The Lived Experience of Person-Centred Care in Residential Homes in New Zealand and Singapore: The Perspectives of Residents, Frontline Caregivers and Family Members

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ABSTRACT

Ageing is an inevitable part of life. The intent to age gracefully and in a dignified manner is held as important by many, but a number of challenges can influence an individual’s ability to control their lives at an older age. Frailty, associated with ageing, with or without the diagnosis of a chronic condition, impacts on the ability to live independently, and for some, precipitates the need to move into long-term residential care. Often the decision to move into a residential or nursing home is driven by family members who feel that they cannot provide the support required for their elderly family member.

With an increase in the ageing population, many nations have started to focus on building more residential home institutions to help meet the demand. Currently within the aged care sector, the drive for quality care and quality of life has shifted the focus from providing basic care needs to one of person-centred care. Person-centred care has been promoted internationally as a quality care model to enhance the life of the older people residing in residential homes, and it values the inclusion of all members involved in the care context as vital in supporting the wellbeing of older residents in the residential home setting.

AIM: The purpose of this study was to explore the lived experience of person-centred care in residential homes from New Zealand and Singapore from the perspective of the residents, family members and frontline caregivers. The philosophical orientation of Van Manen’s lifeworld-hermeneutic phenomenology was adopted as the methodology to guide this study.

METHOD: Interviews were conducted with thirty residents, ten family members and ten caregivers at two residential homes in New Zealand and Singapore.

ANALYSIS: The audio-recorded interviews were transcribed and imported into NVIVO. The data were analysed using Van Manen’s six-step research process.

RESULTS: The data from the three participant groups across the two countries were synthesised and three major themes emerged from the findings: ‘homelike’, ‘maintaining and developing connections’ and ‘workplace culture’. Each theme
attempted to capture the unique and personal understanding of person-centred care as conceptualised by each participant. Relocation to a residential home caused distress and impacted on the resident’s experience of care. However, when there was continuity of their life themes and support from family and staff, this influenced their care experience positively. A care context that supported person-centred values at all levels was described as essential in fostering person-centred care.

CONCLUSION: Some older residents have great difficulty in establishing a sense of home in the residential home settings. The transition into residential care requires further attention. Building collaborative relationships between residents, family members and frontline caregivers are vital in enhancing person-centred care, which fosters the alignment of expectations and preferences. At an organisational level, a supportive care context that provides the physical structure, human resources, and the promotion of holistic care underpins positive person-centred care outcomes.
ACKNOWLEDGEMENTS

When I began my PhD journey, I did not really appreciate where that journey would take me, or, in fact, how I would be ending the journey. It has taken some time and much effort, involving both laughter and tears. However, the older people, their families and the staff who agreed to participate have made it all worthwhile. I have been touched by the stories shared with me and I hope I have done justice to them. I thank them for sharing their lives with me and teaching me so much; without them, I would not have come so far. I dedicate this thesis to the 30 residents, 10 family members and 10 frontline caregivers who gave so much of their precious time.

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CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

Globally, a growing number of residential or nursing homes have adopted person-centred care as a model to improve the quality of life for residential home residents (Boumans, Berkhout, & Landeweerd, 2005; World Health Organisation, 2007). In the United Kingdom (UK) and United States (US), government policy emphasises strengthening the voice of the residents to improve health service provisioning (Department of Health, 2001; McCormack & McCance, 2006). Person-centred care is an essential element of quality health care delivery, and it is frequently advocated in national policies, planning and development of care models, and training of health professionals (Institute of Medicine (IOM), 2001; Ministry of Health New Zealand (NZ MOH), 2002). Although improving residents’ satisfaction with care has gained importance, research has shown that satisfaction with care received remains suboptimal (Kane et al., 2003; McCormack, 2004).

The World Health Organisation (WHO) recognises that care in the residential sector should involve the residents, family members and staff of residential homes working together (WHO, 2007). As stakeholders of residential home care, their values and beliefs can influence how care is provided and experienced. The core value of person-centred care is recognising the personhood of each person (Kitwood, 1997), and this can be achieved when the stakeholders’ voices are heard and incorporated into the planning of the care (WHO, 2007). This contributes toward a more holistic and person-centred approach to health care, where a balanced consideration of the rights and needs of stakeholders are incorporated in planning and the delivery of care.

The value of person-centred care has been embraced by the WHO, who have developed a framework to guide governments in identifying and adapting policy reforms and interventions to their unique settings at national and local levels (WHO, 2007). Successful implementation of person-centred care can best be described as a culture that has established person-centred care as its informed practice.
This chapter provides an overview of the quality of care for residents in long-term care settings and the concept of person-centred care. An overview of demographic changes in New Zealand (NZ) and Singapore, where the study was undertaken, will be given. This chapter will conclude with an overview of the chapters in the thesis.

1.2 AIM OF THE STUDY
The aim of this study was to understand the lived experience of person-centred care in residential homes from New Zealand and Singapore, from the perspective of the residents, family members and frontline caregivers.

1.3 BACKGROUND
1.3.1 AGEING TRENDS
Populations around the world are rapidly ageing; globally the percentage of those 60+ has risen from only 8% of world population (200 million) in 1950 to around 11% (760 million) in 2011, with a dramatic increase still ahead as those who are 60+ are expected to reach 22% (2 billion) by 2050 (Bloom, Canning, & Fink, 2011). The United Nations estimates that the world’s population aged 80 and above will nearly triple in just forty years from 101.9 million in 2009 to 394.7 million in 2050 (United Nations, 2009). These developments are cause for celebration, representing significant improvements in standards of living, lifestyles and major developments in medical science and health systems. The WHO recognises this as one of humanity’s greatest triumphs; however, it is also one of the greatest challenges, with financial implications related to health care demand (WHO, 2000).

The increase in the older population has shifted the burden of disease from infectious to chronic conditions (WHO, 2007). The WHO estimates that disability due to chronic conditions is more common among the oldest population than ever before (20% of those aged 70+, and 50% of those aged 85 and above, have some form of disability)(WHO, 2003). The most common chronic conditions are cardiovascular diseases, hypertension, stroke, diabetes, cancer, chronic obstructive pulmonary disease, muscular-skeletal conditions, mental health disorders and sensory impairments. Several population-based studies have shown that the predictors for institutionalisation among older people are functional disability and cognitive impairment (WHO, 2000). A move into a residential care setting has been associated
with perceived lower quality of life and significant alterations in social interactions, and adaption to changes in privacy, dignity and independence (Boyle, 2004). At the same time, society’s expectation of care services has risen; it is associated with higher levels of education, rising consumerism and greater access to services (Estabrooks, Squires, Carleton, Cummings, & Norton, 2015; Stone & Harahan, 2010). Older people and their families are no longer content with basic levels of essential care and they seek a higher level of humanistic and holistic care where the individual is respected as a whole person with multidimensional needs (WHO, 2007). Improving the quality of care in residential homes is important today and will be increasingly important over the next thirty years and beyond as the population ages (Chassin & Galvin, 1998).

1.3.2 SINGAPORE

The population of Singapore consists of four main ethnicities: Chinese (more than 75%), Malay (13%), Indian (9%), and other (3%). By 2050, Singapore has been identified as being one of the top 10 countries with the highest number of adults over 60 years of age; it is expected to increase from 23% in (2011) to 38% (Statistics Singapore, 2015). The statistics also show that Singapore, with a population of close to 6 million, has one of the most rapidly ageing populations in the world. Singapore’s older population, those who are 65 years and above, is expected to increase from 7.5% in 2002 to 18.4% by 2030 (Singapore Ministry of Health (SIN MOH), 2014). The Singapore government plans to increase the number of residential home beds by more than 50% to 17,000 by 2020 (Chin, 2010).

As Singaporean seniors are the baby boomers who are educated and enjoy their independence, in terms of economic and social needs many wish to continue that independence by remaining at home as they age (SIN MOH, 2014). Between 1995 and 2005, the figures for seniors who lived in their own home, either living alone or with their spouse, has doubled from 9.7% to 19.9% (SIN MOH, 2014). This trend is expected to continue in coming years with older people living separately from their children. Traditionally, when an older person becomes chronically ill and/or severely disabled, families have drawn on the task-driven services of live-in maids or housekeepers and maintained separate households from their ageing parents. In the long run, most families are unable to cope with the demand, especially care related
to medical and nursing needs; eventually, the loved and frail older persons are placed in residential homes (Ju & Jones, 1989; Statistics Singapore, 2015).

In Singapore, admission to residential homes is mainly for those who do not have families or caregivers to look after them within their home, or the caregiver is unable to provide the level of nursing care required. Charges for residential homes vary according to bed types and the patients’ nursing care ‘Category’ (from I to IV) (Agency for Integrated Care (AIC), 2013). The nursing care category provides an indicator of the skilled nursing care required by individual patients, with those classified as Category IV needing the most care, and Category I, the least care. Residential homes, together with other step-down care services for older persons, such as community hospitals, are funded as means-tested subsidised medical care services. The subsidy goes directly to the service providers who use this to offset the bill. The rate of subsidy depends on the per capita income of the family, ownership of major assets, and insurance claims and savings. The subsidy rates range from 10% to 75%, with zero subsidies when per capita income exceeds $2,201 per month (AIC, 2013).

In Singapore, there are over 60 residential homes with a total of 12,000 beds. Most of the homes are managed by charitable and voluntary welfare organisations (VWO) (Wong, Pang & Yap, 2014). The government funds 90% of capital expenditure and 50% of operating expenditure of these organisations that care for the poor and older people. The government also offsets the high cost of institutional care for those who cannot afford the full fees, by offering subsidies to qualified individuals. Most of the homes have long waiting lists (Huang, Yeoh, & Toyota, 2012). Residential homes evolved as an extension of the acute hospital; thus, in addition to nursing care, the residential homes also provide medical, physiotherapy and social activities for the older residents. It is harder to attract doctors and nurses to work in the residential homes, and therefore, the majority of the health care workers consists of foreign staff who come from a myriad of backgrounds and practices (Wong, Pang, & Yap, 2014).

Residential homes in Singapore have minimal legislative oversight. Today the residential homes can determine their own standard and system of care, which have to be reported to the Singapore Ministry of Health (Wong, Pang, et al., 2014). The government continues to administer assessments, such as checking the
doctor/nurse-patient ratio and the standard of care given at all residential homes. Although the residential homes are subject to audits for accountability and transparency, the regulation does not include aspects of quality care (Wong, Pang, et al., 2014).

1.3.3 NEW ZEALAND

Population ageing is not unique to Singapore; all developed countries face similar issues. New Zealand has a population of 4.5 million, and a multicultural population of European descent (69%), Maori (14.6%), Asian (9.2%) and Pacific Islanders (6.9%) (Statistics New Zealand, 2014). The number of people aged 65+ is projected to increase from 500,000 in 2005 to 1.33 million in 2051. By 2051, there will be 1.18 million people aged 65 years and over in New Zealand, representing an increase of 165% since 1999. At that stage, older people are expected to make up 26% of the New Zealand population of 5.05 million. Within the older population, it is the age group 85 years and over that will have the highest growth rate. Population projections indicate that by 2051 there will be 290,000 people aged 85 and over, a six-fold increase since 2001 (Statistics New Zealand, 2014). An increase in the number of Maori older people, who are the indigenous people of New Zealand, will be particularly significant over the next 20 years, with the population increase from 0.91 million in 2025 to 1.18 million in 2038 (Statistics New Zealand, 2015. The increasing numbers eventually increase the proportion of ageing Maori population.).

Although Maori people still have a shorter life expectancy than the New Zealand average, this is improving. The Maori population is projected to grow to almost one million by 2051 (Statistics New Zealand, 2015). Maori aged 65 or more will make up approximately 13% of the total Maori population by 2051 compared to 3.5% in 2001 (a 270% increase). Older Maori people live at home, with only a small minority going into rest homes or long-stay hospital facility towards the end of their lives. This is expected to change with an increase in the ageing population. Whilst there are currently very few ethnic minority elders in long-term residential care, this will change in the near future as Maori, Pacific, and Asian populations are also living longer and this will affect the cultural demographic in the residential care sector (Kiata, Kerse, & Dixon, 2005). An increase in the numbers of ethnically diverse older people who will require long-term care in the future indicates that residential care has to be culturally appropriate and individualised.
In New Zealand, admission to residential homes is mainly by referral through the local District Health Board based on a Needs Assessment Service that determines the level of care required for the older people (NZ MOH, 2013). The needs assessment identifies the level of support required, and need is categorised as ‘low’, ‘medium’, ‘high’, or ‘very high’. Long-term residential care is only considered for ‘high’ and ‘very high’ categories. The long-term residential care subsidy is based on a Financial Means Assessment. A government subsidy that fully covers the cost is available for persons aged 65 and older, subject to an income and asset test (Ashton & Tenbensel, 2012; Grant Thornton NZ Ltd, 2010). To qualify for a subsidy, the value of assets must be at or below $213,297 for a couple requiring residential care or $116,806 for a single person. The residential care subsidy is paid directly to the rest home by the Ministry of Health. For residents who receive superannuation, most of this will go towards care and they will receive a personal allowance of $42.38 a week and clothing allowance of $265.81 a year. There are four categories of rest homes catering for different levels of care. Category 1 is entry level for rest home care where minimum care is required; Category 2 is for those diagnosed with dementia who require a semi-secure facility; Category 3 is for residents who require hospital-based continuing care; and Category 4 is for psychogeriatric residents who have high levels of complex need (NZ MOH, 2013).

According to New Zealand Aged Care Association figures, more than 42,000 people receive care in around 700 certified aged residential care facilities (NZ MOH, 2013); of these, 65% of residents are subsidised by the government, while 35% of residents are not subsidised. Sixty percent of residents are in rest homes, 30% in private hospitals and 10% in dementia care units (Grant Thornton NZ Ltd, 2010, p.76). According to the Grant Thornton Review, approximately two-thirds (68%) of aged residential care facilities in New Zealand are controlled by for-profit operators. This contrasts with Singapore where not-for-profit providers operate most facilities. Many of these facilities are owned by major multinational companies. The residential home care for older people in New Zealand is financed through a mix of public subsidies and private payments.

There is an acute shortage of nurses in aged care, and as a result, about 90% of the care in the rest homes is provided by caregivers or Health Care Assistants (Chen,
The majority of the workforce comprises women aged 45+ years and approximately 31% are migrant workers from the Pacific Islands, Asia, and the UK (Callister & Didham, 2014). The census showed that the health caregivers consisted of European (63%), Maori (14%), Asian (6.5%), Pacific peoples (6.5%) and others (10%) (Callister, Didham, & Badkar, 2009). The sustainability of the workforce is a problem due to low wages, and demanding and physically exhausting workload. Also, the workforce and the work it does is considered unskilled, which leads to a high staff turnover rate (Ferrino, 2013).

Though it was acknowledged that training should be provided to enhance the quality of the workforce (Ravenswood, Douglas, & Teo, 2015; Teo, 2004), a number of barriers such as high turnover and a lack of policy about the requirement for staff to gain qualifications affects its implementation. Kiata, Kerse and Dixon’s (2005) study has indicated that currently there is a mismatch between the number of local and ethnic minority health care workers, and the majority New Zealand European elders. Both Singapore and New Zealand rely on migrant workers to take up caregiving roles in the residential sector and this has led to an over-representation of minorities in residential home jobs (Wong, Pang, et al., 2014; Wong, Yap, & Pang, 2014; Ravenswood, Douglas & Teo, 2015).

HealthCERT (a body of NZ Ministry of Health) oversees the certification and auditing of rest homes and hospitals. This is to ensure the care provided is safe for the residents and that care standards meet the Health and Disability Services Act 2001 (NZ MOH, 2014). The certification audits are completed every one to four years. The audit looks at staffing, standards of care, communication between staff and residents, environment, clinical records, policies, and procedures (NZ MOH, 2014). Within six months of being hired, health care assistants working in residential care are required to complete training related to the ageing process, communication skills, residents’ rights, cultural issues, and practical care skills (Ferrino, 2013). However, the training is not standardised and may be provided by staff at the workplace (Ferrino, 2013).

1.4 RESIDENTIAL HOME CARE

As the ageing population segment increases and changes demographics, an ageing population, a commensurate shift in the way the health care system is designed and organised is essential so that at national level countries are prepared to meet the
health care demands of the older people. Although countries have taken active measures to celebrate ageing, through improvement of infrastructure, policies and wellbeing of older people, many are lacking long-term care provision such as residential homes, rest homes, and hospitals.

Providers of residential homes include private-for-profit and voluntary organisations. The standards for good quality care in residential homes are variable and intrinsically related to existing standards of healthcare and other social, cultural, political and economic factors. For example, in developed countries such as the US and the UK, the regulatory measures emphasise person-centred care while developing countries focus on measures such as basic cleanliness, fire safety and equipment provision, due to limited resources (Koh, 2016).

Admission to a residential home is a major life event and can impact an individual’s sense of wellbeing (Bangerter et al., 2016; Eales, Keating, & Damsma, 2001). Many realise that they have entered an irreversible situation that threatens their autonomy and can further increase separation from loved ones and personal belongings (Bangerter, Van Haitsma, Heid, & Abbott, 2015). The Lazarus Project study on images of long-term care found that facilities projected an image of frailty, despair, loneliness and destitution (Kari & Michels, 1991). Although long-term care facilities seek to provide security and services to meet the daily needs of frail residents, care and activities rendered are mostly not resident-centred (Rubinstein, Black, Doyle, Moss, & Moss, 2011). There is no room for residents to decide and design their daily schedule; instead, they are expected to fit into the routine of the institution, where emphasis is on the group rather than the individual (Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011; Habjanič, Saarnio, Elo, Turk, & Isola, 2012). The lack of choice and control can make residents feel helpless and out of control (Hudson, 1991; M Kellett, 2000; Secrest, Iorio, & Martz, 2005). As such, quality of life has been a major issue in long-term care institutions and many researchers have used various care models to identify the quality of the residents' lives (Bergman-Evans, 2004; Brownie & Nancarrow, 2013). A recent national survey of seventy-three leaders in the long-term care industry in New Zealand found that the provision of quality care and maintaining quality of life are the main issues in residential homes. The results show that there is lack of knowledge among leaders and staff regarding
emerging models of culture change and/or person-centred care in long-term care or residential homes (Miller, Booth, & Mor, 2008).

1.5 QUALITY OF LIFE VERSUS QUALITY OF CARE

Quality of care and quality of life are two terms frequently referred to in research and descriptions of long-term care institutions. Both of these concepts are important and intimately connected. Many residents consider the residential home as their home where they are also treated for medical problems, thus quality of life is closely aligned with quality of care (Kane, 2003). The quality of care should be defined by using the characteristics of the residents, their care needs, the circumstances in which the care is provided, and expected outcomes (McCormack & McCance, 2010). However, providers and staff in the residential sector tend to evaluate quality based on clinical outcomes and cost (Chung, 2009; LeRoy, Treanor, & Art, 2010). Most health professionals believe they have a good understanding of what constitutes quality of care and quality of life, but few appear to consult the residents, the consumers of the care, about their perception of quality care (Henoch, Lovgren, Wilde-Larsson & Tischelman, 2012).

A major issue in research into the quality of life for residential home residents is how quality of life and quality of care are conceptualised and measured. Koren’s (2010) study shows that the quality of care is undoubtedly one of the criteria by which residential home residents measure their quality of life. Boumans et al. (2005) recognised this as an important component of quality of life in residential homes. Though both of these terms seek interchangeable outcomes, they lack universally accepted definitions and methods of assessment. This is related to the ambiguous nature of the term quality, which means different things to different people (Koren, 2010; Mor, Loeone, & Maresso, 2014).

The concepts of quality of life and quality of care are based on individual values and reflect individual perceptions, and are therefore complex and multivariate. Quality of life has been defined as a personal evaluation based on value-laden cognitive and affective judgment (Cooney, Murphy, & O’Shea, 2009), whereas quality of care has been defined as the relative effectiveness of nursing care in maintaining or improving the health status of a set of recipients (Mukamel, 2003). Values are inherent in the definition of relative effectiveness.
Quality of care is further influenced by the complexity of individual values, and additionally judged by objective external standards that are determined by professionals and institutions. Objective evaluation questions are often designed to be unambiguous and require only a yes or no answer (Mukamel, 2003). Quality of care standards are determined by the availability and the training level of the staff, the technical expertise with which the care is delivered, and whether the care has resulted in improved health (Ferrino, 2013). However, individual needs, preferences and satisfaction with care are not addressed and these aspects have been identified as crucial factors in delivering person-centred care. Person-centred care is a multidimensional concept recommended at both international and national levels as a strategy to improve the quality of care received by residents in residential homes (IOM, 2001a; WHO, 2007).

There is evidence of change across the residential and residential home sectors. In New Zealand, the Health and Disability Services Standards, created in 2001 and most recently amended in 2008, has designed the standards to reflect the provision of person-centred care (New Zealand Legislation, 2010). The HealthCERT advisors have included tools to determine whether facilities have a person-centred care foundation on which care is delivered (Ferrino, 2013).

Similarly, in Singapore, as part of ensuring that seniors receive consistent and better quality of care, the SIN MOH has worked with the AIC, an independent corporate body under the Ministry of Health, to oversee all residential home care standards (Koh, 2016). The vision is to make residential homes a home where care is person-centred and dignified (Nursing Home Standards Workgroup, 2014). The domain of the care standards includes competency of staff and aspects of dignified care for the resident (Nursing Home Standards Workgroup, 2014).

Despite the recognition of the values of person-centred care to enhance the residents’ quality of care and life in residential homes and rest homes, long-term care providers from both Singapore and New Zealand continue to delay or resist its implementation. Care providers from both countries struggle to start the process to become person-centred for a variety of reasons, such as not knowing how, a fear of regulatory reprisal, or assuming that providing person-centred care is too costly.
(Ferrino, 2013; Wong, Pang, et al., 2014). Thus, numerous stories of vulnerable residents continuing to receive inconsistent and substandard care still prevails. These problems are not confined to Singapore and New Zealand (Ferrino, 2013; IOM, 2001).

This study of participants' lived experience of person-centred care in the context of the residential home setting aims to generate insight that can, in turn, further inform policy and practice.

1.6 INTRODUCTION TO THESIS CHAPTERS

This thesis is divided into six chapters. Chapter 2 critically reviews the literature available and discusses quality of care in residential homes and the role of person-centred care to enhanced quality of care and quality of life for older residents in residential homes.

Translation of person-centred care into practice will be explored.

Chapter 3 sets out the methods and methodology of the study. Van Manen's (1997) lifeworld-hermeneutic phenomenology methodology was chosen to guide exploration of the complex phenomena of the person-centred care experience.

The results are presented in Chapter 4 as three sequential themes.

Chapter 5, the discussion, explores the key findings from this study in relation to the wider literature. The strengths and limitations of the study are also considered.

The conclusion, Chapter 6, focuses on recommendations for nursing, practice, research, and policy.
CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION
This chapter will review the literature on person-centred care. Person-centred care is recognised and promoted globally as the way to improve care and quality of life in the residential home sector. The limitations of the concept and the challenges to implementation will be explored in sections: (1) development of person-centred care concept; (2) the concept of person-centred care; (3) development of person-centred care in health care; (4) challenges of person-centred care; and (5) person-centred research studies.

2.2 DEVELOPMENT OF PERSON-CENTRED CARE
Person-centred care is now regarded as a critical component in the health and social care industry (McCormack & McCance, 2010; Nolan, 2004). The origin of person-centred care can be traced back to the 1950s, when Carl Rogers, an American psychologist, recommended the approach for client-centred counselling (Koren, 2010). He believed that the model of care provided the client and therapist with the ability to achieve self-awareness and greater potential (Morgan & Yoder, 2012). Informed by Carl Rogers's (1980) work, Kitwood defined person-centred care as “a standing or a status that is bestowed on one human being by another in the context of relationship and social being” (Kitwood, 1997 p.8). He argues that a person does not exist in isolation but instead exists in a context of relationships. Kitwood's work is highly influential in the world of dementia care and it teaches that people must be respected for their intrinsic worth, be socially connected, and supported. His focus of care was to shift away from cognitive disability to respecting the personhood of the person (Innes, Macpherson, & McCabe, 2006).

However, Kitwood’s definition poses some challenges to the assumptions that prevail regarding the scope of care experience. He does this specifically by bestowing the status of personhood upon older people (Davies, Ellis, & Laker, 2000; McCormack, 2003). The idea of having the ability and freedom to make independent choices could potentially exclude the older population who generally suffer from cognitive decline and chronic conditions. Nevertheless, Kitwood (1970) defines person-centred care as placing the needs of the person as an individual at the heart of the care situation.
where the emphasis is on recognition and appreciation of individuality, and mutual respect. Kitwood’s ideology resonates with contemporary models of nursing care. The importance of relationships, as one of the individual needs, is further supported by nursing theorists. Benner (1994) talks about care as relational, involving the nurse and the patient. Likewise, Watson (1988) identifies ten carative factors and explains the need for nurses to enter into a transpersonal caring relationship with the client. Both Benner and Watson have made significant contributions that enhance the value of professional caring.

Kitwood (1997) also recognises that caregiving requires more than common sense, and there should be some understanding of the experience of the person who requires care. In the last decade, a consensus has been reached that care delivery should value the experiences of illness, and acknowledge that the person should be the focus of care delivery and not just the illness (Brooker, 2004; Cowdell, 2006; Edvardsson, Fetherstonhaugh, Nay, & Gibson, 2010; McCormack, 2004; Penrod, 2007).

2.3 LITERATURE REVIEW STRATEGY AND SELECTION CRITERIA

The primary review question was ‘how is person-centred care delivered in residential homes?’ The search was conducted between 2012 and 2016. Literature published in English between 2002 to 2014 was collected from four databases: CINHAL, MEDline, EBSCO and PUBMED. A key search term was employed using the words “person-centred care”, “client-centred care”, “long term care”, “residents”, “family members”, “frontline caregivers” and “experience”. These terms were selected to classify the three stakeholders’ experience of person-centred care in long-term care. Articles were eligible for inclusion in this review if they were based on residents’, family members’ and staff perceptions or experiences of person-centred care. Articles were excluded if they did not pertain to person-centred care, or did not address the expectations or experiences of stakeholders’ meanings of care. The exclusion criteria were: studies done with dementia residents, in hospitals or other acute settings.

In addition, searches were conducted using the primary literature sources. Although this method yielded more than 300 articles, the majority of the studies were on dementia care settings. Once they were removed, there were less than 100 articles
screened for inclusion. However, studies done with family members and staff in a dementia setting were included for this review. In addition to the primary literature sources, the secondary literature sources provided the majority of the articles that supported the key ideas of this research.

2.4 PERSON-CENTRED CARE IN RESIDENTIAL HOMES

The term ‘person-centred care’ has been used interchangeably with other similar terms, such as ‘client-centred care’ (Chapman, Keating, & Eales, 2003), ‘resident-centred care’ and ‘relationship-centred care’ (Nolan & Tolson, 2000). These terms are used throughout the literature and practices to describe care encounters across a range of settings. They share a common intention to promote individuality within the care process, resulting in quality care (Nolan et al., 2004). In the past, residents were expected to fit into the routines and practices of the residential homes but with the shift in the demographic and profile of ageing, there is now a greater expectation on quality care services. The long-term care consumers desire services which are holistic, and which provide greater meaning to their life. The year 2000 marked a historic opportunity to build on positive models for residential home care. Person-centred practice was introduced in residential care services as well as the process to ensure an effective outcome (Kane et al., 2003). A new culture of change movement was initiated with person-centred care as its foundation in residential homes. Person-centred care has become the global philosophy of care underpinning gerontological nursing care and thus has been recently added into the national agenda of many countries (Nolan, 2001).

Since 1986 person-centred care has gained popularity in long-term care in the United States (IOM, 2001). IOM has identified person-centred care as a growing movement in long-term care (Morgan & Yoder, 2012). This model is in conjunction with the US Nursing Home Reconciliation Act of 1987 and has been used to report on how to improve the quality of care in residential homes (Scalzi, Evans, Barstow, & Hostvedt, 2006). Subsequently, person-centredness was added into the quality of health care by the IOM committee. This promotes the awareness that the “resident comes first” in the provision of individualised care, promoting empowerment of residents and a holistic approach to wellness (Caspar & O'Rourke, 2008). The practice of person-centred care in long-term care settings in the United States has been boosted by culture change movements such as Pioneer Network and Eden Alternative (Rahman
& Schnelle, 2008). In the United States, the Hartford Institute for Geriatric Nursing along with the Coalition of Geriatric Nursing Organisations, and the Pioneer Network, for example, undertook a two-year initiative to collaboratively develop person-centred competencies for professional nursing staff (Burger et al., 2009).

In the late 1990s, person-centred care was promoted in residential homes in the UK and has been embedded in the language of multidisciplinary practice with older people (Love & Kelly, 2011). The National Health System Constitution in UK places person-centred care as one of its seven core principles (Health Innovation Network, 2016). This philosophy is also built into National Service Frameworks for Older People in the UK. Today, person-centred care is also central to the policies of the four countries that comprise the UK. The Health and Social Care Act 2012 imposes a legal duty for NHS England and Clinical Commissioning Groups (CCGs) to involve patients in their care (Great Britain Department of Health, 2012). Vision 2020 for Scotland has a focus on supporting self-management (Great Britain Department of Health, 2012). Northern Ireland’s 2020 quality strategy cites ‘patient and client focus’ as one of its three main areas of focus (Great Britain Department of Health, 2012), while the National Health System of Wales ensures that health care is person-centred in Wales (Cairns et al., 2013).

Eden Alternative, pioneered by Dr William Thomas, a US geriatrician, is a person-centred approach (Brownie & Nancarrow, 2013). Like Carl Rogers, Thomas believes that late life is an active phase and he wanted to create a habitat in which people thrived. He believed that human beings wither in institutions, and as such his aim to deinstitutionalise the aged-care facilities involved enlivening the environment with children, animals and plants to create an atmosphere reminiscent of home. The focus is to empower the residents and the staff, where both take up an active role in care, providing a high quality of life and care for residents, and providing a high-quality work life for staff. Along with Eden Alternative, other related movements such as Wellspring, Green House and Pioneer network have remodelled the institution into a homelike environment where all life can flourish (Love & Kelly, 2011). These movements share similar values of person-centred care and emphasise individualised care, empowerment of residents and staff, and endeavours to achieve holistic care (Caspar, Cooke, O’Rourke, & Macdonald, 2013). The focus has shifted to person-centred care that sees residents as individuals and places value on their
contributions, preferences, and uniqueness. Presently, the Eden Alternative model of care is recognised as person-centred care and has become the gold standard of care (Brownie & Nancarrow, 2013). The Eden Alternative model has been adopted in Australia, New Zealand, Singapore, United Kingdom, Republic of Ireland, Germany, Austria, Switzerland, Sweden, Denmark, Finland, Norway, Japan, China, Canada and South Africa (Brownie, Neeleman, & Noakes-Meyer, 2011; Li & Porock, 2014; Lunsford & Janes, 2015).

Person-centred care has a tremendous contribution towards quality of care (McMillan, Kendall, Sav, King, Whitt, Kelly & Wheeler, 2013; Mead & Bower, 2002). Person-centred care is recognised as an effective approach of care that represents value for money because it ensures that services are built on the needs and preferences of the people who use them rather than on the convenience of providers. Reviews for this topic suggested that person-centred care improves outcomes (McCormack & McCance, 2010), such as improving people’s health and reducing the burden on health services (de Silva, 2014). This requires a partnership among the people involved in the care context, where people are given active roles in decision making, and competent staff are trained to facilitate care that empowers people to take part (Lewin, Skea, Entwistle, Zwarenstein & Dick, 2012; McMillan, et al., 2013).

The degree of disability, illness or complexity of the residents’ needs should not be regarded as a barrier to person-centred planning. Each service user should be given the opportunity to plan their care needs (Dowling, Manthorpe, & Cowley, 2006). Person-centred care culture change initiatives for residential home care have gained popularity as the model of care recognises and respects the voices of the older people (Donoghue & Castle, 2007; Rodgers & Neville, 2007; Tellis-Nayak, 2007; Zinn, Mor, Feng, & Intrator, 2007).

The WHO (2007) urges residential homes to adopt person-centred care and, in so doing, uphold the human rights of older people. This involves enhancing the residents' dignity by promoting self-expression and choices. The residential homes are encouraged to innovate care practices by focusing on residents' individual needs, abilities, and preferences. On the international stage, many countries have begun to emphasise strengthening the voice of the older person (Boyle, 2004), and, as such, the focus has shifted from a paternalistic model of care where staff focused on doing
tasks to a partnership model of care where the residents are engaged in their own care.

The focus of care is no longer more measurement-oriented but has shifted to relationship, structure, and how it prevails and affects both residents and staff (Kane et al., 2003). The cultural change now focuses on creating a homelike environment; it is also empowers residents and staff to have active roles in care, provide high quality of life and care for residents, and provide a high-quality work life for staff. The philosophy of person-centred care advocates choice, dignity, respect, self-determination, and purposeful living for older people in long-term care (Chapman & Carder, 2003). Such care has been theorised to improve quality of care and quality of life for residents receiving care in residential homes (Rosemond, Hanson, Ennett, & Weiner, 2012).

2.5 PERSON-CENTRED CARE NURSING FRAMEWORK FOR OLDER PEOPLE

Since early 2000, there has been a greater emphasis on developing models of person-centred care to enhance older people’s quality of care and life, especially in long-term care. Ford et al. (2000) have developed a gerontological model for nursing practice that includes holistic practice, saliency, knowing the patient, moral agency, and skilled know-how. The model includes some enablers for practice, such as the ability to reflect, authority and accountability for practice, therapeutic interpersonal relationships, and a conducive environment for person-centred care practice. Ford et al. (2000) also explored the theoretical underpinnings of person-centred care and proposed that a person-centred assessment should be a humanistic, trusting relationship between nurse and patient that should include use of biography, respecting values, and must consider the older person’s abilities and strengths. Nolan and Tolson (2000) argue that person-centred care overvalues autonomy and independence, which could be a disadvantage for older people who are often the frailest members of society. Nolan (2004) concentrates on other values and develops a more inclusive conceptualisation of person-centred care, which recognises the values of interdependence and reciprocity. Nolan et al. (2004) developed the Senses Framework to describe potential dimensions of person-centred care. This provides a relationship-centred approach to person-centred care. This framework recognises the importance of relationship and recognises the role of all parties involved in the care
of the residents, especially the family and staff. The emphasis of this framework is on all parties; it seeks to achieve a sense of security, belonging, continuity, purpose, achievement, and significance among all the parties. In order to achieve holistic and individualised care, the focus is on relationships and incorporating the needs of all stakeholders, so that the concerns of each party are considered. Nolan et al. (2004) recognised that the characteristics of an environment makes the older person either impoverished or enriched. The attitudes towards older people play a critical role. When staff actively try to create the environment described in the framework, there is an enriched environment. On the contrary, a lack of effort impoverishes the environment.

In addition, McCormack (2001) identified that nurses could promote or retain an older person’s human freedom and autonomy through partnership. When nurses strive to provide care that is consistent with the values of the older people, then the care becomes meaningful and respectful despite the debilitating illness experienced by the older person. A qualitative case study by McCormack (2001) on the older person’s autonomy through nurse-patient interactions highlights the dynamics of power and control, a patient’s access to knowledge, the impact of professional authority, the restrictive nature of institutions, and the effect of family and frontline caregivers on decision making as constraints to the older person’s autonomy.

Mead and Bower’s (2000) literature review results in a clarification of the dimensions of person-centred medical care. They develop a framework with five dimensions of person-centredness. The dimensions are: 1) biopsychosocial perspective; 2) patient as a person; 3) shared power and responsibility; 4) the therapeutic alliance; and 5) doctor as a person. These five dimensions recognise that person-centredness is associated with quality care and that the key elements are the understanding of practitioners about the unique needs of the person and their ability to form therapeutic relationships.

McCormack (2004) identifies four concepts that underpin person-centred care in gerontological nursing practice: being in relation (social relationships); being in a social world (biography and relationships); being in place (environmental conditions); and being with self (individual values). These help to promote the personhood of an older person. The articulation of these concepts through existing models of person-
person-centred practice in nursing raises the reoccurring themes of knowing the person, centrality of values, biography, relationships, seeing beyond the immediate needs, and authenticity. These concepts are outcomes achieved by McCormack (2004) based on a review of five approaches aiming to provide person-centred care: Burford Nursing Development Unit approach; Authentic consciousness; Positive person work; the Senses framework; and Skilled companionship. McCormack’s (2004) philosophical approach sees that in the care context, the nurse is the facilitator of an individual’s personhood, and as such, the nurse has to focus beyond technical competence. The nurse has to engage in authentic humanistic caring practices that embrace all forms of knowing and acting in order to promote choice and partnership in a care context. The model also promotes value clarification for everyone involved in the care so that the needs of the individual are clear. This allows for recognition of everyone in the care context, which is the basis of person-centred care.

Subsequently, McCormack, Dewing, Breslin, Coyne-Nevin, Kennedy, Manning & Slater (2010) developed a person-centred care nursing framework to guide person-centred care in long-term care. It comprises four constructs: prerequisites (the attributes of the nurse); the care environment; care processes; and person-centred care outcomes. The attributes of the nurse include: professional competence; developed interpersonal skills; commitment to the job; demonstrated clarity of beliefs and values; and knowledge of oneself. The care environment focuses on the context in which care is delivered. The care process focuses on delivering care through a range of activities, including working with residents’ beliefs and values, sharing decision making, and holistic care. Expected outcomes include residents’ satisfaction with care, involvement with care, and encouraging them to flourish and grow. The attributes of the nurse and the environment are prerequisites for providing person-centred care outcomes (McCormack et al., 2010; McCormack & McCance, 2006). The framework also recognises that families have a crucial role when undertaking person-centred care (Innes et al., 2006).

In summary, there have been significant conceptual and theoretical advancements in the area of person-centredness for older person care as evidenced by the development of frameworks, such as the Authentic Consciousness Framework (McCormack, 2003), the Senses Framework (Nolan et al., 2004), and the person-centred Nursing Framework (McCormack et al., 2010; McCormack & McCance,
2006), along with the application and testing of these frameworks in practice (McCormack et al., 2010; Ryan, Nolan, Reid, & Enderby, 2008).

2.6 CHALLENGES OF PERSON-CENTRED CARE IN RESIDENTIAL HOMES

While the frameworks on person-centred care have contributed to the understanding of how to effectively operationalise person-centred care in residential homes, implementation of the models has faced a great challenge. Despite gaining popularity within the long-term care area due to its emphasis on getting to know the person and promoting their personhood, the multidimensional concept of person-centred care causes differences in interpretation and understanding the true meaning of the concept. The subjective attributes of the concept are understood differently by different people (Lloyd, 2004). In addition, the concerns or needs of the older person could change over time based on their disabilities and psychological changes. However, researchers and clinicians have focused on outcome evaluation and use a range of tools to evaluate person-centred outcomes that do not capture the true essence of one’s meaning (Epstein, Fiscella, Lesser, & Stange, 2010; Slater, McCormack, & Bunting, 2009). Ever since the incorporation of a person-centred care culture into residential homes, the resident has become the central focus of concern (Love & Kelly, 2011), but research studies have indicated that the emphasis is on factors that could be enumerated and quantified, which have caused a pendulum swing to hyper-regulation, institutional thinking, and even encouraging litigation rather than the intended person-centred outcomes (Love & Kelly, 2011).

The residential home is a social service system and the quality of care is mostly a system oriented institution (Nakrem, Vinsnes, & Seim, 2011). The features of the system influence the prioritisation of residential home care. It is recognised that most residential homes still follow the medical model of care (White-Chu et al., 2009), which continues to emphasise structural standards such as staff input, weight loss, bedsores, or falls, because funding and resources are based on outcomes of these data (Kane, 2001). This indirectly places more value on medical treatments than the subjective elements of person-centred care. As a result, person-centred care practice often occurs within the constraints of measurable tasks rather than focusing on the subjective wellbeing of the residents and their families (Kane et al., 2003).
Doyle (2012) conducted qualitative interviews with residential home residents and found a great disjuncture in meaning between the workings of the residential home as an organization and the textured realities of the "lived experience" of residents. Residents live in a rich world of subjective meaning, which is seldom recognised and seldom validated by the residential home. It has been documented that an institutional environment has more control over the daily lives of residents resulting in negative resident outcomes, including diminished life satisfaction (Kellett, Moyle, McAllister, King, & Gallagher, 2010).

A similar notion shared by Mukamel (2003) recognises that residential homes continue to be regulated, highly organised and staffed because the reimbursement is based on an acute medical model of care. A different orientation is required to capture the complexities of person-centred care practice in the areas of planning, process, and outcome evaluation (McCormack et al., 2010). Research approaches are needed to measure the subjective values of person-centred care within the multiple and complex functions of residential homes (Nakrem et al., 2011). The study by Kane (2003) has shown that there are detrimental effects on the health of older people when control of their daily life and activities is restricted.

The majority of people living in residential homes want to feel empowered and to continue to make decisions about their life (Kane, 2001). To achieve this, the residential home environment should enhance the holistic functioning of the person and the assessment of quality in residential homes should reflect the residents’ goals for their own lives. However, Kane’s (2001), Harnett’s (2010) and White-Chu et al.’s (2009) studies suggest that the medical model of care dominating the residential home facilities which places value on accomplishments of tasks, maintenance of control, and standardisation of the environment often results in the inhibition of autonomy and in patterns of learned helplessness by residents. An observational study shows that residents' passive behaviour results from an encouragement of dependency and discouragement of independence by staff who further fail to acknowledge, or even punish, residents for their independent behaviour (Custers, Westerhof, Kuin, Gerritsen, & Riksen-Walraven, 2012). In contrast, interventions that enhance options for control by residential home residents results in the promotion of health (van Delden & van Thiel, 2001).
The reports of residential home residents show that they are experiencing a low quality of life, such as depressive symptoms, rapid decline in physical and cognitive function, decreased quality of sleep, and disengagement from society (Herrmann & Flick, 2011; Hill, Kolanowski, Milone-Nuzzo, & Yevchak, 2011; Karakaya, Bilgin, Ekici, Köse, & Otman, 2009; Li & Porock, 2014). Thomas (2003), founder of the Eden Alternative, says that older people in residential homes suffer from three plagues: loneliness, helplessness, and boredom. Boumans (2005) further added that institutionalisation traditionally accelerates the deterioration of self-control and self-esteem because everything needs to happen on a time schedule. The lack of control restricts the residents’ feelings and spirits as the staff tend to focus on taking care of the management agenda that is determined by regulations and financial constraints, complicated by inadequate staffing.

