘care’, which would enhance their role in the rest homes. Residents could take up more formal facilitator roles in interactions with co-residents. Examples include residents advocating for fellow residents in requesting support, and setting up and taking part in resident committees. Staff could support the residents over the benefits of what are meaningful activities for the elders.
Illustrating the growing need for further research in this area is the increasing proportion of the older population that has never parented children: and the recognition of death, adoption or estrangement from children. This highlights the need for residents having adequate support, and these advocates could be co-residents.

There is a need for more staff and training for staff, particularly around issues involving loss (of privacy, death of others). Through listening, the residents’ perspective is offered which adds to depth of understanding these elderly people. Ways of appropriately sharing information about the death of co-residents with other residents could be included in education of staff.

Strategies for staff development could explicitly include in rest home management decisions the voices of older people, for example, about opportunities to visit with dying friends and be informed about their passing. Management and staff, and residents could identify ways of preventing further health risks associated with disability and illness by discussing potential situations. Debriefing could be made available to staff by management over unexpected events such as screaming due to resident’s cognitive impairment, or death of residents.

Death is part of the everyday and is an area that remains quiet. Acknowledgement of death in the rest home is meaningful for the elders. Different church denominations offer funeral services at some rest homes. In others, a formal approach surrounding death rituals could be developed. Memorial pursuits would seem straightforward to organise. Residents’ attendances at funerals and services could be encouraged and transport arranged if required. It must be noted that transport, or lack of it, would be dependent on the availability of others.

Identifying barriers to residents is important and may be a staff member helping an elder walk up a ramp or to get out of bed to attend a rest home event. The residents could be given more opportunity to choose alternative spaces to those currently available in line with work activities they are still able to do. Tea making facilities could be overseen by staff. Residents could be given the opportunity to include visitors in teatime rituals.

Residents could be given access to the laundry during the day when staff members are busy elsewhere. To account for future planning of residential care facilities for older people, a reconfiguration of design could include access to spaces that allow the
residents to continue with work such as hand washing of clothes that they have long undertaken. The balance of safety for older people will always be of concern. However, a reconsideration of the contracting arrangements around care could encompass meaningful participation of the residents in the daily tasks in the rest home.

For families of residents, this study offers insight into how hard the elders work in the everyday. The continuation of communication is important to the elders, especially telephone and paper-based communications as the findings in this thesis illustrate. Families can support residents to attend events such as funerals of co-residents or old friends, outside the rest home. Findings from this thesis could be disseminated to management and staff working with older people in rest homes, and family and friends living outside the rest home.

9.6 OVERVIEW OF THESIS
The introductory chapter (Chapter One) of this thesis set out a context for this New Zealand based study. In Chapter Two, a conceptual framework of this thesis was given. Chapter Three considered the methods and methodology used. Descriptive information about the residents was offered in Chapter Four, to add breadth to the study, by describing the whole study population. The demographics and characteristics of 352 residents taking part in the (social) control arm of a randomised controlled trial (PIRC) survey was described in Chapter Four. Information from the survey supplemented the main source of information for this study, the audio-recorded interview narratives of 27 residents. These interviews were also supported by interview summaries, field-journal notes, and my observations, and were the main source of information deliberated in the findings chapters, Chapters Five, Six, Seven and Eight.

By using a mixed-method modified framework methodology, I was able to address diverse aspects of the residents’ lives. The lived experience of rest home life was drawn from the inductive material found in I/C. The inductive approach helped to confirm the credibility of a deductive phenomenological lifeworld approach, which became the most prominent methodology used. Interviews with the residents provided the main source of data for my study. Using an interpretive focus I was initially immersed in the patterns that grew out of the interview data and crystallised those patterns, as subscribed by I/C, into overarching themes. These themes, covering spatial and temporal elements, embodiment and relationships were congruent with van
Manen’s (1990) phenomenological notion of a four stranded lifeworld model, when applied to my investigation of the lived experiences of the residents. The individual strands of lived space, lived time, lived body, and lived relations with others were temporarily teased apart from the phenomenological multiple-helix model that I developed, and applied to the data. Examination and interpretation of each strand became the focus of one chapter from Chapters Five, Six, Seven and Eight. Interpretive findings in each strand were compared to the literature selected for initial presentation in Chapter Two.

Abiding by the six principles for lifeworld research advocated by van Manen (1990), I first turned to the phenomenon of interest advocated in Principle I. In this study, the phenomenon of the lived experience of everyday life of New Zealand rest home residents was explored. Using this approach I was able to focus on describing and interpreting the residents lived experiences of rest home life, suggested in Principle II, and written up in Chapters Five to Eight.

Adhering to Principle III, I characterised lived experience in the findings chapters by reflecting sequentially on the four essential themes of lived space, lived time, lived body and lived relations with others, which according to van Manen (1990) overarch all phenomenological study. Adding Schütz’s (1972) phenomenological concept of typification, which illuminates how meaning is made through a pre-existing stock of knowledge at both individual and societal levels, I positioned the lifeworld component as paramount to my study.

My contribution to critical gerontology is my development and application of a multiple-helix model to the lifeworld of rest home residents. The art of continual writing and rewriting advocated by van Manen’s (1990) Principle IV meant that I was reiteratively able to describe and interpret the lived experiences of the residents in their lifeworld.

Throughout this thesis, I have maintained a strong and oriented relation to the phenomenon under consideration as van Manen’s (1990) research Principle V advises. The multiple-helix model, made up of four parts of a whole, was developed and applied using a lifeworld approach advocated by van Manen (1990) and (Schütz, 1972). The multiple-helix model was my response to van Manen’s (1990) research Principle VI,
which called for a balancing of the research context by considering the parts and the whole.

I illuminated the interdependency of the parts of the whole in the multiple-helix I developed, by interweaving the four individual lived strands, in order to reconstruct the fabric of the lifeworld model. The separate strands adjust to the changes in the other strands and so the multiple-helix is able to retain its overall shape (Figure 9.1).

9.7 CONCLUDING SUMMARY

This thesis adds to current understanding about how older people in New Zealand rest homes experience daily life. The residents experience daily life through eu-work. The experts I consulted were the residents themselves. The main finding in this thesis about the lifeworld of rest home residents is that the elders continue to occupy themselves, albeit with strategies for adaptation, much the same way as always. Bessie speaks for all the residents taking part in this study when she reflects that her lived experience of the rest home is “all in a day’s work”.

The purpose of my research was to increase understanding of what it is like to be a New Zealand rest home resident, so I focused on lived experiences of daily life using a mixed-method approach. I developed and applied a multiple-helix model (Figure 9.1) from a phenomenological understanding of the writings of van Manen (1990) and Schütz (1972, 1970) as considered in Chapter Three. Using the multiple-helix model, my findings about everyday life in New Zealand rest homes have illuminated what van Manen (1990) calls the “bid to recover reflectively the grounds which, in a deep sense, provide for the possibility” of knowledge (p. 173).

Findings in this thesis highlight how the residents make sense of their lived experiences. Age does impact on day-to-day experiences so the past is used to make meaning of current experiences. Demographic and health related findings described in Chapter Four served as a broad backdrop to the study. Added depth was given in Chapters Five to Eight, which explored the lived experiences of 27 residents from the larger group (n=352).

A transformative arche-health (Fox, 1999a) is applied by the residents in order to self-evaluate health and well-being as ‘good’ overall, despite measured health illustrating that many are frail. Frailty notwithstanding, they continue to eu-work at successfully managing relationships and pastimes. Social relations persist with
relational others living outside the rest home. The emotional needs of the elders are, in the main, met by family and friends. Approaches to the lived world maintain the patterns and interactions in the rest homes much as they did when the elders were community-living. The residents in turn support co-residents and staff, along with family and friends while simultaneously self-managing their health. All aspects of this lifeworld involve work.

