UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

EXPLORING THE FACTORS THAT INFLUENCED RESIDENTS WITH MINIMAL CARE NEEDS TO ENTER AND SETTLE INTO A CARE HOME WITH REGISTERED NURSES.

By

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Doctorate in Clinical Practice

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Abstract

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ABSTRACT

Faculty of Health Sciences

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EXPLORING THE FACTORS THAT INFLUENCED RESIDENTS WITH MINIMAL CARE NEEDS TO ENTER AND SETTLE INTO A CARE HOME WITH REGISTERED NURSES.

by Alice Kay Stevens

This grounded theory study explored the influences that surrounded decision making for people with a minimal requirement for care, who entered a care home with registered nurses (RN's) when their needs could be met in an alternative environment. The study was undertaken in a geographical area in England, which has in excess of 3,500 care home beds staffed with RNs. In May 2011, there were reported to be 183 residents with minimal care needs, resident in a care home with RNs. The study utilized a grounded theory methodology as described by Glaser and Strauss with influences from Charmaz. The initial sampling was purposive progressing to theoretical. Interviews were conducted with twelve care home residents responsible for funding their own care home fees, assessed as not requiring care by RNs.

Data analysis was in accordance with the principles of grounded theory and identified two main categories. The first category, entitled "choosing the path" focused on the decision making process which described a perceived paucity of help and support received by participants and their families in identifying and exploring the available options. The second category termed "settling in" related to the process of adaptation to the new environment. It appeared that participants with greater control over the decision making process found it easier to settle into the home, conversely those with the least control found it more difficult to adapt. These two categories linked to form the emerging theory of "crossing the bridge" from independent living to becoming a care home resident.

It is important health and social care practitioners use appropriate evidence based knowledge when assisting older people and their families to consider available options. The findings of the study add to the body of evidence concerning the factors that influence people when considering their future care and the importance of informed decision-making.

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Declaration

Academic Thesis: Declaration Of Authorship

I, ………**Alice Kay Stevens**…………………………………………………………………

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Exploring the factors that influenced residents with minimal care needs to enter and settle into a care home with Registered Nurses.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

Declaration

7. Either none of this work has been published before submission, or parts of this work have been published as: [please list references below]:

Signed: ……………………………………………………………………………………

Date: …30 April 2012……………………………………………………………

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Special thanks go to my supervisors; Sue Green who supported me throughout this long journey and without her tireless input, support and belief, it is unlikely this study would have been completed. Kathy Getliffe, who inspired me to take on this challenge and helped steer me in the right direction, Janice Brown whose tragic premature death ended our relationship and Magi Sque who stepped in and helped me get back on course. Lastly, to Helen Raphael for her willingness to take on the supervisory role in the last months of the study. Her enthusiasm and knowledge of grounded theory were invaluable. They all contributed to the shaping of this study and I am forever in their debt.

Throughout the period, I juggled work as well as undertaking the Doctorate of Clinical Practice. All too often the pressures of work frustrated my attempts to complete the study, which served to make this journey longer that it should have been.

I would also like to thank Caroline Ainsworth my friend, colleague and manager who recognised my potential to undertake this study and to Cynthia Dwyer who encouraged me in numerous ways during her time as my manager. They both realised how important this was for me and whilst they were not able to reduce my workload, they were both very supportive.

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Glossary and Abbreviations

Care quality commission (CQC)

This body regulates health and adult social care services in England, whether provided by the NHS, local authorities, private companies or voluntary organisations. The CQC ensures essential common quality standards are met where care is provided and works towards the improvement of care services. The CQC promotes the rights and interests of people who use services with a wide range of enforcement powers to take action if services are unacceptably poor.

CQC brings together independent regulation of health, mental health and adult social care. Before 1 April 2009, this work was carried out by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. These organisations have been superseded.

Memorandum (Memo)

Memos are considered by Glaser and Strauss as a key tool in grounded theory generated throughout the process to document aspects of the study. "The abbreviated word "Memo" is used instead of the full word memoranda in accordance with their use of the term.

National Health Service Continuing Healthcare (NHS CHC)

NHS Continuing Healthcare indicates a package of continuing care (ongoing care) arranged and funded solely by the NHS. Eligibility for full health funding is based on establishing a primary health need (DH 2009).

Since 2007, the Department of Health (DH) directed PCTs to screen all individuals as to their eligibility for NHS CHC.

National Health Service, Funded Nursing Care (FNC)

If an individual does not qualify for NHS Continuing Healthcare and enters a care home that provides care by RNs, they may be eligible for NHS FNC to contribute towards the RN aspect of their care.

FNC, introduced in October 2001, is a financial contribution provided by the NHS for people requiring care by RNs and living in a care home with RNs. If the individual has need for care by RNs and it is determined that the individual’s overall needs would be most appropriately met in a care home with RNs, then they would be entitled for NHS funded nursing care (FNC). Once the need for such care is agreed, Primary Care Trusts are responsible for paying a flat rate contribution to the care home towards RN care costs.

In 2001, there were three levels of contributions dependent on the level of need. (DH 2001)

Low Band-“The low band of need for nursing care will apply to people who are self funding whose care needs can be met with minimal registered nurse input. Assessment will indicate that their needs could normally be met in another setting (such as at home, or in a care home that does not provide nursing care, with support from the district nurse), but they have chosen to place themselves in a nursing home.”

Medium Band-“People whose needs for registered nursing care are judged to be in the medium banding may have multiple care needs. They will require the intervention of a registered nurse on at least a daily basis and my need access to a nurse at any time. However, their condition (including physical, behavioral and psychosocial needs) is stable and predictable, and likely to remain so if treatment and care regimes continue.”

High Band-“People with high needs for registered nursing care will have complex needs that require frequent mechanical, technical and/or therapeutic interventions. They will need frequent interventions and re-assessment by a registered nurse throughout a 24 hour period and their physical/mental state will be unstable and/or unpredictable”.

In 2007, the Department of Health amalgamated the Low Band to a single contribution entitled Funded Nursing Care (FNC). Recipients of the High Band remained to entitled to the higher level of contribution until such time as their needs changed. (DH 2007)

Nursing Care

For Funded Nursing Care purposes, the Department of Health (DH) has defined nursing care as:

> "*services provided by Registered Nurses (RNs) and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse*”(DH2009, p4).

This definition does not include any time spent by non-nursing staff such as care assistants (although it does cover the time spent by the RNs in monitoring or supervising care delegated to others).

Older Adults

The term older adults are used throughout the study to denote people post retirement age.