Eriksson (2002) further states that the attitude of the staff caused suffering to the residential home residents. In her theoretical framework, Eriksson describes suffering in three forms: as related to illness, as related to care, and as related to life. The framework indicates that the main purpose of care is to alleviate suffering. However, suffering also results from violating a patient’s dignity and human values. In health care, suffering is described as an experience of being neglected and deprived of care (Arman, Rehnsfeldt, Lindholm, Hamrin, & Eriksson, 2004). This causes patients to be wounded and vulnerable in the health care situation. When staff do not understand the patient’s situation and feelings, the trust between patient and staff is reduced and suffering increases (Wiklund-Gustin, 2011).

Boumans (2005) further explained that the lack of understanding by the staff is due to the nature of nursing training, which is mostly based on a medical model that tends to be task oriented: a typical day in long-term care starts with staff having to rouse patients who invariably grumble at the early awakening times. Residents are awakened, dressed, and prepared for breakfast and medications. They are then transported to the day room for breakfast. During breakfast the staff relentlessly have to rush to complete the task of feeding the residents, which normally exceeds their scheduled timing. This causes the staff to feel anxious and does not encourage them to engage in any kind of meaningful interaction with their residents. The focus is merely on providing custodial care and not on restoring residents’ wellbeing. Doyle (2012) added that the long-term care staff perform their routinised activities without
much human interaction; this distances the staff from the residents who subsequently feel devalued and depersonalised even though the services rendered are good.

Burack, Reinhardt, and Weiner (2012) did a five-year longitudinal study to monitor and guide a nursing home system's transformation from a traditional hospital-type model of care to a culture change model with the central principle of person-centred care. A total of thirteen nursing homes participated in the study. The results showed that residents' quality of life was enhanced when they were involved in meaningful activities. The data were collected at three intervals: baseline, two years, and five years. At each point, the residents completed a quality of life interview, including the Duncan Choice Index. At two years there were positive impacts of person-centred care and choice but by year five this had decreased. The results revealed that sustaining person-centred care in nursing homes was a challenge. This study relied on a structured questionnaire to measure person-centred care, which failed to capture the participants' personal meanings and expectations of person-centred care.

Recent reports by media have highlighted the level of abuse and neglect experienced by long-term care residents. Wong et al. (2014) report that nursing care was substandard in Singapore residential homes. Recent scandals in Singapore where staff have been videotaped roughly handling older residents led to public outcry. Similar abuse has also been reported in the UK; BBC TV news in 2011 shows abuse of residential home residents (BBC News, 2011). A report into aged care, “What does the future hold for older New Zealanders?” by Grey Power (2010) indicates that the quality of care problems common in rest homes or residential homes include: residents being left in bed for entire weekends, left for hours after a fall, residents not being toileted regularly resulting in incontinence, residents not being walked regularly, residents suffering from chronic dehydration or malnutrition, residents having buzzers removed from their reach, and generally being treated as little children and not adults with a vast life history and experience. These findings were collaboratively gathered by Labour and Green political party members together with Grey Power. They received 450 submissions (150 written and 300 oral submissions), held 20 nationwide meetings organised by Grey Power where more than 1,200 people attended, and had conversations with various experts, nurses, and caregivers around the country. The report highlighted that the common reasons for poor care
were financial considerations, such as cost cutting and profit generation resulting in a lack of staffing.

The reports clearly highlight that policies and practices of residential homes fail to meet the wishes of the older people themselves. The culture of care practice in residential homes showed that greater value was given to meet the safety and regulatory standards over promoting the residents' choices and independence that are essential for their wellbeing (Palacios-Cena et al., 2013). The lack of person-centred care culture impacted negatively on the residents who felt institutionalised because priority was given to meeting organisational requirements, staff needs, and regulatory concerns rather than the needs of the residents (Sitoh et al., 2005).

Hence, the long-term care institutions are characterised by images of frailty and despair, loneliness and destitution, and above all, a profound sense of loss, a loss not only of things, but of the identity of the residents.

2.7 RESIDENTS’ INVOLVEMENT IN PERSON-CENTRED CARE STUDY

A study of residents’ experience of living in an institution (Randers, Olson, & Mattiasson, 2002) found that residents were not respected for their unique individuality or meaningful existence; rather the focus of care was on the illness and not on the development of the person. The health care staff failed to recognise the psychosocial and emotional needs of the individuals. While the semi-structured approach allowed the residents to freely discuss their concerns, it was limited to only ten categories related to integrity, a subcomponent of person-centred care.

Most of the research studies identified interpersonal interactions among residents and health professionals as a major impact on person-centred care experience for the residents (Bangerter, Van Haitsma, Heid, & Abbott, 2015; Chang, 2013; Nakrem, Vinsnes, & Seim, 2011). An observational and interview-based study by (Randers & Mattiasson, 2000) showed that once staff develop the ability to respect and confirm each and every older person for who he or she is and would like to be, then there was evidence of person-centred care. This study, conducted by Randers and Mattiasson (2000), indicated that meaningful interactions between the older person and the health care personnel are possible when staff help the residents to actualise
their choices. The residents in this study feel that the focus of care is on their dignity, which eventually fosters greater control for the older person. Theoretical frameworks relating to autonomy and integrity were used to explore the interaction between staff and residents (Randers & Mattiasson, 2000). However, these are only a small aspect of the multi-construct nature of person-centred care.

The interpersonal relationship between the resident and staff has been found to be an essential factor in person-centred care (Nolan, Davies, Brown, Keady, & Nolan, 2004). A qualitative study on residents’ experiences of interpersonal factors in residential home care found that residents perceive an imbalance in the individual care approach (Nakrem et al., 2011). There is more emphasis on medical and physical care and less importance given to psychosocial, emotional, and interpersonal aspects of care (Nakrem et al., 2011). A dimensional analysis of person-centred care identified that quality of care is strongly connected to staff-patient interaction, skills, knowledge, and competencies to alleviate patient’s vulnerabilities (McCormack, 2003). Interaction is an important part of interpersonal care from the perspective of the patient or service user. The findings revealed that the individual needs of the residents were overlooked because staff put the least effort in getting to know the residents (Nakrem et al., 2011). Furthermore, individual care requires long-term commitment and a reciprocal relationship on a personal level (Ryan, Nolan, Reid, & Enderby, 2008). Nakrem’s (2011) study data was collected using in-depth interviews with fifteen participants who were cognitively intact from four residential homes in Norway; however, the contents of the open-ended questionnaire used for the interview were not shared. Nevertheless, McCormack & McCance (2006) highlighted that interactions in the care environment have to be tailored to suit the unique needs of each person. This was further reinforced by Morgan (2012) who added that interpersonal relationships are a primary measurement of person-centred care that contribute to customisation and satisfaction of care between those providing care and those receiving care.

A qualitative interview study with four social workers and a physician demonstrated structural and organisational barriers to implementing person-centred care in residential homes (Rockwell, 2012). The study revealed that staff placed greater importance on completing their tasks. The study highlights the issue that residents were not placed at the centre of care processes at times, and that staff did not work
collaboratively with the residents, family members and among themselves. This study used a very small number of nurses who normally had minimum contact time with older people. There was limited interpersonal engagement and flexibility in care to improve the wellbeing of residents. This study also reveals that meaningful relationships are important for the residents. Probably extending this study to frontline caregivers could provide deeper insight into the concept of person-centred care, as they have immediate and the most contact time with the older people.

Brooker (2004) emphasises that the aim of person-centred care is to nurture relationships between all the people in the care environment. The recognition of each person and their wellbeing will ultimately contribute to the quality of care and quality of life. A review by White (2008) identified a supportive environment as a sixth dimension to the existing five dimensions of person-centred care: personhood, knowing the person, autonomy and choice, comfort care, and nurturing. The supportive environment is further divided into three dimensions: support for work with residents, person-directed environment for residents and management, and structural support. The study used the six dimensions of person-centred care to devise a survey with 64 items that was administered to 430 staff of eight residential homes in Oregon, US. It concluded that the environment in terms of structure and organisational attributes was critical for effective person-centred care practices. Although this tool provided some promising results, it might prove too lengthy for clinical applicability, and further testing is needed. Besides environmental conditions, individual values played an important aspect in delivery as well as the experience of person-centred care. McCormack (2004) identifies that individual values influence positive relationships in gerontological nursing. Developing competent staff is a basic requirement for preparation of an effective environment for person-centred care.

2.8 STAFFING INFLUENCES PERSON-CENTRED CARE

An evaluation of a person-centred care toolkit study by (Van Haitsma et al., 2014) reveals that participating residential homes report shortage of staff (55%), staff resistance (44%), and staff turnover (11%) as challenges to implementing person-centred care. Numerous studies have shown that staffing constraints often limit the ability of residential homes to implement person-centred care and to sustain their efforts in this direction (Harrington et al., 2000; Schnelle et al., 2004). Shin’s (2015) study on registered nurse staffing and quality of care of residential home residents in
South Korea shows that a high turnover of registered staff results in poor outcomes for the residents. The findings reveal that there are increased incidences of falls, tube feeding, dehydration, and aggressive behaviours in the residents. Since the survey study uses quality indicators from the South Korean National Health and Welfare, the relevance to other countries is doubtful. With the skill mix approach to workforce planning in residential homes, every staff member has a role in supporting residents in their care. However, Msiorski (2003) observed that strong person-centred care values are able to reduce staff turnover by 10%.

Moniz-Cook, Woods, and Gardiner’s (2000) study recognises that training in person-centred care is vital for staff; it helps them to cope with their demanding job. This study focused on dementia patients and they define the term ‘challenging behaviour’ as “a manifestation of distress or suffering for the person with dementia, or of distress in the care giving staff” (Moniz-Cook, Woods & Gardiner, 2000, p.52). They identified additional training would help the caregivers understand why such symptoms arise, altering their perceptions and helping them understand the associated challenges in supporting the person with dementia (Moniz-Cook, Elston, Gardiner, & Agar, 2008). However, no clear definition on person-centred care was provided. The authors do suggest that knowing the life history of the individual and relating to residents as individuals are key aspects of quality care, which could be seen as constituents of ‘person-centred care’.

Brodaty, Draper, and Low (2003) studied strain and satisfaction among nursing assistants working with residents with dementia. They found that the nursing assistants did not understand the residents’ problematic behaviours and were also frustrated with the demands of the family members (Brodaty, Draper, & Low, 2003). The study recommends interpersonal relationships between staff, residents and their family members through effective educational and support systems. Other research studies support similar ideas and indicate that specialised training and environments would enhance the skills of the staff and provide job satisfaction, which in turn would lead to improved job performance and better care for residents (Cho et al., 2008).

A study by Park (2010) examining nursing staff stress with their caregiving roles and attitudes toward family members and residents in Korea reveals that training plays an important role in reducing stress level. Training has been identified as an important
factor in reducing nurses’ stress levels and enhancing residents’ care in residential homes. Two hundred sixty-seven nursing staff members from 10 residential homes completed the Caregiver Stress Inventory and the Attitudes about Family Checklist. Interestingly, the results showed that care assistants reported more stress and negative attitudes toward family members and residents. They felt inadequate to manage aggressive residents. The nursing assistants and care assistants learnt primarily to care for residents through trial-and-error interventions (Cho et al., 2008), which affected their satisfaction level because the frontline caregivers experienced more burdens and frustrations. But Park’s (2010) study had limitations because of its quantitative approach; perhaps a qualitative approach might have provided more insight into the dynamics between staff and family members.

While training plays an important aspect in delivery of person-centred care, reducing burnout among staff is equally important. Hannan, Norman and Redfern (2001) investigated the relationship between work satisfaction, stress of care, quality of care, and wellbeing of older people. Their literature search highlights that staff burnout was an important factor. It was noted that the characteristics of the residents, such as their dependency level on assistance to perform their daily activities, were found to affect employee stress. Similar notions are also shared by Chappell (2002) and Zimmerman (2005). The structural factors are identified as affecting quality care and wellbeing of the older residents (Hannan et al., 2001; McCormack et al., 2010). However, there is no mention of the unit size that was identified as a structural factor that could contribute to staff work stressors and job performance. The paper concludes that as the staffing level improves, there is a reduction in the stress level of the staff, and a corresponding increase in work satisfaction. Staffing level is only one aspect to improve person-centred care; the staff also have to be equipped with sufficient knowledge and skills to deliver the quality care. The quantity of staff is not a complete solution to providing quality care. Good management support, support from supervisors, peers, family and friends are important factors that help to boost staff morale and reduce burnout. Bowers, Esmond and Jacobson’s (2000) study explored caregiving practices and perceptions of quality care among participants of six residential homes. In-depth interviews with staff and observation methods were used. The grounded theory analysis shows that consistent staffing increases familiarity with residents and thus enhances the quality of care. Similar findings are also shared by Chung (2009) in Australia, and earlier studies by Mattiasson and Andersson (1997) in
Sweden. Bowers (2000) emphasises those who are familiar with residents, and who have established relationships, should be considered when staffing levels were measured. These staff were able to deliver effective person-centred care despite structural constraints due to their familiarity with residents’ needs.

Pekkarinen (2004) examined the relationships between residents’ needs, structural factors, employee work stressors, and the quality of life of the older residents in long-term care units. The study revealed that staff work satisfaction is better for those who work in smaller residential home units. Cross-sectional survey data were collected from 1,194 staff and 1,079 relatives from 107 residential home units. A multilevel modelling analysis reveals that work stressors and time pressures are higher in bigger institutions. This study was conducted in Finland using surveys from self-reported questionnaires. Participants were selected using a cluster sampling method. Large unit size correlated with increased time pressure. This study used physical, psychological, and social domains of quality of life to measure participants’ conceptualisation of quality care, but by no means are these domains comprehensive in understanding the holistic needs of an individual.

The link between levels of work satisfaction, staff stress, quality of care, and morale of the residents was explored in a 46-bed residential home in the UK (Redfern, 2002). Validated scales were used to measure job satisfaction, work stress, organisational commitment, and perceived quality of care, morale, and mental health. Forty-four care staff and 22 cognitively intact residents took part, either completing the questionnaire or being interviewed. The results show that there is a significant correlation between satisfaction and commitment, and the quality of care provided by staff. The correlations between a homely atmosphere perceived by residents and their morale and mental health were low. However, the results did not confirm the link between quality of care and the morale and mental health of the residents. It is clear that the emphasis of this study was on measurable targets. The input from the residents was vital to provide evidence on their satisfaction of care, which also provided inputs required to develop or select quality initiatives (Tellis-Nayak, 2007).

Another study on satisfaction by Chou (2003) involving 70 older people in care facilities in Western Australia shows that resident satisfaction is high when staff satisfaction is elevated. The study assessed how facility staff and resident factors
simultaneously influenced components of resident satisfaction. The participants included 1,146 residents and 983 staff. Resident satisfaction was measured using a self-completed questionnaire that Boldy and Grenade (2001) developed as part of a resident satisfaction assessment package. Resident satisfaction was measured using six scales: room, home, social interaction, meal service, staff care, and resident involvement. Resident dependency was measured by the Resident Classification Scale items (Boldy & Grenade, 2001). The staff satisfaction used the self-completed job satisfaction questionnaire covering five aspects of job satisfaction: personal satisfaction, satisfaction with workload, team spirit, training, and professional support. However, the profiles of the staff who participated are not mentioned; the job scope and related training provided for formal and informal staff are very different, which could impact on the knowledge of what was quality care.

Mellor, Chew and Greenhill’s (2007) study reports that even though the nurses working with older people demonstrate positive attitudes towards older people, they lack significant knowledge in clinical practice issues, the socio-economics of ageing, and specialist care of older people. The purpose of their study was to explore attitudes of nurses working in multi-purpose health service toward older people and gerontology care. A descriptive, non-experimental quantitative research design using a self-reported questionnaire was used. This study was conducted in Queensland, Australia. The measurement tool was used to measure the attitude and knowledge of nurses about older people. However, extending the study to care assistants could have provided valuable insight into the findings. The care assistants are the direct care providers to the older people so their attitudes have a greater impact on the care received by the older residents.

So far the studies have shown that the quality of care or person-centred care is influenced by staffing (Bowers et al., 2000), the care work (Hannan, Norman, & Redfern, 2001), work satisfaction of staff (Pekkarinen, Sinervo, Perälä, & Elovanio, 2004), work stress (Park, Yi, & Kim, 2010), attitude (Mellor, Chew, & Greenhill, 2007), and these were mainly from the perspectives of residents or trained staff.

It has been well-documented that the certified and non-certified care assistants in long-term care settings have the most intimate contact with residents; they are the frontline staff who provide the most personal care for whom they were responsible
The difficulty of their care task depends largely on the average level of disability of the residents. The disability is referred to as the level of functional and/or cognitive impairment, and includes disruptive behaviours. It has been suggested that repeated exposure to demanding, aggressive behaviours impacts negatively on job satisfaction and on job performance of the care assistants (Chappell & Reid, 2002). This negative experience, coupled with limited or inadequate training (Castle, Engberg, Anderson, & Men, 2007), makes the care assistants feel exhausted and emotionally stressed (Edge, 2007).

Frontline care staff are also considered good judges of quality care because their satisfaction not only indicates the differing view but also the quality of service provided (Beck, Doan, & Cody, 2002). They play a key role in facilitating or delivering person-centred care (Innes et al., 2006). The most reliable source to know the true meaning of person-centred care comes from the residents in residential homes; nonetheless, getting the perspectives of staff should help shed light on whether staff members offer residents choices in their daily care activities. Although the retrospective reports from Innes, Macpherson and McCabe’s (2006) study might be biased or flawed by recall error, the experience and perspective can provide critical information on the person-centred care services.

Furthermore, in many countries, the ethnic diversity of the care assistants is noticeable in the context of caregiving (Khawaja, Boddington, & Didham, 2007; Kiata et al., 2005; Wee et al., 2015). It challenges both frontline caregivers’ and the residents’ expectation of care. This diverse care setting has become the norm due to lack of interest from locals to join the workforce; in many developed countries, substantial numbers of care staff are of a racial/ethnic minority group who provide care to residential home residents (Foner, 1994a; Ramirez, Teresi, & Holmes, 2006). This cultural and ethnic diversity causes differences in care approaches, communication styles, work habits, and expectation of care provision and reception; thus, there is more potential for misunderstanding (Ramirez et al., 2006). Among the staff working in residential homes, the care assistants appear to be more likely to experience job stress in terms of emotional/psychological outcomes. This could potentially have repercussions in terms of the quality of care provided.
2.9 FAMILY MEMBERS’ ROLE IN PERSON-CENTRED CARE

Family members play an important role in person-centred care (Bowers, 1988). Family can continue to play an important part in the lives of residents and can provide insight into the resident’s biography. This information is essential for frontline caregivers so they can get to know the residents better and utilise this information to personalise the care given. As individuals age, they rely on family members for support. This support proves vital in enabling older people to continue to influence their care and direct their daily lives even as they transit from a home setting into a residential home (Gaugler, Anderson, Zarit, & Pearlin, 2004; Gaugler, Pearlin, & Zarit, 2003). However, studies have revealed that family members are perceived as obstacles and problems by the staff. Instead of getting to know the family members, staff try to keep a distance from the family members (Janzen, 2001). Bauer's (2006) study explored how frontline caregiving staff experienced working with family members in residential homes. It reveals that working with families is not considered important. The staff are more geared to providing physical care. This study was conducted in 30 residential homes in Melbourne, Australia. Issues on how nurses constructed the role of family was explored by means of conversational in-depth interviews. It also highlighted that staff are overwhelmed with their routine tasks and have no time to engage with family members. Family members remain advocates for providing personalised care, monitoring care, initiating activities of interest for the residents, sharing their life histories with staff, and serving as spokespersons in care planning meetings (Boise & White, 2004).

Although there is consensus that high quality care is person-and-family-centred, Lopez et al. (2013) found that strategies to operationalise these principles are lacking in long-term care. Their study to understand family members’ perspectives on person-centred care reveals that five areas are considered important to family members. Those concerns are: providing basic care; ensuring safety and security; creating a sense of belonging and attachment; fostering self-esteem and self-efficacy; and coming to terms with the experience. Although this study focuses on end-of-life care provided to residents in residential homes with advanced dementia and only 16 family members participated in this study, the findings could be significant for cognitively intact residents of residential homes.
Nevertheless, other studies have indicated that family members do not always fully understand older adults’ preferences for care in the residential home (Carpenter, Lee, Ruckdeschel, Van Haitsma, & Feldman, 2006; Feinberg & Whitlatch, 2001; Reamy, Kim, Zarit, & Whitlatch, 2011). It is evident that family members underestimate the values of the older person across five domains: autonomy, safety, burden, control, and family (Reamy et al., 2011), while Carpenter et al.’s (2006) research shows that family members frequently underestimate the importance of continued growth and development of the older person. These studies were done in home and community settings and work needs to be done to examine whether this discrepancy was also present between family members and older relatives living in a residential home.

Recent research has acknowledged that the value of residents’ inputs regarding care and satisfaction is an indicator of person-centred care (McCormack & McCance, 2006). However, achieving person-centred care and putting the needs of the patient or individual first have received less attention (Kharicha, Levin, Iliffe, & Davey, 2004). In examining approaches to measure person-centred care, some tensions emerge between an ‘ideal’ approach and what is happening in practice. An important tension is the extent to which residents are involved in developing approaches and tools, and the extent to which the tools measure concepts of importance to residents. The concept of person-centred care puts residents at the heart of their health and care, yet few research approaches measure person-centred care driven by residents or are built on aspects identified by residents as being most crucial. Instead, many of the studies rely on observations by proxies, either family members or staff, to provide information on residential home residents’ quality of care and life. This information should be considered highly subjective and does not provide actual or factual information (Aguilar, 2011). While some studies include both resident interviews and proxy interviews, the validity of the proxy is not discussed (Kane et al., 2005). A study by Kane (2005) on how well staff and family proxy reports compare to residents’ own reports on quality of life domains - comfort, dignity, functional competence, privacy, meaningful activity, food enjoyment, relationships, security, and autonomy - shows that the residents’ reports of quality of life and care cannot be substituted. Proxy measures do not show clearly that quality of care is accurately measured. Whilst asking family members to report on a residential home resident’s preferences may be one step removed from providing truly person-centred care, family members are
recognised as key respondents to call upon in understanding residents’ preferences, particularly as the cognitive ability of the older person declines (Reamy, Kim, Zarit, & Whitlatch, 2012).

Doyle’s (2012) phenomenological study on the lived experience of older people receiving community care identified that when frontline caregivers establish interactions between the residents and their family, it constructed meanings and influenced the residents’ experience of care. The engagement of family members enhances active participation of the older person by maintaining consistent relationships, one’s sense of autonomy, lifestyle, home environment, and routines as closely as possible to those that existed prior to moving into the residential homes (Doyle, 2012). These expectations reflect the values of person-centred care (McCormack et al., 2010). Doyle (2012) also recognised that meanings are developed and constructed in an ongoing process, through daily interactions and attitudes, which could even be communicated through subtle behaviours and actions of those close to the residents. Despite the significance of these meanings and the importance of interpersonal relationships to the older person’s experience and wellbeing, the construction of meaning during the care experience has seldom been explored (Doyle & Timonen, 2010). Though Doyle’s 2012 study was done with older people living in community, it would be useful to replicate it in older people living in residential homes.

2.10 LIMITATIONS

Based on the findings from the literature review, it is clear that person-centred care is an effective model of care for older residents of long-term care or residential homes, but many working in the sector lack knowledge and understanding of person-centred care (McCormack, 2004). The complexity of person-centred care makes it difficult for facilities and researchers to determine when, and to what degree, the implementation of person-centred care is achieved.

Person-centred care is clearly a multidimensional construct but which and how many dimensions are appropriate to tap into when considering the wellbeing of the residents who receive the care is less clear. Clendon (2013) recognises that person-centred care in New Zealand residential homes could be demonstrated simply through daily care activities, such as sitting and listening to the person and focusing
on their needs rather than focusing on the tasks that need to be done, or as complex as involving them in a quality improvement process. A culture of accepting people for who they are and where they are at in their life, and incorporating that into their care, are essential aspects of person-centred care (Clendon, 2013). The viewpoints of the service users about the daily care activities could provide meaningful insight into the personal meaning and experience of person-centred care.

Kane (2003) recommended that the involvement of the older people and understanding their experience of care is a useful form of evaluating person-centred care as personal experience involves the person’s mind, body and spirit, the embodiment of the environment, and their life experiences in time and space, which add rich description to their experience and meaning. Research into understanding the needs or experiences of person-centred care from the perspective of the residents is imperative. However, research studies on residents' perspective of person-centred care are limited and appear confusing; only a few studies capture the residents' lived experience of person-centred care.

In addition, getting to know the family members’ expectations of person-centred care play an important role in reporting residential home residents' person-centred care experiences. By gathering the views and experiences of the family members, more detailed information would be collected, which could offer greater knowledge to frontline workers and residential homes to understand the complexities of residents’ and family members’ requirements and recognise where there are gaps in the current provision of care. It is critical to include the family perspective (Aguilar, 2011). Though family members are recognised as key players in the person-centred care model, very few studies include family in research.

Though person-centred models do appear to have established interconnected relationships between older people and others significant to them, the reality in practice shows that it is not driven by the model, rather by the person. The core of person-centred care is to offer choices to residents; however, the multifaceted nature of the person-centred care construct creates many challenges for practice. It is clear that in refining measurement approaches or selecting tools for future improvement initiatives, residents and families need to be placed first in terms of what is measured.
Besides residents and family members, the frontline caregivers also play an important role in providing or facilitating person-centred care for residents of residential homes. The frontline staff know the needs and wants of residents in any aged care facility due to proximal contact with the residents. Love et al. (2011) recognise that the experience of residential home frontline caregivers is as important as the registered nurses and administrators. However, most published research studies did not involve frontline caregivers, rather instead mostly nurses and other health professionals. The views and experiences of the frontline caregivers are equally important as they provide the immediate care services and have the most contact with the residents and their loved ones. There has been a growing interest in understanding the roles and experiences of frontline workers and how frontline care could be made more ‘person-centred’. The views of service users are also key in understanding how to promote independence. Innes’ (2006) focus group study on promoting person-centred care at the frontline included the views of frontline caregivers and service users. The study identifies the structural barriers within which frontline workers function and highlights the personal attributes and qualities that frontline workers bring to their role, and the satisfactions and frustrations of their work. Whilst there were examples of good and innovative frontline work, there were many structural obstacles to overcome for services to be ‘person-centred’. The report is considered useful to researchers, clinicians, service providers, service users, and all those involved in developing services for older people. However, the focus group discussion approach is not adequate enough to capture the personal experiences or meanings of the phenomena, person-centred care by the participants.

Brown and McCormack (2011) recognise that the residential home community comprises residents, family members, and frontline caregivers, and it is essential to factor their feelings and needs so that a shared understanding among them could be achieved. Nolan’s (1997) Senses Framework further supports that a relationship model promotes positive care experiences, where opportunities are created for common understanding of values by the three groups: residents, family members and frontline caregivers. Hence, the viewpoint of the three stakeholder groups is required to measure the effectiveness of person-centred care.
In the light of these findings, current research on measuring person-centred care delivery has focused on the development of tools for evaluation (de Silva, 2014). It has relied on older people’s self-reports (Edvardsson et al., 2010; Van Haitsma et al., 2014). Van Haitsma, Curyto & Spector (2012) gathered data from frontline staff (Chappell, Reid, & Gish, 2007; Edvardsson et al., 2010), family members (Lansmon-Winter, 2008) and tracked care experiences derived from daily care activities (Innes et al., 2006). A particular emphasis has been placed on the assessment of stakeholders’ preferences in everyday care as a key component to delivering person-centred care (Housen et al., 2009; Van Haitsma et al., 2014). However, not much research work has explored the preferences of the stakeholders to find out what was their understanding of person-centred care, and, more pointedly, their everyday preferences.

The current review indicates that studies on person-centred care rely on measurable approaches, which are more system oriented than resident oriented. In other words, if care is to be person-centred, then the primary measures of healthcare quality used should also be person-centred. Thus, the focus has to be on the residents and their immediate social contacts who have tremendous influence on the care activities. With this in mind, the aim of this study is to understand the residents’, family members’ and frontline caregivers’ experience of person-centred care. It is important to take note how a person feels about his or her life; also, the meaning of wellbeing has subjective elements. The review indicates how a person evaluates whether an experience was positive or negative depends on the context in terms of the country, health care setting, practices, and type of instrument used. Most of the related studies are reported from a Western context while a few are from Asia and the Middle East. In order to capture a wider perspective, this study was conducted within New Zealand and Singapore contexts.

Both New Zealand and Singapore have incorporated person-centred care into their health strategy towards older people (NZ MOH, 2012; SIN MOH, 2012). The nursing homes or rest homes are supported by government funding in both countries. The evidence of person-centred care values are clearly reflected in the corporate mission of the homes that participated in this study. The values reflected are respect, compassion, integrity, courage, independence, involvement of family, and partnership. Both homes used skill mix to contain cost, manage staff shortage, and
deliver quality care in long-term care institutions (NZ MOH, 2012; SIN MOH, 2012). The frontline caregivers of the rest homes in New Zealand consisted in equal numbers of locals and immigrants from the Philippines and the Pacific Islands, while in Singapore they were mainly foreigners from the Philippines, Myanmar, and India. Both homes are subject to Ministry of Health audits, which mostly consisted of measurable outcomes such as the number of falls, pressure ulcers, infections, incontinence, skin tears, and staffing. Despite such strong quality processes in both countries, there were reports by media highlighting staff abuse of residents. Although both countries have different cultural orientations, the nature of care provided and experienced showed many similarities. It was decided to conduct this study in both countries.

2.11 SUMMARY

The quality of care and life in residential homes are under constant review in many countries. The concept of person-centred care has been identified as an appropriate model of care to enhance quality care in both Singapore and New Zealand residential homes. It is recognised that the definition and measurement of person-centred care are difficult as a result of the multifaceted nature of person-centred care. It is recommended that the focus of care moves from measurable outcomes to the growth and development of the older person. This requires an environment where connections among the service users - residents, family members and frontline caregivers - are encouraged. The service users’ perspectives and satisfaction with care have been identified as essential aspects in the evaluation of the meaning and success of person-centred care. The frontline caregivers and their job context have been recommended as an ideal basis to explore the service users’ satisfaction. In spite of the growing awareness of the importance of the stakeholder views, there remains a lack of research addressing the views of residents, family members and frontline caregivers on person-centred care; also, there is a need to explore the views of all groups to enhance understanding of how person-centred care can become better incorporated into practice.
CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

This chapter seeks to provide a philosophical and a methodological framework for the study of aged care. It begins by exploring the relevance of the study of experience to the field of nursing, followed by phenomenology and nursing. Next it discusses the origins of phenomenology with a detailed view on Van Manen’s hermeneutic phenomenology. Lastly, this chapter describes the method adopted by this study, the setting and participants, the ethical considerations, and the data analysis.

3.2 NURSING AND EXPERIENCE STUDY

Nurses routinely come across human experiences that are filled with emotional, relational, and meaningful significance for the patients. Especially in the residential home context, health staff spend much time with the residents, and studies have shown that this has a significant impact on the residents’ care experience (Koren, 2010; Nakrem et al., 2011). Patient experiences have been identified as an indicator for evaluating and improving the quality of care (Mainz, 2003). Further, Thomson et al. (2011) recognised that it is essential for nurses to understand themselves and the patient as two distinctive beings, as this provides fresh possibilities for knowledge that is authentic to individual experience.

The concept of meaning is linked to the process of understanding, which is shaped by the beliefs, values and attitudes of the meaning maker (Dowling, 2007). Thus, the lived experience is affected by the cultural values and the social context. Since a residential home is a place of residence for older people, each with their own range of socioeconomic means, education, careers, religions and cultural backgrounds, their experiences will be varied and unique. In order to carefully and accurately identify the essence of their experiences, a phenomenological method was ideal, because this approach makes it possible to observe the phenomena in context.

3.3 PHENOMENOLOGY AND NURSING

Van der Zalm and Bergum (2000) suggest that phenomenology has contributed tremendously to the development of nursing knowledge and practice. Many nurse
researchers have used phenomenology as a research methodology to understand a person’s reality and experience of illness. They have then embraced a holistic approach to the person by valuing the individual and nurse-patient relationship (Benner, 1994; Gaugler, 2005). Murphy (2007) comments that phenomenology allows nurses to understand the meanings people attach to their illness and to the events that disrupt their lives. This develops nurses’ capability to better help the patients. The purpose is not to develop predictive and prescriptive theory, but to reveal the nature of human experience. In a phenomenological sense, knowledge does not inform practice; instead knowledge or understanding happens through reflective practice, which results in understanding (knowledge) that in turn enlightens practice (Van Manen, 1997). The phenomenological study approach also provides an opportunity for participants to re-visit and reflect on their daily care encounters. This process allows participants to make greater sense of situations and events, and explore ways to humanise their caring environment.

Though the use of phenomenology within nursing research has become increasingly popular (McVicar & Woody, 2005), it is noted that there are misuses of the term phenomenology (Van Manen, 1997). The main and common issue is related to the researcher who was detached from the key philosophical ideas of the phenomenological method (Yegdich, 2000). Researchers have shown instances of misunderstanding the philosophical issues underpinning the use of the term phenomenology. This has led to confusion about the use and application of the method (Finlay, 2009). Therefore, it is critical for nurse researchers to articulate and justify the philosophical underpinnings for the selected phenomenological approach (Van Manen, 2007). It has been claimed that such recognition will increase one’s appreciation of the validity of the method and provide rigour to the method (Thomson, Dykes, & Downe, 2011). This recognition also increases the credibility of the study where the researchers are guided by a clear philosophy (Dahlberg, Dahlberg, & Nystrom, 2008).

### 3.4 ORIGINS OF PHENOMENOLOGY

In ordinary life, day-to-day experiences are captured and conceptualized based on one’s preconceptions. The memory of the experience often turns into something other than it actually was, due to being one or two steps removed from direct unfiltered experience. Phenomenology was adopted as a method to learn about
another person's experience by listening to their descriptions of what their subjective world was like for them. Phenomenology attempts to understand this in their own terms as fully as possible, free of other's preconceptions and interferences. Thus, phenomenology strives to clarify one’s receiving abilities and rediscover the true meaning of a phenomenon of study. This qualitative research methodology has become very popular in the fields of nursing, medicine and health research in general, enabling the researcher to study the experiences of patients and staff (Dowling et al., 2006). The approach this researcher used is based on the method of Van Manen (1997) who himself was strongly influenced by the work of Husserl, Heidegger and Gadamer (Dowling, 2007).

3.4.1 PHENOMENOLOGY: HUSSERL

Phenomenology was initially developed by Edmund Husserl (1859-1938), a German mathematician, who defined phenomenology as 'the science of pure consciousness.' He saw it as a discipline that explained how the world was constituted and experienced through conscious acts (Van Manen, 1997). Husserl's focus was epistemological, which referred to an objective approach to study of a phenomenon. He regarded experience as the fundamental source of knowledge (Racher & Robinson, 2003). For Husserl, the rigorous and unbiased study of a phenomenon was possible with phenomenological methodology because of the importance this approach gives to seeing things as they appear in order to arrive at an essential understanding of human consciousness and experience (Giorgi, 2000). Husserl’s phenomenology focused on appearance, which referred to something other than itself (Dowling, 2007). Appearance was considered unique to an individual. The appearance can have many different views. Phenomenology allows a person to study an experience as it occurs.

Phenomenology is essentially the study of lived experience of the life (Van Manen, 1997). The emphasis is on the world as lived by a person, not the world or reality as something separate from the person (Van Manen, 1997). The inquiry into an experience is revealed by unfolding meanings as they are lived in everyday experiences. In the daily context, the phenomenon of an experience normally is not reflected upon, and true meanings are lost because the experience has undergone layers of explanations as to causes of the origins. Van Manen (1997) emphasised that the approach of study should have a means of rigorous and systematic
measurement to ensure the appearance of the experience remained authentic. The true meaning of an experience is not found after being reflected upon, but rather it can be found before even one thinks about it (Thomson et al., 2011). This is important because the true meanings of an experience could be easily erased in the haste of everyday thoughts (Thomson et al., 2011). Husserl’s phenomenological approach states that one has to go back to an experience that was lived before it became an object (Finlay, 2009). He believed that this process of reflection and giving thoughts to one’s experience made one’s life complete because it provides a deliberate effort to reflect on an experience or phenomenon that was taken-for-granted or missed. He also suggested that the meanings given to a person’s experience were assumptions of everyday understanding of embodiment.

Husserl viewed intentionality and essences as key to understanding phenomenology. He saw intentionality as a process where the mind was directed toward objects of study. The conscious act was the starting point in building one’s knowledge of reality. The intention directed one’s focus to develop a description of particular realities. This process would eventually show the researcher the ultimate structures of consciousness. These structures were described as essences that made the object identifiable as a particular type of object or experience, unique from others (Dowling, 2007).

The process of phenomenological reduction or bracketing was developed by Husserl (LeVasseur, 2003). Husserl proposed that one needed to bracket out the outer world as well as individual biases in order to successfully achieve contact with the essences. The purpose is to suspend one’s judgment or to bracket a particular belief about the phenomenon in order to see it clearly. This phenomenological attitude of reduction or bracketing allows the researcher to put aside one’s assumptions and preconceived ideas and look at things with an open perspective. This is vital in order to generate valid data of a phenomenon. Similar thoughts were shared by Van Manen (1997) and McConnell-Henry, Chapman, and Francis (2009) who stated that the essence of a particular phenomenon could only be discovered when experiences were not obstructed by preconceptions or theoretical notions (Racher & Robinson, 2003). Participants’ descriptions of their experiences are considered as the raw data upon which the researcher has to reflect in order to discover the nature of the
phenomenon, intuit the essence of its underlying structure, and describe them (Dowling, 2007).

Husserl's phenomenological approach shows that the data derived were fundamentally epistemological in nature as they provide a description of an experience (Dowling, 2007) with no room for a researcher's preconceptions. His goal was to actually see things ‘as they are’ through intuitive seeing (Earle, 2010). The experiences are examined with the intent of revealing consciousness (Hein & Austin, 2001). He sought to show a purely immanent character of conscious experience by means of careful description.

3.4.2 HERMENEUTIC PHENOMENOLOGY: MARTIN HEIDEGGER

While Husserl focused on understanding beings or phenomena, Heidegger focused on ‘Dasein’ by which he meant a human being. He dismissed the notion of intentionality as described by Husserl, and believed that phenomenology should support the investigation of the ontological question of Dasein (Dowling, 2007). He used the phrase ‘being-in-the-world’ to refer to the way a human being exists, and how a human being was involved in the world (Van Manen, 1997). Heidegger also wanted to explore how people make sense of things, which he considered as a basic form of human existence. Heidegger’s expression of Dasein called attention to the human being whose existence was embedded and immersed in the physical and tangible day-to-day world (McConnell-Henry, Chapman, & Francis, 2009). Heidegger, in contrast to Husserl’s philosophy, sought answers to questions about the world and the objects within it, viewed people and the world as interwoven, and related in cultural, social, and historical contexts (Dowling, 2007). Hence, Husserl's notion of descriptive phenomenology removed the person from the world of phenomena, but Heidegger placed the being in the world (Heidegger, 1962).

Heidegger developed a hermeneutic phenomenology that referred to the philosophy of interpretation (Hein & Austin, 2001) and was interested in interpreting and describing human experience. He claimed that hermeneutics broadened the study of phenomenology by studying the concept of being in the world, rather than knowing the world. The focus was on illuminating details and seemingly trivial aspects within an experience that may be taken for granted in our lives, with the goal of creating meaning and achieving a sense of understanding (Gadamer, 1960).
Heidegger asserted that human existence is a more fundamental notion than human consciousness and human knowledge (Lopez et al., 2013). He believed that understanding was a basic form of human existence. The idea of understanding referred to the way one engaged with the world and not just the way one knew the world (McConnell-Henry et al., 2009). He said that one’s history or background, which includes culture, influences one’s way of understanding the world. The person’s sense of right and wrong, and true and false are determined by this understanding of the world. It is important to note that one’s background cannot be made completely explicit. Rather, Heidegger suggested that people and the world were indissolubly related in terms of cultural, social and historical contexts (Dahlberg et al., 2008).

Heidegger recognised that the researcher had to identify with the participants and their experience of time. This would enrich their personal involvement and enable them to understand the embodied experience of the participants’ true meaning of a phenomenon within the context of the participants’ social, cultural and historical world (Finlay, 2009). The meaning and interpretation of experiences were grounded in time, in Heidegger’s view, and time was considered the horizon of all understanding of human existence (Laverty, 2003). Because of temporal grounding, time gives a fundamental structure to human existence and provides awareness of human existence (Heidegger, 1962). He promoted the conceptualisation of time that must be reflected on in the conduct and outcomes of interpretative phenomenological research. Thus, Heidegger’s interpretative phenomenology considers time to be fundamental to the understanding of a human being and the meaning given to their experiences.