The social reality of rest home life is multi-faceted. As residents, the elders now live under one roof in close proximity to other older people (Table 4.1). They have little say in who resides in the next room or with whom they sit at dinner time. These elders also have minor input in day-to-day dealings with staff. The way in which the residents manage their relationships with staff members are carefully negotiated affairs. Tensions at times make for hard work for residents to manage and maintain pleasant, acquaintance-like terms with large numbers of co-residents and staff.

Relations with others living outside the rest home are also maintained. In Chapter Five, I focused on paper-based keepsakes such as photographs and letters, along with telephone use to explore the residents relationships with others living outside the rest home. In the main, telephone conversations are an adequate way to stay connected with family and friends. The older people illustrate that they are not abandoned by their families. They continue to work at sustaining these satisfying relationships in conjunction with rest home routines. Social contact with kith and kin is not always positive however, and some residents have estranged relationships as explained in Chapter Eight.

The dynamic form of work engaged in by the residents has been recognised in this thesis. In Chapter Five, I examined how spatiality was used by the residents. In Chapter Six, I investigated temporality for the residents. Chapter Seven offered ways in which the older people were embodied within time and space. Chapter Eight was an account of the residents’ experiences with relational others.

Each of the previous four chapters was crafted using an overarching lifeworld approach from individual thematic strands of lived space, lived time, lived body and lived relations with others, as depicted in Figure 5.1, Figure 6.1, Figure 7.1 and Figure 8.1. Tension formed by variation within the thematic strands was represented by
subtheme threads. Application of the multiple-helix model allowed the main findings to be brought to the fore for phenomenological analysis.

In this chapter, the subthemes are rethreaded back into the lived strands, which were in turn rewoven into the fabric of the lifeworld conceptualised by me as a multiple-helix. The entwining of these threads into strands enriched meaning and created a multi-layering in the fabric weave in the multiple-helix model that is my contribution to critical gerontology. The interpretation I have suggested in this thesis signifies one of many possible readings. However, presented with the findings, the reader should be able to recognise the phenomenon, and make their own meaning, which in van Manen’s (1990) terms produces the phenomenological nod discussed in Chapter Three. While I make no claim to represent the opinions of all older residents, Chapter Four provides contextual data of 352 elders that readers can use of to assess the transferability of the experiences of 27 elders as explored in Chapters Five through Eight.

A lifeworld approach posits that all knowledge is principally made meaning of through direct personal experience, so in this chapter the preceding chapters were rewoven into a synthesis which addressed the main research aim: *How do older people in New Zealand rest homes experience daily life?* An initial I/C approach was followed by the development and application of a multiple-helix model containing overarching lifeworld themes, an amalgamation that addressed the research aim as phenomenology demands. The lived experience of a rest home resident in New Zealand is one of eu-work.

Rest home residents continue to live in meaningful ways. Failure to acknowledge what is important in the ordinary, lived worlds of residents leaves an important and growing segment of New Zealand’s ageing population without a voice. Yet, it is imperative to document residents’ lifeworld because as this study shows, rest home residency is not as it appears. For the residents, their day-to-day is based around their life experiences of work. Despite this aged population remaining largely invisible in mainstream society, the residents quietly and constructively continue making meaning through their daily eu-work.
Appendix 1: Political climate 2004-2005, Political cartoon, national newspaper

Rod Emmerson, Private Aged Care, New Zealand Herald, February 16, 2005
Appendix 2: Data collection process

[Diagram showing the data collection process for the Promoting Independence in Residential Care Trial (PIRC). The process includes cluster randomisation, baseline assessments, randomisation of rest homes, and subsequent participant groups and interviews.]
Appendix 3: Interview summary – Lived experiences

<table>
<thead>
<tr>
<th>ID#</th>
<th>Date</th>
<th>What types of leisure and/or physical activities did you enjoy prior to coming to the home?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>past</th>
<th>What activities did you enjoy doing the most?</th>
</tr>
</thead>
<tbody>
<tr>
<td>past</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>present</th>
<th>Do you still do some of these activities now you are in the home? If not, why not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Recently, what other sorts of physical or leisure activities, hobbies or interests have you done, or what sorts of activities would you like to do?

<table>
<thead>
<tr>
<th>recent</th>
<th>Activities</th>
<th>Activities would like to do</th>
</tr>
</thead>
</table>

In your recent visits with family or friends tell me about the activities that you do when you are with them?

<table>
<thead>
<tr>
<th>recent</th>
<th>Resident Out</th>
<th>Others In</th>
</tr>
</thead>
</table>

Tell me about the ways that you keep in touch with family and friends through letters, telephone (or email)?

<table>
<thead>
<tr>
<th>recent</th>
<th>Correspondence Out</th>
<th>Correspondence In</th>
</tr>
</thead>
</table>

**SUMMARY QUESTIONS**

Overall, how would you describe a typical DAY and EVENING for you at the Rest Home

<table>
<thead>
<tr>
<th>recent</th>
<th>Other notes</th>
</tr>
</thead>
</table>
Appendix 4: Promoting Independence in Residential Care (PIRC) Survey
Baseline Information (continued)

B6. a. Community Services Card
   No 0
   Yes 1
b. High User Health Card
   No 0
   Yes 1

B7. Date of Birth
dd mm yyyy

B8. Age last birthday

B9. Date of admission to rest home
dd mm yyyy

B10. Primary Contact
     Living spouse
     Son
     Daughter
     Other relative
     Non-related support person

B11. Gender
     1 = Male
     2 = Female

B12. Ethnic Group (patient records)
     (tick all that apply)
     a. New Zealand European
     b. Maori
     c. Samoan
     d. Cook Island Maori
     e. Tongan
     f. Niuean
     g. Chinese
     h. Indian
     i. Other (such as Dutch, Japanese, Tokelauan)
        (Please specify)

PIRC: Promoting Independence in Residential Care

Respondent Number

Baseline Information (continued)

313.a SNF (Auckland)
   No 0
   Yes 1

313.b Care Needs Level
   Low
   Medium
   High
   Very High

313.4 Weight (taken from notes) kg

315. How are residential fees paid for:
     Privately
     Rest Home Subsidized
     Invalid Benefits

PIRC Questionnaires: Baseline

11/03/2004

NB: do\'t know (DK); refused (RF); NA (NA)
### Diseases

Identified from a list of medical conditions recorded from review summary sheets and medical notes section of the medical record. Please tick all that apply for the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>D91.</td>
<td>Pancreatic carcinoma</td>
</tr>
<tr>
<td>D92.</td>
<td>Dementia/Cognitive impairment</td>
</tr>
<tr>
<td>D93.</td>
<td>Arthritis (OA or RHAU) anywhere except lower limb</td>
</tr>
<tr>
<td>D94.</td>
<td>Arthritis (OA or RHAU) lower limb</td>
</tr>
<tr>
<td>D95.</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>D96.</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>D97.</td>
<td>Syncope</td>
</tr>
<tr>
<td>D98.</td>
<td>HIC</td>
</tr>
<tr>
<td>D99.</td>
<td>Hypertension</td>
</tr>
<tr>
<td>D100.</td>
<td>LVF, CHF</td>
</tr>
<tr>
<td>D11.</td>
<td>CVA IRA Stroke Cerebrovascular disease</td>
</tr>
<tr>
<td>D12.</td>
<td>Other neurological conditions (not stroke), eg. MS, ALS, Intellectual disability or brain injury</td>
</tr>
<tr>
<td>D13.</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>D14.</td>
<td>Lower limb amputation</td>
</tr>
<tr>
<td>D15.</td>
<td>Hip or knee replacement (non acute/planned)</td>
</tr>
<tr>
<td>D16.</td>
<td>Hip fracture</td>
</tr>
<tr>
<td>D17.</td>
<td>Other fractures</td>
</tr>
<tr>
<td>D18.</td>
<td>Falls</td>
</tr>
<tr>
<td>D19.</td>
<td>Diabetes</td>
</tr>
<tr>
<td>D20.</td>
<td>Visual impairment</td>
</tr>
<tr>
<td>T21.</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>T22.</td>
<td>Faecal incontinence</td>
</tr>
<tr>
<td>T23.</td>
<td>Hearing impairment</td>
</tr>
<tr>
<td>T24.</td>
<td>Respiratory disease/ Asthma/ COPD' emphysema</td>
</tr>
<tr>
<td>T25.</td>
<td>Depression</td>
</tr>
<tr>
<td>T26.</td>
<td>Anxiety</td>
</tr>
<tr>
<td>T27.</td>
<td>Chronic pain</td>
</tr>
<tr>
<td>TOTAL</td>
<td>Total number diseases/disorders</td>
</tr>
</tbody>
</table>