Primary Care Trust (PCT)

PCTs are the lead NHS organisation responsible for assessing need, planning and securing all health services and improving health for the local population. PCT's are required to work with a range of partners including local authorities, NHS Trusts, Strategic Health Authorities, other PCTs and local communities.

Self Funder

A self funder is classified as someone who as a result of a local authority assessment is deemed to be responsible for paying for their own care due their having resources above a certain amount called the "capital threshold".

Glossary and Abbreviations

Chapter 1: Introduction

1.1 Introduction

Why do people with a minimal need for care enter a care home with Registered Nurses (RNs)? This research study explores through the experiences of older care home residents the reasons for admission to a care home with RNs when care provided by RNs was not clinically indicated.

This research used a grounded theory approach, aimed at developing substantive theory, to understand participant decision making related to the decision to enter and remain in a care home with RNs. The findings of the study will add to the body of evidence related to factors that influence people when considering long term care and the importance of informed decision-making. It is important that health and social care professionals use evidence based knowledge to support older adults and their families. The study will also assist professionals involved in commissioning long term care provision to understand the importance of offering a range of options designed to suit differing needs.

The glossary on Page ix provides definitions and explanations of the terms used in the study, however two key concepts concerning classification of residential care crucial to the study design are considered below. The Care Quality Commission (CQC), who classifies care homes as with or without RN's, regulates residential care in the United Kingdom (UK). The more familiar terms in use are residential home (care home without RN's) and nursing home (care home with RNs). For the purposes of this study the terms care homes with and without RNs will be utilized.

1.2 Growth in numbers of older adults

In 2008, there were 1.3 million people in the UK aged 85 years and over, and this figure is projected to increase to 1.8 million by 2018 and to 3.3 million by 2033, more than doubling over twenty-five years (Statistical Bulletin 2008).

Figure 1.1 shows diagrammatically the projected increase in the UK population and highlights the significant growth in older adults detailed above.

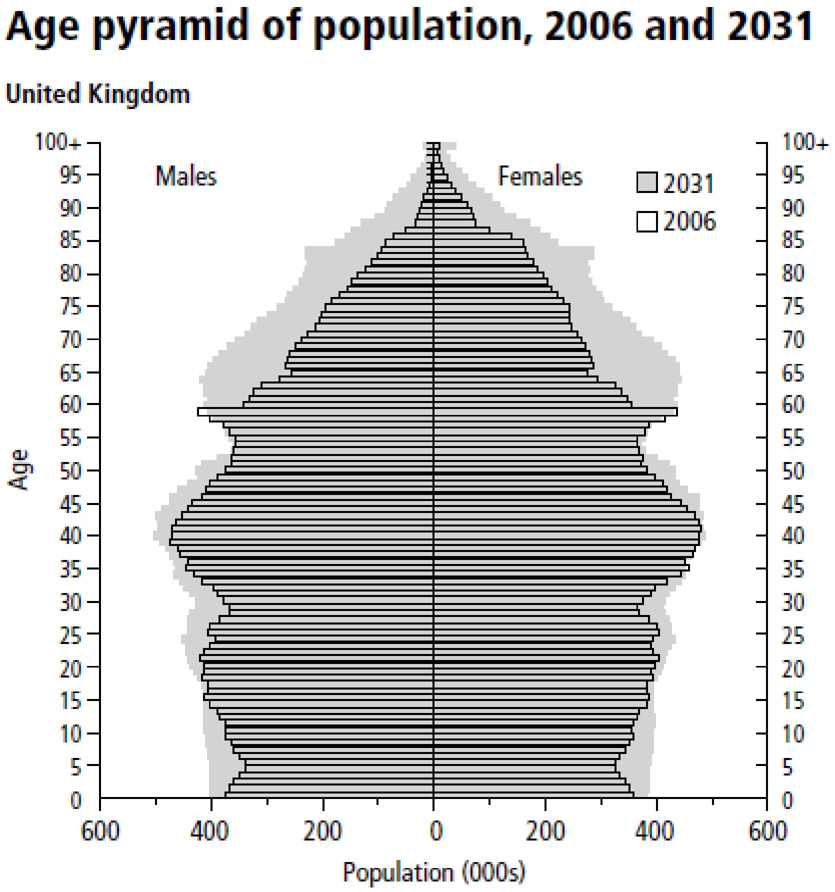


Figure 1.1: Age pyramid of UK population 2006 and 2031 (National Population Statistics (2006 PP2 No 26)

As indicated in Figure 1.1, the number of people aged 90 years of age and above is expected to more than triple by 2033, with the number of people aged

95 and over projected to more than quadruple. The number of centenarians is anticipated to rise from 11,000 in 2008 to 80,000 in 2033, a more than sevenfold increase (Statistical Bulletin 2008). By 2081, the projections suggest there will be over 10 million people aged 80 and over in the UK (National Population Statistics 2006). These shifting demographics will challenge planners to develop affordable, appropriate services to accommodate the needs of an aging population.

The Department of Health (2006) predicts that by 2020 there will be a doubling of the number of people over 85 in the UK requiring their care needs to be met in a care home with or without RNs. The Commission for Social Care Inspectorate (CSCI), the forerunner to CQC, reported in 2005 that there were 19,000 residential care homes for adults in England providing 441,000 places. The report concluded that one per cent of people aged 65 to 74 years of age lived in some form of institutional setting, for people aged 85 years and over the proportion is estimated to reach 26 per cent (CSCI 2005). Within the care home with RNs population, 60 per cent of residents were over 85 years of age (Laing and Buisson 1999). The participants in this study were all aged over 85 years of age, reflecting the age profile of care homes with RNs as detailed above.

1.3 Background to the study

As a Registered Nurse whose remit includes ensuring entitled individuals are assessed to determine their eligibility for National Health Service Continuing Health Care (NHS CHC) and Funded Nursing Care (FNC), I have been interested for many years in exploring why people with minimal nursing needs enter a care home with RNs. My background in rehabilitation places an emphasis on achieving an individual’s full potential and where possible to encourage independent living. The use of care homes with RNs for people when not clinically indicated seemed at odds with the ethos of maintaining and promoting independence by supporting people in a range of options. I wanted to develop a more in depth understanding as to why people enter and remain in care homes.

The roots of residential care can be traced back to 19th Century Poor Law where the work house became the destination for those who could not care for themselves (Townsend 1962). History informs us, these were places to be avoided, feared and only considered as the last resort (Townsend 1962). The National Assistance Bill enacted in 1948, repealed the Poor Law system and decreed the abolition of the workhouse (National Assistance Act 1948 Schedule 7, Part 1). Section 21 of the National Assistance Act 1948 welfare reforms, placed a duty on local authorities to provide:

> " *residential accommodation for persons who, by reasons of age, infirmity or any other circumstance are in need of care and attention not otherwise available to them*"
> (National Assistance Act 1948, Sec 21a).