While time allows people to give common meaning to an experience, time is also seen as past, present and future, which has to be experienced as a unity. The experience of the unity means that what is experienced in the present is consistent with what was experienced in the past and what is expected to be experienced in the future (Heidegger, 1962). It is this history of life events that influences and directs an individual’s values and beliefs. These provide explanations which are needed when crises occur and care decisions are being chosen (Mackey, 2005; McCormack et al., 2010). Heidegger postulated that the interpretation of meaning by the researcher is
influenced by the researcher’s judgment. Those preconceptions, which are based on past experiences, have an impact on current experiences and also influence the meaning of future experiences. Time is considered to influence the continuity of past experiences towards one’s future experience, which could be for better or worse (Alexander, 1987). A cumulative experience could either shut one down or open up one’s access to possible future experience (Adams, 2006).

Heidegger stated that what was to be discovered was not the essence of the phenomenon, but the being of the phenomenon because hermeneutics moves beyond the description, or core concepts, of the experience and seeks meanings that are embedded in everyday life occurrences (Lopez et al., 2013). He rejected the notion of essences and the emphasis of knowing it (Racher & Robinson, 2003). He also rejected the notion of the dichotomy of subject and object implicit in Husserl’s study of philosophy where the researcher as subject had to clear all preconceptions in order to study the object of consciousness. He claimed that we live our life by experiencing it, and not by objectifying to know it (Racher & Robinson, 2003). Thus, as an ontologist he stressed that the questions of hermeneutic study should aim to uncover the meaning of being.

Heidegger said that interpretation was seen as a process to disclose what was already known as a whole and reveal what was already understood (Adolfsson, 2010). He recognised that though things in the world were given meaning when they were understood through interpretation, the phenomenon could only be revealed by understanding those given meanings. Heidegger cautioned researchers undertaking hermeneutic study to remember that the mere fact that they were already drawn to a particular idea or phenomenon showed that they were at risk of overlooking the taken-for-granted aspect of a participant’s daily life (Heidegger, 1962). He reminded researchers to accept and value the descriptions given by the participants as their reality, their meaning of the phenomenon (Dowling, 2007). However, Heidegger (1962) cautioned that the phenomenon was always hidden and required uncovering to show itself. The phenomenon that appeared and was reported by the participants might seem all right even when it was not all right. Thomson, Dykes and Downe (2011) pointed this out as an ever-present situation in phenomenological research.
Hermeneutic phenomenology goes beyond description to discover the hidden meanings (Merleau-Ponty & Smith, 1996). Hermeneutic phenomenology therefore differs from descriptive phenomenology, which emphasises knowledge of the world through the study of consciousness. Heidegger indicated that each individual’s experience was unique, although descriptive phenomenology tries to generalise human conditions. Findings are revealed through explicit descriptive language. The purpose of hermeneutic phenomenology is to modify these generalised findings and incorporate them into the interpretive process of understanding. The hermeneutic phenomenology assumes that phenomena have an essential essence, which can be intuited and studied objectively through the process of bracketing. Hence, Heidegger (1962) maintained that preconceptions were an integral part of the process of understanding.

Unlike Husserl, Heidegger dismissed the concepts of bracketing and phenomenological reduction and maintained that presuppositions are vital to interpretations (McConnell-Henry et al., 2009). Heidegger recognized that previous knowledge is an essential requirement for the hermeneutic researcher, providing the ability to interpret the data as close as possible to the participant’s lived experience. In Heidegger’s (1962) opinion, all understanding is connected to a given set of fore-structures, including one’s background. The fore-structures are the basis for interpretation to build on. A fore-structure is the prior awareness of a phenomenon that influences one’s attention and anticipation directed toward the phenomenon (Benner, 1994; Wojnar & Swanson, 2007). This promotes a common context and meaning between the researcher and participants’ opinions and experiences. Also, the prior knowledge ensures that the researcher could ask pertinent questions for the study. This encourages a greater level of immersion in the data as the researcher continues the process of interpretation as he/she listens to and reads the participants’ descriptions of their experience of the phenomenon. Even as the researcher is immersed, one needs to be aware of these interpretive influences. This interpretive process is achieved through a hermeneutic circle that moves from parts of the experience to the whole of the experience. This movement continues back and forth again and again to increase the depth of engagement with, and understanding of, the texts (Laverty, 2003). This approach allows the preconceptions of the interpreter to be incorporated into the process and moves the preconceptions into new understandings of the interpretative process (Converse, 2012). The explicit
understandings are considered in terms of the whole of something and then re-considered in new perspectives (Giorgi, 2000; Mackey, 2005). The process of understanding is not a linear progression to an end point, rather a lived experience of dwelling with the possibilities of what something could mean. Once the end of the spiralling hermeneutic circle has been reached, the interpreter assumes they have reached the moment of sensible meaning, and are free of inner contradictions.

Heidegger’s philosophy aimed to elucidate the subjective humanistic meaning of an experience to reveal the nature of phenomena as humanly experienced and not to merely reveal casual relationships. Heidegger (1962) conceived of human beings as part of the world where meanings are hidden and require interpretation so that existence could be understood. The goals of hermeneutic research, in line with Heidegger’s thinking, are to enter the world of the person and interpret the unique meaning they assign to their experiences. Therefore, Heidegger’s notion was to uncover the hidden phenomena of our lives as well as their meanings (Adolfsson, 2010). This requires the researcher to be part of the research, as the participant, and to seek understanding of the meaning of being.

3.4.3 HERMENEUTIC PHENOMENOLOGY: GADAMER

Building on the work of Husserl and Heidegger, Gadamer (1960) saw the work of hermeneutics not as developing a procedure of understanding, but as further clarifying the conditions in which understanding itself took place. He developed his own approach to the process of understanding. In his book “Truth and Method”, Gadamer's two main concepts are 'prejudgment' and ‘universality’ (1996). He defined prejudgment as one's preconceptions, prejudices or horizon of meaning that are part of our linguistic experience. Universality is defined as the connection that is created by common human consciousness that makes understanding possible (Earle, 2010). The researcher's socio-historical background and culture are considered an essential part of the researcher’s linguistic background, which influences the development of interpretation and understanding the phenomena of study (Doyle, 2012). Gadamer saw language as fundamental to interpretation of human experience because it gives expression to all reasoning and all thoughts of the interviewer and interviewee. The belief, prior biases, and motivations of the researcher can influence understanding (Chan, Fung, & Chien, 2013). Language shapes both one’s experience and understanding.
In addition to stressing the importance of language, Gadamer (1960) articulated that common human consciousness, or understanding, happens through a fusion of horizons, a dialectical interaction between the expectation of the interpreter and the meaning of the text (Wilcke, 2002). He recognized that every person has their own horizon, which allows them to see things from a particular vantage point. He called this a frame of reference, based on experience and situation, with which one could orient oneself with the world. The horizon is not a limited vision but it can expand as one’s understanding deepens. The fusion of horizons also refers to the encounter between the researcher and the phenomena, in which the two standpoints come together. The researcher allows the standpoint of another to speak in this way so that the perspective of another could be understood (Wilcke, 2002).

Gadamer (1960) further explained that the fusion of horizons occurs through the act of dialogue. This type of genuine conversation happens by asking pertinent questions to seek truth. The researcher maintains an openness to the topic and seeks to formulate questions in such a way that the true meaning of the phenomena can be revealed. Further, it is vital for the hermeneutic researcher to have continuous feedback and discussion with the study participants to ensure that the horizon of the researcher or interpreter and the participant are merged together to gain authentic understanding of the phenomena (Benner, 1994). Interestingly, Smith (1999) pointed out that no two researchers will interpret the data and complete the write-up from the same point of view point, since interpretation of data is also influenced by the researchers’ own conceptions, which are dependent on their own phenomenological worlds and experiences.

It is very clear that in Heidegger and Gadamer’s interpretative philosophy, bias is considered advantageous to the research process. Their interpretive philosophy purports that humans are embedded in their world and the researcher as a human cannot and should not negate their prior understanding and engagement in the subject under study. The prior categories validate the researchers’ interpretations of the participants’ interactions. In fact, the absence could interfere with the interpretation process (Smith, 1999). According to Smith (1999), it is impossible to adopt that attitude, because all interpreted understandings take place through one’s pre-understanding or prejudices, and, as such, elimination of individual prejudices
are seen as impossible (Moran, 2000). Heidegger’s phenomenological view acknowledged that the unquestionable presence of historical influences on one’s understanding has a positive influence on the search for meanings (Palmer, 2001). The aim is not to finally understand the truth, but to understand differently (Palmer, 2001).

3.4.4 HERMENEUTIC PHENOMENOLOGY: VAN MANEN

Van Manen, a Canadian phenomenologist, recognized that phenomenology as a methodology is open to nearly any human experience, and that it has an interpretative element. He claimed that phenomenology uncovers meaning while hermeneutics interprets the meaning. Hermeneutic phenomenology as a methodology can provide a creative approach to understanding a phenomenon, in a way that is reflective, insightful, sensitive to language, and constantly open to experience (Van Manen, 1997). The basic tenet of phenomenology is that one’s most fundamental and basic experience of the world is already full of meaning (Merleau-Ponty & Smith, 1996; Van Manen, 2007). We are enmeshed in our world and immediately experience our world as meaningful because of our relationship with other people. Our historical and cultural context precedes any attempt on our part to understand it or explain it. The purpose of hermeneutic phenomenological research is to bring to light and reflect upon the lived meaning of this basic experience (Van Manen, 1997). He stated that researchers should attempt to describe phenomena as they appear in everyday life before these phenomena have been theorised, interpreted or explained; otherwise the true meaning of the phenomena cannot be understood.

The social, historical and cultural context of the residents, family members, and frontline caregivers contribute to the residents’ care experience in the residential home; this is the complex phenomenon that interests the researcher. Tordes (2014) suggested that in health care, the pivotal concern is to understand the service users’ perspective of care. According to Van Manen, phenomenological research of lived experiences is the starting point for understanding the perspectives or lives of others (1997). This understanding is only possible when it is heard within the lived experience of the participants (Toombs, 2002). Phenomenologists recognise that experiences are in a context that influences the experience in many ways. The meaning of an experience is in the context of social relationships in a historical and
cultural context (Heidegger, 1962). This study recognises that family members and frontline caregivers play a direct and indirect care role in the care experiences of the residential home residents.

Van Manen (1997) accepted that recognising the significance of each experience is a challenge because human beings have a myriad of expressions, behaviours, language and emotions that characterise and convey their moment-to-moment experiences. As such, shared experience can be construed in different ways by each individual. During most instances, one does not pay attention to one’s own experience of an event or subject through involvement in or exposure to it (Heid et al., 2014). Besides this, human beings tend to factor things such as thoughts and feelings when reflecting on their experience, but not their surroundings and context, because it does not claim their attention. Another issue is that trivial situations or meanings can be ignored or overlooked due to taken-for-granted meanings in a person’s daily life.

While other methodologies dismiss or are ignorant of the surroundings that do not claim one’s attention, phenomenological methodology recognizes and accepts that not only could one never escape context but that the ‘being there’ makes the experience what it was. Interpretive or Hermeneutic Phenomenology as a methodology enables phenomenological researchers to understand the experience of ‘Being-in-the-world’ with other people on a daily basis (Heidegger, 1962). The insights from the hermeneutic phenomenological tradition presented earlier are used as a guide for the researcher to study the phenomena of person-centred care as a lived experience by the participants of residential homes.

Hermeneutic Phenomenology offers a key to an explicit and reflective grounding of science in the lifeworld (Thomson et al., 2011). Health science endeavours to understand the meanings of health-related phenomena in everyday experiences of health, wellbeing and illness. Often meanings are implicit and taken for granted. Only through research can the implied meanings become explicit; researchers can then analyse the problems and work towards solutions. Hermeneutic phenomenology guides the researcher throughout the interpretation of implicit to explicit descriptions. The researcher has to interpret the meanings as they are experienced by the participants of the study. This process has to be handled carefully and sensitively;
the researcher must be versatile to catch the lifeworld meanings that make up the exemplars and nuances. The outcomes have to be described without losing the richness of the data.

Phenomenologists from Husserl to Van Manen have said that the lifeworld is the basis of all experience. The experience of engagement is an indispensable prerequisite of one’s existence, which poses an epistemological problem. Relying on one’s perception cannot validate how things are seen because often one sees things that are not there or fails to see things that are shown (Thomson et al., 2011). The foundational demand of researchers in health science is to be able to examine the acts of intentionality, and to see the authentic meanings of an experience. Researchers have to move beyond the natural attitude of everyday experience and take a reflective stance (Dahlberg et al., 2008). Van Manen warns researchers to resist the temptation to surrender to a view of a method that hollows out one’s understandings and cuts one off from the deeper sources of meaning (2007). Van Manen further suggests lifeworld as a research method framework for researchers to conduct hermeneutic phenomenological studies. In order to provide a deeper understanding of the experiences, Van Manen (1997) has provided a phenomenological understanding of the human lifeworld. This is existentially structured according to the lived body, lived time, lived space and lived relations.

3.4.5 LIVED EXPERIENCE THROUGH Van MANEN’S LIFEWORLD
Though there are many phenomenological ways to describe lived experiences, Van Manen’s (1997) four lifeworld existentials encompass most human lived experiences. These are practical and common to all human beings regardless of social, cultural, or historical situations (Adams, 2006; Van Manen, 2007; Van Manen & Adams, 2010). Many nurse researchers and educators have adopted Van Manen’s lifeworld-hermeneutic phenomenological methodology due to its relevance, simplicity, and ability to describe a phenomenon in the context of daily life.

The four dimensions of lifeworld are:

‘Lived body’ (corporeality). Lived body refers to the phenomenological fact that a body is the basic mode of being in the world. The mind is embodied consciousness and the person is an embodied being. The lived phenomenal body is more than a
physical entity that remembers the past hurts, smells, and experiences (Van Manen & Adams. 2010). It is also a vehicle of one’s coping and associated actions in life situations (Van Manen & Adams, 2010). In health care, the meeting between the patient and the staff is mainly through bodily encounters. But how one sees the world is from one’s own bodily perspective and not from the perspective of others. As such, through bodily senses, one encounters and understands the world, which could influence the perception of one’s lived space.

‘Lived space’ (spatiality). Lived space is ‘felt’ space. This is the feeling aroused by the space in which one finds oneself, and is largely pre-verbal. The space in which one finds oneself affects how one feels, so it is more than the mathematical dimensions of length, height, and depth. Hence, the environment one happens to be in could have an effect on the person's disposition, such as mind space.

‘Lived time’ (temporality). Lived time refers to experiences of time chronologically, historically and personally. Time is experienced in various ways: for example, when one indulges in a pleasant activity mood, time could move very fast, but time can be slow when one is in a state of despair. Experiences have to be described in terms of past, present, and future: these form the human landscape of time. Past experiences remain a fixed part of human existence, whereas hope and expectation are future oriented. Hopelessness and a lack of zest for life might threaten the future oriented perspective (Dybvik, 2014).

‘Lived relations’ (relationality). Lived relations refers to the connections one maintains with other human beings. Through interactions with others, commonalities are discovered and bonds are created. It is in communion with others that one’s own humanness can be affirmed; healthy interpersonal relationships provide a sense of adequacy and wellness. Relationships charged with interpersonal significance may be experienced as a special lived relationship. In this living relation, individuals may experience the sense of security and support (Bradshaw, 2012). It is in communion with others that one’s own “humanness” is affirmed (Hayne, 1997, pg. 318). In addition, perceptions of suitable and unsuitable were created through social relationships (Willig, 2011).
These four existential dimensions are thought to pervade the lifeworld of all human beings irrespective of their histories and life circumstances. All obstacles, difficulties, and struggles of life can be defined by circumstances and context. It is vital to note that these obstacles and difficulties can be a different experience for each person due to social, historical, and cultural differences. The four structures of the lifeworld provide the framework for interpreting and understanding these unique life experiences. Each situation and event has to be perceived from a first-person context so that the researcher can get an authentic account. The lifeworld dimensions also enable the researcher to become embedded in the world of the participants. Van Manen (1997) recognises that the lifeworld perspectives provide a lens for the researcher to think in terms of possibilities rather than restricting their thinking to terms of pathology or actuality. The golden rule of hermeneutic phenomenology is to interpret; this allows the researcher to approach the mystery of human consciousness in a careful and respectful manner. Van Manen (1997) said that any study of experience and perception should fundamentally pose questions that correspond to the four lifeworld existentials. His work urges researchers to use these four dimensions as productive categories for the process of phenomenological question posing, reflecting, and writing.

Van Manen's (1997) lifeworld and hermeneutic phenomenology is used as the methodological framework for reflecting, interpreting, and gaining insight into the care experiences of participants. It guided this research to understand the life expression of the participant's text. The researcher’s prior understanding is considered the prerequisite for the act of interpretation (Heidegger, 1962; Van Manen, 1997). The researcher has to test the validity of these prior understandings by engaging genuinely with the phenomena and being open to different perspectives. The researcher has to hold on to the qualities of thorough observation, reflection, and judgement (Finlay, 2009) to ensure that the natural meaning of the care experiences is captured. The researcher’s conscious awareness of prior understandings and the fusion of their own horizon with the text is important and necessary. The lifeworld guides the design of the researcher’s interview questions and it allows the reflective process to enter into a conversation with the text, providing an in-depth insight to the participants’ meaning of care experiences.
3.4.6 REFINEMENT OF THE THEORETICAL FRAMEWORK

Theoretical perspective has been described as the philosophical position that lies behind a chosen methodology (Crotty, 1998). Understanding the meaning of person-centred care phenomenon from the point of view of the lived life of an individual is the aim of this study. The perspectives and intentions of the researcher are grounded in a desire to study the way people experience the person-centred care phenomenon, and the meanings they give to those experiences. The ontology is the study of being. In this case the focus is on the perception of people’s care experience. From an ontological perspective, phenomenologists believe that experience is an essential part of being human and therefore to understand people one must understand their contexts and how they live. As such, knowledge of objects and reality reside in the subjective self (Lincoln & Guba, 2000). The researcher has to support multiple realities that are co-constructed with the participants. This perspective acknowledges that reality is neither right nor wrong, rather it is contextually based and dynamic (Laverty, 2003). Ontology sits alongside epistemology and explains ‘what it means to know’ (Crotty, 1998), to infer the theoretical perspective. Both perspectives help to frame the nature of knowledge being sought in this study and provide in-depth understanding of the person-centred care experience.

The notion of lived experience announces the intent to explore the pre-reflective dimensions of human existence. When one examines McCormack’s four concepts of person-centred care and Van Manen’s four lifeworld dimensions, they share similar views of human existence. The adoption and integration of values and philosophy of these two concepts help to humanise the process of understanding the essence of participants’ experience of care.

Both concepts focus on human beings or persons who live in a lifeworld where meaning is experienced (McCormack, 2004; Van Manen, 1997). The existential philosophy explains that everyone experiences their lifeworld through their senses that are meaningful, and with more experience there is the possibility for fusion of the horizon that makes the experience more meaningful (Husserl, 2004). Van Manen (1997) viewed individuals as constantly sharing their lifeworld with other human beings, and this influences how one sees, understands, and imagines what others think and feel. The feelings are manifested at different levels: feelings that can induce joy and distress, hope and fear, and feelings that make one decide and act. The
feelings and perceptions influence the meaning making of one’s lifeworld. McCormack (2004) added that the history of nursing with older people indicates that the narrow perspective in care delivery, especially in large institutions, defeats the recognition of personhood.

McCormack’s four concepts of person-centred care: being in relation, being in a social world, being in place, and being with self, explain that a person exists in relationship with others, that a person is a social being, that a person has a context through which one’s personhood is articulated, and being recognised, respected, and treated as a person impacts on a person’s sense of self. Van Manen’s (1997) lifeworld dimensions share similar notions and emphasise that the fundamental need of human needs is to be recognised. Van Manen (1997) mentioned that the lived body, lived time, lived space, and lived relations provide a framework for a deeper understanding of nature or meaning of everyday experiences irrespective of one’s circumstances and histories. Both McCormack and Van Manen believe that recognition brings respect, upon which relationships are formed, and through which personhood is bestowed.

Toombs (2002) explained that illness clarifies what it means to have access to the world. But for a person with illness, the body becomes an obstacle that limits and alters their attachment with the world. A breakdown of one’s body means a breakdown of one’s life. The exploration into loss of abilities and how it interrupted the harmonic, easy, and unmindful living of the residents was scrutinised from the phenomenological perspective. The body is viewed as both mental and physical, which are inseparable (Van Manen, 1997). McCormack and McCance (2010) point out that the body perspective enables us to think about illness and disability in different ways within the health care sciences. Most residential home residents have some form of illness and their access to the world is not easy and natural. Van Manen (1997) stated that illness restricts one’s self by limiting freedom, participation in everyday activities, and inhibits one from fulfilling one’s goals and wishes of life. This is reality for many nursing home residents.

The lifeworld recognises that ‘lived relations’ promotes one’s personhood by discovering commonalities and creating bonding. McCormack (2004) acknowledges that ‘being in relation’ is knowing the older person in their social context; he also said
that planning care for older people should involve the significant others, and the needs of the formal and informal caregivers. He further added that an effective relationship requires value clarification between each stakeholder involved in the care. This will form the foundation of person-centred care where choices are respected and negotiated. The concept helps to recognise the older person in their social context, and helps stakeholders plan care that involves the significant others as well as the needs of the formal and informal caregivers. Hence, the care context helps to nurture everyone.

The context of care, where care is provided, has the greatest potential to enhance or limit the facilitation of person-centred care. Both Van Manen and McCormack emphasised place or space, which influence the care provided and experienced. McCormack and McCanse (2010) see the being as the whole human being with the potential to flourish. For older people to flourish in residential homes, they have to be supported by staff who can work collaboratively with the residents and actively use their creativity to customise care practices. The lifeworld sense that the lived time and space reveal how attitudes, beliefs, and practices of an organisation’s culture can shape one’s everyday experience. This is vital for many older people who face uncertainties in their daily life experience at the residential homes.

Van Manen’s and McCormack’s concepts of lifeworld and person-centred care focus on the being or person, and reveal what matters to one. The concepts assist at individual, as well as organisational, level to focus on respecting the values of the service users and service providers, which is central to person-centred care practice. The concepts focus on human existence and how one encounters the world. A careful and guided phenomenological study will guide the participants to find meaning in care and possibly help them to tolerate the incongruity of their situation and establish goals for the future.

3.4.7 VAN MANEN’S SIX STEPS GUIDED THE PROCESS OF THIS STUDY

Van Manen described hermeneutic phenomenological research as a dynamic interplay among six research activities of human science (1990, p. 31-34).
(1) Turning to the phenomenon
The researcher turns inward to the phenomenon through personal journaling and reflection on practice as a nurse providing care for residents of residential homes. Van Manen describes phenomenological research as driven by a commitment of turning to an abiding concern (1997). The researcher’s interest in the topic encouraged her to a greater involvement to understand the holistic aspect of the phenomena of study and lived experience of the participants. The researcher deeply explored the lived experiences, revealed the essential nature of the phenomena, and described the phenomena with insightfulness. This guided the process of formulating the relevant research question.

(2) Investigating experience
Investigating experience is concerned with the methods employed to investigate the lived experience in question. This researcher recruited a purposeful sample and designed an appropriate questionnaire to study the experience of care (see Appendixes A and B). “Being experienced is a wisdom of the practice of living which results from having lived deeply” (Van Manen, 1997, p. 32). The researcher used in-depth interviews to understand the unique experiences of the participants as opposed to simply learning about it through books, journals, discussions and other second-hand accounts.

(3) Reflecting on essential themes
Reflecting on the essential themes characterises phenomenological research. Van Manen points out that there is “a distinction between appearance and essence” (Van Manen, 1997, p. 31): appearance is the original awareness of one’s perception, and essence is the inner essential nature of a thing, the true being of a thing. The purpose of phenomenological research is to have a true reflection and focus on lived experience. The themes for this research were identified from the interviews by reflecting on them during the interview, transcription and coding. Through this thorough process, the researcher endeavoured to capture the essential meaning or essence of the lived experience in question. Van Manen offers activities for isolating themes, interpreting themes, reflecting on themes, and determining incidental and essential themes (Van Manen, 1997). He also suggests three approaches for isolating themes from the transcripts: the holistic approach, the selective or highlighting approach, and the detailed or line-by-line approach (Van Manen, 1997).
The application of this skill is reflected in the section of bracketing and analysis of this chapter.

(4) Writing and re-writing
Van Manen (1997) suggests that the purpose of phenomenological research is to render something into language. Through the process of writing, the participant’s feelings, thoughts and attitudes are made visible. The fundamental meaning of the phenomena is shown through interpretive descriptions, and writing and re-writing of the phenomenological descriptions (Van Manen, 1997, p. 17). By working through the interpretive descriptions, the essence of the meaning of the lived experience was made clear.

(5) Maintaining focus on the phenomenon
The researcher strived to remain focused on the research question at hand in order to maintain a strongly orientated relation to the phenomenon. To establish a strong relation with the phenomenon, the researcher used the lifeworld dimensions to maintain human connectedness (Van Manen, 1997, p. 33). Being orientated in relation to the phenomena has assisted the researcher to gain full and human insight.

(6) Balancing between parts and the whole
The researcher constantly measured the overall design of the study against the significant parts and the total structure. It was necessary for the researcher to step back from the totality of the text to consider how each of the parts contributed towards the whole (Van Manen, 1997). The results and discussion chapters reflect the application of steps four to six (rewriting, focusing and balancing).

3.5 AIM
The aim of this study was to understand the lived experience of person-centred care in residential homes in New Zealand and Singapore, from the perspective of residents, family members and frontline caregivers.

3.6 RESEARCH QUESTION
Van Manen (1997) states that uncovering the research question in a hermeneutic interpretative approach is a usable framework and features five words: ‘how’, ‘lived’, ‘experience’, ‘being’, and ‘meaning’. ‘How’ seeks to uncover ‘the way’ of something,
how is unlike the word ‘why’ which is used to solve problems, explain, or seeks to control. Van Manen (1997) strongly recommends that the words ‘lived’ and ‘experience’ have to be used together because this allows us to question the way we experience the world and to know the world in which we live as human beings. Similarly, the word ‘being’ carries with it the notion that being is a lived experience.

Through the accounts from participants, the “human actions, behaviours, intentions and experiences” (Van Manen, 1997, pg. 19) can be accessed. This provides a deeper understanding of the meaning of the phenomena from the participants’ situated life experience (Hayne & Yonge, 1997). ‘Meaning’ takes one to the quest of seeking to understand as opposed to describing, arguing, predicting, deconstructing, or theorising. Hence, the question for this study was to discover the meaning of lived experience of person-centred care from the perspective of residents, family members and frontline caregivers. This study used the caregivers' job context to explore the experience of person-centred care in residential homes.

The scope of the questions and participants were broad given the general lack of understanding of the experience. This enabled the researcher to gain insight into the holistic understanding of the phenomenon, the culmination of which led to an overarching understanding of the participants’ lived experience.

3.6.1 SETTING

The study was conducted across aged residential care settings in both New Zealand and Singapore. One residential home from each country was selected for this study. This allowed the exploration of the experience of person-centred care from a diverse group of participants. Both settings shared similar values of person-centred care and encouraged family involvement and partnership in care practices.

3.6.1.1 SINGAPORE CONTEXT

The residential home in Singapore was a VWO organization, a religious voluntary group. Local hospitals are the main mode of referring residents for admission to residential homes (SIN MOH, 2014). AIC coordinates the admission process and decides the subsidy level provided to each resident through means testing (SIN MOH, 2014). The home is accredited and eligible for MOH funding.
The residents’ daily charges for their stay varied based on their level of care and bed types. Most residents were categorized as level IV; they required a higher level of nursing care and a few were at category III (AIC, 2013). The charges varied based on the level and outcome of means testing. The subsidy rates ranged from 10% to 75%, with zero subsidies when the per capita income exceeded $2,201 per month (AIC, 2013; Wong, Yap, et al., 2014). The majority of the workforce in long-term care comprised foreigners who are in their early twenties, and mostly from Sri Lanka, the Philippines, Myanmar and India.

3.6.1.2 NEW ZEALAND CONTEXT
The residential home identified in New Zealand was a private religious organization. It is funded by the DHB, which is also the main mode of referring older people for admissions into residential homes. The residents had undergone a Needs Assessment by the local DHB who then determined the level of care each individual required (NZ MOH, 2012). Almost 75% of them in the facility were above 80 years old. The Needs Assessment identifies the level of support a person requires, and the “need” is categorised as 'low,' 'medium,' 'high,' or 'very high'. Those who required ‘high and ‘very high’ level of care were referred to hospital level of care at the residential home.

The long-term residential care subsidy is based on a Financial Means Assessment. In order to qualify for subsidy, the value of assets must be at or below $213,297 for a couple requiring residential care, or $116,806 for one (NZ MOH, 2012). The residential care subsidy is paid directly to the rest home by the Ministry of Health. Some residents receive superannuation (retirement allowance), most of which is absorbed by the care provider. Residents receive a personal allowance of $42.38 a week and a clothing allowance of $265.81 a year.

3.6.2 SEMI-STRUCTURED INTERVIEW
Van Manen (1997) suggests that forming a good research question yielding good experimental material is vital. Innes, Macpherson and McCabe’s (2006) semi-structured interview questionnaire focusing on understanding the lived experience of person-centred care in the job context of frontline caregivers was used to interview the participants. The interview questions were focused on the care experiences in the context of the frontline caregiver’s job context where most care activities were
centred (Appendix A). The interview consisted of three main parts: questions relating to the meaning of person centred care; qualities of frontline staff; and how the job of frontline staff was valued by others. The relationship between the residents and frontline caregivers is pivotal to the experience of good quality/person-centred care support (Innes et al., 2006). The priorities and perceptions of person-centred care as perceived by the three important stakeholders: residents, family members, and frontline caregivers, were systematically and qualitatively explored.

The semi-structured interview method was chosen because it allows for questions to be open-ended yet directed, shaped yet emergent, and paced yet unrestricted (Charmez, 2006). Mason (2002) identified that the interview provides an interactional exchange of dialogue due to its informal style. It was also in line with hermeneutic philosophy, which recognises that knowledge is situational and contextualised, allowing the researcher to ensure that the relevant contexts are brought into focus so that understanding could be clarified. The semi-structured interview method enables the participants to reflect on the meaning of their care experiences. The reflection enables participants to return back to their actual state at an incident. This is the heart of phenomenological study: to gain insight into the authentic meaning of an experience.

The focus was to gain an in-depth understanding of participants’ personal experience as users and providers of care services. The aim was to draw the participants into conversation and encourage them to stay close to the experience and recount their story. The questions were designed to prompt such telling: “Tell me what your meaning of person-centred care is?”, “How do you describe it being demonstrated in your daily care?”, “How do you feel?” When the participants are in a story telling mode, they required very few ongoing prompts. Moreover, the researcher was able to remain focused on the phenomenon that was expressed by the participants and interpret them with greater depth due to its simplified nature. In addition, the openness of the interview approach allowed the participants to share a range of life events that were significant for them. Hence, the modified semi-structured interview provided a sound guide to explore the meaning of participants’ care experiences (Appendix A).
At each level of the interview, questions were asked to assist with further clarification of the questions. At the end of the interview, participants were given the opportunity to clarify questions and discuss further relevant issues. The interviews lasted approximately 60 to 90 minutes, with a mean of 65 minutes. As the topic of the interview was on distinct events of care activities, the information gathered required only one interview. The interviews took place in the residential home, either in the person’s room or communal space, whichever they requested. The researcher ensured that the privacy of the participant and confidentiality of the shared information were maintained at all times (see section 3.7). The residential home context also provided a greater opportunity to understand the embedded experience as participants were able to show the researcher some of the areas or people they talked about.

Van Manen (1997) believes that a person’s way of being in the world can be reflected in their account of everyday lived experience. This study was focused on the residents’ meaning of their care experiences especially during difficult times or illness. The use of a quantitative, or a survey, method to identify or measure care experience will not bring one in direct contact with the experiential quality of the lives of the residents. In decontextualising residents’ experiences of care, the fullness of life can be overlooked and the essence of meaning then will not be captured. Human experience is filled with complexities; the researcher has to listen carefully to participants’ voices and their stories to catch these complex nuances. This requires the researcher to get closer to the life of the participants as they live and experience it, and not just conceptualize it based on abstract ideas or theories (Van Manen, 1984). Van Manen (1997) indicates that this approach allowed him to uncover and capture a deeper understanding of the nature of meaning, which the researcher desired for this study. It was sought to uncover the deeper meaning of care experiences by the residents, family members and frontline caregivers.

3.6.3 PARTICIPANTS
The study required participants who had lived care experience in the area of study; they needed to be willing to talk about their experience, and they needed to be diverse enough from one another to enhance the possibilities of rich and unique stories of the particular experience (Laverty, 2003).
It was evident from the literature review that person-centred care in the residential home is a complex concept because of the context of care and culture of practice. It is recognized that the residents’ experience of person-centred care is influenced by two key players: the family members and frontline caregivers (described below), who are involved in making decisions and providing care. The researcher purposively selected residents, family members and frontline caregivers who had a variety of lived experiences of person-centred care. The participants’ personal meanings of care could be compared with the actual values and beliefs of person-centred concept. It was essential to understand how meanings of person-centred care were understood by the frontline caregivers and family members, and their relevance to residents’ meaning of care. This study was conducted in New Zealand and Singapore to capture diverse experiences of person-centred care from different cultural contexts.

Residents
The number of participants necessary for phenomenological studies of this type vary depending on the nature of the study and the data collected along the way (Thomson et al., 2011). The decision on the number of residents was made based on the time available to conduct the research study and the nature of the study where the researcher had to honour each participant by working intensively with their data; thirty residential home residents, fifteen each from New Zealand and Singapore, were recruited (Appendix B). The residents had to be cognitively intact and able to hold a conversation based on current experiences. They had to be English speaking. The minimum requirement was that they should have had at least a six-month stay in a nursing/rest home. The researcher sought the help of the nurse managers from both homes for recruitment of participants. To ensure that residents were able to participate on the day of the interview, the researcher consulted with the staff nurses, and their expert recommendations were sought. Each interview lasted between 60 and 90 minutes. The researcher continued to engage in interviews with participants, ranging from one to three interviews with each participant until it was decided that a point of saturation and clearer understanding was reached.

Frontline Caregiving Staff
The frontline caregivers were selected by the residential home manager for this study. The frontline caregivers from Singapore were foreign workers, mainly from
Myanmar and the Philippines, who were between the ages of 20 and 30, and who were on two-year contracts (Appendix B). However, one participant had renewed her contract and had been there for eight years. The staff could not account for the number of residents they had for each shift, as they practised task-based care. The staff from New Zealand had a mixture of full-time and part-time staff as well as locals and migrant workers, mainly from the Philippines and Samoa (Appendix B). Each had a resident ratio of six to nine based on staffing level.

The frontline caregivers who participated in this study were identified by the managers from each residential home. There was no age criterion, they should have worked at the current home for at least six months, and they had to be English speaking.

**Family members**
The participating organisations from New Zealand and Singapore also identified five family members each who were English speaking to participate in this study (Appendix B). There was no relationship between the participating residents and family members because of a lack of consensus among the two groups.

As observed in other in-depth care experience studies, the semi-structured interviews allow for unique personal meanings to emerge when conducted with a small sample of individuals (Laverty, 2003). The vital process was to honour each participant by working intensively with their data (Thomson et al., 2011).

**Researcher**
The main goal of the approach to this study was to gain insight into the participants’ experience prior to the meditative or theoretical reflection. The hermeneutic phenomenology provided a framework for the researcher to be sensitive and attentive to the participants’ stories and narratives, to be aware of participants’ context, to maintain the phenomenological attitude, and to understand the true meaning of the phenomena. A common language was possible between the participants and researcher due to the prior experience of the researcher as a gerontological nurse in both countries. We also shared the common intentionality to improve care experiences. The researcher was attentive to the philosophies that underpinned both lifeworld phenomenology and hermeneutics, which recognised that
every experience was an interpretation of one’s moment in life. The researcher’s interpretation was conceived and equated through the participants’ social, cultural and historical contexts since human beings inhabit and share their world with others. As such the reality of an experience for each participant rested in how contextual experience was individually construed.

The researcher used the hermeneutic lens to maintain an open attitude to the subjective experience of the participants so that the unique nature of the phenomena could be understood and grasped (Finlay, 2009). The open attitude allowed the researcher to see things in their immediacy and more importantly to seek a fresh perception of the world. The researcher was aware that the purpose of this study was not to generate evidence for facts, instead to understand the phenomena of the study from its care context as perceived by the participants. Thus, each individual’s account was given importance through this study.

In hermeneutic phenomenology, data included the researcher’s personal reflections on the topic, information gathered from research participants, and depictions of the experience from outside the context of the research project itself, including reflections written by the researcher (Laverty, 2003). The researcher constantly reflected and recorded them, which enriched the findings, where the description and mood associated with each event were captured. The researcher developed greater sensitivity and became aware of the depths and subtleties of participants’ lived care experiences (Van Manen & Adams, 2010).

### 3.6.4 SAMPLE SELECTION AND DATA COLLECTION PROCEDURE

The researcher briefed the participating long-term care institutions on the research project and sought their formal approval to participate in the study. Each participating institution provided a list of participants who could be approached to participate/be interviewed for the study. The residents’ selection was based on their cognitive level which ensured that participants were able to maintain a logical engagement during the interview, and that they had consent from family members. The research questionnaire was hand delivered to the participants by the researcher, and the researcher assisted each participant with their queries of the questionnaire and study (Appendix A). Demographic data was also collected from the residents. The interview was conducted by the researcher at the nursing or rest homes. To meet the
convenience of frontline staff and family members, the interview was conducted at an agreed venue and time. All participants were briefed on the research study and informed consent was sought. Participants were allowed to withdraw from the research project at any time.

The researcher needed to demonstrate an attentive and empathic listening attitude. This attitude determined what and how much the participants would talk about the phenomena. Naturally, the researcher’s listening attitude influenced the level of openness shown by the participants. The researcher was mindful that interviews do not always reproduce realities. Interviews were typically reliant on participants’ capacities to verbalise, interact, conceptualise and remember (Mason, 2002). Further participants’ stories could provide accounts from a particular point of view, probably to serve a particular purpose, for example, residents might not share their personal encounters or expressions, due to concern that those encounters might be shared with others. Similarly, caregivers might feel comfortable talking in terms of professional expectations rather than talking about what actually happens.

3.7 ETHICS

Approval for undertaking this research was given by the University of Otago Ethics Committee (Appendix C) and by the two residential homes who participated in this research study (Appendix D). This process took nearly a year because it involved negotiation and application procedures for two separate settings, and was only achieved in this time frame because there was a need to find another residential home as one of the initial residential homes declined to participate due to a change in management staff. The University of Otago Research Committee recommended attempting to include Maori in the study. However, as there were no Maori residents in the participating New Zealand residential home there were no Maori participants in this study. The researcher discussed the study and its purpose with each participant. Each interview involved a brief introduction and a discussion of the study. Those who agreed to participate had to sign the informed consent form (Appendix E). The consent also included an agreement to record (Appendix E). Hence, the semi-structured interview was audio-recorded. A copy of the completed written consent form and information sheet was given to the participants. The researcher informed and sought permission from the next-of-kin of the residents to ensure they were aware of the study. This procedure was chosen primarily to obtain permission for
residents’ participation from the family members. This was the requirement from both residential homes as they considered keeping the family informed was part of maintaining residents’ rights. None of them declined. Recording was not an issue for any participant at any time. The participants clearly understood the need to tape the interviews and had no reservations about it.

The managers of the residential home selected the participants who could be interviewed for this study as they ensured participants were cognitively intact. All participants were informed in advance by the researcher about the research project and that they were allowed to drop out of the study at any time. A suitable meeting time was arranged for the interview to take place. Confidentiality was assured. A pseudonym was assigned to each participant and recorded in a code book located in a locked cabinet at the researcher’s home. Assigning the pseudonym to the transcribed text located in the computer file ensured confidentiality. The real identities of the participants were not used in any verbal or written presentations or reports.

The researcher was mindful of the vulnerabilities and sensitiveness of the older people and was mindful to take note of such cases during the interviews. It was established that at any time if the participant shows signs of distress or harm then the interview was to be halted immediately. The advice from qualified staff and manager would be sought before making a decision to continue with the interview.

3.7.1 NURSING ETHICS - STANDPOINT OF THE RESEARCHER

The researcher’s own personal and working experiences, beliefs and values, the literature of the field, and consultations with supervisors assisted the interpretation process of this study. In undertaking the interpretative phenomenology study, it was important for the researcher to acknowledge her own standpoint at the beginning of the research. The study involved the researcher’s direct contact with the phenomenon. The researcher studied the participants’ experiences, which she had directly encountered earlier in her course of work.

As a gerontological nurse, the researcher has worked in residential homes, both in New Zealand and Singapore. In the course of daily work, the researcher, who is also a daughter and mother, had been continually confronted with the task of providing care. The nature of her job provided the opportunity to listen to many concerns raised
by residents, family members and frontline caregivers pertaining to care activities. These interviews facilitated an exploration of participants’ intimate descriptive evidence of person-centred care experiences, which was carried out alongside the researcher’s clinical practice in both settings. Hence, as indicated by Van Manen (1997), the researcher gained a particular orientation to the lived world of the participants in order to focus on the phenomena so that meaningful interpretation was possible.

A commitment of equality, a fundamental principle of gerontological nursing, was embraced. This asserts that all individuals, regardless of their origins or culture, are considered of equal value. In relation to vulnerable people, however, I felt placed in a position of being expected to treat them in a manner that I myself would find demeaning or upsetting. My own experience has shown me that older people in residential homes are marginalized and treated as less significant than their peers who live in the community. Moreover, the care services and activities have limited the residents’ opportunities and choices to maintain their personhood. While my own value system does not accept this idea, I have been challenged to reflect on current practices in the aged care homes. I have also been an advocate for older people whom I believed were treated in a less valued manner. This partly led me to take up this study. I determined that I had to hear the voice of the residential home residents rather than provide routine care. I wanted to give the residents an opportunity to discuss openly and freely concerning matters related to their care. I also wanted to allow my experience with them to shift my thinking to be closer to theirs, so that I could understand them and their experiences better. I then began to search for a methodology that would support the type of research I wanted to undertake.