### Medications

Please tick all that apply for the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>Short acting sedatives / benzos</td>
</tr>
<tr>
<td>M2</td>
<td>Other psycho act, major tranquilizers</td>
</tr>
<tr>
<td>M3</td>
<td>Long acting benzos, eg. diazepam / clonazepam</td>
</tr>
<tr>
<td>M4</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>T0PS</td>
<td>Total number psychotrops</td>
</tr>
<tr>
<td>M5</td>
<td>Hypoglycemics</td>
</tr>
<tr>
<td>M7</td>
<td>Opioid analgesics, regularity or prn</td>
</tr>
<tr>
<td>M8</td>
<td>HRT</td>
</tr>
<tr>
<td>M9</td>
<td>Vit D, calcium</td>
</tr>
<tr>
<td>M13</td>
<td>Calcium</td>
</tr>
<tr>
<td>M11</td>
<td>Bisphosphonates</td>
</tr>
<tr>
<td>M12</td>
<td>NSAIDS</td>
</tr>
<tr>
<td>M13</td>
<td>Multivitamins</td>
</tr>
<tr>
<td>M14</td>
<td>ACE inhibitor</td>
</tr>
<tr>
<td>M15</td>
<td>CCB</td>
</tr>
<tr>
<td>M16</td>
<td>B Blocker</td>
</tr>
<tr>
<td>M17</td>
<td>Diuretics</td>
</tr>
<tr>
<td>M18</td>
<td>Other alpha blocker</td>
</tr>
<tr>
<td>M19</td>
<td>Atenol</td>
</tr>
<tr>
<td>M23</td>
<td>Warfarin</td>
</tr>
<tr>
<td>M21</td>
<td>Divoxen</td>
</tr>
<tr>
<td>M22</td>
<td>Prednisone</td>
</tr>
<tr>
<td>M23</td>
<td>Laxatives, simple</td>
</tr>
<tr>
<td>M24</td>
<td>Sedating antihistamines</td>
</tr>
<tr>
<td>M25</td>
<td>Anti-Ulcer treatment, proton pump inhibitor, H2 antagonist</td>
</tr>
<tr>
<td>M26</td>
<td>Anti-cem_retion medication (exol, etc)</td>
</tr>
<tr>
<td>M27</td>
<td>Anti-Pancreas drugs</td>
</tr>
<tr>
<td>M28</td>
<td>Angiotensin II Inhibitors</td>
</tr>
<tr>
<td>M29</td>
<td>Nitrates</td>
</tr>
<tr>
<td>M30</td>
<td>Laxatives with peristaltic stimulants</td>
</tr>
<tr>
<td>M31</td>
<td>Anticholinergic</td>
</tr>
<tr>
<td>M32</td>
<td>Anticoagulants</td>
</tr>
<tr>
<td>M33</td>
<td>Anti-emics</td>
</tr>
<tr>
<td>TOTAL</td>
<td>Total number medications</td>
</tr>
</tbody>
</table>
**PATIENT INTERVIEW**

**Falls Demographics**

"Now, some questions about falls and your confidence..."*

<table>
<thead>
<tr>
<th>Question</th>
<th>Choices</th>
<th>Score</th>
<th>Patient's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K1b Have you fallen in the last year</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>K1c Rate your confidence in your ability to prevent falls</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>K2 Have you had an injury from a fall in the last year</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>K1d What sort of footwear do you usually wear inside the home during the day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Slippers</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(ii) Socks</td>
<td>Hard sole</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Soft sole</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>(iii) Heel</td>
<td>Flat heel</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heeled</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>(iv) Condition</td>
<td>Good</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>K2 Do you wear glasses/contact lenses</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, skip to next page</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K3 Do you wear glasses/contact lenses all the time or only for reading</td>
<td>All the time</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only for reading</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Falls Self Efficacy Scale**

<table>
<thead>
<tr>
<th>Very unconfident</th>
<th>Completely confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Confidence Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF1 How confident are you that you can get dressed and undressed without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF2 How confident are you that you can prepare a simple meal without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF3 How confident are you that you can take a bath or shower without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF4 How confident are you that you can get in and out of a chair without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF5 How confident are you that you can get in and out of bed without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF6 How confident are you that you can travel around the inside of the home without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF7 How confident are you that you can reach into cabinets or a closet without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF8 How confident are you that you can perform light housekeeping tasks without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF9 How confident are you that you can do simple shopping without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF10 How confident are you that you can use public transport without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF11 How confident are you that you can cross roads without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF12 How confident are you that you can do light gardening or hang out the washing without falling?</td>
<td></td>
</tr>
<tr>
<td>SELF13 How confident are you that you can use the front or rear steps at the house without falling?</td>
<td></td>
</tr>
</tbody>
</table>
### Self Rated Health / EuroQol Questions

**Self Rated Health Questions**

Now, some questions about your general health and what you would like to say your health is:

<table>
<thead>
<tr>
<th>Health State</th>
<th>Score</th>
<th>Patient Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**EuroQol Questions**

I'd like to ask you about your health today:

<table>
<thead>
<tr>
<th>EuroQol</th>
<th>Score</th>
<th>Patient Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Self-care</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Usual Activities</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Pain/Discomfort</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Compared with my</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

P.R.C. Questionnaire Baseline

9: 11/03/2004

P.R.C. Questionnaire: Baseline

10: 11/03/2004
### Pain and Fatigue

Note to interviewer: Read out options to older person

"Have you experienced any of the following problems over the past few days?"

<table>
<thead>
<tr>
<th>Problem</th>
<th>Severity</th>
<th>Score</th>
<th>Patient's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1.</td>
<td>Do you have leg or foot pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No pain</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild leg pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate leg pain</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe leg pain</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>A2.</td>
<td>Do you have back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No pain</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild back pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate back pain</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe back pain</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>A3.</td>
<td>Do you have neck or shoulder pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No pain</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild neck pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate neck pain</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe neck pain</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>A4.</td>
<td>Do you have pain in any other part of your body</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Site of pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note to interviewer:
- Record only the worst body area, if more than one

### Cognitive Assessment

Note to interviewer: Tick yes or no box for each question

<table>
<thead>
<tr>
<th>Cognitive Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1. Age</td>
<td>Must be correct</td>
</tr>
<tr>
<td>C2. Time</td>
<td>Without looking at clock give correct time within nearest hour</td>
</tr>
<tr>
<td>C3. Month</td>
<td>Exact</td>
</tr>
<tr>
<td>C4. 201 West Street</td>
<td>Give the address</td>
</tr>
<tr>
<td>C5. Year</td>
<td>Exact except in Jan/Feb when previous year is OK</td>
</tr>
<tr>
<td>C6. Name of place</td>
<td>Exact</td>
</tr>
<tr>
<td>C7. Date of birth</td>
<td>Exact</td>
</tr>
<tr>
<td>C8. Start of WWII</td>
<td>Exact</td>
</tr>
<tr>
<td>C9. Name of present Prime Minister</td>
<td>Exact</td>
</tr>
<tr>
<td>C10. Count from 30 to 1 backwards</td>
<td>Can prompt with 30-15-10 but no further prompts. Patient can perform and self correct but no other assistance</td>
</tr>
</tbody>
</table>