In the years that followed, the provision of residential care developed largely through the public sector, with limited investment from the private and voluntary sector. By 1970, there were 128,209 people over 65 years of age in residential care homes in England, of which, 68 per cent were in local authority homes, 18 per cent in the voluntary sector a 14 per cent within the private sector (DHSS 1971). At the time, this represented two per cent of the population over 65 years. By 1988 there were equal numbers of private and public sector provision and by 1992 the ratio was two to one in favour of private provision (Laing 1995). Throughout this period, there were two sources of public funding for long-term care. Local authorities were responsible for funding care in care homes without RNs, whilst the then Social Security system was responsible for funding care in care home with RNs. The system of admission to care homes was criticised as it resulted in significant numbers of people being admitted to long-term care resulting in what was perceived as the "*perverse incentive*" (Wanless 2006, p9) in favour of residential care (NHS and Community Care Act 1990). The increase in the number of people in residential care also coincided with the debate associated with the reduction in the number of informal carers (disproportionately women) whose role outside the home altered their ability to care for elderly parents (Peace 1997). In contrast to the care home without RNs sector, which remained almost static, care homes with RNs underwent a gradual increase throughout the 1980's and 1990's. In 1985, the ratio of care homes without RNs to care homes with RNs was seven to one, rising in 1990 to three to one and by1994 there had been a complete reversal, with five care homes with RNs for each care home without RNs (Laing 1995).

The NHS and Community Care Act (1990) placed an emphasis on supporting people in their own home and gave local authority, social service departments' responsibility for gate keeping admission to residential care. Social services staff were directed to be brokers and care managers of social care in collaboration with health care staff responsible for assessing, placing and financing those eligible for publicly funded residential care (Wanless 2006). Local authorities did not have to provide the care they were commissioning, which led the way for the development of the private sector (Wanless 2006). The aim was to link the need for care with appropriate assessment and funding (NHS and Community Care Act 1990).

Care managers within local authorities were employed to co-ordinate the selection of appropriate placements, a facility not always available to people funding their own care. Nothing precludes local authorities from assisting people responsible for funding their own care but my experience has demonstrated that possibly due to resource constraints within local authorities, families often have to take on the responsibility for arranging a discharge home or an admission to a care home. I have seen first-hand the difficulties experienced by families, when faced with hospital staff keen to free up an urgently needed bed, urging patients and their families to make decisions regarding long term care often with minimal support and assistance.

Since the NHS Community Care Act (1990) there has been a continued commitment by successive governments to a policy of care in the community. This has resulted in increased emphasis on maintaining older people in their homes for as long as possible based on the premise that this is what older people want. The Wanless Social Care Review (2006) commissioned by the Kings Fund, reiterated the Department of Health aims of promoting choice, independence and prevention of admission to care homes. This supports the general view that admission to a care home with or without RNs should only be considered when older people have significant care needs and when formal and informal sources of care can no longer maintain them at home. In parallel with the discussions regarding managing admission to long term care was the debate around how long term care could be funded.

The Royal Commission on Long Term Care (1999) was tasked with examining the short and long-term options for a sustainable system of funding long-term care for older adults. One of the main recommendations from the report was that:

> *"The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means"* (Royal Commission for Long Term Care With Respect to old age 1999, Summary and Recommendations).

Chapter 1: Introduction

The Department of Health decided not to implement the Royal Commission on Long Term Care (1999) recommendations in full and consequently did not fully address the question of long term care funding. An issue recently revived by the publication of the Report of the Commissioning on Funding of Care and Support (2011). The resultant guidance from the Department of Health (NHS Plan 2000) choose to address the anomaly whereby people who were funding their own care in a care home with RNs, were responsible for funding the total cost of their care package including any element of their care provided by RNs. This had resulted in inequality between those residing in a care home with RNs, and those people living at home or in a care home without RNs, as their nursing needs would be provided by a District Nurse as part of their free NHS entitlement (NHS Plan 2000).

The NHS Plan (2000, p129) introduced "*Free Nursing Care*" (subsequently renamed Registered Nursing Care Contribution) in 2001 for all residents in a care home with RNs who were responsible for paying their care home fees. There were three levels of eligibility "High", "Medium" and "Low" Band with differing rates payable dependent on assessed clinical need. The definitions of the three bands are contained within the Glossary. The majority of care home residents were assessed as being entitled to the "Medium" band indicating they required the services of a registered nurse and were appropriately placed in a care home with nursing. Eligibility to the "Low" band indicated that their needs could be met in an alternative setting. The Low and Medium Bands were amalgamated in 2007 to a single contribution, entitled "*Funded Nursing Care*" (FNC). Currently each Primary Care Trust (PCT) pays the sum of £108.70 per week directly to care homes with RNs across England, as a contribution towards the care residents require by RNs (DH 2009). The responsibility for ensuring that the assessment to determine entitlement to FNC is undertaken rests with PCTs. Most areas employ nurse co-ordinators to undertake or co-ordinate the assessment in accordance with Department of Health guidance (2009).

Chapter 1: Introduction

Due to my professional involvement in this area, it became apparent that there were a number of people living in care homes with RNs who had been assessed as not needing the skills of RNs to meet their care needs. There are two key factors, both of which must apply to determine entitlement to FNC. Firstly, the person must reside in a registered care home with RNs. People residing in a care home with RNs are entitled to an assessment to determine what element of their care requires RN input. Care by RNs was defined by the Department of Health as a:

> "*requirement for Registered Nurses to be responsible for the provision, planning and supervision or delegation of the provision of care".* (DH 2009, Paragraph 5).

In order for a resident in care home with RNs, to be entitled to the FNC contribution, not only do they have to be residing in a care home with RNs but secondly, they are also required to have an identified clinical need as defined above, for care by RNs. Individuals, who reside in care homes with RNs, assessed and deemed not to require RNs for the provision, planning, supervision or delegation of the provision of care are not entitled to the FNC contribution.

The study took place in an English county with a population of 57,000 people aged over 80 years and 9,900 over 90 years of age (Population Statistics 2009). Currently, within the geographical area of the study, there are in excess of 3,500 beds in care homes with RNs, predominantly occupied by people over 65 years, which may prove to be insufficient to accommodate all older adults who require care in that environment. In May 2011, within the study area, there were 183 people living in care homes with RN's, assessed in accordance with Department of Health guidance, as not requiring care by RNs, indicating their needs could be met in other settings (Department of Health 2009). This group of people, resident in a care home with RNs, identified as not requiring care by RNs, are the focus of the study.