Informed by the hermeneutic phenomenological approach, this study was designed to give voice to the everyday person-centred care experience and to reveal how the everyday experience is embedded in an environment structured by a larger web of social relations. Phenomenologists hold that there are multiple, socially-constructed realities, and the meaning given to these realities and what becomes knowledge is always a human construction (Heidegger, 1962; Pickard & Dixon, 2004). Phenomenologists, therefore, not only appreciate the influence of the larger social structure on shaping everyday lived experiences, but they also view human beings as actively involved in shaping their character in the process of their own becoming
In order to achieve this state, one has to step back from the current ongoing experience of everyday life, and with a reflective lens gain insight into the taken-for-granted assumptions (Toombs, 2002; Van Manen, 1997). Once these taken-for-granted assumptions are revealed, the process of reconstructing one’s identity around an alternative story line can begin.

The fundamental aim of the researcher's interpretation was to bring the residents' personal meaning of the phenomena of person-centred care, including factors in the immediate and broader environments that help to shape the meaning, to the surface so that their voices could be heard. The researcher had to facilitate an intimacy with the phenomenon through first-hand involvement and academic reason; numerous articles were read in the area of quality of care in residential homes and on the person-centred care model to identify the current understanding of this area of study. Van Manen (2002) asserts that each researcher should assume that he or she has a limited knowledge of the phenomena of interest and should approach the study as a beginner. In fact, phenomenology is often defined as a science of beginning (Lopez & Willis, 2004). The phenomenological researcher must therefore always adapt the methods to the nature and circumstances of the phenomenon. A set of procedures that work for one phenomenological problem may be unsuitable elsewhere. In this sense, the central instrument of deciphering the phenomenon is the phenomenological researcher. The researcher must be directed yet flexible in the face of the phenomenon. In short, the phenomenologist has no clear sense of what they will find or how discoveries will proceed. Phenomenology also facilitates the process of uncovering meaning and gaining closer understanding of ongoing experiences in everyday life. It helps the researcher to uncover the meaning of a phenomenon like person-centred care, or to discover aspects or qualities that make the phenomenon what it is and without which the phenomenon could not be what it is (Van Manen, 1997). The skill, perceptiveness, and dedication of the researcher are the engine for phenomenological research and they presuppose any specific methodological procedures.

Phenomenology also exposes the common meanings encountered in this world that have social, cultural or historical contexts. Meanings and the language attached can vary from place to place. Additionally, most experiences go unnoticed or are taken for granted due to being perceived as trivial issues or are perceived as not warranting
attention. Therefore, when studying real issues of agreements and disagreements between people, one has to be sensitive and constantly aware of these possibilities. Most residential home situations have a taken-for-granted meaning as to what person-centred care is, how it is to be delivered by the caregivers, and what the actual experience of the care by the residents should be. An example is where the notion of person-centred care is giving greater priority to completion of a task than focusing on the needs of the older people. Even the disagreements about what it means to be a resident or a caregiver depends upon certain taken-for-granted understandings that allow meaningful distinctions and disagreements to occur (Benner, 2004). There are taken-for-granted linguistic and cultural meanings that caused agreements and disagreements between people on care experiences. Underpinning the use of alternative forms of representation is the notion that meaning is not encountered, but constructed (Van Manen & Adams, 2010). The act of interpretation is a creative event of meaning-making. The concept of meaning is linked to the process of understanding and is shaped by the beliefs, values and attitudes of the meaning maker. The definition of meaning is multilayered. Meaning can be defined as the sense and purpose of experience, or it can include how a subject conceives an object's significance and purpose (Toombs, 2002).

3.7.2 BRACKETING

Bracketing is a methodological device of hermeneutic phenomenological inquiry that requires putting aside one’s own belief about the phenomenon under investigation or prior knowledge about the subject throughout the phenomenological investigation (Carpenter, 2007). This method of bracketing is intended to allow a person to see the meaning that belongs to a phenomenon of another’s lifeworld and also brings into focus the uniqueness of the phenomenon in which one is interested (Van Manen & Adams, 2010) and re-achieves a direct and primal contact with the world as human beings experience it (Van Manen, 2007). However, researchers have pointed out that it is humanly impossible for qualitative researchers to be totally objective (Chan et al., 2013). The researchers’ ability to be aware of their own values, interests, perceptions and thoughts are prerequisite before one can set aside the things that influence the research process. Reflective thinking is the key thinking activity that supports the bracketing (Gearing, 2004). Wall, Glenn, Mitchinson and Poole (2004) suggest that the use of a reflective diary is a useful tool to note down one’s thoughts feelings and perceptions. Van Manen (1997) recognises the importance of bracketing which he
addresses as reduction, that helps to bring aspects of meaning that belong to the phenomena of one’s lifeworld.

The lifeworld, as a phenomenological concept, helps the researcher to speak about existential themes because the researcher develops the ability to see the person in the context of the world, regardless of one's historical, cultural, or social background. Van Manen’s (1997) lifeworld dimensions - lived space, lived body, lived time and lived relation - are helpful guides for reflection in the research process. It has the power to unfold the structure of human life and experience when they are used as productive categories for the process of phenomenological questioning, reflecting and writing. The lifeworld dimensions provide a phenomenological lens to re-examine the everyday taken-for-granted situations that normally go unnoticed and are hidden as a phenomenon. They are life events that have gone unexamined without awareness. However, once a person’s lifeworld shifts from taken-for-granted aspects of daily life then the focus gets shifted to the event. Van Manen (1997), who draws from Husserl, directs the researcher to turn to the literature about the topic to become aware of their preconceptions and assumptions about the phenomena of study. This perspective has allowed the researcher to practice a critical review of her own self-awareness, which has developed her attitude of being genuine and able to engage in a conversational relation with the phenomenon. The researcher also requires unwavering commitment to the nature of the phenomenon in order to make sense of it (Van Manen, 1997).

The key assumptions underlining the researcher’s approach to person-centred care were as follows:

- Older people’s values are respected and they are placed at the centre of care
- Older people’s preferences and expressed needs are considered by staff
- Older people’s care activities are coordinated and integrated
- Older people are engaged in meaningful activities
- Older people are part of the society and continue their contribution to society
- Older people are encouraged to develop and flourish
- Older people receive personalized and continuity of care
- Older people have access to appropriate care at all times
- Older people have safety and security at all times
- Family and friends are part of the care
• Team work and collaborative practice among care staff are encouraged through good communication, information and education
• Holistic care comprises physical, social, mental, emotional and spiritual care
• The lifeworld of each participant and the researcher is different and has different experiential qualities
• Each of us may inhabit different lifeworlds at different times of the day, such as a lived world of a person in pain and one without pain

3.8 ANALYSIS

A phenomenology of praxis (practical application of a theory) as proposed by Van Manen (2007) and methodology for data analysis described by Giorgi (1985) guided the data analysis and transformed personal experiences into disciplinary understanding. Van Manen’s (1997) four dimensions of lived world gave the researcher a concrete way to analyse and write up the findings. It situated the researcher in the context of the phenomenon and helped link her experiences to her lifeworld (Van Manen, 1997). The analysis conducted by the researcher was based on the reflective lifeworld approach (Van Manen, 1997). The interviews were transcribed by the researcher, and were uploaded together with the audio records into NVIVO software. The researcher first tried to get a sense of the whole data set by carefully reading all the transcripts. With the phenomenon of the lived experience of person-centred care uppermost in mind, the narrative of each participant was read line by line. Key words were highlighted. The analysis of the data began with a search for meaning units or themes. The initial coding was done based on person-centred care values. The codes were identified and notes were made. In order to ensure accuracy, the initial coding of three participants was done by the researcher independently and discussed with her supervisors. This preliminary work helped the researcher to construct a unified description of the experience under study, and identify and name common themes.

The transcripts of each participant were analysed individually, and themes were formed based on person-centred values. Subsequently, the themes were formed for each group of participants. This process was conducted separately for each country. Finally, a summary of the revealed themes of all participants, groups and countries were grouped according to lifeworld themes. Van Manen’s (1997) lifeworld existential
themes guided the reflective process and the themes were further analysed and categorised accordingly. The researcher was aware that the four dimensions are intertwined and form an intricate unity that Van Manen (1997) refers to as “our lived world”. The researcher further analysed the categories by listening to the audio recordings repeatedly in order to immerse herself in the participants’ description of moments in their life. Attention was also given to voice tone, inflection of words, choice of words, and gestures and emotions of the participants which helped the researcher to obtain the true personal experiences of person-centred care as perceived by the participants. Through language and writing, a hermeneutic interpretation of the data and insights about the meaning of lived experience of person-centred care from the perspectives of residents, family members and frontline caregivers from residential homes in New Zealand and Singapore were revealed and summarised (Van Manen, 1997). The interpretive summaries were revised within the context of the four lifeworld themes and further refined in collaboration with the academic supervisors. In order to gain a comprehensive understanding of participants’ lived meaning, the researcher attempted to immerse herself in the participants’ world and recognised that the experiences and meanings were personal and unique to each individual and generalisations should not be sought.

A primary concern of phenomenological data collection is reaching a point where no new additional data are found that contribute to the concept (Glasser & Strauss, 1967). Reaching a point of data saturation was determined once no new information was obtained from further data. However, Van Manen (1997) indicated that achieving saturation in hermeneutic phenomenology is challenging because the nature of interpretation can never be complete and is always underway. The clarification and discussion process between the researcher and academic supervisors helped to form the emerging themes of ‘homelike’, ‘maintaining and developing connections’ and ‘workplace culture’.

**Validity and Reliability**
Van Manen (1997) enlists four aspects - orientation, strength, richness and depth - as the major quality concerns that a researcher should be mindful of when explicating the lifeworld stories from participants and transcripts. The researcher maintained orientation by genuine involvement in the world of the research participants and their stories. The researcher was sensitive to the social situation of the participants and
how their values and beliefs influenced their meanings. The aim was to ensure that important meanings of the whole experience were not missed (Van Manen, 1997).

A strength of the research was engaging in an interpretative relationship with the transcript. In other words, the researcher sought to learn about the mental and social world of the participants, which was not transparently available. The commitment to capture and do justice to the meanings of the participants was of paramount importance to the researcher, who maintained sustained engagement with the text and the process of interpretation. The residential home context and personal meanings of person-centred care to the participants were critical to this study. The researcher made multiple attempts to write and re-write the text to share the core understanding of the meanings as expressed by the participants. The use of lifeworld dimensions guided the researcher’s capacity to interpret the existential meanings behind the experience of the participants. This contributed to a deeper insight into the participants’ perspectives on lived experience of person-centred care.

Richness to the phenomenological meanings was maintained by narrating the meanings as perceived by the participants. The researcher’s first-hand participation in the real experience context, conducting interviews with participants, and carefully watching and describing the situation supported the richness. The researcher became part of the participants’ world and was able to connect with the phenomena even better. Since the researcher was the only person who collected and analysed the data, there was more opportunity for the researcher to be immersed in the text so that the experience became more and more familiar.

Finally, depth was demonstrated through the text where the researcher has shown the best intentions of the participants. The researcher was constantly aware of herself, her biases and preconceptions that could influence the interpretation of the meanings. The stories and ideas sought from the residential home residents, family members and frontline caregivers were analysed separately; these allowed the researcher to follow multiple storylines that were different from previous research studies in this area. Typically, such studies used residents’ stories or stories from either nurses or family members; rarely were the stories from the three groups of people. The researcher drew the analysis from the fullness of participants’ experience and focused on how it was narrated by the participants. The emerging
patterns and connections within and between the perspectives of the three different groups of participants were analysed. The stories inevitably led the researcher into the care experience and care expectations within the person-centred model of care from a lifeworld perspective.

The circular process of hermeneutical phenomenological writing recognised by Van Manen (1997) was utilised as the writing technique. This process of writing and rewriting developed the researcher’s clarity, promoted reflection and allowed for deeper meaning to be revealed. The researcher constantly had to distance herself from the phenomenon in order to become open to new ideas, and maintain the focus on the phenomenon (Van Manen, 1997). The understanding of the phenomenon from lifeworld dimensions helped to form existential themes and helped to uncover hidden meanings (Dahlberg et al., 2008). The researcher was able to move beyond the initial assumptions and preconceptions due to her unwavering attention to the phenomena and commitment to the research study.

Rigour

Lincoln and Guba’s (1989) alternative criteria was included to improve rigour in the study. They identify credibility, transferability, dependability and confirmability as aspects of rigour. Credibility was ensured by the intimate familiarity the researcher had with the topic and setting. The prolonged engagement with the participants and the data gave the researcher sufficient time to get orientated to the phenomena. This also helped the researcher to establish rapport and gain the trust of participants. The participants showed a greater level of comfort and freedom, which helped them to discuss their concerns freely. The use of a reflective diary enabled the researcher to ensure the data were analysed and interpreted objectively. The use of the reflective journal allowed the researcher to actively construct interpretations of the experiences and question how those interpretations came about (Wall et al., 2004). Through such interpretations, the researcher constantly and carefully studied the text and thoroughly recorded her experience and understanding in a personal memo. The contents of the memo were useful as they guided the reflective process of meaning making by the researcher.

The interpretation by both the participants and researcher added value to the research text (Lincoln & Guba, 2000). The researcher ensured authenticity in her
personal interpretation by being mindful of her preconceptions, so that the voices of the participants were reflected accurately. This was achieved by the use of rich description and, where possible, the use of participants’ words to allow them to speak for themselves. The authentic meanings from the data were gathered by being constantly sensitive to the subtle nuances and cues throughout the interview and data analysis process. The richness of the findings was ensured by being sensitive to the participants’ views and their meanings.

Moreover, access to three different groups of participants allowed insight to be gained into multiple constructions and interpretations of their lived experiences. The data from the multiple sources helped to strengthen the claim and illuminate the essence of the phenomena using different perspectives.

Transferability refers to the probability that the study findings have meaning to others in similar situations (Trochim & Donnelly, 2000). The researcher improved the transferability of these research findings to other settings by providing sufficient description of the interpretative process and context of the study so that readers can judge for themselves the applicability of the research findings to their own setting. The rich in-depth descriptions depicting the participants’ lived experiences and the existential meanings were presented from a lifeworld perspective. Accuracy was maintained by constantly checking the themes against the transcript and actual words of the participants. The convergent and divergent elements in the data were respected and followed through the transcripts so that they illuminated similar as well as new experiences. Generally, applicability of phenomenology research is irrelevant because the researcher wants to describe a particular phenomenon. The transferability of this study was enhanced through a process of review and discussions done with academic supervisors. Ultimately, it is the potential user of this research who determines whether or not the findings are transferable (Streubert Speziale & Carpenter, 2003).

Dependability is met through securing credibility of the findings (Lincoln & Guba, 1985). Dependability or auditability was demonstrated by having another researcher follow the process of the study without reaching contradictory findings. The researcher had frequent sessions with academic supervisors to discuss and clarify the interpretive meanings and gained greater insights and awareness into the lived
experience of the participants. Finally, the findings were shared with peer groups from the nursing faculty; the feedback was factored into improving the meanings of the interpretations.

Confirmability was achieved through the researchers’ use of audit trails to demonstrate the thought processes associated with the interpretation and descriptions. The supervisors of this study were responsible for examining the data, findings, interpretations and recommendations in order to attest that they were supported by data. This activity was a means of establishing confirmability of the research through evidence of similar thought processes and conclusions between the researcher and supervisors (Streubert Speziale & Carpenter, 2003).

Whitehead (2004) further emphasised the need for being transparent with the decision trail process. It ensures the trustworthiness and quality of the findings. A clear description on how common codes, categories and themes, and relationships were formed from the data were reflected on in the NVIVO program. Articulating the decision trail was made transparent with the use of this program. The documentation of personal experience and language further informed the interpretative process (Whitehead, 2004). This allows readers to follow through the research process, which improves the credibility and transferability of the study.

After analysing both my readings and the interview data, I have come to see three main themes of person-centred care: ‘homelike’, ‘maintaining and developing connection’ and ‘workplace culture’. The description of the themes includes definitions of the essential meaning, components and presentation of sufficient data to support the researcher’s conclusion. The findings are internally validated through quotes from the study participants, and externally validated through comparison with the literature. The ultimate test of the validity of a phenomenological inquiry is the concept recognition on the part of researchers who read this study. The validity of the investigation is supported if those who have experienced a similar phenomenon can recognize their own reality in the phenomenological description.

3.9 SUMMARY

The genuine desire of the researcher was to understand the lived experience of person-centred care from the perspective of residents, family members and frontline
caregivers; this was a concern that prompted her to find out what was the common meaning shared by the participants. Van Manen’s (1997) lifeworld-hermeneutic methodology explains that human beings experience the world as embodied beings. The lifeworld dimensions guided the study to understand participants’ experiences as a whole, and to humanise the meaning given to their experiences. The lifeworld dimensions guided the researcher throughout the study process and these dimensions were incorporated, especially into the interview questions and analysis of data. Van Manen's (1997) hermeneutic phenomenology was chosen as a suitable methodology for this research. This methodology is attentive to the philosophies underpinning both phenomenology and hermeneutics. It recognises that every experience is an interpretation of one’s moment in life. This interpretation is conceived and equated through one’s social, cultural and historical context where human beings inhabit and share with others. The reality for each person rests in how contextual experience is individually construed.
CHAPTER 4: THREE THEMES

4.1 INTRODUCTION
The analysis and synthesis of data led to the generation of three themes: ‘homelike’, ‘maintaining and developing connections’ and ‘workplace culture’. Each theme is presented in this chapter, but first details on the participants interviewed are presented.

4.2 BACKGROUND ON THE PARTICIPANTS
A total of thirty residents, ten family members and ten frontline caregivers participated in this study; twenty-five of the participants were from New Zealand and twenty-five from Singapore. Of the thirty residents, three were male, one from New Zealand and two from Singapore. The youngest resident was sixty-eight years old and the oldest ninety-two. Only three residents completed tertiary education, five had college or high school education and the rest had no formal education beyond primary or elementary school. Most of the residents had remained in their own homes before moving into the residential home. There were three residents whose spouses were still alive and visited them. Three of the residents were single, two divorced, and twenty-two were widowed. Most of the residents from New Zealand were born in Europe and migrated to New Zealand, except for six residents who were born in New Zealand. In Singapore, all of the residents were born in Singapore, and out of the fifteen residents, eleven were Chinese, three Indian and one Eurasian. Participants had lived in the residential homes from eight months to seven years and all had been diagnosed with at least one chronic condition (cerebrovascular accidents, rheumatoid arthritis, hip fractures, cancer, diabetes and heart diseases). Twenty-one residents used a wheelchair and nine used a walking frame for mobility.

The profile of the family members (n=10) who participated in this study were one son, one step-son, three spouses and five daughters. The frontline caregivers who participated in this study (n=10) were all female. The median age for the frontline caregivers in New Zealand was forty-five years and in Singapore twenty-six years. The ethnic background of the frontline caregivers from New Zealand consisted of three New Zealanders, and two immigrants, one from India and the other from the Philippines; in Singapore three carers were from the Philippines and two from
Myanmar. All participants were able to recall and articulate their care experiences with the researcher.

**THEME 1: HOMELIKE**

This theme captured the experience of person-centred care for all participants across both countries. For the family members and carers, an important aspect of person-centred care was that the resident should feel at home in the residential care environment. For the residents, feeling at home involved a sense of certainty, comfort, respect, safety and belonging. It was influenced by having one’s own space within a communal environment and the atmosphere of the communal environment. The transition from having one’s own home to living in an institution was difficult for many residents who had to learn to live with others and adhere to the institution’s routines. This affected the residents’ sense of lived space as it was a space that was now shared with others and determined by others. They also had to adjust to a new sense of lived relationality by learning to live with others in their ‘home’ environment. The residents’ sense of lived time was also strongly affected by the residential environment. Their autonomy in managing time was replaced with the needs of the institution in how they managed time in that environment. The care-givers and family members both described their role in promoting a ‘homelike’ environment and described this as related to providing empathy and support for the resident.

The theme of ‘homelike’ consists of five sub-themes:

- Adjusting to the loss of one’s home
- Living in a new environment
- Living with others
- Eating with others
- Adapting to the waiting and the rushing.

**4.2.1 ADJUSTING TO THE LOSS OF ONE’S HOME**

Adjusting to the loss of one’s home to living in a residential home was handled very differently by each resident who participated in this study. Many residents talked about their grief and were still grieving for their losses, such as health, independence, own house, and loved ones. This affected their level of adaptation and acceptance of their move into the residential home and their experience of person-centred care.
Those residents who showed a positive approach to living in the residential home adjusted effectively to the new environment. They demonstrated an understanding of their need for medical help and care, which influenced their acceptance and permanence of their situation. The residents highlighted the advantages of living in a residential home.

_They take care of you well. You press the button and they come to you. I can’t get this in my own home. I feel safe and assured that medical staff are around all the time._ (R3, NZ)

_This is not my home. I understand that there is no choice. There is no one at home to take of me, so I am here. I can get help any time._ (R10, SIN)

The acceptance of the transition was influenced by the residents’ state of certainty or uncertainty related to their current and future life. Those who found that they required medical help and assistance with daily activities due to disability or loss of independence adjusted more readily to the fact of spending the rest of their life in the residential home. The assurance of safety and medical help partly contributed to the experience of ‘homelike’.

_I came here after discharged from the hospital. They told me that I can’t manage myself at home alone. I had to move into a home. I was sent here. You are safe here, the staff are around to help you._ (R12, NZ)

Those who felt that it was an unexpected move showed signs of loneliness, social isolation and depression. They talked about how their lived experience of their body had been altered by chronic illness and its severity imposed losses on their comfort, career, income, freedom, cognitive function pride, self-esteem, dignity, and hope. The grief experience of multiple losses impacted on their current adaptation to the residential home environment. Under these circumstances, the residents struggled to adapt to the residential home environment because they did not have a chance to finish the grieving process.

_I am not happy here, I wish I can go back home. My leg is the cause, I can’t stand up or walk due to osteoarthritis. I have lost the ability to walk. My family sent me here so that I can get professional help. But I wish I can go back to my own house._ (R11, SIN)

_I am a post man, I have been delivering letters for forty years. I know the people in the town and we are close. I miss my family and friends. I don’t know why I am here, they think I have memory problem. I don’t like here, I want to go back to my own house._ (R2, NZ)
I came here after I was discharged from the hospital. They told me that I can't manage myself at home alone. I had to move into a home. I was sent here. (R12, NZ)

Many of the residents’ grief was magnified exponentially when their illness limited their abilities to engage in activities they perceived as essential to their lives, such as visual arts for a person who lost her eyesight, and playing instruments for a person who has hearing problems. The residents showed disruption in their sense of self.

I am a tradesman, was running my own workshop for many years. I wish to go back and continue working in my workshop. But they have told me that my legs are no good after my frequent falls at home. My wife admitted me here. (R3, NZ)

It is miserable without having your eyesight. I enjoyed drawing but I can’t do it now. You feel useless because you cannot do your favourite activities. (R5, SIN)

Three residents, one from New Zealand and two from Singapore, described grief that was compounded by strained relationships with their children.

I am a divorcee and my son has no contact with me, I lived alone. When I became wheelchair bound, I was sent here. (R1, NZ)

My children have neglected me, they do not visit me or support me. I have been looking after myself. Now I realised that I am not fit and need support. So the medical social worker helped to move me here. (R1, SIN)

My son-in-law has an evil heart, he has taken my house and told me move out. My daughter helpless. So I came here. I am heart broken. They have taken my house and money. (R6, SIN)

The losses experienced by the residents were tied to more than one event that contributed to a sense of on-going grief and chronic sorrow. Their past experiences impacted on their current and future lived experiences.

Similarly, the majority of the family members both from New Zealand and Singapore often saw themselves thrown into an ongoing grieving process. They felt sorrow for having moved their loved one into the residential home and expressed a sense of guilt for being unable to look after them at their own home. They were constantly reminded of their family member’s lives before, how they have changed, and how the resident as a person used to be. Though the family members preferred to keep their loved ones in their own home, this was not possible with increasing daily needs and were often exhausted by this. Many family members discussed a sense of
helplessness and felt unsure about how to help their loved ones. Some felt in need of support and help to adjust to this transition.

_I have been taking care of my mum after her stroke for the last five years but two years back dad gradually lost his memory and I found difficult to take care of both of them. I knew it is impossible for me to take care of both of them. I visit dad on alternate days and bring home food for him._ (FM 2, NZ)

_We tried looking after dad at home for 10 years, but over the years his health has deteriorated. We can’t manage any more. We were recommended a few residential homes where he can receive better care. It was a hard decision, I feel sorry to send my dad here. It is painful to see him here. So we take turns to see him._ (FM 3, SIN)

Adjustment to life in the residential home was very challenging for some of the residents and their family members. Their grief, brought on by their many losses, contributed to problems in adjusting to their new living arrangements. The way they coped with their loss influenced the residents’ and family members’ ‘homelike’ care experience.

The frontline caregivers played a pivotal role in determining the residents’ and their family members’ ‘homelike’ care experience by showing empathy and making an effort to ease their grief feelings. The frontline caregivers recognised that the transition experience was painful and miserable for the residents and family members, and they showed empathy by describing what it would be like to have their own family or loved one enter the residential home. They described how this influenced their caring practices by giving the residents and family members adequate space and time to adjust to the environment.

_When the residents move into the home, I can see that they are miserable and do not want to mix around. Everything is strange for them, the environment and the people. I try to spend some time to chat and keep them comfortable._ (CG2, NZ)

_They always say that they want to go back to their home. They talk about their house, garden and children. I listen to them and try to cheer them up._ (CG3, SIN)

_We have a very good relationship. When she came here she was very sad and unhappy. But I tried to cheer her up. Now she looks for me. We have become use to each other._ (CG5, NZ)

The nature of the move to residential care – expected or unexpected - and the way in which they adjusted to their new living arrangements influenced their experience of
“homelike” care. Those residents who felt that the move to the residential home was an expected move showed a greater sense of adjustment to their new environment, but those who felt that it was an unexpected move, grieved and struggled to adjust to their new home. The “homelike” experience was enhanced when family members and frontline caregivers showed empathy and supported the residents’ transitional experience.

4.2.2 LIVING IN A NEW ENVIRONMENT

The majority of the residents and family members reported that the “homelike” care experience was influenced by the physical environment. A “homelike” physical environment influenced the residents’ transition to a residential home and facilitated acceptance. Having one’s own room, bathroom, adequate storage, and access to outdoor garden/walk and to quiet places facilitated the residents’ ability to exercise control in the environment and contributed to their quality of life.

I am happy here, I have my own room with attached bathroom and toilet. I take a walk to the lounge for my meals. You can’t bring much things here, but that is fine. I have a wardrobe, a small fridge, armchair, dressing table. (R6, NZ)

Many New Zealand residents expressed enjoyment in being able to go out to a garden that was accessible from their own rooms. The easy access to outdoor gardens gave them the opportunity for fresh air and sun. They enjoyed being able to access spaces away from the constraint of their individual room.

I stay in my room, during good weather I go out to the garden. Otherwise, I just look out from the glass door and it is a beautiful sight, looking at the plants and flowers. You also get to watch beautiful birds. Lovely sight. (R4, NZ)

The "homelike" experience was diminished in the context of Singapore residential home, where the residents showed no control of their lived space. The physical environment presented as an institution, which was regimented and restricted. The care practices encouraged communal living where six residents shared a room. There was no room to place their own belongings. Each resident was provided with a bed, portable table top and a small cupboard. Further, they shared the toilet and bathroom, which upset many of the residents. They were frustrated to put up with irritations and poor hygiene caused by other residents.
There are six of us who share the room. You just have to live with what they give you. (R2, SIN)

The toilets can be very dirty because people urinate on the toilet seat and floor. I usually wash the toilet with some water before using. (R3, SIN)

The residents from Singapore mentioned that sharing living spaces caused them inconvenience because they had to compromise their preferences related to their personal practices.

I normally get up at 3am to take my shower, otherwise it will be troublesome because you have to wait very long for each of them to finish their showers. (R7, SIN)

These residents also complained that communal living limited their privacy and freedom of choice. They cited inconsideration by others when choosing television programs. Those who gave way to others elected to retreat to their own room and be by themselves.

Majority of them are Chinese so they will turn on the Chinese channels; I just go into my room and lie down. (R10, SIN)

I like watching TV but most of the time I can’t watch what I want. I prefer to lie down in my bed and listen to my radio. (R12, SIN)

Besides the physical environment of the residential home, having the freedom to bring in their own possessions such as furniture, pictures, drawings, clothes, and accessories improved the “homelike” experience for the residents from New Zealand. They showed a greater sense of emotional happiness having their possessions around; it also gave the residents an identity, a sense of belonging, and provoked positive memories that were unique and meaningful.

Those stones were given to me by my husband after each of his navy trips. We travel have travelled together for many years and these are gifts from him. I missed him. These things brings the memory of our happy moments together. (R1, NZ)

These are paintings done by me, I had a lot of them but I can’t bring all of them. At home, this painting was also above my bed and my children hanged it the same way here. My children hanged a few of my paintings here, I wish I could still paint, but my hands and eyes are not good now. (R12, NZ)

In addition, some family members from New Zealand helped to normalise the environment as more homelike by bringing in and arranging the personal
possessions of residents. Family members tried to normalise the living environment of the residents by making it look closer to their own home so that the residents could adapt to the environment better.

Family members further fostered the “homelike” lived space by bringing in televisions and radios so that the residents could enjoy watching and listening to their usual programs. This allowed the residents to have continuity with their past, which enhances their current lived experience. Family members expressed greater satisfaction with the lived space when there was easy access to toilets, dining areas and the outdoor garden from residents’ own room.

_She has her own room with bathroom. We have brought the TV, radio and some furniture and photos. We try to make it look like her own room where she was living before coming here. It is important because she spends the whole day in the room._ (FM3, NZ)

The family members from Singapore felt that they had limited access and control over the residents’ living space. They commented that the residents’ privacy was infringed because they had to share the room with five others. They felt that more could be done to create a space closer to ‘homelike’. They suggested that the ‘homelike’ experience could be enhanced by painting the rooms with bright colours and having private rooms for family visits. The lack of quiet and private spaces discouraged and disrupted family gatherings and private conversations.

_We are not allowed to go up to his room, the staff normally will bring dad down and we will sit at the lounge with him. I don’t know what is happening up there. The staff normally brings him down._ (FM 5, SIN)

_Her room is miserable looking. It is crowded with six of them sharing the room. The room is very dark and dull looking. Need to brighten up the room by painting bright colours and hanging posters. Provide entertainment with Television and radio._ (FM1, SIN)

_It will be nice to have a quiet and private place where the family can chat with the residents. A place where we can feel free to make drinks and chat and not interrupted by anyone._ (FM4, SIN)

Generally, the physical space of the New Zealand residents promoted greater “homelike” care experiences because the residents’ sense of lived space accommodated their personal possessions, which enabled a sense of continuity with the past. By being able to make their current sense of space more like the space they were used to gave them comfort and less disruption from their past. In Singapore
residents’ sense of lived space was a rupture from their previous experiences, which they found distressing.

4.2.3 LIVING WITH OTHERS

This aspect of the “homelike” theme describes the residents’ experiences of adjusting to living with others and the difficulties this posed when other residents were unable to function to the level the participants were able to. The homelike experiences of residents from both countries were affected by co-residents who were disruptive. When co-residents with dementia disrupted their environment, many residents felt distressed. They described the constant wandering, behaviour problems, and noise levels as disturbing and upsetting. This created an environment where some residents felt insecure and had to constantly check whether anyone had entered their room or disturbed their belongings. Some were affected by the noise level caused by the cognitively impaired residents. They were unable to sleep and rest well.

*It is upsetting to see someone lying in your bed, they just enter your room and disturb your things.* (R10, NZ)

*I feel terrible here. She screams all the time and making so much noise. Every day she is asking for her mom and dad. So I try to avoid going to the lounge.* (R6, NZ)

*You can see them urinating and pooing in the lounge. It is very smelly and I’d rather remain in my room than to see all this.* (R15, SIN)

Family members in Singapore suggested that the institution should give careful thought when cohabiting the residents in the same room. One of the family members expressed concern for the placement of her dad with a noisy and disruptive resident. Another family member wished that their father could have a room-mate with whom he could converse because the language barrier affected his ability to have meaningful communication with the current room-mate.

*Dad is placed in a room with Chinese residents. The Chinese residents can’t speak English. So they hardly communicate. It is strange, sleeping in the same room but don’t know much about each other.* (FM4, SIN)

Some residents in New Zealand expressed concern that their access to outdoor spaces and other areas was restricted at times due to the safety needs of the residents with dementia who wandered around. The residents expressed
unhappiness because their access to the outdoor garden to enjoy nature was compromised due to the need to contain wandering residents.

Well there's quite a lot of people with early dementia and there are three people who two in particularly who keep wanting to wander and they so every now and again they close the doors. (R2, NZ)

I'm in a wheelchair and find this quite frustrating because I feel that those of us that can get around rationally, well speaking for myself, were prevented from going outside and all that sort of stuff you know. (R4, NZ)

Living with disruptive co-residents also affected the residents’ experiences of activities within the residential home. They found that the objective(s) of the activities session were not always achieved because of the varying abilities within the groups. They complained how the residents with dementia disrupted the activities and that staff had to divert their attention onto them. Hence, they felt they received less attention and input.

It would be good if people are given the option to decide whether to take part or not to in the activities. There are people who are confused and unable to follow who disrupts the flow of the activity. (R5, NZ)

Well, there is a group of us who sit at the activity table on Tuesdays and Thursdays morning. The activities ladies is usually busy with the dementia residents because they were trying to get up and walk away. She often leaves us and take the person to walk. Then it get bored and tired. (R3, SIN)

Most activities were designed for dementia residents and not for normal people. They found the activities to be meaningless. (R2, SIN)

Most programs in the residential homes are for residents with dementia. The activities consists of sitting around and talking about the old days. I don’t like it. I want to have a discussion something to keep my brain going. Many a times, the people keep quiet or walk away. The staff had to run after them. (R15, NZ)

Overall, living with others affected the “homelike” care experience as the residents with dementia caused disturbance and disruption to the residents’ daily life. However, some participants felt sorry for the residents with dementia and empathised with them. They realised that sooner or later they could be going through similar behavioural problems. In other words, they were greatly upset that in a few years, they might also suffer from dementia.

I see them, I feel bad... I might be like them in few years’ time. I don’t wish to live like them. It is better to die. It will be awful to watch a person who has lost her mind. (R9, NZ)
However, some of them were thankful for being cognitively intact and tried to engage with the cognitively impaired residents and assist them with some of their needs whenever possible.

*I feel sorry for her sitting and closing her eyes all day. It is a sad state. At times I sit beside her and help her with her drinks and cakes during tea time.* (R9, SIN)

*At lunch time, I sit beside “J” and we talk. I assist her with her meals. Sometimes she just stares at her meal, so I try to remind her to use the spoon to feed herself.* (R1, NZ)

Cohabitation with residents of vastly varying cognitive abilities affected the ‘homelike’ experience for some of the residents because in ensuring safety of residents with dementia, the freedom and independence of other residents was restricted. The behaviour of the residents with dementia had disturbed and caused distress to the cognitively intact residents. Some of them made their life purposeful by assisting the residents who required help in terms of social chatting or assistance with activities. A few found it distressing because they anticipated that they might face similar cognitive problems eventually. The residents’ experiences of the lived space within the residential home was greatly affected by those with whom they had to live.

### 4.2.4 EATING WITH OTHERS

Eating with others was associated with the theme “homelike” as this involved nourishment, fostered independence, promoted self-esteem and provided comfort to the residents. Dining and food was highlighted as an important feature of each day for most residents. Additionally, several participants showed interest in knowing what the meal was for the day. They sincerely wished that their food preferences were considered and they longed for well prepared and tasty meals. The most common complaints about food was in reference to that which was uncooked, cold, bland and small portions. They became upset when their food preferences were either ignored or overlooked. Residents and family members alike commented on the social impact the environment had on the dining experience, which detracted from the connotation of it being ‘homelike’.

*I am served with acidic tomatoes in my food, which I can’t eat. I only eat the acid free tomatoes. Most of the time I do not eat my meals and just take a glass of milk.* (R1, NZ)
The scrambled eggs are too watery and the bread becomes watery too. (R3, NZ)

The food is too cold and does not look appetising. (R10, NZ)

The residents showed signs of frustration and distress due to their food preferences being neglected and were unable to exercise choice about what they ate. A few of them felt annoyed and helpless when staff ignored the specific details on how to personalise the residents’ food experience.

I do not eat meat, but they serve me meat. This happens especially during evening dinner. So I eat sandwiches if available otherwise have some biscuits for that evening. They don’t pay attention to your request. (R5, SIN)

Generally, the family members from New Zealand commented that the food appeared tasty. However, some family members from Singapore felt that the meals were not appetising, especially for those who received a pureed diet. They preferred that the pureed dishes were served on their own so that residents can exercise their choice about what they ate. Family members from both countries suggested that the home should make drinks, fruits and snacks accessible to residents throughout the day. They believed that this would increase the residents’ nutrition and improve the ‘homelike’ experience.

I feel that the medication he was taking had caused slurring of speech and his swallowing is also affected. As a consequence he is on liquid diet now. The diet does not look appetising and tasteless. They should prepare and serve the meal in a more attractive manner. More frequent small meals might help to nourish her. (FM2, SIN)

They should create more flexibility with fruits and drinks, residents should be offered more fruits and drinks in between their meals. This will help them with their bowel movement. (FM5, NZ)

The family members felt that the meal situations could be more ‘homelike’ if staff were focussed on ensuring the residents were well nourished. They hoped that staff genuinely considered the food preferences of residents and provided the residents support with their meal, for example, assistance with feeding and drinking. Most family members found the eating situations to be a sore point and they shared common care practices that affected residents’ nourishment. In addition, they showed distress when staff would leave the meal tray at a distance from residents who could not reach it, which was compounded when the resident’s eyesight was poor. Furthermore, they identified staff shortages as a cause for delay or neglect in
feeding residents who needed this level of support. Family members made a point of being around during meal times so that they could help out and ensure their loved ones were fed adequately and appropriately.

_The other day I came in during tea time, noticed that her drink was in front of her and not given. The caregiver do not show interest or initiate care._ (FM1, SIN)

_The other day I saw how the caregiver was rushing to feed the poor old lady still having food in her mouth. She was impatient and kept on telling the resident to eat faster._ (FM3, SIN)

_The staff have no time to feed mum who eats very slowly, she was losing weight after she arrived here. I tried to be here during meal times so that I can feed her and she is much better._ (FM1, SIN)

Moreover, the social aspect of dining contributed to a ‘homelike’ care experience, both for residents and family members. The residents enjoyed the dining experience with family and friends, and a number of family members demonstrated that their presence at mealtimes made it a social encounter. However, one family member from New Zealand found that her loved one was deprived of the social opportunity because staff did not attempt to bring her mother to the dining lounge. Instead she was left to feed herself or wait to be fed either in her room or bed. The family member wished that her mother was given the opportunity to socialise, dine and interact with others.

_A few times I have noticed that mum was left in the bed to have her meals. It is only five in the evening and she is already dressed into her night gown and in bed. I prefer her to go to the dining for her meals. She gets to meet her friends and have a chat with them. Psychologically, she will feel better._ (FM3, NZ)

However, frontline staff commented that the overwhelming job demands and time constraints were issues. They shared that changing the resident into day clothes and transferring them to the dining table required additional time. This became especially difficult when functioning within the constraints of staffing limitations. They perceived that it was more timesaving to leave the residents in their own room and feed them their meals in their room. Hence, the experience of ‘homelike’ dining for residents was compromised by staff due to their perceived efficiency. However, through their presence, most family members ensured that the resident’s feeding and dietary needs, meal preferences and dignified dining was maintained.
In addition, dining was an opportunity for residents to socialise as they met their regular peers at this time and engaged in small talk with them at the dining table. They enjoyed the company of residents whom they liked and also became dissatisfied when they were not given a choice to sit where and with whom they wished. In addition, residents became upset when they had to sit with those who were deemed to be noisy, disruptive and messy. They hoped that staff would pay more attention to their sitting preferences and ensure that these were available each day. Of note, the seating arrangements were further disrupted whenever irregular staff were doing the shift. At these times the dining experience was perceived as strange and upsetting for some residents.

There is the four of us who sit at the dining table during each meal. I look forward to see them. We chat about the food, people and war stories. But sometimes, we get others into the group or we are shifted to other table, it spoils my day. You are sitting with strangers, don't know what to talk. Sometimes you get noisy people at the table. This happens whenever there are non-regular staff on the shift. (R1, NZ)

The residents shared that the “homelike” dining experience could be enhanced by making the environment more conducive to pleasurable engagement. The residents were contented with the dining layout that has dining tables for smaller groups of people. They suggested that it could be made more “homelike” by including features such as kitchen cabinets, table cloths, and colourful curtains. However, it was the noise level that ultimately affected their pleasurable dining experience. The increased noise level caused by trolleys, machines and staff talking amongst themselves affected the residents’ dining experience. Residents identified that the noise caused irritation, tired them out and affected their appetite.

Some family members from New Zealand also commented that the dining area could be made “homelike” by improving the colour of the walls, table cloths, and having placemats. However, the family members from Singapore could not comment on the physical layout of the dining space, as dining took place in a multipurpose hall where daily activities were carried out and was converted to an eating area during mealtimes. This institutional-like meal practice was further reinforced as residents were lined up along a stretch of long tables and had their meals on metal trays.