**SCORE ☐ ☐**
**Geriatric Depression Scale**

Choose the best answer for how you have felt over the past week:

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Patient's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you basically satisfied with your life</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Have you dropped many of your activities and interests</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel that your life is empty</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you often get bored</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Are you in good spirits most of the time</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Are you afraid that something bad is going to happen to you</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel happy most of the time</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Do you often feel helpless</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you prefer to stay at home, rather than going out and doing new things</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel you have more problems with memory than usual</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you think it is wonderful to be alive now</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel pretty worthless the way you are now</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Do you feel full of energy</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Do you feel that your situation is hopeless</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Do you think that most people are better off than you</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
</tbody>
</table>

---

**LATE LIFE FDI**

**INSTRUCTIONS FOR DISABILITY QUESTIONS:**

In this set of questions, I will ask you about everyday things you do at this time in your life. There are **two** parts to each question:

First, I will ask you **How often you do a certain activity.**

Next, I will ask you **To what extent do you feel limited in doing this activity.**

Explain each question and subsequent answer options:

For the first question (How often do you do the activity?), please choose from these answers:
- Very often
- Often
- Once in a while
- Almost never
- Never

[Show Disability visual aid 1 to interviewer]

For the second question (To what extent do you feel limited in doing the activity?), please choose from these answers:
- Not at all
- A little
- Somewhat
- A lot
- Completely

[Show Disability visual aid 2 to interviewer]

For example, you might feel limited because of your health, or because it takes a lot of mental and physical energy. Please keep in mind that you can also feel limited by factors outside of yourself. Your environment could restrict you from doing the things, for instance, transportation issues, accessibility, and social or economic circumstances could limit you from doing things you would like to do. Think of all these factors when you answer this section.

For each question, please select the one answer that comes closest to the way you have been feeling.

Let's begin...
### Disability Questions

<table>
<thead>
<tr>
<th>How often do you...?</th>
<th>How much do you feel limited in...?</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Mean Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>91. Keep (navigating) touch with others through written, phone, or email.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>92. Visit (visiting) friends and family in their home.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>93. Provide (providing) care or assistance to others. This may include providing personal care, transportation, and running errands for family members or friends.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>94. Take (taking) care of the hands of your home. (This includes managing and taking responsibility for household chores, laundry, and housekeeping.)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>95. Work (working) at a volunteer job outside your home, or in the next home.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>96. Take (taking) part in active recreation. This may include swimming, golf, tennis, or swimming.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>97. Take (taking) care of household business and finances. This may include managing and taking responsibility for your money, paying bills, dealing with the management of your home or your financial resources.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>98. Take (taking) care of your own health. This may include managing daily medications, following a special diet, scheduling doctors appointments.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

### Disability Questions (continued)

<table>
<thead>
<tr>
<th>How often do you...?</th>
<th>How much do you feel limited in...?</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Mean Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>99. Travel (Traveling) 2 miles or less to work or elsewhere.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>100. Take (Taking) care in a regular family program. This may include cooking for yourself, running errands, weight lifting, or exercise classes.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>101. Work (working) on the property of your home.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>102. Get (getting) set for alternate public or personal services.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>103. Take (taking) care of all personal care needs. This includes bathing, eating, and toilet.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>104. Take (taking) care in personal social functions. This may include cooking, social events, community or religious groups.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>105. Take (taking) care of local errands. This may include managing and taking responsibility for shopping for food and medication, and going to the bank, library, or doctor.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>106. Take (taking) care for yourself. This may include cooking, eating, and toilet.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR FUNCTION QUESTIONS:

In this following section, I will ask you about your ability to do specific activities as part of your daily routine. I am interested in your sense of your ability to do it on a typical day. It is not important that you actually do the activity on a daily basis. In fact, I may mention some activities that you can't do at all. You can still answer these questions by assessing how difficult you think they would be for you to do on an average day.

Factors that influence this level of difficulty you have may include: pain, fatigue, fear, weakness, soreness, ailments, health conditions, or disabilities.

I want to know how difficult the activity would be for you to do without the help of someone else, and without the use of a walking stick, walker or any other assistive walking device (or wheelchair or scooter).

[Show Function visual aid 1 to interviewer]

Please choose from these answers:

None
A little
Some
Quite a lot
Cannot do

Let's begin...

| Function Questions (For those who do and do not use walking devices) |
|-----------------------------|-------------|-------------|-------------|-------------|
| 1. Unbending the lid off a previously unopened jar without using any device | None | A little | Some | Quite a lot | Cannot do |
| 2. Going up and down a flight of stairs inside, using a handrail | None | A little | Some | Quite a lot | Cannot do |
| 3. Feeding oneself or feeding oneself (including managing feeding utensils) | None | A little | Some | Quite a lot | Cannot do |
| 4. Running a mile or more | None | A little | Some | Quite a lot | Cannot do |
| 5. Using common objects for preparing meals (eg. can opener, potato peeler or can opener) | None | A little | Some | Quite a lot | Cannot do |
| 6. Holding a full glass of water in one hand | None | A little | Some | Quite a lot | Cannot do |
| 7. Walking a mile, taking rests as necessary | None | A little | Some | Quite a lot | Cannot do |
| 8. Going up and down a flight of stairs outside, without using any handrail | None | A little | Some | Quite a lot | Cannot do |
| 9. Running a short distance, such as to catch a bus | None | A little | Some | Quite a lot | Cannot do |
| 10. Resisting overload while standing, such as to push a light weight | None | A little | Some | Quite a lot | Cannot do |
| 11. Sitting down and standing up from a low, soft chair | None | A little | Some | Quite a lot | Cannot do |
| 12. Picking up and taking off a sweater jacket | None | A little | Some | Quite a lot | Cannot do |
| 13. Reaching behind your back as if to assess a belt through a belt loop | None | A little | Some | Quite a lot | Cannot do |
| 14. Slipping up and down from a chair | None | A little | Some | Quite a lot | Cannot do |
| 15. Opening a heavy, outside door | None | A little | Some | Quite a lot | Cannot do |
| 16. Roping open a package of meat with a pair of scissors or using a pair of scissors | None | A little | Some | Quite a lot | Cannot do |

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### Function Questions (Continued)
(For those who do and do not use walking devices)

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pouring from a large pitcher</td>
</tr>
<tr>
<td>Getting into and out of a car/vehicle</td>
</tr>
<tr>
<td>Hitting a couple of miles on uneven surface, including hills</td>
</tr>
<tr>
<td>Going up and down stairs, rails or stairs inside, using a handrail</td>
</tr>
<tr>
<td>Up a handrail and moving it, in order to clean</td>
</tr>
<tr>
<td>Using a step stool to reach into a high cabinet</td>
</tr>
<tr>
<td>Making beds, including spreading and tucking in bed sheets</td>
</tr>
<tr>
<td>Carrying something in both arms while climbing a flight of stairs (e.g., laundry basket)</td>
</tr>
<tr>
<td>Reading, once from a standing position to pick up a piece of clothing from the floor</td>
</tr>
<tr>
<td>Walking around one floor of your home, taking in one conversation throughout, doors, furniture, and a variety of floor coverings</td>
</tr>
<tr>
<td>Getting up from the floor (as if you were laying on the ground)</td>
</tr>
<tr>
<td>Washing dishes, pets, and utensils by hand while standing on one foot</td>
</tr>
<tr>
<td>Walking several blocks</td>
</tr>
<tr>
<td>Taking a smile, brisk walk without stopping to rest</td>
</tr>
<tr>
<td>Standing on and off a low chair</td>
</tr>
<tr>
<td>Walking on a slippery surface outdoors</td>
</tr>
</tbody>
</table>

Score: 5 = some; 4 = slight; 3 = moderate; 2 = considerable; 1 = extreme

---

**Function Questions for those who use walking devices**

**Note to interviewer:** Use ‘Function visual aid’.

The following are questions only for people who use walkers or other walking devices.