This thesis is divided into eight chapters, with each chapter focusing on a different aspect of the study. Italics have been used to emphasize key concepts. This chapter has provided a brief introduction to the background to the study and the relevance to health and social care practitioners. .

Chapter Two explores current long term care provision within the UK, examining the home and residential care sector. The available options with regard to delivering and financing long term care are also examined. The use of the literature review in a grounded theory study is discussed as well as how the literature has been incorporated in this study.

Chapter Three details the rationale behind the choice of qualitative grounded theory as the preferred methodology and explores the basic underpinnings of the method. The various models of grounded theory are considered, as are the reasons for choosing the classic grounded theory approach. The concepts of symbolic interactionism and constructivism are explored with their resultant influence on my choice of whose version of grounded theory was adopted is discussed.

Chapter Four discusses the methods utilised and provides detail as to how the study was conducted with reference to the core principles of grounded theory. The cyclical process of data collection and data analysis within a grounded theory approach utilising the constant comparison method will be presented. The ethical implications when conducting research on vulnerable adults are also considered.

Chapter Five explores the processes utilised to analyse the data within a grounded theory methodology. The principles and the process followed in relation to coding and data analysis are described. The methods used to identify and modify codes are identified and how relevant codes were developed into categories will be explained.

Chapters Six and Seven provides a detailed explanation of the findings, identifying and explaining the categories "*choosing the path*" and "*settling in*". Identification of the properties of the categories, how they were refined and how they relate to the core category will be discussed. This chapter will also demonstrate how these categories linked to form the emerging theory.

Chapter Eight discusses the study findings, suggests recommendations for practice and considers areas of further interest for future research.

Chapter 2: Background: An exploration of long term care

2.1 Introduction

This chapter will explore the options available to individuals requiring long term care and the various funding sources available. The use of the literature review in a grounded theory study will also be discussed.

2.2 Current care options

Currently there are a number of ways older people can be supported and assisted with their personal care needs. Domiciliary care agencies registered with the CQC, can provide carers to assist with personal care and domestic services directly into an individual's home (Dalley 2001). Alternatively, there is an ever-increasing range of sheltered housing schemes that offer accommodation coupled with access to a warden (Dalley 2001). Having access to support and assistance if required can provide reassurance for people choosing to remain in their own home (Counsel and Care 2006). The growth of enhanced support such as "extra care" schemes (Dalley 2001) can provide the full range of personal care delivered to the residents own home and can offer extra security. Gaining popularity, although the model originates from 1918, are retirement villages. Designed as communities for older people where their needs can be met in a variety of settings, with the potential to adapt to an individual's changing needs. Some incorporate care homes with and without RNs allowing residents to have all their care needs delivered within the community. They offer an expansion of the sheltered care model with a range of facilities available, which can include small shops supplying basic commodities within the complex (Dalley 2001).

Chapter 2: Background: An exploration of long term care

Residential care provision for older people is divided into two main types; care homes with and without RNs in accordance with the type of care being provided (The Care Home Regulations 2001). Care homes with RNs are required to have a Registered Nurse on duty throughout the twenty-four hour period and are intended to provide care for people with a range of complex medical and nursing needs (Mozley *et al.* 2004). The nature of an individual's needs tend to encourage a greater degree of medicalisation than would be required in a care home without RN's or other options. Care homes without RNs tend to provide care for people who are more functionally able. The exceptions to this are care homes without RNs that provide care for people with dementia. This group of people may present as being physically able but often have a level of cognitive impairment, which makes living independently very difficult to achieve safely. They may not require RNs to deliver their care but benefit from a safe supported environment, provided by 24 hour supervision.

There is a requirement for care homes to be registered by the Care Quality Commission (CQC) and to demonstrate they have the level of skills required to meet the needs of the people within their care (CQC 2009). All care homes registered with CQC have to identify the type of care they can offer. Categories include "*older people*", "*dementia*", "*physical disability*" and "*younger adults*" and care homes are required to admit people whose needs are within their registered care categories (CQC 2011).

Two factors should be taken into account when considering admission to a care home. Firstly, does the individual concerned require care by RNs and secondly, is the care home registered to accommodate their care category with the clinical skill to meet their needs? Care homes are subject to regular inspection by the CQC and are assessed and graded, with zero indicating an unacceptable level of care and three being excellent. The ratings are based on a number of factors including quality of care.

Care homes with RNs are able to admit an individual whose clinical needs are less than the homes' registration category. Therefore, it is acceptable for a care home with RNs to admit someone assessed as not needing care by RNs. Care home managers are responsible for assessing potential residents in advance of accepting them for admission to ensure the home has the clinical skills required to meet their identified needs (CQC 2010). Differentiating between care that requires the skills of RNs and that can be undertaken by care staff often relate to a combination of factors. Examples include, clinical procedures including feeding via a gastrostomy tube, the need for hoisting during manual transfers, complex medication regimes requiring monitoring or regular management of a pressure ulcer.

A number of issues can arise if individuals are admitted to a care home with RNs when this level of care is not required. There is often a shortage of affordable provision, which may contribute to difficulties associated with locating a bed in a care home with RNs. These shortages can result in delayed discharges from hospital or may delay admission for someone who requires an urgent move to a care home with RNs (Morgan *et al*. 1997). In addition, there may be other factors which impact on the individual, for example, the range of opportunities for social interaction on offer may not meet the needs of the more able resident. A comparative qualitative study (Boyle 2004) explored the perceived level of choice and control between those living in a care home with those living in their own homes. They explored factors including time required to get up in the morning, when to see friends and visitors and privacy. They found that care homes with RNs, due to their medical orientation were associated with greater restrictions on autonomy compared with those people in care home without RNs. The study showed residents in care homes without RNs had the highest level of decisional autonomy over those in care homes with RNs, whereas, those living at home, but reliant on domiciliary care had the lowest level of autonomy, unsurprising due to the manner, in which domiciliary care is configured. Those in care homes perceived themselves as having a greater level of control than those in their own homes especially if they lived with someone or were reliant on domiciliary care services contracted to visit at a certain time. These findings would suggest that if someone is reliant on assistance to undertake activities of daily living then a care home without RN’s affords the highest level of autonomy.