The frontline caregiver’s notion of homelike dining was identified in terms of technical aspects, such as understaffing, routines, and the demonstration of efficiency through...
multi-tasking. They talked about their proficiency in feeding by strategically placing themselves between two residents and taking turns to feed them. The staff spoke in terms of completing their feeding tasks and clearing the dishes and trolleys within a set time-frame rather than making dining a homelike experience for the residents. They mentioned that the demanding workload and poor staffing caused them to rush the meals with the residents. Issues related to residents’ preferences, food satisfaction and socialisation during dining was rarely mentioned.

*I normally feed two to three residents each time. We have to rush feeding all the residents within an hour. Some days when we are short of staff, it is even worse.* (CG 2, NZ)

A few residents and family members shared their observations of feeding during meal times: staff reportedly forcefully fed residents who refused to eat, food falling onto residents’ clothes, and failing to wipe the resident's mouth after eating which caused a sticky feeling around the mouth.

*It is sad to see the food dribbling from the resident's mouth and staff are still forcing the food into their mouth. The two common words you hear are “swallow” and “open your mouth”. You can see some residents refused to open their mouth, so the staff have no choice but to force the food into the mouth.* (R1, NZ)

The residents and family members identified this eating experience as not homelike or pleasurable for the residents because the staff did not show care and consideration to the feeding needs of these individuals. They also acknowledged that staff shortages were one cause, whereas a few of them also blamed it on the attitude of the staff. Generally, they felt the dining experience of those who required assistance with feeding was less desirable.

Overall, residents and family members perceived that the highlights of the day were the meals and food, but they expressed great concerns with the food service. Food preferences were overlooked, and residents had to constantly remind staff of their likes and dislikes. Family members were concerned with some staff who were seen as less caring and disinterested in ensuring residents received adequate fluids and food and/or assistance with feeding. They also wanted the environment to be more ‘homelike’ by providing more opportunity for residents to access free snacks, fruits and drinks.
4.2.5 ADAPTING TO WAITING AND RUSHING

The homelike care experience of the residents was influenced by their lived time in the residential home, which was seen as waiting, whilst the frontline caregivers experienced it as rushing. The two common words associated with time that repeatedly emerged throughout the interviews with residents were ‘waiting’ and ‘boredom’. Those residents who were less dependent and mobile showed greater capacity to be in control of their time and how it was spent. They decided on activities that were meaningful for them and showed the capacity to be in control of their time by making decisions on the timing of their daily activities; for example, when to wake up or go to bed, whether to engage in group or personal activities. The waiting moments for their care needs were easily accepted because of their level of independence. They accepted the fact that there were other residents who were less fortunate, such as those who were bedridden or immobile and who really needed the attention of the staff, so they were willing to wait. Others with a similar level of independence found time as meaningful by contributing towards the daily activities of the home. These activities involved assisting with laundry, helping out in activities for an event or assisting other residents with their needs. In this way, they found their time was spent purposefully and gave them greater meaning.

_Time just goes on. You have to do things you have to do. I know that others need more help than me. I try to do most of the things by myself. I have my TV and books to keep me occupied. I help with paper decorations for events such as Christmas, Melbourne Cup and Easter._ (R9, NZ)

_I help out in the laundry daily by folding the clothes. Currently, we are practicing singing for a New Year show in a fortnight. We did those decorations for the coming event. I feel good when I can do something, otherwise it will be boring._ (R5, SG)

Time was not associated with just one’s level of mobility but also the ability to get around the institution on one’s own. The freedom to get around prevented them from being confined to their room or space. The residents from New Zealand who used a mobility scooter found that they did not have to wait for others to arrange things for them. They were able to take themselves to the outdoor garden, and move around as they liked in and around the home.

_I am pleased that I have the scooter, I do not have to wait for others as I can move around as I like. I get out to the garden, activities area, move up and down the elevator. It is a good feeling that you are not dependent on others and freedom to do what you like._ (R1, NZ)
The residents perceived that quality care was missing when they were made to wait, which influenced their meaning of time as uncomfortable, uncertain, frustrating and distressing. They equated longer waiting times with a decreased quality of life. The common situations identified by the residents in which this arose was in waiting for staff to attend to their personal care needs. Waiting was described by most of the residents as a stressful time filled with anxiety and uncertainty, which were often hard to handle as the time appeared to be filled with a never-ending fear of whether the staff will show up and at what time. Those who received prompt care felt that their wellbeing was looked after well. On the other hand, when the care was delayed, the residents felt a sense of neglect and helplessness, which, in turn, caused physical discomfort and emotional distress.

I am in pain because the pad hurt my groins but the carer neglect my cry and I was told by the night staff that I have blisters on my groins. They neglect my cry and I had to suffer. (R4, NZ)

Well, I get upset when I have to wait too long for things. They said I will back in a minute, and they only show up after 15 or 20 minutes and sometime they do not show up at all. It is irritating because they don't keep up to what they had said. Time is very important to me and I hate waiting. I haven't got much time to live and I don't want to waste my time sitting here and waiting. (R14, SIN)

They make you wait at the dining table after your meal because they had to clear and wash the dishes. It is too chaotic and noisy. You have no choice but sit here and wait till one kind soul comes. (R3, NZ)

Just when I have to wait for something which I think is quite urgent and I can't then the carer leaves me to attend to another person who press the bell. I feel unsafe and hoping she will return quickly. (R2, NZ)

The most distressing situations were associated with waiting for assistance with elimination needs that was mostly ignored or delayed by staff.

They left me on the commode for a long time, did not answer to my call bell. With my sore back, it was unbearable to sit for such a long time. (R8, SIN)

I had to go to the toilet to “poo” but she took so long to answer my call bell. Then she told me to do in my pad. I can't do that it is awful. After a long discussion she brought me to the toilet unhappily. (R11, NZ)

I had to wait too long for the carers to bring me to the toilet, so I urinate on the bed and lying in my urine. It is very shameful and painful. (R13, SIN)

You have to wait too long before they answer your call bell. I told her I need to go to the toilet and she told me I can do it on bed because I have a urinary catheter. But I wanted to move my bowels. You can easily feel that
she is unhappy to take you to the toilet. Makes me feel miserable and helpless. (R11, NZ)

I try not to ask them for help. But, sometimes, I have nobody else to ask. I wanted a bedpan but it would take so long for someone to bring it to you. I got tired now. Now they leave the bedpan in my room so that I could give it to myself. But I am not steady and sometimes I’d spill it and they’d have to change the bed. Some think that I did it on purpose. Who would do something like that on purpose, for heaven’s sake? About the only thing you can do is hope that those nurses don’t work with you that day. (R13, NZ)

While a few wheel-chair bound residents avoided the waiting situations by demonstrating their self-determination and control, they realised that they were still made to wait because staff wanted to complete their scheduled tasks on time. One of the residents from New Zealand expressed her concern about how she was made to wait at the dining table for more than half an hour before the meal.

I tell you what a lot of people getting tired about that is waiting, waiting for food and anything. If someone is taken to the dining room they are taken at 5pm and they have to wait till close to six for their dinner. The carers leave us there and go to the nurse’s station for their handover. Why should this handover take place at this time, can’t they chop it off. Why should it come along at that point of the day? Keeping everyone sitting and waiting. The handover should be done at another time so that it does not cause inconvenience to the residents. I have found it out sometime and decided not to go to the dining area till close to dining time. What is the use of wasting your time sitting at a table where you are unable to interact with others? (R1, NZ)

The residents also experienced time as either moving slowly and boring, or fast and engaging, in relation to the activities of each day. Residents wished that the activities could be more meaningful by considering the residents’ past interests and habits as this would make the activities more relevant and therapeutic. Similar concerns were shared by the family members who identified the habits and hobbies of their loved ones with the staff, hoping that this information would be considered when planning activities for residents.

I have informed the staff to bring down mum for bowling on Mondays and Thursdays. She enjoys going for bowl even before coming here. But sometimes the staff don’t bring her. (FM 2, NZ)

When the residents engaged in activities that were part of their lives prior to admission to the residential home, they showed a greater sense of involvement and looked forward to the activities. Such activities included bingo, bowling, singing and crossword puzzles. But for others, the physical and/or cognitive decline affected their
capability to continue with these activities. Others saw these activities as a way to just pass the time, without any value for them.

_ I don’t like bingo and singing. I found it too boring. I did rather do knitting or read book in my room. (R5, NZ)_

When the activities were engaging and purposeful, the residents found the time passing to be interesting and engaging. Those who identified the activities not a part of their life, found the activities as meaningless and the experience of time as boring.

4.2.6 SUMMARY

The move into the residential home was viewed by the residents as either the safest option or as a defeat and disgraceful. Those who felt it was the safest option showed less difficulty in achieving a homelike experience. However, those who viewed it as devastating and threatening found it difficult to establish a sense of the setting as homelike. Hence, the events perceived by the residents as contributing to their move into the residential home affected their level of adaptation to the new environment and to accept it as homelike. The homelike experience was further influenced by living with other residents and positive feelings were encountered when the level of noise and disruption caused by others was bearable. Dining, physical environment, and time and waiting were the other factors that influenced and determined whether the care was “homelike”.

The lifeworld interpretation demonstrates that the lived space of the New Zealand residents was more homelike due to a less institution-like appearance. The Singapore residential home promoted communal living, where the facility was shared among the residents, which affected the residents’ homelike experience. The homelike experience was better for residents who were more independent and showed control of their lived time than those who were dependent and found that their lived time was controlled by staff. For the latter group, lived time was seen as waiting and boring. Family members and frontline caregivers play an important role in enhancing residents’ homelike experience by adding quality to their lived time and space.
THEME 2: MAINTAINING AND DEVELOPING CONNECTIONS

4.3 INTRODUCTION

The admission to a residential home imposed difficulties for the residents in maintaining relationships with family and friends. Often relationships with staff and residents become particularly important and crucial to residents’ quality of life. The theme ‘maintaining and developing connections’ was to maintain past relationships and develop new ones captures the desire of all participants to be recognised as a person and to recognise others. All participants agreed that family relationships were an important aspect of the residents’ emotional wellbeing. Those who lacked family support expressed a sense of isolation and described a poor quality of life. Data from all three groups of participants contributed to this theme. The residents wanted to maintain their relationships with family and friends whilst also developing new relationships with frontline caregivers and other residents. The interpersonal qualities of the frontline caregivers have a great impact on both residents’ and family members’ experience of care. Another aspect was connection with the outside world; there was collective acknowledgement that connection with the community and the ability to go out of the home were important for the wellbeing of the residents.

The person-centred care experienced was related to having a sense of connectedness that was influenced by relationships. The theme of ‘maintaining and developing connections’ consists of four elements that constitute the experience:

- Family relationship
- Nurturing relationship
- Interpersonal Relationship
- Outside world connection

4.3.1 FAMILY RELATIONSHIPS

The adaptation to the change in lived space for the residents was facilitated by family relationships and the development of new relationships with front-line caregivers. The residents and family members believed that maintaining and expanding their connection to include frontline caregivers who were part of their immediate living environment in the residential home was important. Yet it was also noted that proximity to others did not necessarily lead to connection due to a number of factors.
The residents articulated preferences for maintaining relationships with their family members and friends. The continued connection provided a sense of purpose and meaning for the residents to go on each day in the residential home. The social relationship and interactions provided familiarity and minimised the feeling of loneliness and isolation for the residents. Emotional stability was greater when they were in the company of their family and friends; it improved their sense of wellbeing.

For example, this resident described the importance of weekly visits from her son and sisters:

*I have my son who comes every evening, and weekends brings me out for a wheelchair ride. The staff knows and they normally leave me on the chair till my son leaves. On weekends, I am showered and dressed for my outing with my son. I have good family support. My sisters visit me twice a week.* (R8, NZ)

Another resident remained unhappy about her move to the residential home but this was ameliorated to some extent by the daily visits from her daughter:

*I wished that I can stay in my own home, but things have turned difficult. My daughter tries to visit me every day. If there is any issue the staff contact her immediately and she drops in immediately. She sees to all my comfort. I am blessed.* (R1, SIN)

The visits by the family members helped to minimise the distress caused by relocation into the residential home for the resident. Likewise, the family members expressed their sense of love and duty by visiting their loved ones. They empathised with their loved ones who had to be moved into a strange environment and surrounded with strangers. They felt sorry for their loved ones and showed their continued love and support through their regular visits.

A family member shared the initial experience of moving her dad into a residential home, which was painful. In order to overcome their guilt, conscious of relocating her dad into the residential home, the family made frequent visits.

*We tried looking after dad at home for 10 years, but over the years his health has deteriorated. We can’t manage any more. We were recommended a few residential homes where he can receive better care. It was a hard decision, I feel sorry to send my dad here. It is painful to see him here. So we take turns to see him.* (FM 3, SIN)
Another family member found that she was unable to cope with her dad’s aggressive and wandering behaviour. Thus, she had to resort to sending her father to the residential home for professional help:

*I make it a point to come at least alternate days. I am staying not very far from here. I normally check with the staff how dad has been and ask them for advice on tips on how to support dad with his dementia needs. It was very tough to manage dad at home. He becomes restless and aggressive before moving here. He also went missing. Though I feel sorry for him to move into a residential home but this is the best choice for him. I tried to sit down and talk to dad so that he remembers us and his surroundings.* (FM 2, NZ)

The family member considered the move into the residential home was the best choice based on safety, and the professional help required for her dad who suffered from early dementia. For many residents, family visits were the highlight of their lives and they greatly looked forward to them. The following two residents shared about the support received from their family members. The frequency of their visits and contact with staff further enhanced their care experience because the staff, family members, and residents became comfortable with each other. Greater understanding influenced their care experience.

One resident felt reassured by her daughter’s love and frequent visits. This gave her the confidence that the daughter would ensure her overall wellbeing.

*My daughter comes frequently. If I have any concerns I will inform her and she will talk to the staff.* (R8, NZ)

This resident valued not only her daughter’s company but the role she played in interacting with the staff. One of them shared that though she missed the presence of her children, she recognised that they had their own commitments, and hence preferred not to disturb them. She was glad that they took turns to see her on weekends.

*I have two sons and a daughter. Every Sunday they take turns to visit me. They are busy so I don’t wish to trouble them.* (R6, NZ)

Distance was an issue for this resident whose sons lived in other countries but the frequency of their phone calls made her happy. Another resident without family looked forward to visits from friends. She commented:
Once in a while, my friends and church members drop by to see me. They bring along flowers each time and wheel me out to the garden. (R7, NZ)

If families were separated by distance, some residents and their family members maintained their connectedness through regular phone calls and skype videos. The residents looked forward to the calls and the contact delighted them and gave more meaning to their life. One of the residents shared about her weekly skype with her sons from Australia:

I have 2 sons who are married and living in Australia. We skype on every weekend. I don’t want to trouble them. They are lovely boys, they always send me presents. (R10, NZ)

This resident perceived that it was a logical move to go into the residential home. She used technology to remain in contact with her sons who were overseas. Some residents reminisced about their relationships with family and friends, and the corresponding sense of connection through the sharing of stories and photographs is an effort to bring their past connections and relationships into their current existence. One of them showed her family photo and reminisced about the experience associated with that photograph. Her facial expression, eyes and mood changed immediately and she showed much pride and love.

That’s my husband, we met in a ship and got married the next month. We have four children. (pointed at the pictures and mentioned their names). That is our house in the background. (R10, NZ)

Family members from New Zealand improved the residents’ sense of self by hanging photos and small items that are meaningful for the residents. It helped the residents to enjoy their reminiscing moments. However, this was not feasible in the Singapore context due to communal sharing.

Nevertheless, both residents and family members felt that the residents’ quality of care and quality of life were influenced by the amount of family support one had in the residential home. They felt that those who had good family support received better quality of care. They believed that the involvement by family members made a difference in the care provided by the staff. The family members played the role of an advocate in communicating the needs and the rights of residents. The residents sensed that greater weight was given to family members’ voices than their own. The residents felt that recognition was only given to those with family support, which is
not a value of person-centred care. Thus, the residents perceived that those with family support were given better care than those without any support. The visits helped both residents and family members maintain and continue their connectedness, which gave meaning to their life. It was interpreted that the visits and support by the family members influenced a higher level of care for the residents.

This indicated that the standard of care was related to how much family support one received.

*One should have a strong family support, otherwise you are not treated with respect and care. They think that there is no one to support you. (R3, SIN)*

This resident felt that the care given to those who have family support was better than those without family support. The following two residents felt that having family support improves one’s care from staff because the staff had additional pressure from family to ensure their care was up to standard.

*I used to stay alone, I am a divorcee and I have only one son who hardly visits me. Once my health deteriorated, I was moved here from the hospital. My son has not visited me. I saw him two years ago when he had to sign some document. I have not seen him since then. It is miserable. One has to fight for their own rights. (R1, NZ)*

*If you do not have a family, your life here will be difficult because there is no one to speak for you. (R1, SIN)*

A few residents were upset with their family members for not taking the responsibility of looking after them and did not forgive them for moving them to the residential home. The social stigma of moving into a home was too painful for these residents. They associated this with neglect by family members. Some of these were overwhelmed with sorrow to such an extent that they tried to shut themselves away from their network of relatives and friends. Three residents, one from New Zealand and two from Singapore, shared that the move into the home was a desperate and helpless move because the children were not supportive and neglected them.

The following two residents were emotionally disturbed because they perceived that the children had neglected them instead of supporting them. They sought the help of a social worker.
I wished that I can stay in my own home, but things have turned difficult. My children do not support me and my savings are gone. I can't work anymore and my health is getting poor. I need assistance, so I sought the help of the medical social worker and she helped me to move into the home. (R1, SIN)

I am very unhappy with my daughter and son-in-law, they forced me to sell my house and took my money. I had heart surgery and they do not allow me to live with them. The social worker arranged to send me here. (R6, SIN)

Overall, relationships and support from family members and friends were critical to the residents’ experience of care; they helped to buffer the sense of isolation and enhanced the residents’ emotional wellbeing. Most residents valued family relationships and the level of support provided by their family influenced their personal experience of care. They showed an increased sense of trust and security. Those who felt poorly supported or neglected by family members showed a state of depression and anger. The visits made by the family members helped both the residents and family members to maintain their relationships at the residential homes. It is obvious that the continuity of connection is associated with increased satisfaction with care.

4.3.2 NURTURING RELATIONSHIPS

All the participants recognised that having a nurturing relationship contributed towards person-centred care. Despite their role differences and individual differences, each of them agreed that nurturing helped to deepen their connection and sustain the relationship. Mutual trust and support were identified as elements of a nurturing relationship.

The residents and family members observed that the frontline caregivers had a critical part to play in the residents’ lives on a daily basis. They were not only involved in providing care but they had become part of the residents’ world too. The mutual understanding improved nurturing relationships and social contacts between the residents, their family members and the frontline caregivers. The relationship with the caregivers gradually became stronger because of the inevitable nature of contact through caregiving and receiving. The residents and family members highlighted that the regular staffing enhanced mutual understanding, and improved relationships and consistency in care. One of the residents who knew her caregiver very well, mentioned how their interaction had evolved between themselves and their families.
Another resident acknowledged that the opportunity to interact with frontline caregivers was slim because they were mostly busy. But both the residents and the frontline caregiver tried to squeeze some time to make jokes and talk to each other during the care activities.

The staff are good without them it is tough. They are mostly busy, but sometime we talk and joke together, I have been here for eight years, so more or less we have come to know each other better. (R8, SIN)

This resident felt sorry for the staff member who appeared to have a demanding workload. Over the years, both the resident and staff had got to know each other better. This helped their relationship. Likewise, the family members acknowledged that mutual understanding between them and the staff improved the care service; it was more consistent and personalised. They too identified the importance of regular staffing in order to deliver person-centred care where expectations could be met. They appreciated the care service and gave credit to the contribution of frontline caregivers. They also felt sorry for frontline caregivers who had to struggle every day with their heavy and demanding workload. Family members also eased the frontline caregivers' workload by being personally involved in some of the care activities. They looked forward to working alongside the caregivers, which gave them opportunity to know the caregivers better, and at the same time, share relevant information of their loved ones so that the wellbeing of the residents could be enhanced. Through the sharing of the residents' biography, the family members were trying to highlight the preferences of the residents, which is essential for person-centred care.

One family member appreciated the service provided by the staff and her added value to the care by updating the staff on the preferences of the residents.

The staff are good, they take care of mum well. I appreciate their service, especially the regular staff, without their help it would be difficult. They are friendly and see to her needs. I let them know on mum’s preferences so that she can get best care. (FM1, SIN)
Regular staffing had helped this family member to establish rapport and to communicate the preferences of the resident to the staff. Another family member was satisfied with the level of communication with the staff.

*I have been coming here many years, this has given me opportunities to know the staff and interact with them with ease. They take good care of my husband. It is a tough job but the girls are doing a good job. I can't manage the care by myself. We rely on the caregivers. We have come to know them and the staff too know me, and our family members. They are providing reasonable care. If my husband has any problem they will quickly alert me. If I am going to be out of town, then I let the staff know and they will take care of my husband. (FM4, NZ)*

Similarly, the frontline caregivers felt sorry for the losses that residents have faced in their life time, especially moving away from their own home into a confined institutional setting. They recognised the residents pain and tried to nurture them by showing emotional connection.

Two frontline caregivers recognised the sorrow caused by the transition.

*They always say that they want to go back to their home. They talk about their house, garden and children. I listen to them and try to cheer them up. (CG3, SIN)*

*We have a very good relationship. When she came here she was very sad and unhappy. But I tried to cheer her up. Now she looks for me. We have become use to each other. (CG5, NZ)*

They saw family members as an extension of the residents’ lifeworld. The compliments given by the family members gave them affirmation, and they felt valued and nurtured. There was mutual agreement that both parties worked in partnership towards the wellbeing of the resident.

One frontline caregiver felt that there was a sense of family bonding when the family members showed greater respect towards her.

*They don't see you as just taking care but they treat you like their family member, we have closer bonds. (CG2, SIN)*

Another frontline caregiver felt that the family member was comfortable with her and usually looked out for her.

*I think she is comfortable with me. She always looks for me and updates me if she is to bring her mum out or if she is out-stationed. (CG5, NZ)*
Interestingly, residents and family members found that the mutual trust between staff and family could be further improved if staff have comprehensive insight into the medical condition and treatments of the residents. They felt that when staff were well informed of residents’ medical conditions and treatment, it helped towards care that is personalised and safe. They encountered issues related to safety and fear due to frontline caregivers’ ignorance of residents’ medical or treatment conditions. Family members wished that staff and doctors were more open and honest with them so that they could be at ease. The trust level increased when they were kept informed of changes related to the condition and medication of their loved ones. Some family members became upset when they were not consulted about the implementation of change in treatment or medications for their loved ones. They shared situations where they observed sudden changes in the behaviour of the residents and only after some time came to realise that it was the effect of medication change.

One resident shared about her fear of unsafe care when attended by a non-regular staff member:

*I am worried when attended by non-regular staff, they don’t know your medical condition and the pattern of care. I get worried for my safety.* (R2, NZ)

Safety was a concern for this resident whenever attended by a non-regular staff member. Another resident had to adopt an aggressive stand with staff so that she received safe care.

*Be knowledgeable about the job... for example, I have very bad psoriasis on my leg and the staff was about to put cream on it. I stopped her but she insisted. I told her off and told her not to come near me. The doctor had already told me not to apply anything on that area. Some of the staff don’t know what they are doing.* (R1, NZ)

This resident perceived that she had to take control of the situation whenever she was attended by staff who were unfamiliar with her condition and treatment. Another resident hoped that the staff understood her medical condition better:

*They do not know your medical condition, I am on furosemide and I need to go to toilet frequently but I need assistance. They are unhappy and tell me to wait since I have been to the toilet just now.* (R7, NZ)
One of the family members was curious about the sudden change in her dad’s behaviour and only realised later that it was due to changes in his usual medication:

*After a month his admission, we realised father was sleepy whenever we visited him. We were curious and not sure why he was sleepy all day. We only came to know that because he was noisy and unsettled at night, he was given some sleeping tablet which affected his behaviour.* (R14, SIN)

The competency with which the staff related to residents, and their management of the medical condition and appropriate treatment, contributed towards person-centred care. The trust level was enhanced when staff showed more openness and honesty in keeping the family members informed. The level of satisfaction in the care provided was associated with the level of trust experienced by the residents and family members.

In addition, the residents explained that socialising and forming relationships with peers helped to nurture them. The relationships were fostered through engaging in facility-based recreational activities and eating communal meals. These events brought residents together, promoted social interaction, and created shared experiences that provided conversation starters for initiating personal exchanges.

Four residents expressed how they maintained their social connection with other residents. One of them looked forward to having interaction with others who met the person’s social needs.

*I enjoy talking to people, I get a chance to chat with others.* (R14, NZ)

This resident created a friendly atmosphere by having interaction with other residents. Another resident had her own selective group of friends:

*There is three of us who meet during activities and dining time and have a chat.* (R8, NZ)

Two of them had their own special friends, whom they looked out for everyday:

*I enjoy the conversation with (anonymous); we have common interests and mutual understanding.* (R6, SIN)

*I look forward to (anonymous) company, we were able to share our war stories.* (R3, NZ)
The sharing of common bonds and interests and the ability to interact appropriately provided a sense of connection and being nurtured. A few residents spoke about peers with readily apparent disabilities for whom they felt empathy. They assisted these residents in various ways, as a companion, a helper when required, and providing assistance with eating and during group activities.

Two residents related how they assisted their peers with disabilities:

I look out for (anonymous), she can't communicate in English so I make sure her needs are communicated to the staff because we share the same race and religion. (R2, SIN)

I always look out for (anonymous) and sit beside her at the dining table. She needs help with feeding and I assist her as much as possible. (R5, NZ)

These residents made more meaningful connections through caring for their peers who required help. However, the peer relationships were not the same for everyone; a few found it difficult to make friends with other residents even though they had been in the home for a long time. They believed that other residents were unable to interact appropriately and caused unnecessary noise and disruption. They preferred to view them as strangers without much contact. One of the residents commented that she could not hold meaningful interaction with her peers because most of them had early dementia and caused disruption.

They don’t have much to talk about. They can be noisy and disruptive. I prefer to remain in my own room, it is more peaceful. Some of them who pass by my room might salute in the morning or we exchange ‘good morning’ that’s all. (R2, NZ)

The resident found it difficult to hold rational conversations with her peers and appeared to be disturbed by the noise caused by those with cognitive decline. Another resident saw the peers as strangers and felt awkward talking to them:

It is difficult, you don't know them and most of them cannot talk. We don't talk much. (R1, SIN)

Some residents attempted to nurture each other through the sharing of common interests and assisting others who required help. However, exploration of further accounts of participants revealed that nurturing relationships were a challenge due to a lack of common mutual agreement among the participants. There was variation in
their preferred and actual relationships that affected the type of relationship they wanted and experienced.

Typically, the residents and family members looked forward to genuine relationships with the frontline caregivers who could understand their needs. Mutual trust helped the participants to give and take in the relationship, and led to opportunities to make decisions, an important aspect of autonomy. The residents and family members wished that they could discuss their personal interests freely with the frontline caregivers. Being able to confide in frontline caregivers led to increased connectedness. The residents felt more independent when their wishes were considered. However, they felt disappointed when the frontline caregivers showed a lack of empathy and interest in them. They were able to differentiate between staff who showed genuine interest in them and those who were superficial. Most of the frontline caregivers preferred to invest more time in emotional care but the tendency to be task-focused overpowered the aspects of person-centred care. It was clear that mutual and trusting relationships took time to develop as some participants felt that the others could have done more to nurture each other. A critical factor that affected nurturing relationships among the three groups of participants was interpersonal interaction.

4.3.3 INTERPERSONAL INTERACTIONS WITH STAFF

The frontline caregivers were sometimes the only source of social interaction for some residents in residential homes. They played a critical role in reassuring and acculturating new residents to residential home care. They were responsible for alleviating fears and anxieties for many of the residents. The interaction between residents and frontline caregivers involved very intimate activities of daily living including bathing, dressing and toileting. This interpersonal interaction was not restricted to clinical care but also for the psychosocial wellbeing of the residents.

Effective interaction or communication skills included both verbal and non-verbal skills. It was not just the words but the body language and facial expressions that added layers of meaning to the interactions. From a person-centred point of view, it could be understood that each interaction and its associated meaning was dependent on the people involved. A frontline caregiver who acknowledged and respected the wisdom and choices of each resident could be regarded as showing
greater respect for a resident’s personhood. It was perceived as important for frontline caregivers to be sensitive towards residents’ and family members’ needs.

The residents and family members found that the interpersonal skills demonstrated by the frontline caregivers influenced the effectiveness of their relationships. They felt that those caregivers who displayed effective interpersonal skills were those who had good qualities and the right attitude. The residents and family members identified a number of qualities essential for the frontline caregivers, such as being motivated, flexible, understanding, caring, patient, compassionate, gentle and friendly. They recognised that those caregivers who demonstrated such qualities were more empathetic and understanding towards the residents.

The following three residents listed the positive qualities that frontline caregivers should demonstrate to improve the interpersonal interaction between them. They commented:

*One should have cheery disposition, and who really does care for you not a matter of being a job but living up to the job that’s expected of them.* (R5, NZ)

*The person has to be helpful and polite.* (R8, SIN)

*The old people here are sick and lonely; the caregivers need to be compassionate and caring towards them.* (R1, SIN)

These residents perceived that they were able to build connections with staff who showed positive attributes that reflected through their interpersonal skills. Two family members felt that the long-term contact had helped to established rapport with the frontline caregivers. One of them felt comfortable with the level of care provided by the staff and appreciated their help.

*I have been coming here many years, this has given me opportunities to know the staff and interact with them with ease. They take good care of my husband. They are doing a good job. I can’t manage the care by myself. We rely on the caregivers. We have come to know them and the staff too know me, and our family members. They are providing reasonable care. If my husband has any problem they will quickly alert me. If I am going to be out of town, then I let the staff know and they will take care of my husband.* (FM4, NZ)

*More or less we had come to know the staff. Some have been doing the job for many years. They recognise us, and always wheel mum down for us to see during visiting hours. Mum enjoys eating desserts. So I leave a few with the staff to give to mum every day. We appreciate their help and every*
**Christmas we get some gift to the home to appreciate their service and help. (FM 1, SIN)**

The interactions helped to build a sense of connectedness and relationality. Likewise, the frontline caregivers considered that interaction with the resident during their delivery of care was vital. As one frontline caregiver shared:

*Some residents can interact and some can’t. I make it a habit to introduce myself and what I am going to do. So that the residents are less anxious and able to cooperate with the care activities. (CG2, NZ)*

But some residents said that they lacked information about daily care activities. They felt that frontline caregivers did not keep them informed or explain what they were doing. One resident with partial vision expected staff to communicate care plans. She complimented some friendly frontline caregivers who gave her information without being asked:

*Staff has to introduce and explain what they are doing, I can’t see well but I can still hear. Talk to me and tell me what they are going to do. Caregivers (mentioned two names) always explain to me what they are going to do. (R4, SIN)*

The interactions with the residents were not limited to care activities but involved the personal life of the residents and frontline caregivers. Some frontline caregivers found that the residents enjoyed talking about their past, which helped them to understand the resident as a whole person who had another life before coming to the residential home. They realised that residents felt happy whenever they talked about their family. The frontline caregivers reciprocated by sharing their own personal life with the residents. This created emotional closeness between the residents and frontline caregivers; staff showed more empathy towards the residents and understood the residents in the context of their past, present and future. This helped staff to be sensitive to, and anticipate the needs of, the residents, which led to satisfaction. One resident mentioned:

*….. We chat during care, talk about us and our families, we develop more personal relationship. You can sense that their mood changes and suddenly they open up and share their stories. We talk about our personal and family life and we update each other. (CG1, NZ).*

Family members further added to frontline caregivers’ understanding of their loved ones by sharing information about the residents’ biography and on their likes and
dislikes. They hoped that this information would contribute towards a better understanding of the resident and also improve the interaction between them that would ultimately result in improving the wellbeing of the resident. The relatives wanted to talk more often with the frontline caregivers and wished the frontline caregivers could show greater initiative in giving information, especially on issues that worried them that they wanted to discuss. They felt that sometimes staff did not show concern in the moment and showed disinterest to their concerns. The style of conversation adopted by a few frontline caregivers caused distress, and frustrated some of the residents and family members. The residents shared their unpleasant encounters with the frontline caregivers who displayed poor interpersonal skills, which affected their care experiences negatively. The residents perceived that frontline caregivers passed unpleasant remarks, chatted among themselves rather than engaging with the residents, and they failed to listen.

One resident felt that the staff were nasty to her:

Some of them do not have the right attitude, you cannot be nasty to the patient. (R15, NZ)

Two residents felt that the staff were not interested in the resident, and instead they interacted among themselves:

Sometimes I feel that I am talking to a pole, their mind is not in the job. I can also hear staff chatting along the corridor and making so much noise. I am not saying that they cannot chat but the chat is not conducive to the person who is being looked after. They chat among themselves instead of chatting with the residents. It shows that their mind is not in the job. (R3, NZ)

Listen to me and involve me in your discussions because I don’t like to sit in a room where everyone is talking about me but not to me. (R10, SIN)

These residents perceived that their sense of self was not recognised by the staff who ignored their presence. Another resident overheard unpleasant comments from the staff:

They should learn to speak less, I can hear what they say along the corridors. It hurts. I heard the staff angrily telling another staff that she is not going to answer the call bell of a resident because she just attended to the person. (R3, NZ)
The following two residents commented on some frontline caregivers’ poor interpersonal skills and mentioned that they should develop their listening skills:

*They have to have patience, do not rush during shower, while feeding us, and listen more and talk less.* (R3, NZ)

*They should be prepared to listen, keep their ears wagging and keep their mouths closed. They need to learn to listen rather than asking what are you and your grandmother are doing.* (R1, NZ)

Some residents, from their observation of frontline caregivers’ body language, commented that they showed disinterest in their job and were merely there for the money. One of them commented:

*When you look at some of their faces and eyes, you know very well that they are not interested in the job. You have a look at their faces and their eyes it shows that they could not give a damn.*

Another resident felt that the frontline caregivers were not emotionally involved with their work:

*I guess they are able to walk out any time and find another job. I don’t think that they have taken this job seriously.* (R15, NZ)

Some family members were compelled to interact with frontline caregivers because they noticed deficiencies in the care delivered. Their perception of person-centred care was determined by the staff’s ability to meet the basic cares of their loved one. Though most of them found the care to be satisfactory, some felt that their loved ones were made to wait when it came to changing soiled bedding and clothing, and with repositioning. A few commented that they had to constantly remind the staff of residents’ personal needs, including hygiene, meals, dressing, appointments and laundry. Often family members made visits to ensure that the needs of the residents were followed.

The following two family members ensured that their loved ones received appropriate person-centred care by frequently making checks to ensure that they could close the gaps in the care provided by the staff. As two family members commented:

*I come daily to collect mum’s used clothes and wash them at home. Though I have reminded the staff to keep her clothes aside but sometimes the clothes were sent to laundry. I also ensure that she uses her hearing aids and dentures. I also wanted to make sure that she has magazines to*
read. Her jug of drink is filled up. I am working night shift every day. I know the caregivers are doing their best to clean mum and give her meals. Though I have told the staff, this things don't get done. I don’t blame them, because the staff changes frequently. So I drop by before going to work to make sure she is alright. (FM 1, NZ)

My wife does not eat meat, I have informed the staff but they serve her meat. This happens especially during evening dinner. She has to resort to eating sandwich or biscuits for that evening. The serving of meal is not given enough thought to meet my wife’s request. (FM 5, SIN)

These family members felt that consistent care was lacking in the residential home due to inconsistent staffing. They often had to remind the staff of residents’ needs. One family member commented that staff did not show respect to residents’ needs:

Though they knew that mum goes to Sunday chapel every week but she is being missed on several occasions. Staff do not give importance to mum’s spiritual needs. (FM5, NZ)

The family members also sensed that some caregivers were not welcoming and distanced themselves. They perceived that the frontline staff avoided contact with them and gave the impression that the role of family members was only to talk and provide emotional support to the resident while the caregivers saw to technical tasks and physical care delivery. The opportunity to get to know the staff and connecting with them became slim.

Two family members shared about the lack of opportunity to talk to frontline caregivers:

I don’t get much chance to get to know the staff. Mostly when we arrive, they wheel down mum to the lounge where we sit down with her and then once visiting hours is over, they wheel her back. (FM2, SIN)

The staff are mostly busy, can see that they are rushing with their job. So there is no chance to talk to them. Even when I get the chance, the call bell rings and they have to run. (FM4, NZ)

These family members expressed interest in engaging with the frontline caregivers who provided most of the care for their loved ones. But the opportunity was limited as the frontline caregivers appeared to be busy with their work most of the time. The ethnic diversity also caused language barriers, resulting in loss of communication during the process of giving care. A substantial number of frontline caregivers in Singapore came from countries such as the Philippines and Myanmar, who spoke mainly English besides their native language. Many of the residents were not
English-speaking and spoke only their own ethnic languages. Some of the residents as well as frontline caregivers relied on an interpreter to convey their messages. On many occasions the family members were the interpreters for the resident. Though some staff took the initiative to learn the language, the majority managed the daily interactions with sign language and with the help of others who could assist with translation, if one was available.

One family member felt that some staff took the initiative to learn the language which helped understanding:

*Majority of them are foreigners from Myanmar and Philippines. They speak English while mother speaks Cantonese and Hokkien. One or two staff had learnt the language and able to communicate with mum. Some use sign language or get others to translate for them.* (FM4, SIN)

This family member recognised that the opportunity for interaction was limited for her mum due to staff who were mainly foreigners and spoke only in English. One family member was used as a translator to improve communication:

*Dad has difficulty talking to the staff who only spoke English. Whenever I am around, I help to interpret his needs to the staff. But I am not here most of the day. I can see he is getting frustrated.* (FM3, SIN)

Family members from New Zealand also observed that the language barrier between the resident and frontline caregivers contributed to a less committed relationship. They observed that frontline caregivers were comfortable to do the care but not with communication. The family members could sense the residents’ frustration with the frontline caregivers due to this language barrier. Most of the residents who became frustrated with their unsuccessful attempts to communicate with the staff finally gave up and stopped talking to the staff. Generally, both the residents and family members from both countries showed acceptance of the situation, and felt that nothing could be done as the workforce of residential homes was comprised mainly of immigrants and foreigners.

Generally, residents and family members recognised the contribution of their frontline caregivers and found that interpersonal relationships promoted greater understanding and connection among them. Poor interpersonal skills increased the vulnerability of the residents. When interaction was affected due to the language barrier, it led to helplessness and isolation for the residents. Nevertheless, all
participants expressed that the care experience was meaningful and satisfactory when communication was therapeutic and greater understanding shown during interaction.

Some of the frontline caregivers found it difficult to deal with residents with behaviour problems and family members who had unrealistic expectations. They also found it difficult to interact and deal with residents who suffered from cognitive decline.

One frontline caregiver found that interaction with dementia residents was a waste of time:

_It is hard work especially taking care of dementia residents. They don't know what is going on so I just have to do my best. You can't talk to them._

(CG2, NZ)

This attitude probably reflected the lack of adequate training of the staff in managing residents with cognitive impairment. This staff member possibly placed a greater value on task completion, and thus a lower priority on interaction with the resident. A number of frontline caregivers also found it difficult to deal with family members whom they perceived as having unrealistic expectations, or they failed to understand their work or workloads. Frontline caregivers were aware that much of their practice fell short of their ideals and associated caring with time, and therefore saw a heavy workload as an obstacle to provide ideal care. They felt that their efforts and limitations were least considered by family members who always tried to pick on their mistakes and complained about their standard of care. Time was identified as a critical factor that impeded the delivery of person-centred care.

One frontline caregiver commented that the demands of the job did not allow her to provide perfect care at times:

_When more than two people who want the care at the same time then being short of staff really affect the quality care. You had to rush with your work, you have no time to stop and think. You cannot do a one hundred percent care, because you have another lot of residents to look after. It is difficult to please the family every time, they need to understand our constraints._

(CG5, NZ)

The interpersonal encounters shared highlight that there was lack of trust between family members and frontline caregivers. The frontline caregivers viewed the family
members as constantly checking on their work. Their self-morale was low because they felt that their work was least recognised. The frontline caregivers also lacked awareness on person-centred care and gave importance to performing their routine tasks.

4.3.4 RELATIONSHIP WITH OUTSIDE WORLD

Isolation from the outside world was a problem for both the residents and their family members. Many described the time spent by the residents in the residential home as boring and depressing. For many residents, their contact with their family members was only occasional moments due to distance or other commitments. When staff appeared rushed and busy, they did not engage in meaningful conversation or relationships. In some cases, fellow residents were not talkative and this also contributed to the resident’s loneliness and boredom. The residents also felt that there was a discontinuity from their previous lifestyle where they had the freedom to go out whenever they wanted. Residents from New Zealand who were mobile with a walking frame or electric scooter experienced independence because they could decide and move around without depending on others. They enjoyed the ability to go to the garden and other activities outside.

The following two residents enjoyed their ability to get outside the residential home:

*I normally go out to the garden with my walker. I have planted some herbs with the help of the gardener. I have informed the cook to use them so that food has more flavour.* (R9, NZ)

*I can go everywhere with my electric chair. I feel sorry for many of them; they can’t go out. I don’t feel confident to go out on my own so when my sisters come in then they will take me out. I just have to write down on the book what time I am leaving and with whom. No one bothers you, I like the freedom.* (R8, NZ)

These residents showed more optimism with having the freedom to move around in the home and ability to go out of the home whenever they had an opportunity. Some looked forward to volunteers taking them out for a walk at a nearby park. But they were disappointed with the frequency; they wanted to have the freedom to go out on their own but their requests were often declined. This caused tension in the relationships between staff and residents. The residents showed frustration when they could no longer maintain their previous lifestyle. The unresolved anger and
feelings of injustice are reflected in their attitude towards the staff. As one of them commented:

*I can still walk with the frame and I like to walk to the park. I have a lady, who walk with me to and from the park. But she only comes once fortnightly. I know the staff has no time, I have asked them to let me go out on my own but they refused and claimed that it is for my safety reasons. I don’t know why they should refuse, I am fine and I will be back safely. It is frustrating because they refuse to allow me to go out. I am not like others, I can still walk with the frame.* (R5, NZ)

The majority of the residents who were frail and in wheel chairs depended on the staff to take them out. They always looked forward to the next outdoor trip and shared pleasant stories about their trips. They described a sense of freedom when they had a chance to go out and connect with the outside world. They were disappointed with the infrequency of the event.