**When you use your cane, walker, or other walking device, how much difficulty do you have?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>FD07. Walking a mile, taking rests as necessary</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD08. Going up and down a flight of stairs outside, without using a handrail</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD10. Sitting up and down from a chair</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD15. Opening a heavy, outside door</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD25. Taking around one floor of your home, taking into consideration thresholds, doors, furniture, and a variety of floor coverings</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD26. Walking several blocks</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD27. Taking a mile, brisk walk without stopping to rest</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>FD28. Walking on a slippery surface, outdoors</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

Score: 5 = some; 4 = slight; 3 = moderate; 2 = considerable; 1 = extreme
### Life Satisfaction Index Z (Neugarten et al., 1961)

*Note to interviewer: Read out options to older person (ie Agree, Disagree, Uncertain)*

<table>
<thead>
<tr>
<th>No</th>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Patient's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1.</td>
<td>I am just as happy as when I was younger</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L2.</td>
<td>These are the best years of my life</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L3.</td>
<td>This is the dreariest time of my life</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L4.</td>
<td>Most of the things I do are boring or monotonous</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L5.</td>
<td>Compared to other people I get down in the dumps too often</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L6.</td>
<td>The things I do are as interesting to me as they ever were</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L7.</td>
<td>I've made plans for things I will be doing a month or a year from now</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L8.</td>
<td>As I grow older, things seem better than I thought they would be</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L9.</td>
<td>As I look back on my life, I am fairly well satisfied</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L10.</td>
<td>I have gotten pretty much what I expected out of life</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L11.</td>
<td>When I think back on my life, I didn't get most of the important things that I wanted</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L12.</td>
<td>In spite of what people say, the lot of the average person is getting worse not better</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>L13.</td>
<td>I have gotten more of the breaks in life than most of the people I know</td>
<td>A</td>
<td>D</td>
<td>U</td>
<td></td>
</tr>
</tbody>
</table>

---

### General Demographics

*Note to interviewer: Read out options to older person
'T'd just like to ask you some questions about you and your family...'*

**Question** | **Choices** | **Choose ONE only** | **Score** | **Patient's Score** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P1: Thinking back to when you first entered this new home, how did you feel about being committed</td>
<td>Extremely reluctant, Somewhat reluctant, Neutral, Somewhat enthusiastic, Very enthusiastic</td>
<td>0, 1, 2, 3, 4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>P2: In general, how satisfied have you been with your stay in your new home</td>
<td>Extremely dissatisfied, Somewhat dissatisfied, Neutral, Somewhat satisfied, Very satisfied</td>
<td>0, 1, 2, 3, 4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>P3: How long do you expect to stay in this new home</td>
<td>Less than one month, One to six months, Six months to one year, More than one year, Not sure</td>
<td>0, 1, 2, 3, 4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>P4: What is your marital status</td>
<td>Married/divorced, Widowed, Separated/broken up, Never married</td>
<td>0, 1, 2, 3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>P5a: How many children have you born or raised</td>
<td>(i) Sons, (ii) Daughters</td>
<td>(i) Sons living, (ii) Daughters living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P6b: How many of your children are still living</td>
<td>(i) Sons living, (ii) Daughters living</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Note 1 to interviewer: If no living children skip to P10
Note 2 to interviewer: If no living sons skip to P7a*
General Demographics (continued)

Let's talk about your children.

P7A. How many of your children live in this city?  
Daily 4  
Weekly 3  
Monthly 2  
Occasionally 1  
Never 0

P7B. How many live in this island?  
Daily 4  
Weekly 3  
Monthly 2  
Occasionally 1  
Never 0

P7C. How many live in other provinces?  
Daily 4  
Weekly 3  
Monthly 2  
Occasionally 1  
Never 0

P7D. How many live overseas?  
Daily 4  
Weekly 3  
Monthly 2  
Occasionally 1  
Never 0

P8. How often do you see/visit children with one or more of your children?  
Daily 4  
Weekly 3  
Monthly 2  
Occasionally 1  
Never 0

P8. How often do you have phone or mail contact with one or more of your children?  
Daily 4  
Weekly 3  
Monthly 2  
Occasionally 1  
Never 0

F9. What is the highest level of education that you attained?  
Primary School 0  
High School 1  
Associate 3  
University 3

F10. What is your main lifetime occupation?  
Code  

F11. What is your spouse's main lifetime occupation?  
Code  

F12. Explain to the participant that you wish to ask several questions about their financial situations now and before they entered the home.

F13. Thinking about your current situation, how would you rate your financial situation?  
I can't make ends meet 0  
I have just enough to get along 1  
I am comfortable 2

F14. Thinking about your financial situation before you came into the home, how would you rate it?  
I can't make ends meet 0  
I have just enough to get along 1  
I am comfortable 2

F15. Do you have private health insurance?  
Yes 1  
No 0

PIRC Questionnaires: Baseline  
PIRC: Promoting independence in Residential Care  
Respondent Number  

Ethnic Group (add report)  
a. New Zealand European  
b. Maori  
c. Samoan  
d. Cook Islander  
e. Tongan  
f. Malaysian  
g. Chinese  
h. Indian  
i. Other (please specify)  

What country were you born in?  
a. New Zealand  
b. Australia  
c. The United Kingdom  
d. The Netherlands  
e. Other European country  
(free text)  
f. Pacific Island  
g. Asia (includes India, Pakistan)  
h. Other  
(please specify)
### Social Activity Index

*And now some questions about friends and family...*

<table>
<thead>
<tr>
<th>Question</th>
<th>Choices</th>
<th>Score</th>
<th>Patient's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC1 How many close relatives have you seen in the last month</td>
<td>Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC2 How many close relatives outside the home do you exchange letters,</td>
<td>Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>telephone calls or email with a few times a year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC3 In general, how many close friends do you have (people that you</td>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>feel at ease with, can talk to about private matters and can call on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for help)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC4 How many of these close friends live in the residential home</td>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC5 How many of these close friends live elsewhere</td>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC6 How many of these close friends living outside the homes have you</td>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>seen in the last month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC7 How many close friends outside the home do you exchange letters,</td>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>telephone calls or email with a few times a year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC8 How long have you known most of your close friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read out choices only if patient is alert</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social Activity Index (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Choices</th>
<th>Score</th>
<th>Patient's Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC9 Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?</td>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>If 'No' or 'I don't need help', skip to SOC 11.</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>SOC10 In the last month who has been most helpful in providing you with emotional support</td>
<td>Spouse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daughter</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Son</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sibling</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Niece</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nephew</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grand-daughter</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grand-son</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other relative</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Another resident</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friend outside the residential home</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care staff of home</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No one</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>SOC11 Of all of the things that you do, either as a pastime or as part of your daily life, what things do you like to do the most (eg, reading, being with friends, going out)</td>
<td>More than once a day</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every day</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Most days</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A few times a week</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>About once a week</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less than once a week</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