As well as addressing the social and physical needs of care home residents the cost of placement is also, a factor when considering the differences between care homes with and without RNs. The fees for care homes with RNs may be several hundred pounds per week in excess of the fees for care homes without RNs. Within the study area, from my personal experience the fees for a care home without RNs are on average £500 per week and care home with RNs on average in excess of £700 per week. A fee difference, which, over time, has significant impact on personal and possibly public resources should an individual’s ability to fund the cost of the placement, diminish. In the event that care home fees become unaffordable, local authorities have a responsibility to meet the needs of those who meet their eligibility criteria for services (DH 2001b). That does not automatically mean the local authority will fund the cost of the care home as they may seek to provide other alternatives (DH 2001b).

2.3 Funding for care homes

The resources to fund residential care provision is via three main routes; a combination of means tested public finance, top up money from family and friends or entirely by private means. There may be alternative sources of funding via charitable organisations and the voluntary sector but admission is often restricted to those with a professional or religious affiliation. Some homes only admit people who have a past association with, for example, the clergy, journalists or the armed services and their funding derives from these sources.

Entitlement to local authority support is via a "*means tested*" assessment and is dependent on the individual having assets, including property in excess of £23,250 defined as the "*capital threshold*" (SCC 2009). Individuals with resources above the capital threshold are responsible for funding the total cost of their own care until such time as their assets reduce below the above level. Local authorities are then responsible, in some instances jointly with the older person to finance the placement and to ensure care needs are met. As mentioned previously the cost of a care home with RNs within the study area is in excess of £700 per week, costs that over time can soon escalate resulting in individuals becoming reliant on public resources to fund their care. In the study area, as of May 2011, the PCT's internal data relating to care home FNC expenditure, identified over 50 care home residents who had resided in a care home with RNs in excess of 10 years, including four who had lived in the home for over 15 years. Two people, who had lived in a care home with RNs for over 10 years had been assessed as not requiring care by RNs.

There has been a reduction in the number of people funded by local authorities in care homes, from 2.1per cent (208,530) of people aged 65 and above living in care homes in 2009, compared to 2.5 per cent (241,200) in 2005 (CQC 2009). This reduction may reflect, in part, the rise of alternatives to residential care, such as intermediate care, respite care and extra care housing. Another factor may be the increase in the number of people funding their own residential and nursing care (Wanless 2006). Laing and Buisson (2008b) cite an increase in care home residents funding their own care from approximately 110,000 in 1998 to 418,000 in 2008. This estimate only accounts for those people who are funding the cost of the care home in full, it does not take into account, care funded by local authorities or by NHS Primary Care Trusts. People admitted to care homes with RNs when not clinically indicated tend to be those individuals who are funding their own care rather than those whose care home fees are funded by local authorities (Mozeley 2004, Netten *et al*. 2001).

The increased purchasing power of local authorities means they can negotiate competitive rates for those being funded through public resources, but these savings can be to the detriment of individuals responsible for funding their own care (Wanless 2006). Local authorities operate within a level of fees, which many care homes consider is too low to be sustainable and consequently prefer not to accept people reliant on local authority funding. Instead, some homes may decline to accept local authority rates and concentrate on admitting those who are responsible for funding their own fees and can be charged an increased amount. The Office of Fair Trading (2005) reported that one in five homes charged more for self funders and my experience would suggest that this percentage is increasing. Due to a potential funding differential between the local authority and private funders, it is suggested that the increased rate payable by self-funders is needed to supplement the fees paid by the local authority residents (Wanless 2006). Care homes are responsible for setting their own fees based on their costs and what they consider the market will sustain. Some care homes vary their fees based on the size and location of the room and others operate with a fee base that reflects changing needs (Laing and Buisson 2008b).

If families request a particular home the local authority will often allow families to pay a "*third party top up*", which is the difference between the local authority rate and the care home fees (DH 2001b). This allows families to choose a home whose fees are in excess of the rate the local authority rate will fund and agree to pay the difference themselves (National Care Forum 2009). The cost of the "*third party top up*" can extend to several hundred pounds per week. This option is not available for the care home residents to fund themselves, unless part of a deferred payment arrangement (DH 2001b) as their resources have already been taken into account when considering their financial liability as part of their means tested assessment.

The proportion of people assessed as being responsible for paying for their residential care and those who require financial assistance from local authorities or charitable institutions varies across the country mainly as a result of economic status (Wanless 2006). The value of an individual's home is taken into account (either in totality or part if there are dependents still living in the home) when calculating financial worth (Wanless 2006). Therefore, areas with high property prices will have a greater number of people responsible for paying their own fees than areas with lower average prices or fewer home owners (Peace 1997). As funding for social care is means tested, older adults often complain that the system penalises those who have saved for old age. Between a quarter and a third of all care home placements nationally are wholly funded from private resources (Wanless 2006).

Local authority spending on residential care placements has risen at a faster rate than for home care (Wanless 2006). Between 2004 and 2005, 60 per cent of local authority budgets were spent on paying for placements in care homes of both types (Wanless 2006). Many local authorities, due to financial constraints have reduced their home care provision for those assessed as being in the lower level of need, concentrating instead on providing more intensive packages of care to fewer people (Wanless 2006). This development is at odds with the evidence that providing social care for people with lower care needs can delay the need for high level social care such as a care home (Wanless 2006).

Since the growth in the care home market there have been numerous studies exploring how long term care can be delivered (Mozely *et al.* 2004, Peace 1997, Wilcocks 1987). Despite considerable interest in residential care, the preliminary literature review confirmed a paucity of studies related to why people enter a care home with RNs when their clinical needs do not indicate a need for that level of care. The preliminary literature review confirmed a lack of relevant studies and supported the need for further research in this substantive area, to explore from the perspective of the care home resident, the factors that influenced decision making for individuals with minimal need for care admitted in to a care home with RN's. Why did this numerically small but important group of people with the financial resources to decide where and how care was being delivered, choose to enter a care home with RNs when their needs could be met in other settings?

2.4 Literature review

The purpose of a literature review is to highlight the extent of existing knowledge regarding the area being researched, which will enable the current study to be put in context, provide justification for research in this area and to identify gaps in knowledge related to the research area (Parahoo 1997). The timing and appropriateness of conducting a literature review when using grounded theory method is the subject of considerable debate. Glaser and Strauss (1967) emphasise the need to avoid coming to the research with preconceived ideas or theoretical frameworks. Glaser (1992, p31) in particular, is adamant that the researcher should not be "*contaminated*" by the literature, which he considers will constrain the generation of categories. The aim of grounded theory is to develop theory grounded in actual observations not as they have been conceptualised in previous work (Glaser and Strauss 1967), which is their justification for not undertaking a review of the literature. Glaser (1978) stresses that the researcher should have as few preconceived ideas regarding the research phenomenon as possible, to avoid a biased interpretation of the data. Dey (1999, p251) contends that the researcher should approach the research with an "*open mind not an empty head*".