The following two residents looked forward to their outing activities:

*I like to go out for a drive but you need to wait. We have to take turns. I hope they can bring us out more regularly.* (R3, NZ)

*They bring us out by bus for meals and outings especially close to festive seasons. We enjoy going out.* (R1, SIN)

Outdoor activities were a favourite for these residents. It provided a sense of independence and autonomy. Some family members contributed towards the residents’ connections with the outside world by taking them out for a drive, an event or a meal. This provided an opportunity for both parties to have family time outside the institution and a chance to meet with relatives and friends. This also provided the residents a short break from their monotonous life at the residential home.

The following two quotes shows how family members helped their institutionalised loved one to continue their connection with the outside world:

*Dad enjoys going out but the staff has no time to see to that so whenever I come I transfer him onto the wheelchair and go around the garden and sit at the cafe for a drink.* (FM5, NZ)

*My children bring me out for a drive or meal on alternate weekends. Last month, they brought me to a restaurant to celebrate my birthday. There were a lot of them, they had invited our relatives and friends. I felt very happy.* (R7, SIN)
These family members tried to normalise life for their loved ones by taking them out for drives and meals. A connection with the outside world was a means of escape from their daily regimented lifestyle at the residential home for many of the residents. It also gave them a sense of independence and belonging to a community because the residents felt that they could continue their previous lifestyle. The connection to the outside world was important for the residents and an important element of person-centred care.

4.3.5 SUMMARY

Overall, the theme of maintaining and developing connections emphasised the importance of relationships with family members, friends, staff or the wider community in the outside world and is described as an integral component of person-centred care. Relationships and relationality were important for feeling at home for the residents. The genuineness of a relationship was assessed through the frontline caregivers’ interpersonal skills. The verbal and nonverbal skills of frontline caregivers influenced how the residents and family members experienced the care. Frontline caregivers felt motivated when they were recognised for their contribution. Peer relationships and maintaining relationships with the outside world are also important components of person-centred care.

THEME 3: WORKPLACE CULTURE

4.4 INTRODUCTION

The workplace culture was described as highly influential on the experience of person-centred care. Participants described the importance of values that in turn influenced practice. Effective person-centred care practice was described as care that was consistent and individualised. It was noted that most participants experienced person-centred moments when care was satisfying and rewarding. However, the residential homes found it challenging to sustain those moments and maintain a culture of person-centred care. The participants highlighted that the workplace culture imposed challenges that impacted on, and often limited, the person-centred nature of their experience. Workplace culture was divided into two themes, a clash of personal values, and organisational support; the latter has the subthemes of physical environment, meaningful activities, competency of staff, and morale of staff.
4.4.1 CLASH OF VALUES

Residents’ and family members’ experience of care were positive when they felt that their values and preferences were considered by the staff. The residents’ satisfaction with care was greater when staff recognised their capabilities and involved the family in the care activities. When staff showed a greater interest in getting to know the residents in the context of their past and family context, it helped the staff to understand what was important and mattered to the residents. The genuine involvement and empathetic engagement helped the staff to anticipate and pick up cues from residents’ verbal and nonverbal expressions, which could have been easily missed. The incorporation of this information into the care practice helped frontline caregivers to recognise and incorporate the desires, wishes and needs of the residents. The residents and family members expressed appreciation and valued the staff who recognised their physical and emotional needs.

When there was greater bonding between the residents, family members, and frontline caregivers, it helped the residents and family members to get to know the staff better. There were more opportunities for negotiation, collaboration and acceptance among them, and the level of interaction moved beyond a service provider and service user level to a personal level. Once the focus of care was on the person, then the frontline caregivers were able to value and honour those who required care. One of the residents commented:

*I have been here for more than 5 years, I am familiar with “Y” my caregiver. She knows what to do and I am very comfortable when she attends to me. We make jokes, talk about our families. (R8, NZ)*

The family members shared a similar notion:

*I have been coming here many years, this has given me opportunities to know the staff and interact with them with ease. They take good care of my husband. They are doing a good job. I can’t manage the care by myself. We rely on the caregivers. We have come to know them and the staff too know me, and our family members. They are providing reasonable care. If my husband has any problem they will quickly alert me. If I am going to be out of town, then I let the staff know and they will take care of my husband. (FM4, NZ)*

The stepson of a wheelchair-bound resident shared his comfort level with the staff and appreciated their help:
More or less we had come to know the staff. Some have been doing the job for many years. They recognise us, and always wheel mum down for us to see during visiting hours. Mum enjoys eating desserts. So I leave a few with the staff to give to mum every day. We appreciate their help and every Christmas we get some gift to the home to appreciate their service and help. (FM1, SIN)

The daughter of a family member suffering from early dementia was concerned about her dad’s safety and showed a sense of guilt for relocating her dad. She shared how she worked along with the staff to improve the quality of care for her dad:

I make it a point to come at least alternate days. I am staying not very far from here. I normally check with the staff how dad has been and ask them for advice on tips on how to support dad with his dementia needs. It was very tough to manage dad at home. He becomes restless and aggressive before moving here. He also went missing. Though I feel sorry for him to move into a residential home but this is the best choice for him. I tried to sit down and talk to dad so that he remembers us and his surroundings. (FM2, SIN)

Likewise, frontline caregivers agreed that it was an advantage to know the residents’ and family members’ preferences. This helped the frontline caregivers to deliver consistent care, which helped the residents’ self-determination. Those who had longer working experience were appreciated by residents and family members for their skills in understanding residents’ needs. This understanding enabled the caregivers to anticipate the care needs and ensure it was personalised. The families and residents noted that the more experienced caregivers had a greater flexibility in being able to meet their needs. It was commonly agreed among most participants that a shared purpose enabled them to collaborate towards a common goal of enhancing the care of the residents. The following two frontline caregivers from New Zealand, who have been working for many years, shared their commitment towards the wellbeing of the residents.

I have worked for 20 years, it is commitment and love for the job that keeps me here. I enjoyed seeing the residents and giving them the care they want. It gives me satisfaction. (CG3, NZ)

I worked for 18 years, I know the residents very well. I am happy to come to work though it is hard work. I enjoy my work. (CG1, NZ)

However, all participants agreed that some staff did not show the same understanding, and instead maintained a distance in their relationships and tried to avoid contact with the residents and family members. It was recognised that they
either lacked interpersonal competency or prioritised daily routines over interactions, so much so that they showed rigidity and inflexibility in their care practices. Two residents commented on how staff maintained their distance by focusing on doing their task and neglecting the importance of human connection:

............they rush during shower, while feeding us... They hardly talk to you. They complain about their workload and don’t complete their job probably. (R3, NZ)

They don’t talk to you when doing the care, they just come in dash out. You feel strange. But I understand, because they have other residents to look after. (R10, SIN)

The family members also shared moments when they felt distanced by the staff and their care preferences were ignored because staff placed a higher priority on tasks rather than the individual. A family member felt sorry for the frontline caregivers who appeared to be rushing all the time to complete their job:

The staff are mostly busy, can see that they are rushing with their job. So there is no chance to talk to them. Even when I get the chance, the call bell rings and they have to run. (FM4, NZ)

A daughter of a resident shared that she does not know the staff well because the opportunity for contact with the staff is limited.

I don’t get much chance to get to know the staff. Mostly when we arrive, they wheel down mum to the lounge where we sit down with her and then once visiting hours is over, they wheel her back. (FM2, SIN)

The husband of a resident commented that on many occasions the meal preference of his wife was overlooked by the staff who were preoccupied with completion of their task at hand:

My wife does not eat meat, but they serve her meat during meals. This happens especially during evening dinner. She has to resort to eating sandwich or biscuits for that evening. The serving of meal is not given enough thought to meet my wife’s request. (FM 5, SIN)

A similar notion was shared by the daughter of another resident who was upset that the staff did not ensure that her mum gets to go to the chapel every Sunday:

Though they knew that mum goes to Sunday chapel every week but she is being missed on several occasions. Staff do not give importance to mum’s spiritual needs. (FM5, NZ)
Overall, the participants described their care experiences as meaningful when the care was delivered according to the residents’ values and expectations. But when there was a clash of values, the care experiences were described as distressing thus affecting the care experience. The staff with longer working experience showed greater confidence and developed better bonding with the residents and family members. The care experience was better for the residents and family members when it was personalised and consistent, and delivered with human connection.

4.4.2 ORGANISATIONAL SUPPORT

All participants described effective interventions at the organisational level, specifically related to the physical environment, continuity of care, meaningful activities, competency of staff, staffing, and morale of the staff as beneficial in improving the care experience. They felt that the environment had to be conducive and comfortable for service providers and users. The context of care has to support person-centred values and provide the resources to implement the process.

4.4.2.1 PHYSICAL ENVIRONMENT

The physical environment of care was recognised to have significant impact on person-centred care experience for residents and family members. Considerable efforts were being made by the homes in New Zealand to ensure that the facility promoted person-centred care. The residents and family members showed satisfaction with the provision of individual rooms with en suite facilities. Many preferred to remain in their own room, and determined their own level of activity. They greatly enjoyed their privacy and quiet moments. The environment provided the individual space for the residents to do what they wanted without being disturbed by others or their behaviour. One of the residents from New Zealand expressed that having her own room provided privacy and freedom to do what she wanted:

I prefer to be in my own room. Take it easy and enjoy the peace. I am happy. I usually spend my time reading, knitting and watching television. Having my own room gives me more privacy and freedom to decide what to do. I don’t go out to the lounge, one can become depressed and disturbed because of behaviour of some residents. (R1, NZ)

The family members were grateful for the organisational support for allowing them to personalise the residents’ rooms with their personal possessions. A family member commented:
She has her own room with bathroom. We have brought the TV, radio and some furniture and photos. We try to make it look like her own room where she was living before coming here. It is important because she spends the whole day in the room. (FM3, NZ)

But the home in Singapore supported communal living, which affected the care experience because the residents lacked their individual space and had to share the space with other residents. The cleanliness and quality of the physical environment was important for the residents who showed their frustrations when they had to put up with inappropriate behaviours of other residents. In order to avoid such situations, some residents had to make changes to their daily schedule, such as taking showers at three in the morning, when the bathroom and toilet were in a clean condition. The residents appeared to be upset but were helpless as they felt that nothing could be done to improve the situation. Family members of Singapore residents interpreted that the residents’ quality of care could be improved if they were given choices in selecting their rooms and roommates. They felt that the residents’ quality of life was affected when they had to share the room with others who were noisy, disruptive or uncommunicative. The daughter of a Eurasian resident commented that the opportunity for her dad to interact with others in his room was limited due to the language barrier. She indicated that the organisation should factor opportunity for interactions when allocating them to a room.

Dad is placed in a room with a Chinese residents. The Chinese residents can’t speak English. So they hardly communicate. It is strange, sleeping in the same room but don't know much about each other. (FM4, SIN)

Some of the residents and family members commented that sharing the physical environment with those who were less cognitively intact restricted residents’ freedom and caused distress. The residents with sound minds had restricted access to the outdoor garden and other facilities due to safety concerns for others. A resident shared that occasionally her access to the garden was locked by the staff due to safety concerns of the early dementia residents. She found this limited her choice and freedom:

Well there’s quite a lot of people with early dementia and there are three people who two in particularly who keep wanting to wander and they so every now and again they close the doors. I'm in a wheelchair and find this quite frustrating because I feel that those of us that can get around rationally, well speaking for myself, were prevented from going outside and all that sort of stuff you know. (R4, NZ)
The families and residents also commented that family contact was important for the residents’ sense of self. However, the participants from Singapore found that the fixed visiting hours restricted their number of visits. As one family member commented:

*We are only allowed to visit during visiting hours. So it is hard to visit on weekdays because of work. I come on weekends to visit dad.* (FM 5, SIN)

Generally, family members felt that aesthetic improvements to the physical environment could help in nurturing and healing the residents. They suggested adding soft colours to the physical environment, having free access to snacks and drinks, and a conducive environment for family interaction could add quality to the care. A family member commented on the physical aspect of the resident’s room and suggested enhancing the place with bright colours and paintings:

*Her room is miserable looking. It is crowded with six of them sharing the room. The room is very dark and dull looking. Need to brighten up the room by painting bright colours and hanging posters. Provide entertainment with Television and radio.* (FM1, SIN)

On the other hand, another family member commented on having conducive private rooms with facilities to make drinks so that they do not get interrupted by staff or residents:

*It will be nice to have a quiet and private place where the family can chat with the residents. A place where we can feel free to make drinks and chat and not interrupted by anyone.* (FM4, SIN)

Generally, all participants felt that the physical environment was designed to provide some level of basic and safety needs to ensure clinical efficiency. They suggested more could be done to improve the person-centred care experience.

**4.4.2.2 ORIENTATION AND FAMILIARISATION**

It was recognised that residents and family members experienced a range of emotions related to the new move and needed support and guidance in accepting the move. Many family members and residents felt that the organisation could have provided support by ensuring regular staffing, preferably a staff member who should be assigned to see to residents’ care from the day of admission. Family and residents commented that regular staffing helped residents, family members, and
staff to be familiar with each other. The care experience was enhanced because staff were familiar with the needs of the residents and their families, which contributed towards consistent and personalised care. The residents and family members showed greater satisfaction with the care practices because they could relate well with the staff and their preferences were considered. The following resident shared her comfort level with her caregiver, where both of them freely shared their personal stories:

*I have been here for more than 5 years, I am familiar with “Y” my caregiver. She knows what to do and I am very comfortable when she attends to me. We make jokes, talk about our families.* (R8, NZ)

Another resident added that the level of security with usual frontline caregivers was greater because they could provide appropriate care:

*“B” is my usual caregiver, we work along very well. He knows my preferences and patterns so I feel secured and comfortable.* (R1, NZ)

However, the experience of care was not satisfying when non-regular staff were assigned to take care of the residents. This caused unfamiliarity between the staff and residents and their families. Moreover, the care experience was distressful for all of them. A resident expressed her concern whenever non-regular staff were assigned to look after her. She became worried whether the staff had any insight into her medical needs and would be able to provide safe care:

*I am worried when attended by non-regular staff, they don’t know your medical condition and the pattern of care. I get worried for my safety.* (R2, NZ)

One of them worried whenever attended by non-regular staff. She was concerned about her weak leg and afraid that the staff might do harm to her during care:

*Whenever new caregivers are assigned for me, I have to guide them on how to transfer me. Especially my weak leg which had to be supported at all times. So I am very fearful and have to be careful.* (R14, SIN)

Another resident came to the conclusion that consistent care was impossible because the frontline caregivers constantly changed at the residential home:

*I don’t see consistent faces, mostly the staff looking after are different. So I can’t expect the same care every day.* (FM3, SIN)
Similar concern was shared by a family member who commented:

*You don’t see consistent faces here the staff are rotated all around. There is no regular staff that attends to mum. Regular staff will help a great deal because she will get to know mum and her dementia condition. So care be more consistent.* (FM5, NZ)

A family member mentioned that the inconsistent staffing affected the care and she had to constantly remind staff on missed cares. She also commented that some staff showed discontent:

*It is difficult here because you do not see the same staff everyday, after two days when you come, you notice that she is not having her panty hose. When you remind the staff some of them are not happy. I have seen in one of the homes where they placed a chart in the room indicating the likes and dislikes of the residents. That will help the staff especially part time staff to know how the care to be delivered to each residents.* (FM5, NZ)

The residents and family members found that inconsistent staffing affected the care experience, which led to feelings of stress, being unsafe, and frustration. This has been interpreted to mean that the organisation should look into adequate and regular staffing to improve the participants’ care experience.

### 4.4.2.3 MEANINGFUL ACTIVITIES

The residents and family members expected that at the organisational level there was insufficient planning put into designing activities for the residents. They expected the residents’ past and present interests, hobbies, mental and functional ability were factored in and activities were individualised so that the residents could continue to flourish and grow. They wished that the activities were meaningful and able to provide sensory stimulation to the residents. They identified meaningful activities as those activities in which residents had engaged in their past and which had greater meaning and purpose. The residents showed enthusiasm and pride when they were engaged in such activities. However, many felt that the activities were designed remotely without considering residents’ potential, which was not beneficial for the residents. They felt that the residents had no choice but to fit into the timetabled activities, which were frequently meaningless for the residents.

The following two family members helped to facilitate the residents’ interest with activities. One of them hoped that staff were aware of residents’ interest and ensured the necessary items were provided to the residents:
Whenever I come, I see mum just sitting and doing nothing. She likes doing crossword puzzles but only one or two staff gives her the book to do but most of the time no one knows what mum can do so she just sits without doing anything. Not healthy for her brain. (FM1, NZ)

The husband of another resident noticed that the wife was unhappy when she was involved in a group game. He knew her interest and organised to get the relevant items to her so that she could continue to participate in her hobbies:

...my wife used to do origami and played crossword puzzles. She dislikes throwing balls. So I bring along the items so that she can continue with her interest. (FM2, NZ)

A daughter of one of the residents felt that her mum could benefit more from outdoor activities such as going out to the garden. She perceived that the outdoor activity will enhance her mother’s sense of freedom, but she realised that the staff could not facilitate such a visit. Whenever she visits her mum, she made it a point to bring her out to the garden.

...mum likes to go out for wheelchair ride, but no one can do it here. She hates sitting inside her room. So I try to wheel her out to the garden. (FM4, SIN)

Generally, both the residents and family members wished that the organisation recognised the talent and capacity of the residents when designing activities so that their human potential could be enhanced. They believed that the sanction and endorsement for activities exists at an organisational level.

Some residents and family members perceived that the residents’ mental and functional capacity gradually declined since their move into the residential home. This was related to the lack of relevant physical and stimulating activities for the person whose maximum potential went unrecognised and untapped. Instead they noticed that there was too much use of psychotropic drugs. Family members reported that residents very quickly ended up being drowsy and in wheelchairs all day. The following family member commented that her father, who was mobile upon admission, lost his ability to walk after a few months due to lack of opportunity for mobilisation:

A short time after he came here he had trouble walking ... I noticed that he never got the opportunity to walk. (FM1, NZ).
Another family member discovered after a few visits that the reason for her mother’s drowsy state was a lack of appropriate activities and competent staff. It was perceived that staff lacked competency to engage effectively with the resident and organise appropriate activities. She managed to communicate and got the doctor to change the medication which improved the resident’s condition:

_There was a time when we noticed that mum was drowsy all the time and we came to know that she was on sedative medications. We told them to stop or modify the medication. That helped and she is more alert now._ (FM4, SIN)

One family member perceived that their mother could not engage in activities because of inappropriate use of medication which made her sleep most of the time:

_Mum was becoming quiet and sleepy whenever we visit her. I thought her health was deteriorating. But later I discovered that they have been giving her sedative medication. We have given strict instructions to not to give mum morphine or any form of sedative medications without consulting us. She is much alert now._ (FM3, NZ)

Aspects of food quality and dining were very important for both the residents and their family members. They expected the organisation to oversee the quality of food and dining. The residents longed for appetising and tasty food during each meal. The family members wished the organisation recognised the importance of the residents’ nutrition needs by improving their access for small frequent meals and drinks in between meal times. They felt that more could be done to hydrate and nourish the residents. Mainly, for those on a pureed diet, family members commented that the food should look more appetising. One family member commented that the food appeared tasteless and suggested that providing frequent small meals would improve the nutrition for her dad:

_He has slurring of speech and his swallowing is also affected. As a consequence, he is on liquid diet now. The diet does not look appetising and tasteless. They should prepare and serve the meal in a more attractive manner. More frequent small meals might help to nourish him._ (FM2, SIN)

The daughter of a resident suggested that the home should provide access to simple snacks to supplement meals:
They should create more flexibility with fruits and drinks, residents should be offered more fruits and drinks in between their meals. This will help them with their bowel movement. (FM5, NZ)

Another family member complained that the food was uninteresting and residents were not given adequate fruit:

_Mum does not like the food here, it is too bland for her. They don’t offer much fruits. So we always buy food and fruits for her. (FM3, SIN)_

Although the frontline caregivers observed that the residents were disturbed when they were served a meal not of their choice or poorly prepared, they felt that it was not within their capacity to change it. They saw it as not within their job scope and as such they could not improve the condition. These notions were shared by the following two staff members:

_Sometimes the kitchen staff deliver wrong food to the resident, e.g. a person on normal diet was given a mashed or pureed meal. Especially, if this happens in the evening, there is no way we can exchange for another meal because the kitchen staff are away. Sometimes I prepared sandwiches for the residents but they seldom eat it. (CG1, NZ)_

_Some of them like to eat rice but they were given noodles. There is no way I can change for them because noodle is the only food for that meal. This made the resident very unhappy. (CG3, SIN)_

Typically, it was agreed that improvement to the physical environment, in terms of colour, activities, and meals could improve residents’ care.

4.4.2.4 COMPETENCY OF STAFF

Largely, all participants agreed that the competency of frontline caregivers contributed to quality care. Competent frontline caregivers were perceived as those who were responsive to the needs, preferences and expectations of residents and family members. All participants reflected that the most effective and appropriate intervention at an organisational level was to have frontline caregivers who were adequately trained in skills and attitude to provide person-centred care. It was observed that both of the residential homes adopted a skill mix service for a cost-effective workforce. The homes operated with one registered nurse who oversaw the care provided by frontline caregivers. The frontline staff were non-skilled and anyone could join the workforce. They received on-the-job training for the first two days, mainly provided by another senior frontline caregiver. They were expected to innately
possess the attributes required to deliver quality care. The training did not include elements of person-centred care. The frontline caregivers perceived that they understood and had adopted a person-centred philosophy of care. Some identified aspects of person-centred care such as valuing the individuals and respecting them. Two of the frontline caregivers shared about their perceptions of person-centred care that reflected some values of the concept:

The care should be one that we will do it to ourselves, or our loved ones. (CG4, SIN)

…..care that you will give it to your family member. (CG5, SIN)

But for many, person-centred care was ‘good care’, which was referred to as simply providing basic care to the residents. They saw their lived time as “too tight”, because of a demanding workload that limited their capacity to incorporate residents’ choices into their caregiving. The following three frontline caregivers described the meaning of good care mainly in terms of seeing to residents’ hygiene:

A good care means when the family can see the resident is nice. I mean, he gets a shower, he’s totally, totally clean, you can see one person is really clean. (GC3, NZ)

Good care is helping the residents to wash and change especially with shower. Also feeding the residents you require help. (CG1, SIN)

Care which shows that your residents are given good shower, dressed up neatly. Also keeping their rooms neat and tidy. (CG1, NZ)

Their orientation of good care could also have contributed to the residential home culture and practice where immediate comment and feedback were given to frontline caregivers related to outcomes of their care activities. They were complimented for jobs that were well done, especially when the residents under their care were presented well and their rooms or space were kept clean and tidy. Probably, this would have led them to focus on delivering ‘good care’ to ensure residents’ cleanliness and presentation. One frontline caregiver feared that she would be reprimanded by her seniors for not ensuring the resident had been washed well or toileted.

When the residents are washed and dressed well then there is less work for those who take over from you. The family is pleased and happy to see the residents are clean and tidy. (CG4, NZ).
The nurse manager and nurses make rounds, and they look out to ensure the residents are washed and dressed up well. Also their room are tidy and no smell. (CG5, NZ)

Knowing that they’re safely put to bed and that they’re happy at the end of the night. (CG2, NZ)

The frontline caregivers’ notion of ‘good care’ revealed that doing the basic care and keeping the residents and their environment clean was of paramount importance. They received negative remarks from their peers or seniors whenever the level of cleanliness dropped. Poor care was mostly associated with part-time or new staff who were perceived to be lacking in skills required to perform the routine care.

Whenever there is casual staff, the care is less than perfect because you can see that the residents are not dressed well and there is more work for those taking over. (CG4, NZ).

Both organisations supported and provided training for newly employed caregivers. The training mostly covered skills required to deliver basic care, control infection, and conduct fire drills. Frontline caregivers demonstrated their proficiency by being technically competent in these skills and having the ability to complete their job on time. Both of the residential homes did not have mandatory training on person-centred care or an equivalent.

On third day of the orientation they should do the job on their own. First day is they watch you doing the job, second day some hands on and third day perform the job on their own. During these three days the buddy will supervise them. (CG3, NZ)

We will go through the orientation checklist, e.g. manual handling and infection. I will show them on how to handle hoist machine so that they can transfer the residents safely. (CG4, NZ)

The training provided is good, we are orientated to how to perform the nursing skills and the routine job. (CG2, SIN)

Generally, it was observed that the aim of orientation was to get the new staff familiar with the routine work of the caregiver and to teach time management. This explained why the staff were too involved with doing their care tasks on time and gave little importance to the person. The residents and family members recognised their shortfall and identified their lack of relevant training and right attitude were the cause for poor care. However, it was interpreted that the organisation expected person-centredness as an innate ability of the staff that they should bring to work, while
participants felt that the organisation should support providing person-centred training to staff so that they could provide quality care.

The results indicate that the participants identified person-centred care was not a time-consuming task; instead it only required concentrated, focused time, belief and commitment from all levels of staff, which required organisational support. The frontline caregivers felt that the extraordinary stressful conditions, under which they usually worked, did not support such quality care. It was clear that relevant training and satisfaction of staff were important factors that influenced the residents’ and family members’ level of satisfaction with the care received.

4.4.2.5 STAFF MORALE

Job satisfaction and retention of frontline caregivers were directly related to the status of the caregivers. Adequate support, clear career path, reasonable pay, training and a reward system improved the morale of staff and their retention. The appreciation and cooperation shown by residents, family members, peers and management helped to boost the morale of frontline caregivers. They enjoyed their work when they were valued by others; staff felt closer to residents and their family members and care tended to be person-centred. Their morale was affected when their hard work was not appreciated. Lack of staffing, recognition and a heavy workload further affected the frontline caregivers’ morale

……this is a difficult job and poorly paid ……not many want to do this job. (CG1, NZ)

…… staff just resign because they realise this is not what they want to do. (CG5, NZ)

Some only work for weeks before they realised that this job is not for them. But there are few who have worked more than 20 years while some only worked a couple of weeks. (CG3, NZ)

It is very upsetting, you trained someone and they leave. It is waste of our time. Then you get another new staff, you had to go through everything again. (CG2, NZ)

The caregivers sensed that their role in providing care was seen as insignificant and given low status because it was non-skilled; the job mainly involved duties such as cleaning, toileting and feeding the residents. As such it is not appealing to work as a caregiver.
I don’t think people know what we actually do, most of the time they look at us as if we are not doing our job. (CG1, NZ)

People think anybody can do the job. But if they actually see what we do then they will understand that it is hard work. (CG4, NZ)

Some of them perceived that most of those who came into the job were unaware of the job requirements and physical demands; as such one new staff member realised that the job was labour intensive and involved cleaning and washing; they left that employment after a short time.

It is difficult for one to be stable in this job, staff resign because of hard work, poor pay and people go for better jobs and some going back to studies. (CG4, NZ)

…… staff just resign because they realise this is not what they want to do. (CG5, NZ)

Some only work for weeks before they realised that this job is not for them. But there are few who have worked more than 20 years while some only worked a couple of weeks. (CG3, NZ)

It is very upsetting, you trained someone and they leave. It is waste of our time. Then you get another new staff, you had to go through everything again. (CG2, NZ)

The above comments were mainly from a New Zealand context where the majority of frontline caregivers were regular staff who were middle aged, and almost 30% to 40% of the other non-regular staff were employed on a part-time or casual basis. The part-time and casual staff comprised mainly young mothers with small children and young university students who were there to make some pocket money for their daily expenses.

Interestingly, the caregivers in the Singapore context did not have similar concerns. They were mainly foreigners and recruited from the Philippines, India, and Myanmar. They were very young, between the ages of 18 and 25. Most of them were heavily in debt, which was incurred from securing a job in Singapore through an agent. Further, they had a two-year bond with the residential home and breaking the bond involves a huge sum of money to pay back. The heavy financial commitment kept the staff in the job. The majority of them usually left the residential home after their two-year contract to join acute setting hospitals for better income and career prospects. Hence, the staff profile and recruitment of staff appeared different in both countries so the caregivers in Singapore had no similar concerns to New Zealand.
However, all of them emphasised teamwork and felt the support from management and staff was important for their morale and good care. Some of them felt good when they were given affirmation for their work and contribution. The morale was high when their suggestions were heard and incorporated into the residents’ care. Many commented that their role was to take instruction from the nurses and follow the schedule. This mindset affected their approach of care because they could not make judgements and decisions to deliver person-centred care.

*The nurse assigns the residents to take care for each day. I usually refer the family to the nurse if they want to know anything about the residents. We are not supposed to talk to the family about residents’ treatment or medical condition.* (CG4, NZ)

*Caregivers are not included in the discussion of the residents’ treatment or condition. Though we are have most contact with the residents but we are excluded.* (CG4, NZ)

Teamwork was also affected whenever some of them had to work with staff who were unfamiliar with the job or who did not have the right attitude. The team spirit was dampened when working with these staff members and caused unhappiness, which affected delivery of good care. Some complained that they had to manage two-person activities by themselves. This engendered unhappiness and distress, and it was felt that the standard of care for the residents was compromised. The lack of teamwork caused work stress to the frontline caregivers who became upset and frustrated.

*Lack of teamwork can frustrate and make me unhappy at times, because I had to wait too long for help. Sometimes the person do not cooperate with you. I had to clean and change the resident alone. This is very painful to my body, makes me frustrated. Also I cannot be gentle with the resident because you have to use your strength to move them alone. This can make you extremely tired.* (CG2, SIN)

*There is insufficient help from your peers when you need them for assistance, especially for those residents who require two person assistance.* (CG3, NZ)

*Some staff are not reliable, they do not turn up to work or give short notice that they are unwell. It affects teamwork because we are shorthanded. Teamwork is very difficult because all of us are fighting for time to complete our job and write the notes before we leave. The existing staff will have to struggle.* (CG2, NZ)

*I found that some staff make excuses not to come to work you know what I mean.* (CG3, NZ)
Maybe sometimes a few more hours or maybe one extra care worker would be nice just to float between all of us say like to help with sling hoists or something like that. (CG1, NZ)

Typically, the morale of the staff improved when their contribution was recognised by others and the organisation. It was clear that the leadership of the organisation had a vital role to play in creating a culture of person-centred practice. The values of person-centredness had to be translated into actual practice with the support of the organisation.

4.4.3 SUMMARY

The lifeworld experience of participants’ care revealed that their individual values and beliefs were incongruent. Providing an opportunity to bring service providers and users together so that they could clarify their values and beliefs was described as important and this created greater understanding and negotiation between the participants. The organisation played a critical role in communicating person-centred care values and supporting the staff. Building staff morale contributed to staff retention and satisfaction, and led to greater empowerment and ability of the staff to be person-focused. The quality of care experienced was greater when the focus of attention was on individuals and their unique needs.
CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

The phenomenological approach provides the opportunity to explore the experience of patient-centred care from residents, care-givers and families in residential care in New Zealand and Singapore. The themes identified reveal the existential concerns that were significant for the individual participants. Using phenomenology as the research methodology allowed the participants’ vivid and powerful detailed descriptions of their care experiences to come alive. Nuances in the experiences emerged as the researcher was able to engage with the participants’ world. This study gave importance to, and recognised, the innate dignity of each individual being who participated in this study and to their existence.

Hermeneutic phenomenology identifies meanings and understandings of everyday life that are bound by context (Thomson et al., 2011). The findings of this study conducted in New Zealand and Singapore with a small number of participants are not necessarily generalisable to other population groups. The strength of phenomenological study is the opportunity to understand a phenomenon from the participant’s perspective. This study reported participants’ experience from two different cultural contexts, Western and Asian. It also included a diverse group of participants who influenced the care context and practice. The residential home settings differed in a number of ways. In New Zealand, the living arrangements afforded greater privacy, while in Singapore residents experienced communal living. One limitation of the synthesis presented in this chapter could relate to the different experiences of “space”. However, the longing to go back to their own home was a common experience among the residents. Both residents and family members wanted to maintain their relationships except for a few residents who perceived that they were neglected by their children. In Singaporean residential homes, the frontline staff were all from overseas and relatively young. In New Zealand, there was a balance of overseas and domestic carers who were more mature in age. The participants were from two different countries, different ethnic backgrounds, and varied age groups whose lifeworlds were varied. Although this could have possibly limited the synthesis presented in this chapter, the focus of the study remained to understand the individual experience of person-centred care. Van Manen (2002) suggests hermeneutic phenomenology is not to seek absolute truth but to gain
insight into the meaning of human experience. Hence, this study presents interpretations of the residents, family members and frontline caregivers from New Zealand and Singapore, informed by the participants’ narratives, as well as the researcher’s own personal experience of working with older people.

Three major themes encompassed the participants’ experiences: ‘homelike’, ‘maintaining and developing connections’, and ‘workplace culture’. The themes were derived from analysing the interconnections of experiences as shared by the participants. Van Manen’s four lifeworld existentials offered a lens through which to explore and navigate the interview data from three groups in two settings and uncover the essences of lived experience for the participants (Van Manen, 1997). It was through the lived body that the participants experienced living in a residential setting. From this study, the participants discussed their experiences of lived time: the residents were often waiting for care, and the caregivers often did not have the time to give the care they wanted; their experiences of lived relationality: both residents and family discussed the importance of maintaining old connections and creating new ones; and their experiences of lived space in an environment that was often under-resourced and the work of caregivers under-valued. As noted earlier in the methodology chapter, there is congruence in the concepts of Van Manen’s existential lifeworld and McCormack’s (2004) concepts of person-centred care; however, the themes were closely aligned to fit into McCormack’s four person-centred concepts (Appendix F). The discussion will focus on McCormack’s (2004) four core concepts central to person-centred care: being in relation, being in a social world, being in place, and being with self.

5.2 SUMMARY OF RESULTS

The aim of this study was to acquire a deeper understanding of residential home residents’, family members’ and frontline caregivers’ lived experience of person-centred care using person-centred care and lifeworld principles. The hermeneutic–lifeworld phenomenology guided the interpretation of the themes. The three major themes, ‘homelike’, ‘maintaining and developing connections’ and ‘workplace culture’ were important aspects related to the experience of person-centred care for the participants of this study. The themes were identified based on what was significant for the individual being.
The theme ‘homelike’ was significant for the residents whose experience was influenced by individual acceptance of their relocation. Some accepted the move and adjusted, while others found it devastating and threatening. The physical environment and social connections with family and staff were important factors in adjusting to the relocation.

The second theme of ‘maintaining and developing connections’ revealed that an integral part of a person-centred experience was relationships. All participants found that positive relationships were essential for the wellbeing of all. The relationship was built on the basis of mutual trust and with the intention to nurture each other.

The final theme of ‘workplace culture’ revealed that the context of care should facilitate and promote values and beliefs related to care. These had to be congruent to promote shared meaning amongst stakeholders of residential home care. The person-centred care experience was also affected by the level of staff competency, staffing and staff morale.

Overall, the lived experience of person-centred care was shown to be a complex phenomenon that varied from individual to individual. The careful and sensitive approach to the meanings of each theme showed that the phenomena of person-centred care was an individual experience, and only the being could experience the meaning in the context. The meanings are closely linked to the four core concepts of person-centred care, as identified by McCormack (2004). Thus, in order to maintain the authenticity of the meanings in the context of both person-centred care and lifeworld phenomenology, the discussion is focused on the being and presented in four parts: being in relation, being in a social world, being in place, and being with self.

5.3 BEING IN RELATION

A person’s identity is defined by the relationships one establishes over time and throughout life. Being in relation is an essential aspect of person-centred care (McCormack & McCance, 2010). The concept of relationship is also emphasised in the lifeworld phenomenology and person-centred philosophy, which recognise that as social beings each individual wants to have a sense of connectedness and mutual interdependency to make their life more purposeful and meaningful (Bradshaw,
Playford, & Riazi, 2012; McCormack & McCance, 2010). Heidegger (1962) recognised that the phenomenological perspective view of human essence is being in relation with others. Similar themes emerged in this study which identified relationship as a key aspect of quality care for the participants. Indeed, models of nursing, irrespective of their underpinnings, have emphasised the importance of relationships (McCormack et al., 2010; Peplau, 1952; Rogers, 1980; Watson, 1988). Slater (2006) mentioned being in relation as one of the seven attributes of person-centredness. Nolan’s (2001) ‘Senses Framework’ model of nursing recognised the importance of relationship. This study identified that maintaining family relationship and developing relationships between service provider, service users, and peers were a significant aspect of participants’ experience of care.

This study’s findings revealed that residents’ ‘home-like’ care was influenced by having meaningful relationships and interactions. The results showed that the relationship between the residents and family members was significant and played an important part in their daily life. The residents’ homelike care was influence by their relationship with family members, frontline caregivers and peers. Bauer (2006) affirmed this notion and emphasises that the human connection is essential for one’s social and personal meaning of life. Especially, it was critical for the older residents who had experienced increased isolation and loneliness due to the sudden move into the residential home (Lyons, Specht, Karlman, & Maas, 2008).

The residents affirmed their humanness through the bonds they maintain with their family members. It was through family that some achieved purpose and meaning to go on each day. It gave greater meaning to many, especially towards the later stages of life. All of them indicated that the support from their family was vital and it helped them to deal with the difficult circumstances of their life in the residential home.

Similarly, many family members who expressed grief and guilt for moving their loved ones into the residential homes felt that their support and physical presence provided greater emotional strength and confidence for the older residents. Kellett’s (1997) results show similar findings and recognise that family support provides greater emotional stability to the residents who are mostly weak and vulnerable. The current results reveal that family members enhanced the relationship further by taking residents out for trips or social gatherings. The family members achieved a sense of
satisfaction that they were able to continue their responsibility for the wellbeing of their loved ones. This is consistent with the results of Talerico (2003), which associated quality care with family relationships.

Research on residential home care shows that the staff have a significant role to play in enhancing residents’ and family members’ experiences of quality care (Muenchberger, Ehrlich, Kendall, & Vit, 2012). The results reveal that the quality care experience for the residents and family members was dominated by their relationships with the frontline caregivers. The person-centred care experience of residents and family members was influenced by having a reciprocal and collaborative relationship with the frontline caregivers that made them feel more ‘homelike’ and provided a greater sense of security. McCormack (2003) highlights the importance of relationship in the person-centred care model, which requires greater understanding and respect for values. Quality care is about having a nurturing relationship between health professionals and patients (Kitwood, 1997).

The current findings reflect an earlier study by Ploeg, McAiney, Donald, Carter, Martin & Taniguchi (2013), which emphasised relationships among the residents, family members and staff as essential for quality care. The partnership and social contact with the frontline caregivers assisted the residents and family members to become familiar with the care context and practices of the residential home. The interpersonal skills of the frontline caregivers determined the degree of contact the residents and family members wish to have with the staff. When frontline caregivers showed genuine interest and care through their verbal and body language, the residents felt engaged and valued. For example, when staff greet with a smile, show positive interest, and are engaged therapeutically, the care experience was infused with compassion and love (Zimmerman et al., 2005). The family members experienced a sense of comfort and reassurance once they were able to work collaboratively with the frontline caregivers. The positive interpersonal skills influenced the reciprocal relationship and made life easier for the residents and family members, because they could confidently rely on frontline caregivers for support and advice. Specht’s (2000) study shows similar findings and emphasises that the partnership or relationship is an important criterion for quality care. It is evident from the results that the participants rated their person-centred care
experience according to the therapeutic relationship they had with the frontline caregivers.

The residents’ and family members’ interpretations of quality care were significantly related to their interpersonal encounters with the frontline caregivers. Both groups of participants recognised that the frontline caregivers played a major role in the daily care of the residents. They found that dignified, meaningful daily life for the residents required reciprocal interpersonal relationships with the frontline caregivers. Bradshaw’s (2012) study supports similar ideas and claims that showing respect and recognition to an individual’s identity can further improve quality care. The findings support recent research results by Bangerter (2015) who recognises that residents feel very comfortable with staff who show compassion and are sensitive to residents’ feelings and needs. This is consistent with the current study where the interpersonal encounters with the frontline caregivers contributed to the care experience of the residents and family members. Several recent studies reached similar conclusions about the importance of relationships that contribute towards achieving quality care. Researchers in Australia (Bellis, 2010) and Sweden (Sacco-Peterson & Borell, 2004) found that residential home residents who were asked to reflect on quality expressed the importance of relationships with caregivers and others. A theoretical model of residential home care quality developed by Rantz (2012), based on focus group discussions with residential home workers, administrators, and regulators, posits that staff interaction with residents and individualised care are central dimensions of quality.

The findings also indicate that there were constraints in relationships between residents and staff due to culture and language differences; this caused communication barriers and a lack of shared meanings. Cultural safety is a concept receiving greater international attention in the literature (Chao & Roth, 2005). It recognises the importance of cultural identity, individual wellbeing and considering individual rights (Anderson et al., 2003). Since there was a shortage of local caregivers or health assistants, this role was being filled by people from other countries who lacked fluency in the local language. The language barrier between the staff and residents caused ineffective communication and led to a perception of uncaring attitudes. This caused a barrier for some in establishing relationships. Nevertheless, the long-term connections enabled both parties to recognise and
anticipate the needs of each other. Families took every opportunity to ensure staff were well informed of residents’ needs and facilitate meaningful relationships between the residents and staff. This is in line with studies of McGilton (2007), which shows that the closeness of the relationship between residents and staff is associated with positive behaviours of the staff.