---

RIHC Questionnaire: Baseline

20  11/03/2004

RIHC Questionnaire: Baseline

20  11/03/2004
**PIRC**
Promoting Independence in Residential Care

**Measurements**

<table>
<thead>
<tr>
<th>BLOOD</th>
<th>Blood Pressure (sitting)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Systolic</td>
</tr>
<tr>
<td></td>
<td>Diastolic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARM.</th>
<th>Derm Byen (Arm length)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Centimetres</td>
</tr>
</tbody>
</table>

**Elderly Mobility Scale**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Functional Level</th>
<th>Score</th>
<th>Patient Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS1.</td>
<td>Lying to sitting</td>
<td>Needs help of two people</td>
<td>0</td>
</tr>
<tr>
<td>EMS2.</td>
<td>Sitting to lying</td>
<td>Needs help of two people</td>
<td>0</td>
</tr>
<tr>
<td>EMS3.</td>
<td>Sitting to Standing</td>
<td>Needs help of 2+ people</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Note to interviewer: Use stopwatch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS4.</td>
<td>Standing</td>
<td>Stands with only physical support</td>
<td>0</td>
</tr>
<tr>
<td>EMS5.</td>
<td>Functional reach</td>
<td>Under 10cm or unable</td>
<td>0</td>
</tr>
<tr>
<td>EMS6.</td>
<td>Get</td>
<td>Maximum physical support to walk and constant supervision</td>
<td>0</td>
</tr>
<tr>
<td>EMS7.</td>
<td>Timed 5 m walk</td>
<td>Unable to cover 5 metres</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Note to interviewer: Use stopwatch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS8.</td>
<td>Timed up and Go Test</td>
<td>Refer to Manual</td>
<td></td>
</tr>
</tbody>
</table>

**PIRC Questionnaires: Baseline**

*NB: don't know (DK); refused (RF); NA (000)*

27
11/03/2004
### FICSIT 4-test Balance Scale

Enter seconds = 0 if task not attempted because of failure at an earlier task.

Enter seconds = 1 if task was attempted but participant lost balance immediately.

<table>
<thead>
<tr>
<th>Task</th>
<th>Seconds</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAL1: Stand with feet together in side-by-side position (maximum of 10 seconds)</td>
<td></td>
</tr>
<tr>
<td>BAL2: Stand with feet together in semi-tandem position (maximum of 10 seconds)</td>
<td></td>
</tr>
<tr>
<td>BAL3: Stand with feet together in tandem position (maximum of 10 seconds)</td>
<td></td>
</tr>
<tr>
<td>BAL4: Stand on one leg (maximum of 30 seconds)</td>
<td></td>
</tr>
</tbody>
</table>

*Note to interviewer: Use stopwatch*

---

### INTERVIEWER CHECK LIST

Please ensure the following end the end of the session:

1. REST HOME NUMBER FILLED IN ON FRONT
2. DATE FILLED IN ON FRONT
3. RESPONDENT NUMBER FILLED IN ON FRONT
4. INTERVIEWER CODE FILLED IN ON FRONT
5. CHART REVIEWER CODE FILLED IN ON FRONT
6. RESPONDENT NUMBER ON EACH PAGE
7. ALL APPLICABLE BOXES THROUGHOUT QUESTIONNAIRE FILLED IN
Appendix 5: Participant Information Sheets and Participant Consent Forms

Promoting Independence in Residential Care: PIRC Social Study

Participant information for residents taking part in audio-taped interviews

Please keep this sheet for your information. For questions, please contact:

Liz Kiata 09 373 7599 ext 82874
Associate Professor Ngaire Kerse 09 373 7599 ext 84467
Associate Professor Tim Wilkinson 03 337 7899

---

A further invitation…

Thank you for taking part in the Promoting Independence in Residential Care trial (PIRC).

You are invited to take part in a sub-study of the PIRC trial, the ‘Social Study’ that has as its focus the lived worlds of older people living in long term residential care facilities. This sub-study will help us further understand how older people staying in residential care live in their everyday worlds. The visits will be offered at a time and place convenient to you and each will take about ½ an hour of your time.

We will invite about thirty-five (5%) of the people taking part in the PIRC trial to be involved in this part of the social study which uses two forms of data collection. We would like to offer you two social visits to talk about ‘a week in life of…’ A record of how you spend your time will be written up in a journal format by the visiting researcher. We would also like to audio-tape the discussion to ensure that the journal correctly reflects what was talked over. Additionally, audio-taped narrative offers the opportunity to reflect more accurately the experiences of the speaker.

The audio-tapes will be transcribed by the research interviewer who will be the only person to have access to the recordings. The interview transcripts will be available only to the social researchers of the PIRC trial. The tapes and transcripts will be kept in a locked cupboard in the Department of General Practice and Primary Health Care, The University of Auckland, for a period of ten years before being destroyed by shredding. No material which could personally identify you will be used in any reports on this sub-study or the overall trial.

Permission will be obtained from all participants to change identifying data to pseudonyms which will ensure confidentiality. You may withdraw yourself or any information traceable to you at any time up until 1 February 2006 without giving a reason.

Your participation in this part of the sub-study is entirely voluntary (your choice). You do not have to take part. If you choose not to take part, any care or treatment that you are currently receiving will not be affected. If you do agree to take part, you are free to withdraw from the
sub-study at any time, without having to give a reason. Withdrawing at any time will in no way affect your future health care. To help you make your decision please read this information sheet. You may take as much time as you like to consider whether or not to take part in this part of the sub-study. If you require an interpreter, this can be arranged.

We may use your anonymised data at a later stage for a connected study, which will be strictly controlled in accordance with the Privacy Act.

If you have any queries or concerns about your rights as a participant in this sub-study, you may wish to contact a Health and Disability Advocate at the Health Advocates Trust, telephone 0800 555 050, Northland to Franklin or the Health and Disability Consumer Advocate, ph 03 377 7501.

This sub-study is part of the PIRC trial and has received Ethical Approval from the Auckland Ethics Committee on (date) on behalf of the Canterbury Ethics Committee.

The principal investigators for the overall study are:

Associate Professor Ngaire Kerse
Department of General Practice
and Primary Health Care
The University of Auckland
Tamaki Campus
Private Bag 92019
Auckland
Tel: (09) 373 7599 ext 84467

Associate Professor Tim Wilkinson
Department of Health Care
of the Elderly
The University of Otago
Christchurch Clinical School
Princess Margaret Hospital
Christchurch
Tel: (012) 337 7899

If you would like some more information about the Social Study, please feel free to contact Liz Kiata, 09 373 7599 ext 82874, Associate Professor Ngaire Kerse 09 373 7599 ext 84467 or Associate Professor Tim Wilkinson 03 337 7899.

Thank you for taking the time to be interviewed.
Promoting Independence in Residential Care: PIRC Social Study
Consent form for residents taking part in audio-taped interviews

<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>I wish to have an interpreter</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Maori</td>
<td>E hiahia ana ahu ki tetahi karwhakamaorikarwhaka pakeha korero</td>
<td>Ae</td>
<td>Kao</td>
</tr>
<tr>
<td>Samoan</td>
<td>Oute mana 'o ia iai se fa 'amatala upu</td>
<td>Io</td>
<td>Leai</td>
</tr>
<tr>
<td>Tongan</td>
<td>Oku ou fiema 'u ha fakatoniua</td>
<td>Io</td>
<td>Ikai</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>Ka inangaro au I tetai tangata uri reo</td>
<td>Ae</td>
<td>Kare</td>
</tr>
<tr>
<td>Niuean</td>
<td>Fia manako au ke fakaasoga e taha tagata fakakokokoko kupu</td>
<td>E</td>
<td>Nakai</td>
</tr>
</tbody>
</table>

I have read and I understand the information sheet dated 27 February 2004 for residents taking part in the audio-taped interview section of the social study of the PIRC trial.

- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing or future health care.
- I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.

Yes No I consent to my interview being audio-taped.
Yes No I consent to be contacted after the conclusion of the trial if necessary.
Yes No I consent to my information being used for future related studies subject to approval by an accredited New Zealand Ethics Committee.

I, ____________________________________________________________ (print full name)

of ____________________________________________________________ (print address)

______________________________________________________________

hereby consent to take part in the Promoting Independence Trial (PIRC)

______________________________________________________________ Signature of participant

______________________________________________________________ Date

Full name of researcher______________________________ Signature of researcher

______________________________________________________________ Date

PIRC-Social study audio consent form, Version 2

#ID

230
An invitation...

You are invited to take part in a research study because you are living in a rest home. This study is trying to find out about a way to try and improve function for older people living in residential care. It is part of research carried out over the last 5-7 years to improve function and reduce falls and injury for older people. Previous studies have shown that older people in residential care are able to increase activities and staff are able to help them with this. This study is trying to help physiotherapists; occupational therapists and health care assistants work together more with older people to increase activity and overall function. We hope to make life easier for older people living in residential care.

The School of Nursing and the Department of General Practice and Primary Health Care at the University of Auckland and the Department of Health Care of the Elderly at the Christchurch Clinical, University of Otago will be coordinating this study.

Your participation is entirely voluntary (your choice). You do not have to take part in this study. If you choose not to take part, any care or treatment that you are currently receiving will not be affected. If you do agree to take part, you are free to withdraw from the study at any time, without having to give a reason. Withdrawing at any time will in no way affect your future health care. To help you make your decision please read this information sheet. You may take as much time as you like to consider whether or not to take part. If you require an interpreter this can be arranged.

What are the aims of this study?

The main aim of the study is to:

- Determine the impact of increasing activity through promotion of independence by health care assistants on overall function and well being of older people.

The study also aims to find out the impact of promotion of independence on:

- Satisfaction with life
- Ability to complete activities of daily living
- Ability to complete simple tasks
- Costs of health care services
- The organisation and how it runs

What types of people can be in the study?

All older people who are resident in ........rest home are able to participate in the study.
How many people will be in the study?

We estimate about 700 residents and 32 rest homes will be involved in this study.

What happens if I do decide to take part?

If you decide you would like to take part, your participation would be for three months to one year only. A research gerontology nurse, who has been specially trained for this project, will interview you. You will be asked questions about your health and asked to complete several simple tasks such as standing up, reaching forward and bending over. All of the residents in the study at ... resthome will either try out a more active way of caring for residents (the active group), or continue the same way (the control group). Your health care assistants and the staff at ... resthome will then either continue to care for you in the same way (the control group), or offer extra encouragement to increase your activity and 'practice' your daily activity. For example this may mean they encourage you to help with bathing more often, stand up several times instead of once, or walk down the hallway several times instead of once or twice a day. These 'extra activities' will be decided on by talking with you, your caregiver and the Nurse Manager and only after everyone has agreed on what is important for you. The decision as to whether you are in the 'active or control' group will depend on which home you are in not anything about you or the staff caring for you.

During the study a research interviewer will interview you at the end of three months, again at six months, and finally at the end of the year to see what has changed.

If you are in the control group we would like to offer you a social visit to talk about how life is for you in the rest home and your ideas about physical activity and getting about during your lifetime. This social visit will take about 1/2 an hour and will be offered at a time convenient to you.

You may also be asked to be part of a smaller study that measures how much activity you do during the day and night. This involves wearing a small device called an up-timer to measure your activity. If you are part of this smaller activity study, then a small device will be taped to your outer thigh for twenty-four hours. This will not interfere with your normal activities.

We would also like to gather information about any falls you have while we are working with you and the staff at ... resthome. We would also like to be able to contact your doctor, the hospital and any other health providers that you may come in contact with over the year to find out about health costs and what has happened to you. We may wish to contact you after the study has finished for further information about how you are managing.

How many interviews will there be?

In total there will four interviews. The first interview will take place at the start of the study and last about 30 minutes. The second interview will be after three months, and also take about 30 minutes. The third interview will be after another six months; again for about 30 minutes and finally one year after beginning the study we would like to interview you again.

PIRC – Version 2
What is the time-span for the study?

The study is expected to start in January 2004 and will continue until the end of 2006.

The risks and benefits of the study

Taking part in this study will take some of your time and require you to answer a series of questions and complete some simple tasks. The only risk from this study is that increased activity may cause more muscle aches, falls or in some way make your medical conditions worse. In general, increasing activity is good for health. If you are part of the smaller study there is a small risk of you reacting to the plastic dressing, however you will be asked if you have had previous allergy to adhesive agents before application. If you have then an alternative way to secure the up timer will be used. Your usual medical care will not be affected in any way by participation in the study, or by declining to participate or withdrawing from the study at any stage. If you and your doctor feel it is not in your best interests to continue to participate in this study we will stop the program. Similarly your doctor may at any time provide you with any other treatment he/she considers necessary.

By conducting this study, we hope it will be of benefit to the wider population. There is no guarantee that you will benefit directly from being involved in this study, however other studies have shown that increasing activity and function makes older people feel better and maintain independence so you may benefit directly. The results obtained from your participation may help others in the future.

Compensation

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation. If your claim is accepted by ACC you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner.

ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum compensation payable.

There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators. If you have any questions about ACC, contact your nearest ACC officer or the investigator.

Confidentiality

The study files and all other information that you provide will remain strictly confidential. No material that could personally identify you will be used in any reports on this study. Your GP will be informed of your participation in this study. Upon completion of the study your records will be stored for 10 years in a secure place at the central coordinating centre in Auckland. All computer records will be password protected. We
may use your anonymised data at a later stage for a connected study, will be strictly controlled in accordance with the Privacy Act.

Your rights

If you have any queries or concerns about your rights as a participant in this study, you may wish to contact a Health and Disability Advocate at the Health Advocates Trust, telephone 0800 555 050 or the Health and Disability Consumer Advocate, ph 03 377 7501.

Finally

This study has received Ethical Approval from the Auckland Ethics Committee on (date) on behalf of the Canterbury Ethics Committee. If you would like some more information about the study please feel free to contact Kathy Peri, (09 373 7599 ext 83935, Dr Ngaire Kerse (09 373 7599 ext 84467) or Associate Professor Tim Wilkinson (03 3377899).

Study Investigators

The principal investigators for this study are:

**Dr Ngaire Kerse**
Dept of General Practice and Primary Health Care
The University of Auckland
Private Bag 92019
Auckland

Tel: (03) 373 7599 xtn 84467

**Tim Wilkinson**
Department of Health Care of the Elderly
The University of Otago
Christchurch Clinical School
Princess Margaret Hospital
Christchurch

Tel: (03) 237 7899
I have read and I understand the information sheet dated 13th January 2004 for residents taking part in the PIRC study in residential care.

- I have had the opportunity to discuss this study with the investigator. I am satisfied with the answers I have been given.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing or future health care.
- I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- I understand that the treatment, or investigation, will be stopped if it should appear harmful to me.
- I understand the compensation provisions for this study.
- I have had time to consider whether to take part.
- I know whom to contact if I have any side effects to the study.

Yes  No  I consent to be contacted after the conclusion of the trial if necessary.

Yes  No  I wish to receive a copy of the aggregated result. I understand that there may be a significant delay between data collection and the publication of the study results.

Yes  No  I consent to my GP being informed of my participation in this study.

Consent, version 3
Yes  No  I consent that the researcher may have access to my medical information, including hospital records and that no material that could identify me will be used in any reports on this study.

Yes  No  I consent to my information being used for future related studies subject to approval by an accredited New Zealand Ethics Committee.