Chapter 2: Background: An exploration of long term care

Charmaz (2006) suggests that it is impossible and probably undesirable for the researcher to suspend existing knowledge. She argues that the reason the subject area is of interest to the researcher is probably due to some previous knowledge or experience. Strauss and Corbin (1998) take the view that a preliminary review of the literature is justified to enhance the researchers' theoretical sensitivity with the main literature review undertaken following analysis to support emerging theory. The concept of theoretical sensitivity will be explored further in Chapter Three. Glaser (1998) acknowledges a literature review may be a prerequisite in order to satisfy the demands of ethics committees and prospective funders of research. In these circumstances, he warns researchers to be mindful of the literature biasing the study. Due to my involvement within this area of practice, it was inconceivable that I could approach the topic without having formulated some opinions based on my previous experience. Charmaz (2006) asserts this reflects my interest in the subject area and therefore, my choice of research topic. It was incumbent on me to explain my preconceptions and identify the steps I had taken to ameliorate their affect on the study. This allows the reader of the research to evaluate the extent my views may have biased the study. Further explanation as to how this was addressed will be discussed in Chapters Three and Four.

The review of the literature was conducted in two phases. The preliminary literature search assisted me in determining to what extent the topic area had already been explored. The second phase of the literature review helped explore the development of patterns within the data, once categories and patterns started to emerge. A literature review formed part of the research study and was a requirement in order to demonstrate a justification for the research to gain both research governance and ethical approval. A comprehensive preliminary search of the literature was conducted using several different bibliographic databases during the development of the research protocol. Searches of the databases Medline, Cochrane Database of Systematic Reviews, Cumulative Indices for Nursing and Allied Health

Literature(CINAHL), Allied and Complementary Medicine Database (AMED), British Nursing Index (BNI) and PsychINFO were undertaken to establish the extent of existing research in this area. The search terms "*Nursing home care*", "*Care home with nursing*", "*Continuing care*", "*Long term care*", and the North American term "*Long term care facility*" were utilised. The selected search terms initially identified a large number of studies in excess of 50, but very few studies related to the proposed study area. There were few studies exploring why people chose to enter a care home with RNs and fewer still that explored the issue from the older adults' perspective. The majority of studies identified, focused on three main areas; the quality of care in a nursing home (Fahey *et al* 2003, Rantz *et* al1996*);* the carer perspective related to the impact of having a loved one admitted into care (Haden 2001, Penrod and Dellasega 2001) and the lack of resources available for publicly funded placements.

The apparent lack of UK based studies on care home admission led me to investigate whether other countries had explored this issue. Researchers in countries such as the United States of America and Sweden had conducted research related to admission to a care home, which helped to inform the study and provide useful background information. The following four key studies identified as part of the initial literature review, helped illustrate the issues and served to confirm the suitability of the research topic as an area for further examination. Kosberg (1992) highlighted that the two greatest fears faced by older adults are firstly, a fall from which they are unable to get themselves up from, and secondly, institutionalisation. Mattimore *et al.* (1997, p818) interviewed 105 hospitalised elderly patients and found 30 per cent suggested that they would "*rather be dead than live in a nursing home*". If entering a care home is viewed with such distaste then why would older adults without the need for care by RNs enter a care home with RNs?

Several studies (Bennett *et al.* 2000, Grando 2002, Netten *et al.* 2001) explored the impact on individuals of residence in a care home. A pilot study undertaken in the UK on the appropriateness of care homes with RNs, using a retrospective audit of nursing home case notes concluded that one third of people in the care homes were inappropriately placed (Bennett *et al.* 2000). This study reviewed the case notes of 157 older adults admitted to care homes between 1993 and 1995 but failed to identify reasons for the inappropriate placement. Retrospective studies based on case notes are reliant on the accuracy and comprehensiveness of care home notes. The notes were not written for the purpose of identifying causative factors relating to reasons for admission which limits their usefulness. These studies were also undertaken several years ago which may affect their relevance to the current situation.

The Department of Health commissioned a longitudinal (1995 to 2000) study to examine the appropriateness of placement decisions and the characteristics of individuals admitted to care homes (Netten *et al.* 2001). This study examined age, sex, diagnosis and factors associated with admission to care homes of over 2000 individuals within 18 local authority areas. The authors acknowledged that the information relating to reasons for admission had not been collected for the purpose of the study, thus they advise the reader to be cautious in interpreting the results. In addition, local authority staff had identified the reasons for admission to the care homes, hence they may not have reflected the individual's view, again calling into question their usefulness. Their results concluded that approximately one fifth of participants in care homes with RNs did not require that level of care.

A study in the United States of America by Grando *et al.* (1996) explored why older adults with "light" care needs enter and remain in care homes with RNs by interviewing the care home residents. Data was collected from three nursing facilities in the USA. RNs were asked to identify which residents' required "*light care*" which was defined as:

> "*requiring little daily assistance and had no clinical conditions needing monitoring or skilled care and who were alert and orientated*" (Grando *et al.* 1996, p48).

Twenty residents were interviewed and asked a series of 18 open-ended questions aimed at identifying the reasons why they had entered the care home. The findings indicated that many admissions to care homes had been preceded by a period of hospitalisation or a health event. The definition of 'light care' as a term to describe the level of care required caused some ambiguity and some residents put forward by the homes were found to have greater care needs than were considered suitable for the research project. One of the limitations of the study was that the findings might not be transferable to England due to differences in the alternatives to care home admission. Despite having sought the perspective of the residents in care homes, the authors did not explain why such residents sought RNs care when they were in the '*light care'* banding. One option suggested by the study was the participants' lack of knowledge about alternatives on offer. Other reasons cited were having had a health event, not wanting to live alone and perceived inability to care for themselves.

There has been a dearth of recent studies examining the factors relating to admission to a care home with RNs and even less have explored the issue from the UK perspective or sought the views of care home residents directly. This was surprising given the importance of being able to offer appropriate long term care to older adults. This small sample of studies identified gaps in the level of current knowledge regarding this subject area and highlighted a need for research into why people are choosing to enter a care home with RNs when their needs could be met in an alternative setting. Due to the lack of information related to this phenomenon, a qualitative inductive methodology was deemed most suitable in order to gain insight into the substantive area from the participants' perspective. Therefore, although there are many different methodologies within the qualitative paradigm, grounded theory was chosen as the most appropriate for this study. Grounded theory afforded the researcher scope to explore participants' experiences leading to admission and settling in to a care home. A detailed rationale regarding the choice of methodology will be discussed in Chapter Three.