The results highlight that the frontline caregivers experienced difficulty at their workplace between the task to be completed and the relationship with the residents. These two dimensions were present in all care situations but were weighted differently by the frontline caregivers depending on how much priority they give to the needs of the residents. All participants agreed that the frontline caregivers had to always rush to complete their tasks, which limited the time for meaningful interactions among them. Most of the participants perceived that frontline caregivers were unable to attend to the details that were important to the residents, due to the focus on completion of tasks rather than on the resident. This is acknowledged by Kellet (2000) who comments that the culture of care practices in residential homes tend to be dominated by task completion rather than paying more importance to the needs of the individuals. In addition, Rodriguez’s (2011) findings uncover that when the residential homes are driven by a profit motive, frontline caregivers’ work is intensified, making an already challenging job even more demanding, and ultimately limiting the capacity to feel emotional attachments that arise from care work. The results reveal that the frontline caregivers felt pressured and feared that they would be reprimanded by their peers if they did not complete the routine tasks. This is consistent with a previous study by Bowers (2000) who further identifies that the fear of litigation or regulatory penalty as reasons for being routine focused. Galland (2006) recognises that person-centred care should be resident-centred instead of task-centred and this is possible when the frontline caregivers have autonomy and flexibility to customise the care according to the residents’ individual needs. It is obvious from the results that the care culture of the residential homes limited or restricted the frontline caregivers’ freedom to practise person-centred care because they gave priority to the tasks rather than building quality relationships with the residents and family members. Kolanowski (2015) further identifies that time constraints and the lack of sufficient staff are other reasons for staff to be more task-centred. The results reveal that the frontline caregivers have to manage competing
demands during work, which gave them inadequate timely information to address residents' issues.

The lack of staff and inconsistent staffing affected the development of relationships among the participants and impacted the experience of care. Kolanowski’s (2015) and Bowers’ (2000) results indicated that the staffing pattern did not support provision of twenty-four-hour person-centred care, especially during evenings and weekends. Rantz (2004) claims that inconsistent staffing contributes to inconsistency in the level of care, which upsets and frustrates the residents because the non-regular staff lack the insight into a resident’s regular and specific needs (Van Haitsma et al., 2014). The inconsistent staffing and assignment caused distress to many frontline caregivers, due to having no insight into residents’ expectation of care and poor peer support. The present findings further show that the relatives’ emotional investment in the staff is faced with many challenges due to frequent changes of staff; the inconsistency disrupted the process of relationship building. Family members also expressed frustrations as the staff turnover caused them to repeat and reinforce the needs of their loved ones (Hertzberg & Ekman, 2000).

However, Castle, Engberg, and Aiju Men (2008) observed only a weak association between residential home staffing levels and quality of care. They concluded that adding more staff is not necessarily a sufficient means of improving the quality of care in residential homes. Nevertheless, the findings by previous studies recognised that irregular frontline caregivers were more task focused because they lacked familiarity with residents and could not invest in relationships with the residents and family members that required more time (Bangerter et al., 2015). This is in line with Cammer et al.'s (2014) findings which added that consistent staffing is relevant in supporting all types of relationships and is highly valued by residents, families and staff. The current study shows that a well-functioning relationship with the staff might increase the family members' possibilities of having influence and control over the care that was favoured by the residents and their family members. This finding is consistent with Attree (2001) who found that the care experienced by residents and family members was described as personal when staff showed emotional connections. This finding also raises interesting questions from a lifeworld perspective, because not all participants expressed similar experiences. The phenomenological orientation helps to understand how one interprets a situation as
humanising or dehumanising as based on the culture and tradition of the person. Future phenomenological studies should factor the residents’ past life experiences when doing similar research study as the residents’ current expectation of care is heavily influenced by both their past and current life (Laverty, 2003). In addition, interpersonal skills impacted on the level of care experience for some; positive skills contributed to a greater sense of care while negative skills led to unhappiness and dissatisfaction. A homelike environment was experienced when frontline caregivers respected the individuality of the residents and involved them in meaningful interactions.

The results reveal that the residents’ quality care perception was also influenced by their social exchanges with other residents; this is consistent with previous studies (Yeung, Kwok, & Chung, 2013). The residents sought out people to share their views and stories in order to cope with the transition experience positively. They developed new social spheres through common experiences and interests. This is in line with Yeung, Kwok, and Chung’s (2013) results, which reveal that genuine personal encounters are possible when the residential home residents exchange their experiences with each other. The ‘homelike’ environment was influenced by their connection with other residents through interaction and showing support for each other in good and bad times. The interaction and friendship created a new future identity for the residents.

Research on residential home residents has found that residents experience less depression and loneliness when they have greater peer support (Carpenter et al., 2006; Fessman & Lester, 2000). Positive peer relationships have been found to contribute to thriving in residential homes, in promoting growth and psychological wellbeing (Bergland & Kirkevold, 2005). The sense of camaraderie enabled the residents to cope with their current situation, especially when they have similar diagnoses or disability needs. This finding aligns with Fitzpatrick (2000) who identified that the psychosocial characteristics of the individuals influence the dynamics of shared space. However, another most prevalent relationship description consists of friendly exchanges with a lack of close or intimate connections. The current findings show that some participants found it difficult to move beyond causal greetings to form more satisfying relationships, and many mentioned that they felt lonely.
However, the results also reveal that the residents avoided others who required higher levels of physical care or confused residents with whom discussions or sharing problems were not possible. Hauge and Kristin’s (2008) and Tsai and Tsai’s (2008) results show that the presence of residents with dementia is seen as a potential stressor for alert residents because of the emotional disturbance caused by their disruptive behaviour. Another study by Chang (2013) shows stress is caused by negative dysfunctional behaviours. Some residents showed feelings of sorrow and fear watching the dysfunctional behaviours of their cognitively affected peers as they were afraid that sooner or later they might exhibit similar behaviours as their condition deteriorated. These ideas are consistent with the experience of the residents who participated in this study.

5.4 BEING IN A SOCIAL WORLD

People are interconnected with their social world and are creating and recreating meanings through their being in the world. The meanings are projections of their values, which represent what is important for each of them. Heidegger (1962) considered, that as human beings, one is always in the world with others. This affects one’s understanding (Smythe, 2004). The participants’ experience of care was inevitably constructed based on their personal and social context. The residential home context was their social world where each of them played a critical role in providing and receiving care.

Although moving into the residential home was a logical decision, the residents expressed sorrow for losing frequent social contact with their family members and the outside world. They felt extremely lonely and depressed because of the reduced contact with their loved ones. This is in line with Drageset et al.’s (2008) findings that reveal increased contact with family members improves feelings of loneliness and mortality outcomes among residential home residents. This study also highlights that the residential home residents longed to go back and live with their family, and lead a normal life in their own home. This is supported by Heid (2014) whose study reveals that this is due to residents being in a state of denial, finding it hard to accept and adapt to the new environment. The residents' lived body found it difficult to fit into the social world of a residential home context, which was seen as strange with strange people. Some showed better adjustment to their new social world while others
showed displacement and a continuous struggle. McCormack and McCance (2010) relate this to the disruption to one’s world especially during major illness or life events, where one’s stable foundation required for structures of life start to fall apart.

A significant finding in gerontology literature is that the residents’ wellbeing is enhanced when staff become interconnected with the residents (Chung, 2009; Edvardsson et al., 2011; McGilton & Boscart, 2007). The understanding of residents’ values and beliefs help to give insight into the residents’ intrinsic worth (Ford & McCormack, 2000). The current study revealed that when staff cherished these moments with the residents, it helped the residents to recreate their meaning in life. The articulation and sharing of biography helped to share values and beliefs of the older person.

Kellett, Moyle, McAllister, King, and Gallagher’s (2010) findings further reveal how the residents initiate and sustain the relationship with the staff through sharing of personal and biographical information so that the staff will get to know them at a personal level. This is consistent with the present results, which showed that both residents and family members initiated social conversations with the frontline caregivers to share personal and specific information of the residents. Previous studies recognise that the personal information allows the frontline caregivers to individualise the care. This is possible due to a greater awareness of residents’ specific likes and dislikes (Kellet, 2007; Sebern & Whitlatch, 2007), which are the fundamental basis of person-centred care (McCormack et al., 2010). The personal stories shared by the residents helped to define them and created an identity; this provided greater insight for the staff to see the person beyond their current self and their meaning of care.

The frontline caregivers integrated the personal information of residents into the current care; this created ‘homelike’ care for residents because their old habits were respected and continued with the assistance of the staff. Zisberg, Young, Schepp and Zysberg’s (2007) findings are consistent with this study, which recognises that maintaining personal routines at a time of major life change could give positive benefit to the residents though it was challenging for staff. This might be explained by the fact that personalised care routines comprise an individual’s world, lifestyle or identity (Kane, 2001). When residents were unable to do this, family members often
shared similar stories with the staff. They expressed gratitude when such details were seriously considered and incorporated into the care. However, when frontline caregivers were unable to recognise the significance of residents’ information or stories, then the relationship was seen as ambiguous by the residents and family members (Kellett et al., 2010). The current findings were consistent and revealed that inclusion of specific details into the daily care of the residents enhanced the care experience for the residents and family members. The experience of person-centred care was enhanced because the care was perceived to be more personalised when factoring the preferences of the residents.

Another advantage of sharing the personal information was that it allowed a more meaningful interaction between the frontline caregivers and residents as well as their family members. The residents’ ‘homelike’ care experience was enhanced when information about their past was incorporated into the interaction by the frontline caregivers. Hertzberg (2001) highlights that the residents’ care experience is enhanced because they are given a chance to reminisce about their past. These are mostly pleasant experiences which they can focus on instead of the presence of current pain or misery. This is acknowledged by Welsh (2012) who further recognises that reminiscing on the past helps the residents to adjust to life losses, transitions and helps them to think positively.

The sense of the social world was seen as encouraging for the residents and family members when the frontline caregivers also desired to show emotional attachment towards the residents. This study found that the frontline caregivers considered the residential home as their second home and positioned themselves as family members and/ or friends for the residents. They perceived the residents as their grandmother/father, aunty/uncle or mother/father. This is in line with Lopez, Mazor, Mitchell, and Givens’ (2013) findings, which show that participants desire and appreciate the family-like relationships with each other.

While there were moments of positive care experiences reported, the results also revealed tensions between the participants due to differences in their social world. The social world of frontline caregivers’ work context was seen as demanding and overwhelming for the frontline caregivers, due to routine tasks and a lack of staff and time. These findings confirmed that most frontline caregivers placed a higher
significance upon doing their routine tasks and gave less value to the personhood of others. This view has been widely acknowledged by previous studies, which explain that this is due to many residential homes continuing to operate under the medical model tradition (Bauer, 2006; Deutschman, 2001; Pasupathi & Lockenhoff, 2002). This model encourages staff to focus on meeting residents' basic needs such as hygiene, grooming, nutrition, elimination and physical comfort in a timely and efficient manner (White-Chu et al., 2009). The medical model of care emphasises routines, the need for organisational efficiency, and control over the delivery of flexible care. This focus limits scope for interpersonal connections (Bangerter et al., 2015). This is supported by Hertzberg (2001) who points out that improving the social relationships is not in the job scope or a prescribed way of working, so caregivers give less priority to getting to know the residents and family members. This practice is consistent with the institutions that participated in the study; frontline caregivers appeared to be overly concerned about their job performance and completing it within a certain time frame, which they associated with efficiency. Hence, current results revealed that task-centred care was preferred and encouraged in the homes; this limited the opportunity to interact among the three stakeholders of care. This approach of care distanced the frontline caregivers from the residents and family members. The sense of social world was seen as impersonal and lacked human connection.

Previous studies have revealed that residents experienced boredom and loneliness due to the absence of meaningful socialisation with the staff. These results are similar to several studies (Chuang & Abbey, 2009; Coughlan & Ward, 2009; Hjaltadóttir & Gústafsdóttir, 2007). The current study revealed that the job demands and lack of staffing limited the opportunity for interaction between staff and residents. This contributed to negative aspects of residents’ care experience because staff showed greater priority to their task at hand than investing in therapeutic relationships with the residents.

The intensification of work among staff in residential homes increases demands to do more work with less support, leaving less time for vital social and emotional support for residents (McGilton & Boscart, 2007; Shin, 2008; Wagner, 2008). A possible explanation for being too routine-focused is that it gives a structure for staff to carry out their daily work (Edvardsson et al., 2011). However, a disadvantage of becoming too accustomed to doing the job as routine work is that staff become more
mechanical and less flexible with their care actions. Their focus is on fulfilling the job demands, which contributes to inflexibility and low tolerance for fulfilling the psychosocial and emotional needs of residents and family members, even though these are aspects of holistic and person-centred care. Zimmerman (2005) found similar trends, and explains that routine work and task-oriented attitudes to care can erode person-centred care attitudes over time. This is evident in this study where residents and family members felt that staff were rigid with their care approaches, which caused distress. At the same time, frontline caregivers perceived the residents and family members as demanding because they had to constantly juggle between the routine tasks, and the demands of the residents and family members. Nonetheless, there was considerable variation in frontline caregivers’ views and behaviours, as some of them displayed person-centred care values and gave importance to the needs of residents and family members. Chung’s (2013) study highlights that when staff coordinate with and engage with the residents in the care activities, it helps to enhance residents’ choice and autonomy. The quality and level of interpersonal connections helped to humanise the social relationships and enhance the person-centred care experience.

The two greatest concerns that affected the residents’ and family member’s social world were food and activities. The findings revealed that indulging in meaningful activities helped to enhance the social world of the residents in the residential home. When residents engaged in activities that interest them, this helped them to pursue their interests and enhanced their sense of wellbeing. The results showed that residents wished to continue to participate in activities that were part of their life prior to admission to residential homes. The engagement in usual activities provided a sense of contribution and being valued; this enhances the personhood of the residents. Most participants agreed that the activities had to be more person-centred, taking into consideration the residents’ interests and habits and not just coming up with activities to occupy or pass the time of the day. Choi (2008) found that stale programming and a lack of meaningful activities contributes to depression in older people. Many residents in this study have indicated the activities were boring.

However, most of them looked forward to outdoor activities; they showed joy and a sense of freedom whenever they were given an opportunity to go out of the residential home. This is consistent with previous studies that show a resident’s
sense of wellbeing is higher when they have opportunities for outdoor activities, such as going for a walk in the garden or a drive around the city. This gives them a sense of social world that is similar to the one they had before coming to the residential home (Hjaltadóttir & Gústafsdóttir, 2007). The residents and family members felt that the frequency of outdoor activities should be increased; however, they acknowledged that there were limited resources to do this. Family members contributed to residents’ outdoor activities by taking them for a drive, a walk, or taking them to family and social events. Garre-Olmo et al.’s (2012) results recognise that this gives the residents a sense of freedom to see the outside world instead of isolating themselves in the residential home. Those who have mobility issues kept themselves connected and engaged with the outside world by reading newspapers and engaging in small group discussions on current events. These people perceived quality care as being alert and current with their surroundings. Their sense of self was enhanced when their freedom to do what they wished was supported.

The results reveal that the family members were unhappy with the level of activities provided in the evenings and weekends. They felt that the residents’ level of care was poor because they were not engaged and stimulated, which was essential for their mental alertness. Bowers (2000) recognises that this is due to the lack of staff who handle activities. These staff members only work during the day and are away in the evenings and weekends. The residents’ potential and capability went untapped and eventually unnoticed. This was worrying for the family members who were upset to see the physical and mental condition of their loved ones deteriorate since their admission.

Further, the results reveal that those residents who were frail were more disadvantaged because they were deprived of activities. The staff perceived that these residents did not benefit from the activities. Chung (2012) stressed this is for the benefit of the staff who want an easier life so they leave the residents to lie in bed the whole day. Another possible explanation is the stereotypical ageist outlook of staff who perceive that older people are incapable of doing activities (Hjaltadóttir & Gústafsdóttir, 2007). Family members were distressed by this attitude that deprived the residents of the opportunity to engage in meaningful activities that promoted their growth and sense of worth. Furthermore, the family members felt that the immobile state contributed to wastage of muscles and affected the nutritional and elimination
needs of the residents, which was considered as poor care. Although the residents in the residential homes were physically too weak to do certain activities, they perceived meaningful activities as important and desired activities that were possible and valuable for them. What were meaningful activities differed from the three groups of participants as well as the physical status of the individuals. It is essential to design activities that meet the residents’ needs.

Food and dining was not just seen as nourishment but also an important aspect of residents’ social world. One important aspect of ‘homelike’ care was having choice and control over food. Food represented quality of life, and for the residents, it was one of the few things that brought them joy. The findings reveal that some of the residents and family members were unhappy when food preferences were not considered seriously. Previous studies by Brocklehurst (1996b) found that only 22% of 240 resident care plans in 11 British facilities actually documented food preferences. Gaugler’s (2005) research study shows that staff are less knowledgeable about residents’ preferences than they are about their physical condition. The residents’ results highlighted that they were unhappy that the food did not meet their preferences, portions are too small, undercooked and lacking in taste. This is consistent with the findings of West (2003); poor quality cooking caused the residents distress and frustration over their lack of control over their meals. The current results reveal that some of the residents showed their power and control by refusing to eat the food.

In addition, the residents’ food intake was also influenced by the social environment; they found the dining environment as less conducive for pleasurable dining. The noise level affected their pleasure in dining experience. This is consistent with Hung and Chaudhury’s (2011) study, which shows that increased noise level caused by medicine and food trolleys, heavy traffic, and staff talking among themselves affects the residents, disturbs their appetites, sleep and rest, and causes irritation. The residents from Singapore further experienced a more institutional-like dining atmosphere because they had their meals in the common activities area. In addition, the institutional feeling was reinforced with meals served on metal plates. In New Zealand, the residents’ dining was enhanced with ‘homelike’ social features such as specific dining areas, with dining tables for fewer people, and of a smaller size. Other
features such as kitchen cabinets, tablecloths, and colourful curtains further complimented the social aspect of dining.

The findings revealed that food was also a socialising point, where the residents engaged in small talk with their peers. They enjoyed the company of residents whom they liked. They also became dissatisfied when they were not given a choice to sit where and with whom they wished. This is consistent with an earlier study by Keller (2014) who mentions that staff underestimate the importance of residents’ socialising during meal times. Previous studies have found that residents were upset when they had to sit with residents who were distracted, noisy or messy with their eating (Crogan, Evans, & Velasquez, 2004; West et al., 2003). An earlier study has shown that residents are less sociable at meal times when they are unhappy with the meal practices (Galland, 2006). Similar findings are consistent in this study where socialisation among residents correlated to respecting their sense of preferences, in terms of where to sit and who their table mates were. But staff underestimated the social importance of residents meeting people at meals and changing eating places. The lack of control on these matters caused the residents to feel helpless and frustrated.

The current results reveal that the social aspect of dining was seen by some of the frontline caregivers as a task that had to be accomplished within a time frame. The whole dining process was turned into another task-focused job. This coincides with Woo, Chi, Hui, Chan, and Sham’s (2005) study that identifies that due to staff shortages, the feeding needs are neglected, which contributes to poor nutrition for the residents. The results of this study showed how the frontline caregivers tried to sit strategically to improve their efficiency of feeding. They took turns to feed two or three residents at one time. Similar findings are shared by Schnelle et al. (2004). Nonetheless, some family members made the dining experience for the residents into a ‘home like’ social moment by being there physically during the meal times. For those who required feeding, the family members ensured that the residents ate well.

The frontline caregiver’s notion of quality care related to food was discussed more in terms of technical aspects such as understaffing, crowding, cleaning and clearing. This is consistent with West, Ouellet and Ouellett’s (2003) results that indicate staff fail to appreciate the importance of residents’ food preferences. The staff maintained
that it took extra time to get the residents to and from the dining room for each meal. They preferred to leave residents in their own rooms and feed them their meals there.

Overall, residents and family members perceived that the highlights of the day were the meals, but they expressed great concerns with the food service. Food preferences were overlooked; residents had to constantly remind staff of their likes and dislikes. Although a few of the frontline caregivers attempted to communicate the residents' food preferences to the kitchen staff, the discrepancy still occurred due to inconsistency of staffing at the kitchen. Family members were concerned with some staff who were seen as unconcerned in ensuring residents were getting adequate fluids and food. Family also wanted the environment to be more 'homelike' by providing more opportunity for free snacks, fruits and drinks. The existential need to have flexibility and freedom in meeting the basic needs was an important aspect of person-centred care for the family members and residents.

Moreover, the results from the frontline caregivers revealed that they were in a social world where they faced horizontal violence, which affected the team work required for person-centred care. Chung (2012) stresses that the care activities should be organised to support and empower all staff so that they could respond to residents' needs and desires. For example, teamwork would be encouraged, and additional staff training provided to enhance efficiency and effectiveness. This study reveals that the lack of teamwork contributed to residents’ and frontline caregivers’ unpleasant care experience. Hoff (2004) identifies that training and ongoing support for staff on person-centred care practice is critical as these will develop staff to recognise and overcome individual differences and enhance their team spirit, in addition to enhancing their efficiency in person-centred care. As such the institution had an important role to nurture and guide frontline staff to carry out person-centred practice through ongoing training (McCance, McCormack, & Dewing, 2011; McCormack & McCance, 2006). However, frontline caregivers’ details on trainings were scant and there was little or no reference to training that supported their competency to provide person-centred care. Hence, this explained the limited definition and insufficient description of person-centredness by the frontline caregivers, which possibly contributed to the lack of person-centred care culture practice and relevant training to staff.
The sense of social world was clearly influenced by participants’ perspectives, which related to their beliefs and values. Sharing of life stories enhanced meaningful conversations among the participants, which enhanced the care experience and social world of the participants. When there was continuity with preferences, especially related to activities and food, the social world was experienced as ‘homelike’, which promoted one’s autonomy and choices (Lee, 2001). When care activities were undertaken as routine activities, it caused tension in the social world of participants, because the individual was seen as a unit instead of a being (Cooney et al., 2009; Tsai & Tsai, 2008). However, for those residents who showed greater autonomy in structuring their own activities for the day, they experienced more ‘homelike’ care because they decided not to fit into the routines of the residential home; instead they wanted the routines to fit into their schedule. Their social world allowed them to continue to make choices. The sense of not being confined by rules enhanced the residents’ self-esteem (Boyle, 2004).

5.5 BEING IN PLACE

Being in place evolves from the lifeworld lived space, which refers to participants’ environment. Being in place reflects the experience of staying at home. Home plays a critical role in maintaining a sense of personal identity for the residents (Bangerter et al., 2015; Robinson, Reid, & Cooke, 2010). This is because home, unlike many institutional care facilities available to frail older people, does not compromise their independence (Riedl, Mantovan, & Them, 2013). Home is a place where control over one’s own life can be freely exercised (Hauge & Kristin, 2008). Further, Wilhelmson (2005) also agrees that besides freedom and control, home also shapes and maintains personal identity by maximising a sense of personal competence and control (De Veer & Kerkstra, 2001). The current study reveals similar notions where the care expectations emphasised personalised space, which included the ability to continue with their habits and preferences. Bangerter (2015) recognises that when the care is personalised, it improves the resident’s self-esteem and wellbeing because they are able to continue with their previous lifestyle with minimum changes.

Many residents expressed loss, particularly in their personal space, upon their relocation to a residential home. It was recognised that when the personal space provided privacy and autonomy, it had the potential to enhance ‘homelike’ meaning
(Kane, 2001; Thomas, 2004). Molony (2010), who investigated the meaning of ‘not home’, describes it as having unfamiliar things, strangers, group discipline, uniforms and incomprehensible language. These aspects of ‘not home’ characterised the current care experience of both residential homes. Molony’s (2010) study indicates that the physical and psychological environment of the residential homes should be made comfortable as a home for the residents. The physical space should respect the residents’ privacy and preferences to enhance the homelike and person-centred atmosphere.

Shaller and Fund’s (2007) study reveals that the design of the facilities contributes to an experience of person-centred care. Kane (2001) comments that when the structures are less institution-like, it promotes a more homelike atmosphere. This study referred to environment as any environment in the facility that was frequented by residents, including, but not limited to, the residents’ rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. The current study revealed that family members found the characteristics of the building to be weakly related to feeling at home for the residents. In particular they expressed that there was limited opportunity to have private conversations with their loved ones because of the lack of private space and constantly being disturbed by other residents. The family members from Singapore found too many beds in a room hindered their conversations with their loved ones and limited the opportunity to discuss personal issues. This is consistent with Chapman and Carder’s (2003) findings which highlight the inconvenience that may reduce a family member’s desire to visit. Similar notions are reflected in Talerico, O’Brien and Swafford’s (2003) study which reveals facility characteristics such as restricted visiting hours, lack of quiet space for family gatherings or private conversations, or uncomfortable settings limited family members’ comfort.

The study by Chang (2013) highlights that home is considered as more than a physical space for the residents, who associate it with their individual value, cultural identity, sharing with friends and loved ones, and reflecting one’s history and identity. Having no home creates a crisis for the residents, as they have nothing to reflect their own unique identity or essence (Chang, 2013). This lack of identity, in turn affects the experience of care for the residents (Heliker & Scholler-Jaquish, 2006). Comparatively, the residents from New Zealand experienced a more homelike
environment because of the individual space which facilitated their privacy and autonomy (Welsh et al., 2012). Kane (2001) recognises the importance of private space because it allows the residents to be alone when they desire. This also allows those who prefer to limit and protect their communication. However, private space was not possible in the Singapore context, where the residents shared the space and experienced communal living. The space did not resemble a homelike environment, instead it was more hospital-like; it contributed to the residents feeling disempowered. These results are similar to many previous studies (Chuang & Abbey, 2009; Coughlan & Ward, 2009; Bjaltadóttir & Gústafsdóttir, 2007; Murphy, 2007; Tsai & Tsai, 2008) which share similar concerns. Murphy et al. (2007) contends that suitable personal space promotes self-identity and self-value of residential home residents.

Shaller (2007) mentions that a homelike environment is not achieved simply through enhancements to the physical environment but through emphasis on the individual, relationships and a psychosocial environment that welcomes each resident and makes them comfortable (Bradshaw et al., 2012). This study showed that the residents missed their family, friends and the daily routines of their past lives, as previous studies revealed (Chang, 2013; Lee, 2001). Paying attention to place in care relationships is increasingly seen as important as it contributes to the wellbeing of all involved in the care (Corbin, 2003). The current findings indicate that the residents showed greater satisfaction and happiness with the environment whenever they were visited by their family and friends. The residents’ adjustment and adaptation to the residential home environment was correlated to frequency of visits by family members (Tornatore & Grant, 2004). The residents feel secure because they feel that the family members acted as their advocate, listened to their concerns and communicated with the staff (Talerico et al., 2003). The visits and support gave a ‘homelike’ space for the residents and family members who felt loved and empowered (Sloane et al., 2004). This study reveals how family members contribute towards enhancing residents’ ‘homelike’ space by bringing residents’ personal possessions such as furniture, photos and pictures, and other small items, and displayed them in residents’ rooms or space. This provides a personal touch and a greater sense of place that is ‘homelike’ (Bern-Klug & Forbes-Thompson, 2008; Brocklehurst & Dickinson, 1996a). This finding coincides with previous research studies by Kellett, Smith, Baker and Chadwick, 1997; Kellett, 1998), which further
reveal that the support by the care team is essential to help the residents and family members to adapt and cope with the new environment.

The present study reveals that residents and family members express ease and comfort when they are supported by the care team. Brodaty, Draper and Low’s (2003) and Harnett’s (2010) studies reveal that the adequate support from staff and management helps residents and family members to familiarise themselves with the place in terms of physical environment and practices. The study by Murphy (2007) highlights that the routines and rituals of the residential home can complicate the environment. This notion coincides with the current study, which revealed that most residents and family members had to find their own way to familiarise themselves with the environment. However, those family members and residents who showed an interest in getting to know the place, also made the personal effort to personalise the space. Those family members frequently showed up at the residential home, expressed more comfort, and became part of the care team. They freely moved around and made the place ‘homelike’ for the residents as well as for themselves. This is the basis of the person-centred care principle.

This coincides with the current results where the participants wanted the environment to recognise their individuality and preferences. Bangerter, Van Haitsma, Heid and Abbott’s (2015) study reveals that when staff encourage care linked to residents’ past and provide opportunity for self-expression then the environment becomes personalised.

5.6 BEING WITH SELF
Knowing the values of each other and incorporating that knowledge into care practice was shared as a person-centred experience by the participants. McCormack and McCance (2010) have said that respecting the person’s values is central to person-centred care, which contributes towards human flourishing. Person-centred care is not a momentary event but has to be a culture of practice supported by all levels (McCormack & McCance, 2010). They added that this requires commitment from policy makers, management of facilities, and staff. This is evident from the current study, which revealed that a clash of values among participants, ineffective translation of person-centred values, and values of workplace influenced the participants’ person-centred care experience.
Interestingly, the results reveal that some participants showed optimism towards the care and wellbeing while others did not. Van Manen’s (1997) phenomenological perspective explains that this is because human beings as emotional embodied beings use their sensations and feelings to interpret experiences. The perceptual or bodily experience is unique because it is based on the values and beliefs of each person. This supports the current study on why some participants experience care as good or acceptable while others see it as below standard.

Those older residents who associated stigma with their experience of living in a residential home showed emotional suffering. These residents felt that they had lost meaning in their own existence and considered it as a shame to live in a residential home (Dwyer, Nordenfelt, & Ternestedt, 2008). Especially this was evident among the residents from Singapore who showed a great amount of emotional suffering due to cultural expectations. This was in line with Chang (2013) whose research findings further explain that this is due to traditional Asian values of filial piety, where it is the responsibility of the family to take care of the older person. The Asian cultural norms suggest that caring for one’s parents by putting them in a residential home is tantamount to neglect (Chang, 2013). The norm is for parents to move in with their children once they are unable to take care of themselves. In contrast, Chang’s (2013) study of older residents from a Korean residential home also reveals that the residents show a sense of relief after their move into the residential home. They felt free that they were no more a burden to their family. This experience coincides with the current study where the residents repeatedly mentioned that they did not wish to be a burden to their family. Overall, most residents accepted that due to decline in health and chronic conditions, the move into a residential home was a safer option both for them and their family members.

Research has shown that people find meaning despite adversity through survival, determination, and inner strength (Moore, Metcalf, & Schow, 2006). The perceptual or bodily experience of person-centred care encountered by each resident from this study is unique, based on their beliefs and values that form the basis of their expectations. The embodied care experience is influenced by their past experience; those who lacked family support felt more vulnerable while those with strong family support showed a greater sense of wellbeing. The embodied experience also
showed that some perceived that they were seen as objects, as they perceived that staff ignored their existence, while others remained in control and enforced their independence and freedom despite experiencing similar situations. Hammer’s (1999) study on residential home residents reveals that the reaction of each participant is unique and dependent upon his/her life story though they share the same environment. The study provided examples of how one can find privacy or exposure in the same setting depending upon the reality created by the participant, influenced by values and beliefs that had defined the person prior to relocation to the residential home.

Previous studies indicate that moving into a residential home is viewed as a loss of dignity because the older person has to be removed from their social setting and become dependent on others for help due to illness or disability (Chang, 2013; Pleschberger, 2007). This threatens their self-image, self-determination and also their mental state due to being dependent for their needs (Brooker, 2004). This coincides with current findings where a decline in health and an inability to carry out one’s everyday tasks affected the residents’ senses of worth and self. They showed a feeling of helplessness and the loss of autonomy and independence. This negatively affected the residents’ care experiences. However, Welsh, Moore, and Getzlaf’s (2012) results explain that despite limitations, the residents continue to seek meaning and purpose each day, and those who age successfully adopt strategies such as positivity, commitment, optimism, and future planning that enhance meaning in life despite meeting adversity. Hence, one has to understand that continuity in life does not occur spontaneously, it requires an individual’s active search for instances that provide it.

The residents and family members experienced quality care when they shared the same value as the staff. This influenced their verbal and non-verbal contact. This is in line with previous studies by Burgio (2001) and Medvene (2006) which reveal that positive communication skills contribute to quality care. When staff showed love and genuine care in their interactions and care activities, it gave a sense of ‘homelike’ meaningful care experiences (McGilton, Robinson, Boccart, & Spanjevic, 2006). This was consistent with the current findings where the residents were able to interpret the care shown towards them as genuine or superficial. The attitude of the staff was considered to influence the care rendered; qualities such as passion, commitment
and caring were identified as positive factors, while those who lacked these qualities inadvertently reflected their attitude in their care actions. This made the residents and family members feel threatened and vulnerable (Bauer, 2006).

Staff and residents perceived the passage of time differently. The current findings were consistent with a previous study where two different cultures of time existed between staff and residents because of tension in their values (Dwyer et al., 2008). Van Manen (1997) refers to time as a human landscape consisting of past, present and future. The current results revealed that past experiences remained a part of residents' current existence as a reminiscence of the past; counting on their past achievements provided hope and expectation for their future. The residents cherished their moments of past life and were eager to share these with the staff. The residents' experience of objective time highlighted that they were bored and were kept waiting most of the time. Lived time was experienced as dragging and appeared like hours for the residents because they were made to wait and at times neglected. The waiting was a shared experience by most residents that caused restlessness, impatience and threatened the being of the residents. The residents were in a culture of waiting for whom the time was moving extremely slowly while the staff experienced time as too tight; they felt they were overwhelmed with routine tasks. The staff experienced time as pressurised and rushing as they had to complete their task at hand. The staff increasingly tried to fit their routine tasks into the pressure of their 'clock time', which made them rigid and overly focused on time. This contributed to negative care experiences for the residents; staff placed greater value on providing physical care for residents within the shortest span of time. Sadly, it contributed to neglecting the interpersonal aspects of care. Previous studies support these findings and identify this as how the staff determined their efficiency in their jobs: the ability to complete assigned tasks within a specific duration (Burgio et al., 2001; McGilton et al., 2006). The pressure of objective time limited the interpersonal opportunities between the staff and residents.

Bramble, Moyle, and McAllister's (2009) results reveal that language and cultural aspects of a person also influence their sense of values. Smith and Hung (2012) study indicates that a good understanding of a person's traditional values and cultural practices influence one's wellbeing. The present study revealed that this had contributed to frustration and misery for some residents and family members. Most of
the frontline caregivers were from different races and ethnic groups from the residents, and were not familiar with the residents’ specific cultural needs. The language barrier strained the relationships and led to further isolation of the residents. Staff often stayed away from residents who spoke a different language, had communication difficulties or they were less motivated (McGilton & Boscart, 2007). Language barriers significantly affected residents’ care experience, because they could not easily confide in the frontline caregivers. However, McGilton, Robinson, Boscart and Spanjevic’s (2006) results highlight that the residents welcome having relationships with frontline caregivers; they wait eagerly for a lead from the staff to inform them that a relationship is possible. This was consistent with the current study.

When the views and preferences of residents and family members were not considered by the staff looking after their care, they felt that they were treated as an object, while the results from the frontline caregivers revealed that they were overwhelmed and struggled to complete their job demands on time. In addition to their demanding workload, their reasons included staffing issues, lack of training and negative attitudes of staff. This is in line with Tellis-Nayak and Tellis-Nayak’s (1989) and Innes et al.’s (2006) research findings, which further highlight factors such as low socioeconomic class and the lack of formal training; these factors contribute to a lack of competency among frontline staff to deliver person-oriented care. Family members in this study recognised these shortcomings, and actively participated in the care of their loved ones. This was also seen by the family members as a way to fulfil their responsibilities and to overcome feelings of guilt.

Bauer’s (2006) findings reveal that staff distance themselves from family members when they are annoyed and stressed by the demands made by the family members. This coincides with the current study where some frontline caregivers from both countries showed similar behaviours; they preferred to maintain disengaged relationships with the family members whom they saw as demanding and threatening. Previous studies have identified that a lack of confidence or low self-esteem affects the frontline caregivers’ relationships with the family members (Corazzini et al., 2013; McCance et al., 2011). The lack of competency is associated with low self-esteem and lack of confidence (McCormack & McCance, 2010). This was evident in this study where the frontline caregivers perceived that the family
members were constantly there to check on their work and they found the family too difficult to please. Nonetheless, there were some staff who were recognised as pleasant and displayed positive attributes.

The findings revealed that frontline caregivers also have to be aware of their own self and values, and have an understanding of how these could impact on their care decisions. According to Borg, Karlsson, Tondora and Davidson (2009), the quality and quantity of person-centred care practices for ‘homelike’ care depends on the frontline staff's beliefs and acceptance of a person-centred philosophy, their knowledge and abilities to develop a therapeutic resident-centred relationship, their skill in interacting with the residents and family members, and personal qualities such as empathy, kindness and patience. Although person-centred care is widely promoted in long-term care and nursing (Bradshaw et al., 2012), the results revealed that it could be difficult to achieve. Though the participants shared some person-centred care moments, it was seen as a challenge to sustain the commitment towards person-centred care culture. Bangerter (2015) further elaborates that person-centred care culture requires a sustained commitment from the organisation, ongoing facilitation and training, and commitment at all levels. This study shared similar notions and identified that workplace culture impeded the provision of person-centred care in both countries. This is consistent with McCormack’s (2004) concept of person-centred care.

The results revealed that a lack of training in person-centred care values influences frontline caregivers' interpretation of person-centred care, which they termed as ‘good care’. They interpret ‘good care’ as physical care that was associated with meeting residents' physical needs such as bathing, feeding and transferring. Shaller (2007) recognises that the person-centred care philosophy requires strong support and the participation of the management who hire, train, compensate and support a workforce committed to person-centred care. When this was not practiced, the care provided by the caregivers was easily influenced by their own values and beliefs, which led to variations in the level of quality care. This was evident within the current study where the demographic profile of the frontline caregivers showed that that they were mostly foreigners or immigrants; thus, there was a high possibility of their cultural and socioeconomic status influencing their interpretation of quality care or person-centred care. The findings revealed that their job orientation and occasional
training sessions were mostly related to technical skills. Though the values of the organisation incorporated the philosophy of person-centred care such as relationship, individuality, respect and dignity, these values were not translated into the training and ongoing support for the frontline caregivers. Galland (2006) recognises this as a common problem with the health sectors and comments that this is due to a lack of articulation of what person-centred care involves.

Nonetheless, the results suggested that the benefits of training extended beyond those afforded to residents; it allowed frontline caregivers to feel competent and flexible in their attempts to provide person-centred care. Zimmerman et al.’s (2005) results recognise that training and education provide staff empowerment over their own work situation, and increases their level of commitment and engagement in the goal of obtaining the best care for the residents. The study revealed that the frontline caregivers who received limited training on person-centred care practices that impacted on residents’ care were viewed as inflexible and lacking human touch.

The overview of the discussion of the person-centred experience of care highlighted the complexity of the concept of personhood and its articulation in residential home practice. It raised a range of issues from individual to organisational. Interconnected relationships are identified as a person-centred model of care where residents, family members and frontline caregivers found it empowering. However, the successful residential homes had to be careful not to be driven by the model itself or economic efficiency, but rather be person-focused. The reality of the challenges of everyday residential home practice should not focus on chasing after an ideal of person-centredness, but instead strive for a constant state of ‘becoming more person-centred’ in their practice.

It is critical for the organisation to translate many of these complex concepts into practice. This is one of the key challenges noted from both residential homes.

### 5.7 LIMITATIONS

This study has a number of limitations. The study focused on participants’ experiences that were unique to the individuals and to their settings. This study is specific to two residential homes, one in New Zealand and one in Singapore. The findings may not be generalised to a larger population, nor could findings be used as
the basis for theoretical constructs for policy decisions due to the use of a small purposeful sample size of participants. In addition, due to a lack of similar research studies, this study cannot be transferred to other similar settings. However, this study is fortunate in that it includes a divergent group of individuals who had an impact on the residents’ person-centred care experience. Although the smaller sample size might be a limitation, the reduced sample size allowed for a richer depth in analysis and interpretation of the data in these two different cultural contexts. Expanding similar research in different countries and with a larger number of participants would add further value to this study. The lifeworld-hermeneutic phenomenology methodology guided the researcher’s deeper and more interpretative outlook. This helped the researcher to interpret meanings from the data beyond the immediate apparent content (Van Manen, 2007). The findings of this study have captured the essence of, and shed light on, participants’ meaning of the phenomena of ‘lived experience of person-centred care’.

The study results were captured in a specific moment and reflect the temporal nature of our being. The phenomenological perspective emphasises that everyday preferences can change in importance or interpretation based on individuals’ internal and external factors. The researchers and readers will require caution when utilising the data from this study (Carpenter et al., 2006). A similar study if conducted now might reveal different findings because of the effect of temporality. The exploration of these ideas within a larger, more diverse sample is necessary, which may result in additional meanings or different meanings on the person-centred care experience. According to Van Manen (1997), the reliability of a study like this lies in the recognition of others. Knowledge gained from this study can therefore be used as a basis for ethical discussions and raising awareness. Although broad generalisations may not be possible, the commonalities across accounts from participants and the two countries provides useful insights that have wider implications.

Person-centred care is a multidimensional construct which comprises prerequisites, contextual issues, care processes and outcomes (McCormack et al., 2010). This study is specific to a contextual issue and focuses on one area of frontline caregivers’ job context where most care experiences of residents, family members and staff take place. The semi-structured interview method enabled the participants to spontaneously share their personal life stories. Though this study did not cover the
multidimensional construct of person-centred care, a deeper meaning of participants’ lived experience of person-centred care based on frontline caregivers’ job context was captured. Nonetheless, to fully understand the nuances of the phenomenon, it might be interesting to analyse the views of other health professionals in the residential homes.

Ethical concerns were attended to at an early stage in this study to the extent that the participants actually stated that they derived some benefit in taking part. It was recommended by the committee to factor Maori health in the New Zealand context during the study. However, there were no Maori residents during the interview stage of the study. Though the demographic data of the residents was divided into three age group ranges: 65 to 75, 76 to 85 and 85 and above, the majority of the residents residing in the residential homes were 85 and above.