I, __________________________________________ (print full name)

of __________________________________________ (print address)

_____________________________________________________________________

hereby consent to take part in the Promoting Independence Trial (PIRC).

_________________________________________ Signature of participant

_________________________________________ Date

Full name of researcher __________________________________________

_________________________________________ Signature of researcher

_________________________________________ Contact telephone number for researcher
Appendix 6: Summary letter

Promoting Independence in Residential Care: PIRC Social Study

Liz Kiata 09 373 7599 ext 82874
Associate Professor Ngaiire Kerse 09 373 7599 ext 84467
Associate Professor Tim Wilkinson 03 337 7699

Mr A Citizen
Rest Home House
Evening Street
Auckland

Dear Mr Citizen,

Thank you for taking part in the Promoting Independence in Residential Care trial (PIRC). I appreciate the time you spent speaking with me about the types of leisure and social activities that you have been involved in over the years.

I enjoyed my time with you, and am pleased that you are willing to meet with me again to verify the information that we discussed last time we met.

My understanding of the main points of our discussion are as follows:

The types of activities and leisure that you enjoyed prior to coming to Rest Home House were:

- As a boy you played football at school.
- You and your siblings were too busy to have much leisure time as you all helped your mother with everyday chores and worked to make ends meet.
- You occasionally went to the pictures when you were working on the railways.
- You and your wife had 7 children, and you worked “pretty hard” loading trucks on the railways. You worked for the railways until your retirement at age 60.
- When you retired from the railways you continued to work part time at a local school as a handyman.
- You were a member of the Railway Union for a number of years.
- You were and remain a keen gardener.
- You also did volunteer work including attending sports events.
- When you had retired, you and your wife traveled around New Zealand.

The activities that you enjoyed doing the most were:

- Handymen work especially when the work involved being of help to others.
- Gardening.

The activities that you still do now you are at Rest Home House include:

- Handymen work for management and residents.
- Gardening.
- Staying in contact with family and friends both in person and by phone.
- You also go to indoor bowls once a week where you assist blind bowlers (church hall).

PIRC-Social study verification letter, 888-888
Activities that you no longer take part in:

- Organizational work

Physical or leisure activities, hobbies or interests that you would like to do more often:

- You are very active in the workings of the rest home and act as an advisor for management in the care of the extensive gardens.
- You have been living at Rest Home House for five years, and have remained independent by keeping yourself busy helping others with day-to-day tasks.

Recent visits with family and friends include:

- You have female friends who visit you regularly.
- Your daughters visit you every weekend, and you often go out for a drive and stop at a café for a coffee.
- Two of your daughters have arranged to take you out for lunch this week for your birthday.

Ways in which you keep in touch with family and friends include:

- You have your own phone in your room, and keep in contact with your friends and daughters living in Auckland.
- Your son telephones you from overseas, on a weekly basis.

A typical day for you at Rest Home House would include:

- Breakfast
- Shower (self)
- Walk around Rest Home House’s grounds
- Morning tea
- Rest Home House activities (newspaper reading and discussion)
- Lunch
- Gardening
- Afternoon tea
- Friend or family member may visit (or read)
- Happy Hour
- Tea
- Watch television
- Bed

If you would like some more information about the Social Study, please feel free to contact Liz Kista, 09 373 7599 ext 82874. The principal investigators for the overall study are:

Associate Professor Ngaire Kersse  
Department of General Practice & Primary Health Care  
School of Population Health, Tamaki Campus, The University of Auckland  
Private Bag 92019, Auckland  
Tel: (09) 373 7599 ext 84467

Associate Professor Tim Wilkinson  
Department of Health Care of the Elderly  
Christchurch Clinical School, Princess Margaret Hospital  
P.O. Box 800, Christchurch  
Tel: (01) 337 7899

Thank you for taking the time to be interviewed and verifying the details of the interview.

Yours sincerely,

Liz Kista, PhD Candidate  
Social researcher, PIRC Trial
Appendix 7: Map of rest home sites
### Appendix 8: Resident information

<table>
<thead>
<tr>
<th>First Name</th>
<th>Age range</th>
<th>Time in rest home</th>
<th>Size of rest home</th>
<th>Type of rest home</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice</td>
<td>85-94</td>
<td>&gt;4 years</td>
<td>Large</td>
<td>Owner Operator</td>
<td>Auckland</td>
</tr>
<tr>
<td>Barbara</td>
<td>75-84</td>
<td>6-12 months</td>
<td>Medium</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
<tr>
<td>Bessie</td>
<td>85-94</td>
<td>2-4 years</td>
<td>Medium</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
<tr>
<td>Bill</td>
<td>85-94</td>
<td>6-12 months</td>
<td>Large</td>
<td>Chain for profit</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Catherine</td>
<td>75-84</td>
<td>&lt;6 months</td>
<td>Medium</td>
<td>Church and Welfare</td>
<td>Auckland</td>
</tr>
<tr>
<td>Clifford</td>
<td>85-94</td>
<td>&lt;6 months</td>
<td>Large</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
<tr>
<td>Daniel</td>
<td>75-84</td>
<td>2-4 years</td>
<td>Medium</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
<tr>
<td>Daphne</td>
<td>85-94</td>
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<td>Medium</td>
<td>Owner Operator</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Eric</td>
<td>75-84</td>
<td>&gt;4 years</td>
<td>Large</td>
<td>Chain for profit</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Flo</td>
<td>75-84</td>
<td>1-2 years</td>
<td>Medium</td>
<td>Owner Operator</td>
<td>Auckland</td>
</tr>
<tr>
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<td>75-84</td>
<td>&gt;4 years</td>
<td>Large</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
<tr>
<td>Harry</td>
<td>85-94</td>
<td>&gt;4 years</td>
<td>Large</td>
<td>Owner Operator</td>
<td>Auckland</td>
</tr>
<tr>
<td>Iris</td>
<td>85-94</td>
<td>2-4 years</td>
<td>Medium</td>
<td>Chain for profit</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Jack</td>
<td>75-84</td>
<td>6-12 months</td>
<td>Medium</td>
<td>Owner Operator</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Jean</td>
<td>85-94</td>
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<td>Large</td>
<td>Chain for profit</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Lena</td>
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<td>6-12 months</td>
<td>Medium</td>
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<td>Auckland</td>
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<tr>
<td>Lillian</td>
<td>65-74</td>
<td>&gt;4 years</td>
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</tr>
<tr>
<td>Mary</td>
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<td>6-12 months</td>
<td>Medium</td>
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<td>Auckland</td>
</tr>
<tr>
<td>Maura</td>
<td>85-94</td>
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<td>Nancy</td>
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<td>Large</td>
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</tr>
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<td>85-94</td>
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<td>Chain for profit</td>
<td>Christchurch</td>
</tr>
<tr>
<td>Robert</td>
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<td>&lt;6 months</td>
<td>Large</td>
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<td>Christchurch</td>
</tr>
<tr>
<td>Simone</td>
<td>85-94</td>
<td>6-12 months</td>
<td>Large</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
<tr>
<td>Terence</td>
<td>85-94</td>
<td>6-12 months</td>
<td>Medium</td>
<td>Owner Operator</td>
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</tr>
<tr>
<td>Tom</td>
<td>85-94</td>
<td>2-4 years</td>
<td>Medium</td>
<td>Owner Operator</td>
<td>Auckland</td>
</tr>
<tr>
<td>Vera</td>
<td>95+</td>
<td>&gt;4 years</td>
<td>Large</td>
<td>Church and Welfare</td>
<td>Auckland</td>
</tr>
<tr>
<td>Walter</td>
<td>75-84</td>
<td>2-4 years</td>
<td>Large</td>
<td>Chain for profit</td>
<td>Auckland</td>
</tr>
</tbody>
</table>
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