As the categories were developed and findings were being refined, a further search was undertaken expanding the topic areas to include the terms "care home" with the terms "admission and transition". A small number of relevant studies were identified and they have been incorporated into the chapters related to the study findings. Further targeted literature reviews were undertaken as an aspect of data analysis once patterns and categories had been identified. Examples of relevant literature were woven into the theory and treated as more data requiring constant comparison (Glaser 1998). Specific areas of data became the focus of the literature review to see if the topic had been addressed by other authors and will be discussed in greater detail in Chapters Six and Seven.

2.5 Summary

This chapter detailed the background to the study, the changes to the provision of long-term care and the rapid expansion of the private care home market. The rationale for undertaking the research study was also explored. The use of a literature review within a grounded theory methodology and how that related to the topic area was also considered.

Chapter Three will review the choice of research methodologies and discuss their respective merits. The rationale for selecting a qualitative approach will be considered. The limitations and advantages of a grounded theory methodology and the theoretical underpinnings of the method will be reviewed including an explanation as to why it was considered the most appropriate method for the study.

Chapter 3: Choosing the methodology

3.1 Introduction

This chapter discusses the rationale for choosing a qualitative grounded theory approach, and explores the theoretical underpinnings of the method. The reasoning for adhering to the core principles of traditional grounded theory as described by Glaser and Strauss (1967), as further elaborated by Glaser, with influences from Charmaz (2006) will be described and justified. The ethical issues relating to conducting research with vulnerable people is also considered.

3.2 Qualitative research methodology

Most research can be classified into one of two main research paradigms (Kuhn 1970); positivism and naturalism. Paradigms set out the epistemological position, define the research assumptions, influence the research methods and provide techniques for data analysis and interpretation. Guba (1990, p17) defines a paradigm as a "*basic set of beliefs that guide action*". The positivist paradigm is usually associated with deductive reasoning, quantitative research methods that starts with a preconceived theory or hypothesis. This paradigm was not considered appropriate for a study, trying to explore human behaviour in an area where there is limited established knowledge.

The contrasting epistemology to positivism is associated with the qualitative paradigm and often referred to as the naturalistic approach (Lincoln and Guba 1985). A naturalistic paradigm recognises and emphasises the complexity of humans and their ability to alter and shape their experiences. Emphasis is on a greater understanding of the lived human experience, which may be interpreted differently by different people. Central to the naturalistic perspective is the belief that people cannot be studied in the same manner as the natural sciences. Naturalistic studies endeavour to study people in their own environment, with the interpretation behind actions dependent on being studied in context (Lincoln and Guba 1985). Understanding is created through the shared interaction between the researcher and those they research. Denzin and Lincoln (2005) describe qualitative researchers as:

> "*attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them"*
> (Denzin and Lincoln 2005, p3).

A qualitative study was in keeping with the study intentions of seeking to understand and interpret why older adults choose to enter a care home with RNs when their needs could be met in alternative setting. Qualitative research derives its strengths from the flexible manner in which the methodology can be applied, the ability to study people in a natural context and the potential to consider processes as well as outcomes (Hammersley 1992, Silverman 2001). Inductive theory incorporates a flexible approach which makes it appropriate for studies where there is little known about a topic (Silverman 2001). What some authors perceive as assets within the qualitative paradigm, others consider as failings. Qualitative research has been criticised as being too subjective, anecdotal, unsystematic, lacking in transparency, difficult to replicate and biased (Bryman 2004, Charmaz 2006). Qualitative research and in particular grounded theory, can counter these criticisms by demonstrating a systematic, transparent research method, which sets out the process to be followed and addresses the potential for bias. It became apparent that this study was best suited to a qualitative methodology as I was seeking to explore what influenced decision making relating to why older adults enter residential care.

Chapter 3: Choosing the methodology

Denzin and Lincoln (2005) contend that qualitative methodology has evolved from its origins in ethnography and studies in the "field" in the early 1900s through to the current day. They suggest that the history of qualitative research can be divided into eight "*moments*" which depict a broad chronology of key phases that have evolved into present day practice (Denzin and Lincoln 2005, p15). Denzin and Lincoln (2005) describe the first "moment" of qualitative research as encompassing the "*traditional period*" associated with the lone ethnographer setting out for distant parts to document their experiences in the "*field* "and focussed on narrating an individual's life story. This phase extended from the post war years up until the 1970's with its influence on research still prevalent today.

The second phase identified by Denzin and Lincoln (2005) in which the modernist ethnographer and sociological participant observer, sought to address the scientific concerns regarding rigour in qualitative research. This according to Seale (2004) provided the impetus for an attempt to formalise qualitative methods encapsulated in the work of Glaser and Strauss (1967) and Lofland (1971). The "*modernist phase*" saw the beginnings of the work between Glaser and Strauss with their study "*Awareness of Dying*" (1965) and the development of grounded theory. The modernist phase, developed into the third moment entitled "blurred genres" (Denzin and Lincoln 2005). This stage covered the period from 1970 to 1986 and afforded qualitative researchers a variety of paradigms, methods and strategies to utilise in their research. Theories developed and refined during this period included symbolic interactionism and constructivism which shaped qualitative research and influenced the development of grounded theory (Denzin and Lincoln 2005). The remaining "*moments*" whilst providing an interesting chronology of qualitative research are not relevant to this study and will not be discussed further, instead I will focus on the rationale for my choice of methodology for the study.

Chapter 3: Choosing the methodology

An important aspect when choosing the methodology was to consider the nature of the research topic and whether the methodological approach possessed the potential to address the aims of the study. The choice of methodology should take into account data sources, the best way of obtaining robust relevant data, whilst incorporating the special needs, requirements and limitations of the potential participants (Bryman 2004).

In addition, it was essential that I could clearly identify and be aware of my own knowledge, skills, and theoretical beliefs about how the world should be understood and studied (Denzin and Lincoln 2005). My view of the world was influenced by my experiences and cultural history, which required exploration to ensure it meshed with the methodological stance being considered. Denzin and Lincoln (2005) assert that good qualitative research facilitates the disclosure and clear presentation of the researcher's values to enable the reader to judge the quality of the research. As a novice researcher, my views regarding the various research methodologies were not fully developed which demonstrated receptiveness to exploring the different perspectives. This was of benefit as it enabled me to come to the research with an open, enquiring mind without methodological preconceptions.