5.8 STRENGTHS

Merleau-Ponty (1996) says that phenomenological experiences are descriptive and not constructed or created. As such, the participants’ description of the phenomenon of this study does not require a deductive system, hypothetical confirmation, reference or theoretical models, thus it does not require an explanation system (Giorgi, 2000). The data collected was the primary source and following Giorgi’s guidelines it was never collected to provide evidence for existing theoretical constructions (2000). Although phenomenology does not require a particular theory or view to analyse things as they appear, the researcher used Van Manen’s lifeworld-hermeneutic phenomenology to explicate and fully grasp the essential structures and meanings of the participants’ experiences (Van Manen, 1997).

The lifeworld approach guided the interview, interpretation of the data, and final analysis. It further guided and supported the researcher’s interpretation of the results, illustrating the findings with quotations, and discussing the findings. Van Manen’s philosophical perspective of the lifeworld allowed the researcher to understand the participants’ embodied experiences, in regards to time, space, body and relationships. Through the philosophy of person-centred care and lifeworld, the study participants were encouraged to reflect on their life and care practices, and to recognise the range of alternatives to enhance their individual decision-making possibilities. Participants had the opportunity to uncover their meanings and
intentions of person-centred care experience. Additionally, the approach of the study had triggered some of the participants to realise that they did not have to passively accept circumstances and surrender control; instead they could start consciously shaping their own lives by exploring options for creating a meaningful existence. The lifeworld-phenomenology research methodology probably triggered some participants to recognise the taken-for-granted meanings and ways to improve the care in the residential home. Van Manen (1997) recognises these as steps towards one’s autonomy and independence.

Hermeneutic phenomenological interpretation involves life experiences and is inextricably linked to the interpretation of the interpreters themselves. The researcher ensured that the intended meaning was captured by conducting repeated interviews and returning to the participants to affirm their interpretation. The use of a hermeneutic phenomenology interview style allowed the researcher to return to the object of inquiry again and again, allowing an increased understanding and complete interpretative account of participants to be achieved. The researcher made every effort to be true to the phenomena of the study by being cautious during the interviews and interpretative analysis to avoid bias and prejudices, through the effort of using a reflective diary and regular support from academic supervisors. This enabled the researcher to suspend the taken-for-granted meanings and to look at the world with a reflective lens while holding the pre-understandings in abeyance. This led back to the origin and authentic meaning of the phenomena.

The use of hermeneutic phenomenology methodology emphasises the need to understand the participants’ experience of care in their social context, so that the essential structures of the care experiences could be uncovered. This allowed the researcher to capture and interpret the embodied care experiences through the participants’ rich descriptions from both New Zealand and Singapore. Thus, the findings add to the knowledge and understanding of the person-centred care phenomenon and highlight the importance of understanding residents in their social context, and illustrate how meanings are constructed through context. Interestingly, the results from both countries showed that there were common concerns that influence the participants’ person-centred experience. However, the physical space was more person-centred for residents from New Zealand than those from Singapore where the residents’ sense of privacy and dignity was compromised due to
communal living. The methodology allows the fusion of horizon between the researcher and data, which closes the gap between the researcher and participant, and unfamiliar to familiar. Hence, this had added validity to the study from a phenomenological lens.

The phenomenological attitude and writing allowed the researcher to see the uniqueness of the phenomenon of life in the residential homes, in all its complexity and strangeness. It helped the researcher to re- evoke and illuminate the phenomenon in its context. The researcher had to be patient and wait for the phenomenon to reveal itself within its own complexity, rather than imposing other external structures on it, such as theories or models. The open attitude brings the strands of hermeneutics phenomenology and lifeworld perspectives together and puts both to work in the research practice.

5.9 CONCLUSION

This study used the frontline caregivers care context as a source to study the phenomenon of person-centred care, a quality care concept. The emphasis of person-centred care is on the well-being and quality of life as defined by the individual (McCormack et al., 2010). The philosophy of person-centred care is to develop an understanding of the individual in the context of their social environment so that their values and beliefs could be identified and recognised by the staff. The interpretative findings reveal that residents’, family members’ and frontline caregivers’ contemplation of quality care issues and the meaning of quality care is an individual experience (Crandall, White, Schuldheis, & Talerico, 2007). The reaction of each participant was unique and dependent upon their life history. Thus, the same environment meant different things to different people. This concern was expressed by participants of both countries. The integrated data analysis emerged with a major theme for each group of participants, but the concerns shared focused on either by enhancing or limiting the experience of residents’ quality of care on the meaning of ‘homelike’.

The person-centred care concept and lifeworld dimensions identified that having a ‘homelike’ environment depends upon relationship, and a committed workplace culture that provides a critical role in shaping the care experiences of the participants. The lifeworld approach helped to deepen the understanding of person-centred care
phenomenon. The ability to care for the residents as a whole person is considered the essence of good health care practice in person-centred care (McCormack, 2003). Staff are expected to incorporate the values of the residents and family members, and they should work in partnership to enhance the care experience of the residents (Attree, 2001). The environmental constraints either limit or enhance the person-centred care practice and experience of care. The two factors highlighted by this study, that influence care experiences in residential homes were relationship and environment.

The limitations and strength of this study highlight and recommend future research studies, policies and practices to enhance the quality care experience of residential home residents. These are discussed in the following chapter.
CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This study was undertaken to explore the lived experience of person-centred care by residents, family members and frontline caregivers of residential homes from New Zealand and Singapore. This final chapter draws on the findings from this study to highlight the wider implications for future research and for policy and practice.

6.2 SUMMARY AND CONCLUSION

The lifeworld-hermeneutic phenomenological approach was adopted to study the participants’ lived experience of person-centred care. The themes ‘homelike’, ‘maintaining and developing connections’ and ‘workplace culture’ emerged from the findings, and from these three broad themes, it was concluded that person-centred care for the participants was a unique individual or ‘being’ experience. However, there were both commonalities and differences among the participants’ experiences from both countries. The four concepts: being in relation, being in social world, being in place, and being with self helped to explore and interpret the findings within the lifeworld dimensions and person-centred care philosophy.

A significant finding that emerged from this study was the limited attention within the research world to the role of frontline caregivers and their contribution towards person-centred care in a long-term care setting. Most studies on person-centred care in residential homes have focused on residents living with dementia. There are very few studies that include cognitively intact residents’ perspectives on person-centred care. Some extend the study to nurses, and, in some instances, family members’ perspectives were sought. The majority of the studies used qualitative methods to study the experience of person-centred care; however, very few used a phenomenological approach to study the participants’ person-centred care experience. Consequently, there are very few empirical research studies that focused on frontline caregivers’ perspectives of person-centred care, who had regular contact with the residents and family members, and performed direct care tasks.

Second, this study highlights divergences in the perception of person-centred care from the residents, family members and frontline caregivers. The broad theme of
‘homelike’ emerged as person-centred care. Home was more than a physical space for the residents; it was conceptualised as an extension of, and an integral part of their identity, allowing for confirmation of self-worth and the continuation of growth. The home gave a base for the older person to envision possibilities, preserve hope and experience person-centred care. Important aspects of ‘homelike’ or person-centred care were linked to relationships with family, staff and peers. Both the residents and family members wanted to maintain their relationships and recognised that it was vital to form new relationships with the frontline caregivers who performed most care needs for the residents. The residents and family members felt that quality care was associated with the interpersonal relationship they had with the frontline caregivers. The caring conversation and meaningful relationships showed connectedness and a sense of control, especially at a time when they were struggling with chaos. It was emphasised that skilled communication and positive attitude was essential for frontline caregivers in order to engage in meaningful communication. There was also evidence that frontline caregivers associated person-centred care as performing the routine and technical tasks. Their priority was to complete their routine tasks on time. This approach did not fit within the person-centred approach; rather the care was seen as task-driven instead of resident and family-driven. However, these findings do suggest a need to know more about the challenges faced by frontline caregivers and how challenges can be overcome within the work culture of a residential home setting to improve the quality of care and life for the residents and their family members.

Third, the residents' and family members' perspectives of person-centred care were focused on personalised and consistent care. It was obvious that their focus was on the growth and development of the resident, an outcome of the person-centred care approach. However, the findings suggest that the contextual challenges caused barriers to achieve this outcome. Challenges such as learning culture, work culture and physical environment were cited as common causes to affect person-centred care practice. Both residents and family members emphasised that food and activities were two critical aspects of residents’ ‘homelike’ quality care events. More emphasis was needed to make these activities person-centred. Food played an important part in the residents’ daily life; however, often their food preferences were overlooked or they were poorly prepared. The frontline caregivers could enhance the residents' dining experience by not disrupting the residents’ sitting arrangements and
by limiting the noise level caused by staff and equipment. Activities have to be meaningful and meet the preferences of residents. Individualising activities to meet residents’ preferences could benefit them and enhance their sense of freedom. Most residents preferred the outdoor activities, but were unhappy that the frequency was reduced due to the limitation of resources.

Fourth, a challenge for effective practice of person-centred care was the basic assumptions of person-centred care held by frontline caregivers. It involved their beliefs and interpretation of beliefs – values and emotions that have been understood as truth and are unconsciously demonstrated in practice. The espoused values of person-centred care did not match the behaviours of real practice. This was justified by the theme ‘good care’ that emerged from the frontline caregivers. The demanding nature of the job and lack of relevant training did not support reflective practice, so they took for granted that their care work was associated with person-centredness. The lived experience of person-centred care highlights that caring relationships require the opportunity to negotiate and clarify the values and beliefs of the residents, family members and frontline caregivers. The disclosure of values could help the stakeholders to understand the particular views of each other and the importance of operationalising those preferences. The respect for others’ values and beliefs creates a context to support person-centred care. The residents’ and family members’ satisfaction of care was increased when their preferences and values were considered. Biography was recommended by family members as a mode to identify and communicate the values of the residents to the frontline caregivers. This is supported as a tool to enhance person-centred care.

Fifth, the frontline caregivers required more support to balance their competing values: person-centred care values versus organisational values. A context of learning culture for effective implementation of person-centred care was vital. The current model of training for frontline caregivers showed that they were not engaged with the principles of person-centred care and as such they could not operationalise it into practice. A positive learning culture would recognise and overcome individual, group and organisational barriers to an effective person-centred culture. A supportive learning culture ensures commitment, a tolerance of productive tensions, an ability to learn from mistakes and enable innovation. The work culture should facilitate the delivery of person-centred care, where the concept should drive the routine work of
the staff. This would support teamwork and flexibility in care, which will result in greater satisfaction for staff and residents.

Sixth, the study is a significant advance over prior work in this area of interest. The data collected from both countries suggests that the participants had moments of person-centred care experiences; however, it was a challenge to sustain it as a culture in both the residential homes in New Zealand and Singapore. It was clear that though the written values of the organisation showed person-centred values, it was a challenge to operationalise it. The medical model of care tends to dominate the residential home care practice and system. Good quality care residential homes are homes that personalise care for the service user by putting their preferences first so that they can exercise more choice and control over their own care. The care practices should ensure residents’ needs are met in ways they choose, and not according to how staff believe things should be achieved. Once the staff recognise the importance of valuing the life history of the residents, they will then be able to see the unique individual and value their choices. This enables the staff to recognise the distinct nature of the resident and not just one of many in an institutional setting. This approach helps staff to take perceived complex issues and make them appear easy.

Seventh, another issue highlighted that affects person-centred care culture is inadequate staffing. Staff were literally fighting for time to complete their task, while residents felt that they were rushed and family members felt they were being avoided. Moreover, the inconsistent staffing affected the consistent care pattern and caused distress to residents and family members. Person-centred care practice emphasises consistent staffing and establishing rapport with service users, which is lacking in real practice. The frontline caregivers suggested enhancing their image by training, recognition and a better pay scale, which would attract and retain committed staff to the job. This will contribute to higher job satisfaction and staff wellbeing as well as the wellbeing of residents.

Eighth, the lifeworld-hermeneutic phenomenology perspective highlights that the residents who described themselves as at home seem to be engaged in an optimistic view of their existence, which gave a frame of reference to explore possibilities within their current residential home context. Those who described themselves as not at home seem preoccupied with their loss and were unable to experience their world in
a positive way. They made few friends and did not trust others, spent much time immersed in regret, and showed a state of despair. Much of their psychic energy was devoted to lamenting their loss of home and attempting to formulate solutions to their unhappy situations. There was no potential for growth for these individuals who seemed to be immobilised with unhappiness. Many realised that due to ill health, they had no choice but to make adjustments to their new environment. However, it was a challenge for many older residents.

Ninth, a resident’s conceptualisation of home was an extension, and integral part, of their identity. It was emphasised that the care provided by the frontline caregivers directly and indirectly supported the residents and family members to retain or to regain a sense of home that confirmed the residents’ self-worth. It was evident that the residents’ unique structuring of their reality was based upon their life events that dictated a sense of ‘homelike’ or ‘not homelike’. It was this reality that had to be recognised and provided for when attempting to assist individuals to become at home. While assisting the residents to accept their residential home as a home was frequently found in the care plans of residents of long-term care facilities, specific interventions to address the accomplishment of this goal were lacking. Appreciating the older residents within a person-centred framework would allow the staff to recognise the residents as individuals with potential. The optimistic outlook is a worthwhile approach rather than the more traditional frameworks that have been used in relation to group-based care that reduces mental and physical acuity of the residents and distances the staff from the residents.

Tenth, the study has shown that there is a relationship in all human events that influences the process of change and integration within one’s life. The findings of this study show that the previous life events and personality of the person have a tremendous influence on how one adjusts and accepts the transition to a residential home environment. Staff of the residential home have to see the person in totality, considering their past, present and future. It would be a serious mistake to believe that, because some do, all older dependent persons adjust to long-term care facilities in time. Residents who do not have a sense of home experience were denied self-actualisation or exuberant wellbeing. Staff have a key role in creating the ‘homelike’ experience for residents and family members by recognising each person as an individual within their personal context and customising the care activities to suit the
needs of the resident. Once the individual needs are recognised then that could illuminate what is important in an environment for each person to ensure care activities are congruent and person-centred. The challenge faced by many frontline caregivers was their capability and competence to assess the residents in terms of their individual frames of reference or goals of life.

Eleventh, Van Manen’s lifeworld dimensions provided a holistic context to study the lived experience of the residential home participants’ meaning of person-centred care. The experience was studied in relation to time, space, body and relationality to make sense of the lived meaning. The approach gave the researcher an opportunity to imagine the participants’ lifeworld. Lifeworld-hermeneutic phenomenology helped to understand the subjective world of the participants and delve deeply into the meaning that they gave to their experience of care, while keeping in mind that all understanding was ultimately interpretative and hermeneutic. The meanings and themes emerged after a process of co-creation between the researcher and participants, in which the very production of meaning and themes occurred through a circle of readings, reflective writing and interpretations. Through this process, the search was toward understanding the participants’ lived experience of person-centred care from lifeworld philosophical perspectives.

Twelfth, it was clear that the meanings and understanding of the participants’ everyday care experience were bound by context; this study is exclusive to one residential home each in New Zealand and Singapore with a small number of participants, and therefore it cannot be generalised to other population groups. As suggested by Van Manen, the current hermeneutic phenomenological study did not yield absolute truth but provided a glimpse of the meaning of participants’ personal experience of person-centred care. Van Manen’s lifeworld-hermeneutic phenomenology provided the philosophical underpinnings to fully understand the contextual, complex life of the residential home residents’ care experiences, including the family members and frontline caregivers who had direct involvement in the care of the residents. This study presents interpretations of the residents, family members and frontline caregivers as well as the researcher’s own experiences working with aged people, their family members and staff of residential homes.
Thirteenth, hermeneutics allows for an additional layer of abstraction and interpretation through the lens of the researcher to make meaning of the phenomenon in a way that is credible and maintains faithfulness to the participants and their interpretations. Using the hermeneutic paradigm enabled understanding of the research phenomenon within the context of the participants’ experiences. The researcher ensured rigour of the study by adopting a reflective attitude, and having ongoing conversations about personal bias and prejudices throughout construction of interpretation and writing. In addition to adding to the body of knowledge concerned with lived experience of person-centred care in residential homes, this research approach, through its reflexive nature, enabled the researcher to engage in her own learning journey towards a deeper understanding of the phenomenon being researched and the methodology adopted.

Fourteenth, engaging with the participants of residential homes during this research study has enabled the researcher to reflect on her own experiences as a gerontological and clinical nurse and educator. The researcher’s understanding of the phenomenon was influenced and shaped by the chats and exchanges that took place throughout this study, which gave a common language and meaning between the researcher and participants. Meanings that were unnoticed and unacknowledged as an important source for person-centred care have been recognised as critical factors for the practice of person-centred care.

In summary, the findings suggest that individuals create their own experience of being at home based upon previously established patterns that have characterised their life histories. Different themes assume varying degrees of importance unique to the person. When relocation of home becomes necessary, individuals seek continuity of life by maintaining relationships with family. Family members wish to maintain their responsibility and be part of the residents’ life in the residential home. It is concluded that the experience of ‘homelike’ is an individualised phenomenon, although some commonalities exist. It was found that in the residential home context, learning culture, work culture and physical environment have significant impacts with the acceptance of the environment as home; the interpersonal relationship with the frontline caregivers was a key determinant that contributed to a sense of ‘homelike’ in the residential home.
The themes that emerged from residents and family members justified that person-centred care was about individualised care; the residents wished to be respected and empowered, and not to be ignored or belittled. This study recognises that the frontline caregivers have to be prudent and not simply conform to the culture of time and task, but to recognise the rich and varied past of residents. Also, that caregivers have an awareness of how residents experience time, space, body and relationship, not solely in old age, but especially as it is experienced after their admission to residential homes.

It is evident that much work remains to be done in ensuring ‘homelike’ or person-centred care in residential homes, where bestowing the personhood of the residents has to be the focus. The management, staff, and even policy makers have a role to play to affect person-centred care practice in residential homes. The mind-set of a residential home as a place to die has to be replaced with the idea and understanding that it is a place to live and live well. The vision of person-centred care has to be articulated and translated into practice; this will enable staff to be more informed and inspired to generate a culture of person-centred care.

6.3 RECOMMENDATIONS
The aim of this study is to understand the lived experience of person-centred care in residential homes in New Zealand and Singapore from the perspective of residents, family members and frontline caregivers. A number of recommendations have emerged from the findings. Firstly, specific research recommendations are shared to fill gaps in current knowledge. Secondly, recommendations for policy and practice are discussed, which could both aid the practice of person-centred care and further add to knowledge on this subject.

6.3.1 RESEARCH RECOMMENDATIONS
From the above themes, four specific areas for future research were formulated to enhance the person-centred care practice in residential homes.

First, a study should be taken to explore the specific roles of frontline workers and the requirements of them by residents and family members. The views of all three groups could provide an alternative and more focused approach to the previous system and the service-based approach that has dominated research. This will help
them to articulate their views and make them more explicit. Further, what one believes ought to be done, and what one understands to be true can be clarified. This approach could specifically attempt to draw together the shared and diverging views of those who deliver and use the service.

Second, a study of frontline caregivers to explore their motivations, satisfactions and frustrations in their role will indicate the challenges faced by frontline caregivers to deliver person-centred care. It could also investigate the diversity of frontline caregivers, relating to age, education, and ethnicity.

Third, research is required to gather a wider perspective of person-centred care by residential home residents by performing broader and more detailed coverage of contextual influence on person-centred care experience. This information will offer greater knowledge to understand the complexities of contextual issues and recognise the gaps in the current provision of care.

Lastly, a study aimed to understand how the management can translate person-centred care philosophy into practice. This could offer insights into the complex process of communication, training, funding and resources that support person-centred care practice.

6.3.2 POLICY AND PRACTICE RECOMMENDATIONS

Despite differences in financing and organisation, both New Zealand and Singapore face similar challenges in meeting the long-term care needs of an ageing population. The mind set of policy makers is that long-term care requires a relatively low level of skills; as such the workforce mainly consists of unskilled foreign workers coupled with retired older people and volunteers. This brings about the importance of understanding the different ethnic cultural practices, beliefs and their unique needs. Therefore, long-term care both in New Zealand and Singapore will need to re-evaluate their model of care, which is heavily focused on providing basic care to the older person, and move towards providing more person-centred care. It is necessary to give importance to the residents’ needs, their family structure, living arrangements, religion, language, and diet (WHO, 2007). The key theme is providing culturally appropriate service to all ethnic groups, a vision that is in-line with the World Health Organisation (2007).
Issues about skill mix exist in residential homes throughout the world, where nurses’ hours are replaced with caregivers, nurse aides, or health care assistants. However, nurses hold responsible decision-making roles in residential homes. Thus, they have a critical role to facilitate the training and competence of the frontline caregivers to support a person-centred care culture.

Nurses have to pay attention to the transition experience of the residents and explore ways to make it feel more ‘homelike’ for the residents. They should plan an orientation program for residents and family members to familiarise them with the environment and culture of practice. They can introduce like-minded residents to buddy with the new residents in order to alleviate their fears; this will help the residents to transition well and adapt to the new environment easily. One condition for providing person-centred individualised care is that nurses try to understand what previous meaningful experiences older people have had. Listening with openness and respect to what older persons narrate therefore constitutes an important starting point in the care of older people when moving into a residential home.

Nurses are in a key position to facilitate relationships between residents, family members and frontline caregivers. Creating opportunities to bring the three groups of people together will help to improve an understanding of differences and commonalities among them, which will create an opportunity to seek common goals towards person-centred care needs. This will create an opportunity to articulate and clarify personal beliefs and values and provide a better understanding of the residents’ past, present and future goals. Nurses should recognise family members’ contributions and form partnerships to enhance residents’ person-centred care experience. They need to recognise that family members wish to play a vital role and maintain their responsibility for monitoring the care for their loved ones.

Nurses should support frontline caregivers to adopt flexibility and teamwork in delivery of care in order to overcome the task-focused care. Implementing strategies to integrate residents’ and family members’ preferences into the daily care activities of frontline caregivers, such as regular staffing and personal charts to communicate residents’ preferences, will enhance the person-centred care experience.
Nursing leaders should facilitate teamwork among frontline caregivers and create more opportunities for innovation among the team by engaging frontline caregivers during handovers and involve them in the decision-making process. The care needs of the residents can change from day to day, which requires planning and ensuring the needs are being communicated to staff clearly and in advance. This will enable the frontline caregivers to anticipate residents’ needs, which will eventually result in staff satisfaction as well as satisfaction of residents.

Nurse leaders should plan training activities to enhance the competence of frontline caregivers, in terms of knowledge and attitude instead of focusing only on technical skills. Person-centred care focuses on relationships, which indicates that interpersonal skills are important for staff so that they can engage in authentic humanistic caring practices that focus on personhood. The impact of poor interpersonal communication can be profound and often increases the vulnerability experienced by the residents. The training provides relevant knowledge and skills for frontline caregivers to confidently prioritise the care activities to suit the needs of the residents. Training also empowers the staff who can then confidently engage with the residents and family members. This will lead to an increase in motivation and staff retention.

Policies should advise on creating an environment that avoids cohabitation of cognitively intact and impaired residents; this impacted on residents’ social interaction, distress due to inappropriate behaviours, and limited freedom due to safety issues. A closer look into the needs of the two different groups and catering to their specific needs will further enhance the person-centred experience of these two groups of residents.

Regulatory policies and nurse leaders should include the voice of residents, family members and frontline caregivers in order to add quality to current accreditation standards of residential homes. The voices will provide evidence of whether the current care activities and contextual issues pose any concerns to person-centred care experiences. Nurses must not only provide reliable support, resources and serve as advocates, but also pay more attention to the environment of the residential home to make it feel more like home.
6.4 SUMMARY

Person-centred care in a residential home is not just about keeping the residents clean and helping with their daily needs but also being attentive to the personhood of the residents, family members and frontline caregivers. Each individual is characterised by their own personal values and beliefs, and the residential home also has deep rooted structures and conventions that influence how the care is experienced by the service providers and users.
REFERENCES


Park, M. (2010). Nursing staff stress from caregiving and attitudes toward family members of nursing home residents with dementia in Korea. *Asian Nursing Research, 4*(3), 130-141.


Wiklund-Gustin, L. (2011). To intend to but not being able to frequent attenders’ experiences of suffering and of their encounter with the health care system. *Journal of Holistic Nursing, 29*(3), 211-220.


APPENDIX A.1 – INTERVIEW QUESTIONS RELATED TO VAN MANEN’S LIFEWORLD
<table>
<thead>
<tr>
<th>Interview Questions Related To Van Manen’s Lifeworld</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spatiality</strong></td>
</tr>
<tr>
<td><strong>Resident</strong></td>
</tr>
<tr>
<td>What was it like when you first came in here?</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
</tr>
<tr>
<td>What do you think was it like when the residents came in here?</td>
</tr>
<tr>
<td><strong>Family</strong></td>
</tr>
<tr>
<td>What do you think was it like when your family member came in here?</td>
</tr>
<tr>
<td><strong>Resident</strong></td>
</tr>
<tr>
<td>What do you like or dislike about living in this environment?</td>
</tr>
<tr>
<td>Interview Questions Related To Van Manen's Lifeworld</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Spatiality</strong></td>
</tr>
<tr>
<td><strong>Caregivers</strong></td>
</tr>
<tr>
<td>What do you think the residents like or dislike about living in this environment?</td>
</tr>
<tr>
<td><strong>Family</strong></td>
</tr>
<tr>
<td>What do you think your loved one or other residents like or dislike about living in this environment?</td>
</tr>
<tr>
<td><strong>Resident</strong></td>
</tr>
<tr>
<td>Does the environment promoted your sense of being?</td>
</tr>
<tr>
<td>Prompts: living space, sense of lostness, strangeness, vulnerable, excited and stimulated</td>
</tr>
<tr>
<td><strong>Caregivers</strong></td>
</tr>
<tr>
<td>Do you think that the environment promotes the residents sense of being?</td>
</tr>
<tr>
<td>Prompts: living space, sense of lostness, strangeness, vulnerable, excited and stimulated</td>
</tr>
<tr>
<td>Interview Questions Related To Van Manen’s Lifeworld</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Spaciality</strong></td>
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<tr>
<td>Do you think that the environment promotes the residents sense of being?</td>
</tr>
<tr>
<td><strong>Family</strong></td>
</tr>
<tr>
<td><strong>Caregivers</strong></td>
</tr>
<tr>
<td><strong>Family</strong></td>
</tr>
</tbody>
</table>

Prompts: living space, sense of lostness, strangeness, vulnerable, excited and stimulated
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<thead>
<tr>
<th>Spatiality</th>
<th>Temporality</th>
<th>Relationality</th>
<th>Corporeality</th>
</tr>
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<tbody>
<tr>
<td><strong>Resident</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel protected and free to do what you want?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| | | | |
| **Carers** | | | |
| Do you think that the residents feel protected and free to do what they want? | | | |

| | | | |
| **Family** | | | |
| Do you think that the residents here feel protected and free to do what they want? | Is there opportunity for the caregivers to spend time with you and listen to your concerns? | | |
| Do you have any recommendation to improve the care and quality of life for your loved one? | | | |
APPENDIX A.2 – INTERVIEW QUESTIONNAIRE


Warm up
Welcome and introduction to project, housekeeping, expense forms, confidentiality, anonymity, consent forms.

Tape on
• Introductions.
• Start of interview.

Person-centred care
• What does the term ‘person-centred’ care mean to you?
• What does good-quality care mean to you?
• As a service user, what do you want from caring situations – is this different from things you have identified above?
  Prompts include: choice, independence, flexibility, reliability, familiarity, friendship (relationships).
• What currently helps the frontline caregiver staff to achieve good-quality care?
• What stands in the way of you receiving good-quality care?
  Prompts include: management, training, resources, skills, personal qualities.
• What needs to change to improve care for you?

Qualities of frontline workers
• What do you think are good characteristics of frontline workers?
• What qualities do you think frontline staff bring to their job (strengths)?
  Prompts around: gender, age and ethnicity. Prompts around: personal qualities, e.g. good listening, patience, practical skills.
• What do you think contributes to job satisfaction for the frontline staff?

How job is valued by others
• How do you think the job of frontline staff is seen by other people?
  Prompt distinction between: society generally, other organisations/professions, your organisations and management, carers, service users.

Challenges of working effectively with families
• What is your experience of working with frontline health care staff?
• What type of relationship do you have with frontline health care staff?
• Have you experienced difficulties when working with frontline health care staff?
Prompt on specific issues around: frontline health care staff working with minority ethnic communities and potential conflicts in wishes of frontline health care staff and residents.

Management, training and recruitment
How much emphasis does the organisation places on the following issues:
- Training
- Formal supervision
- Relationships with managers
- Resources

What is the level of staff turnover in the organisation?
- Reasons for leaving?
- Recruitment issues?
- Levels of staff absence?

Cool down
- Any final issues wish to raise before session ends?
- Thanks for participating.
- I will be around to take any questions you might have after tape goes
APPENDIX B – DEMOGRAPHIC TABLES
### Profile of Participants (Residents)

<table>
<thead>
<tr>
<th>S/No</th>
<th>Residents</th>
<th>Gender</th>
<th>Age</th>
<th>Occupation</th>
<th>Condition</th>
<th>Ethnic</th>
<th>Yrs of admission</th>
<th>Mobility status</th>
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<tr>
<td>1</td>
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<td>Female</td>
<td>92</td>
<td>Journalist</td>
<td>Heart disorder</td>
<td>NZ European</td>
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<tr>
<td>2</td>
<td>R2</td>
<td>Male</td>
<td>85</td>
<td>Postman</td>
<td>Hip Fracture &amp; Stroke</td>
<td>NZ European</td>
<td>7 months</td>
<td>Wheelchair</td>
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<tr>
<td>3</td>
<td>R3</td>
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<td>85</td>
<td>Tradesman</td>
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<td>NZ European</td>
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<td>86</td>
<td>Nurse</td>
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<td>NZ European</td>
<td>7 years</td>
<td>Wheelchair</td>
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<td>R5</td>
<td>Female</td>
<td>70</td>
<td>Gardener</td>
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<td>NZ European</td>
<td>4 years</td>
<td>Walking Frame</td>
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<td>R6</td>
<td>Female</td>
<td>79</td>
<td>Nurse</td>
<td>CVA</td>
<td>NZ European</td>
<td>5 years</td>
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<td>90</td>
<td>Housewife</td>
<td>Heart disorder &amp; Diabetes</td>
<td>NZ European</td>
<td>9 months</td>
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<td>R8</td>
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<td>80</td>
<td>Housewife</td>
<td>Hip Fracture</td>
<td>NZ European</td>
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<td>Female</td>
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<td>Librarian</td>
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<td>NZ European</td>
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<tr>
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<td>Female</td>
<td>77</td>
<td>Housewife</td>
<td>Cancer stomach</td>
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<td>R11</td>
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<td>89</td>
<td>Teacher</td>
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<td>Policeman</td>
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<td>R1</td>
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<td>89</td>
<td>Helper</td>
<td>Diabetes &amp; Stroke</td>
<td>Chinese</td>
<td>1 year</td>
<td>Wheelchair</td>
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<td>Lawyer</td>
<td>CVA</td>
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<td>85</td>
<td>Housewife</td>
<td>CVA &amp; Fracture leg</td>
<td>Chinese</td>
<td>4 years</td>
<td>Wheelchair</td>
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<tr>
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<td>R5</td>
<td>Female</td>
<td>83</td>
<td>Housewife</td>
<td>Stroke &amp; Blind</td>
<td>Chinese</td>
<td>7 years</td>
<td>Wheelchair</td>
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</table>
## Profile of Participants (Residents)

<table>
<thead>
<tr>
<th>S/No</th>
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<th>Yrs of admission</th>
<th>Mobility status</th>
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<td>Chinese</td>
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<td>Walking frame</td>
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<td>Cleaner</td>
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<td>Eurasian</td>
<td>3 years</td>
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<tr>
<td>24</td>
<td>R9</td>
<td>Female</td>
<td>73</td>
<td>Clerk</td>
<td>Hip fracture</td>
<td>Chinese</td>
<td>2 years</td>
<td>Wheelchair</td>
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<tr>
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<td>R10</td>
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<td>82</td>
<td>Housewife</td>
<td>CVA</td>
<td>Indian</td>
<td>9 months</td>
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<tr>
<td>26</td>
<td>R11</td>
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<td>87</td>
<td>Clerk</td>
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<td>Chinese</td>
<td>8 months</td>
<td>Walking frame</td>
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<tr>
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<td>R12</td>
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<td>CVA</td>
<td>Indian</td>
<td>2 year</td>
<td>Walking frame</td>
</tr>
<tr>
<td>28</td>
<td>R13</td>
<td>Female</td>
<td>79</td>
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<td>Diabetes &amp; Stroke</td>
<td>Chinese</td>
<td>6 years</td>
<td>Wheelchair</td>
</tr>
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<td>29</td>
<td>R14</td>
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<td>75</td>
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<td>Chinese</td>
<td>6 years</td>
<td>Wheelchair</td>
</tr>
<tr>
<td>30</td>
<td>R15</td>
<td>Female</td>
<td>88</td>
<td>Housewife</td>
<td>Stroke</td>
<td>Chinese</td>
<td>3 years</td>
<td>Walking frame</td>
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</table>

Rows 1-15 – represent participants from New Zealand
Rows 16-30 – represent participants from Singapore
CVA – Cerebrovascular Accident
### Profile of Participants (Frontline Caregivers)

<table>
<thead>
<tr>
<th>S/NO</th>
<th>Frontline Caregivers</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Years of Work Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CG 1</td>
<td>Female</td>
<td>55</td>
<td>Pacific Islander</td>
<td>18 years</td>
</tr>
<tr>
<td>2</td>
<td>CG 2</td>
<td>Female</td>
<td>38</td>
<td>Filipino</td>
<td>3 years</td>
</tr>
<tr>
<td>3</td>
<td>CG 3</td>
<td>Female</td>
<td>58</td>
<td>Maori</td>
<td>21 years</td>
</tr>
<tr>
<td>4</td>
<td>CG 4</td>
<td>Female</td>
<td>23</td>
<td>European</td>
<td>1 year</td>
</tr>
<tr>
<td>5</td>
<td>CG 5</td>
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<td>48</td>
<td>Indian</td>
<td>7 years</td>
</tr>
<tr>
<td>6</td>
<td>CG 1</td>
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<td>24</td>
<td>Filipino</td>
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</tr>
<tr>
<td>7</td>
<td>CG 2</td>
<td>Female</td>
<td>23</td>
<td>Filipino</td>
<td>2 years</td>
</tr>
<tr>
<td>8</td>
<td>CG 3</td>
<td>Female</td>
<td>32</td>
<td>Myanmar</td>
<td>8 years</td>
</tr>
<tr>
<td>9</td>
<td>CG 4</td>
<td>Female</td>
<td>27</td>
<td>Myanmar</td>
<td>2 years</td>
</tr>
<tr>
<td>10</td>
<td>CG 5</td>
<td>Female</td>
<td>22</td>
<td>Filipino</td>
<td>2 years</td>
</tr>
</tbody>
</table>

Rows 1-5 represent participants from New Zealand.

Rows 6-10 represent participants from Singapore.

### Profile of Participants (Family Members)

<table>
<thead>
<tr>
<th>S/No</th>
<th>Family Member</th>
<th>Relationship</th>
<th>Age</th>
<th>Ethnic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FM 1</td>
<td>Daughter</td>
<td>59</td>
<td>NZ European</td>
</tr>
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<td>FM 2</td>
<td>Daughter</td>
<td>62</td>
<td>NZ European</td>
</tr>
<tr>
<td>3</td>
<td>FM 3</td>
<td>Daughter</td>
<td>52</td>
<td>NZ European</td>
</tr>
<tr>
<td>4</td>
<td>FM 4</td>
<td>Wife</td>
<td>73</td>
<td>NZ European</td>
</tr>
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<td>5</td>
<td>FM 5</td>
<td>Daughter</td>
<td>69</td>
<td>NZ European</td>
</tr>
<tr>
<td>6</td>
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<td>Son</td>
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<tr>
<td>10</td>
<td>FM 5</td>
<td>Husband</td>
<td>88</td>
<td>Chinese</td>
</tr>
</tbody>
</table>

Rows 1-5 represent participants from New Zealand.

Rows 6-10 represent participants from Singapore.
Dear Dr Whitehead,

I am again writing to you concerning your proposal entitled “Person Centred Care in Long Term Care: The Personal Perspective of Residents, Frontline Caregivers and Family Members”, Ethics Committee reference number 13/116.

Thank you for your letter responding to the Committee, which was received on 30 May 2013. We acknowledge the revisions made to the application document, Information Sheets and Consent Forms which have simplified and clarified the information for your participants.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Could the following minor amendments please be made prior to the documents being provided to participants:

Please ensure the following statement on contacting the Human Ethics Committee is included at the end of your Information Sheet:

“This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.” The current statement is only used for a Category B departmental approval.

A minor typo was noted in the Information Sheet for residents: “Participants do not need an specific knowledge.”

Please note that in the Information Sheets you advise that data will be retained for at least 10 years, however in the Consent Forms you advise that data will be retained for at least five years. Can you please amend the Consent Forms so that they align with the Information Sheets.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

31 May 2013

Dr L Whitehead
Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace, Levels 2 and 3
University of Otago, Christchurch
Yours sincerely,

[Signature]

Mr Gary Witte  
**Manager, Academic Committees**  
Tel: 479 8256  
Email: gary.witte@otago.ac.nz

c.c. Assoc. Prof. L Whitehead  Director  Centre for Postgraduate Nursing Studies (Chch)
APPENDIX D - EMAIL APPROVALS FROM PARTICIPATING NURSING HOMES

Margaret Pearce <margaretp@psotago.org.nz>  
4/30/13 to me

Sara

I have reviewed your application and discussed with the senior staff and I am happy to support you undertaking research at Ross Home. I am out of the office from today until next week.

I suggest you let me know when you would like to start the research etc and then we could arrange to meet.

regards

-------- Original message --------
From: Jonathan Jk
Date: 11/01/2015 23:02 (GMT+08:00)
To: meera vathy
Subject: Re: support for PhD study

Dear Sara

We are keen to support the study; however, as it's involved our staff, the residents and family members whom she required to acquire their individual consent.

We will require the school's introductory letter, your CV and undertaking that no personal confidential and institution information should be published.

Looking forward to hearing from you.

Thank you and regards

Jonathan Koh
APPENDIX E - APPLICATION FORM FOR ETHICAL CONSIDERATION OF RESEARCH AND TEACHING PROPOSALS INVOLVING HUMAN PARTICIPANTS

Reference Number: 13/116
Date: 25 March 2013

Person-Centred Care in Long Term Care:
The personal perspective of residents, frontline caregiving staff and family members

INFORMATION SHEET FOR LONGTERM CARE RESIDENTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

Person-centred care is a key concept guiding efforts to improve long-term care, e.g. rest homes or nursing homes. Elements of person-centred care include knowing the person, maximizing choice and autonomy, nurturing relationships, and a supportive environment. Person-centred care fosters the residents to have greater choice and control of their needs that improves quality of life. The Older residents are able to live in an environment of trust and respect.

Further, person-centred care allows the staff of long-term area to develop strong partnership with older residents and their families. Last but not least, staff is able to know the older residents’ preferences, and anticipate the residents’ needs and adapt accordingly.

The aim of this study is to gain a deeper understanding of older people’s own views on person-centred care while dependent on long term care and evaluate the frontline caregiving staff and family members’ perception of person-centred care nursing. Data will be collected in New Zealand and Singapore.

This project is being undertaken as part of the requirements for a PhD in Nursing at the University of Otago. Participants will be invited to take part in a face-to face interview with the researcher at their rest homes or nursing homes. Questions for this interview are listed in Appendix 1. I am looking to interview residents who are 60 years old and above and who are able to conduct the interview in English. Participants do not need any specific knowledge to participate. The interview will take no longer than one hour and will be audio-recorded after receiving the participant’s permission.

The data collected from the resident, frontline caregivers and family members will be compared to identify similarities and differences related to perception on person-centred care.
These findings provide baseline data and information for the development of individualised nursing care from residents’ point of view facilitating ideas for further development of individualised care in long term care settings.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for at least 10 years in secure storage. The personal information held on the participants such as contact details, audio tapes, will be destroyed at the completion of the research.

The names of the participating organisations and the participants will be kept anonymous. You will be given the opportunity to view the data during the interview and once the research is completed. You will be given opportunity to alter or correct information before the data analysis occurs.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

If you have any questions about our project, either now or in the future, please feel free to contact either:

Sarathambal S and/or A Prof Lisa Whitehead
Centre for Post Graduate Nursing Studies
Email: Sarathambal8@gmail.com Email: lisa.whitehead@otago.ac.nz

Contact number: (64)02102330271 (New Zealand) (65)90668430 (Singapore)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information e.g. audio tapes will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least ten years;

4. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve participant’s anonymity.

I agree to take part in this project.

............................................................. .....................
(Signature of participant) (Date)

Please provide a phone number that I can contact you on to discuss further.

Name: ____________________________________
Contact no: _______________________________
### APPENDIX F – THEMES ALIGN WITH McCORMACK’S PERSON-CENTRED CONCEPT FOR DISCUSSION

<table>
<thead>
<tr>
<th>Chapter 4 RESULTS</th>
<th>Chapter 5 DISCUSSION</th>
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<td><strong>Themes</strong></td>
<td><strong>Sub Themes</strong></td>
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<td>Adjust to loss-influence by family support</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Living in a new environment</td>
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<tr>
<td></td>
<td>Living with others</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eating with others</td>
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</tr>
<tr>
<td></td>
<td>Adapting to waiting &amp; rushing</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining</td>
<td>Family relationship</td>
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<tr>
<td>connection</td>
<td>Nurturing relationship</td>
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<td>Interpersonal relationship</td>
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<td>Outside world connection</td>
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</tr>
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<td></td>
<td>Morale of staff</td>
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