Several different approaches may have provided the appropriate methodological perspective including phenomenology, ethnography and grounded theory. Each approach and their respective merits were considered as to their suitability to address the study topic. Ethnography focuses on observations that occur within the participants' natural environment, influenced by how individuals' surroundings affect behaviour (Hammersley 1992). This approach would have provided a view of life in a care home but would not have explored decision making. Phenomenology aims to describe how the person has experienced phenomena and interpreted their world (Heidegger 1962). This would have provided an insight into what it was like to enter a care home, but not explored the influences that guided decision making.

The above methodologies may have been suitable for aspects of this study, but the aim was not only to explore residents' experiences but also to understand the reasons why the decisions had been made to enter a care home and to develop substantive theory. Grounded theory has been credited with being an approach, which facilitates the understanding of human behaviour in a social context (Benoliel 2001, Schrieber and Stern 2001) and is considered suitable for investigating social problems or where there is a requirement to adapt to changing situations. Hence, I considered it an appropriate method to explore why older adults with minimal care needs choose to enter a care home with RN's.

Several other factors led to grounded theory being identified as the most appropriate method for this study. Grounded theory possessed the potential to explain the substantive area of decision making within long term care and explore the processes employed when settling into a care home with RNs. The cyclical grounded theory techniques of flexible sampling, data collection and analysis provided the framework to obtain rich qualitative data to construct theories "grounded" in the data (Charmaz 2006). Grounded theory through its systematic and transparent processes can counter some of the criticisms of qualitative research and make it more acceptable to professionals who are more familiar with quantitative research. Glaser (1972) argues that grounded theory is a general inductive model not defined by any one theoretical perspective, facilitating its use with any data and research paradigm. Glaser's stance notwithstanding, grounded theory tends to be associated with qualitative research and the naturalistic paradigm.

To fully appreciate the rationale involved in the selection of the methodology for this study, it would be beneficial to explore the previously mentioned terms of grounded theory, constructionism and symbolic interactionism which are discussed in the following section.

3.3 Grounded theory

Grounded theory is an inductive, naturalistic method used to learn about the world and to explore human behaviour (Glaser and Strauss 1967, Glaser 1992). The concept of grounded theory is attributed to Glaser and Strauss and detailed in their book "*The Discovery of Grounded Theory"* (1967), which incorporated its own particular style of sampling, data collection and analysis with the aim of generating theory (Glaser and Strauss1967, Glaser 1992, Strauss and Corbin 1998, Charmaz 2006). The method is characterised by the concurrent use of data collection with analysis, which facilitates the identification of the emerging concepts by the utilisation of the constant comparison method of data analysis. Grounded theory methods help to conceptualise participant experiences thus facilitating their interpretation.

Glaser (1992) stated that the purpose of grounded theory was to generate concepts and theories about relationships that explain, account for and interpret variation in behaviour in the area under study. Grounded theory offered researchers an alternative to quantitative studies and the descriptive qualitative studies prevalent during the period as it sought to explain the phenomenon under investigation in a systematic way, as well as enabling the academic rigour of the study to be defended. Glaser (1998) describes grounded theory as both a method and a methodology which has identifiable stages and phases which proves to be attractive to novice researchers due to its structured nature incorporating clear guidelines (Schreiber and Stern 2001).

Glaser and Strauss (1967) distinguished between two types of grounded theory, substantive theory and formal grounded theory. Substantive theory is grounded in the data on a specific substantive area and serves as a basis for the second, formal grounded theory. Formal theory involved the development of higher, more abstract level of theory from a compilation of substantive grounded theory studies regarding a particular phenomenon (Glaser and

Strauss 1967). The majority of grounded theory studies lead to the generation of substantive theory (Glaser and Strauss 1967). Glaser and Strauss (1967) explain that a theory is a theory because it:

> "*explains or predicts something*"
> (Glaser and Strauss 1967, p43).

And a theory can only be achieved by the

> "*joint collection, coding and analysis of data"*
> *(*Glaser and Strauss 1967, p43).

According to Silverman (2001) a theory is:

> "A set of concepts used to define and/or explain some phenomenon" (Silverman 2001, p3)

It is important when conducting a grounded theory study to focus on the main concerns of the participants, rather than those identified by the researcher. If grounded theory is applied correctly, the key issues will emerge through the use of grounded theory methods. However, due to the requirements of research ethics committees and research proposals, researchers are required to identify an area of interest to justify the value of conducting the study.

Since the work of Glaser and Strauss achieved recognition, there has been much debate and disagreement about how grounded theory should be applied. Strauss, working with Corbin (1998) devised a structured, formalised method of data analysis related to axial coding. This resulted in accusations by Glaser (1992) that the complexity of and over reliance on coding resulted in "*forcing*" the data rather than allowing it to emerge. Glaser (1992) was critical of the work of Strauss and Corbin as he considered that they had deviated from the original concept of grounded theory, which was the development of conceptual theories and instead had developed work that simply described behaviour and validated rather than developed theory. Cutcliffe and McKenna (2004) argue in preference to studies that describe research, we should be striving for research that:

> "*Interprets, explains and problem solves*" (Cutcliffe and McKenna 2004, p130).

This divergence of opinion surrounding grounded theory, led researchers to explore other verifiable methods of analysing data and to consider the fundamental underpinnings regarding the method. Many authors consider that grounded theory has its theoretical foundations in symbolic interactionism, which is one of the interpretivist perspectives in the study of life and human conduct (Blumer1969, Benzies and Allen 2001, Jeon 2004). Glaser does not support this view and argues the fundamental differences between the two approaches but the concept has much to offer qualitative research and will be explored further in the next section.

3.4 Symbolic interactionism

Becker (1993) described symbolic interactionism as providing a lens or framework for understanding human behaviour. The concept stemmed from the work of George Herbert Mead at Chicago University, who sought to interpret the meaning of human behaviour. Mead's student Herbert Blumer (1969) is credited with naming, developing, and documenting the concept of symbolic interactionism. Symbolic interactionists' assume that individual's act based on the meaning that things have for them and that they are continually interpreting and re-constructing the meaning of his or her environment in a constant interaction with themselves and others (Bryman 2004, Blumer 1969). Bryman (2004) attempts to simplify the concept by stating:

> "*our notion of self emerges through an appreciation of how others see us" (*Bryman 2004, p14).

Three basic assumptions underpin symbolic interactionism (Blumer 1969). The first is that:

> "*human beings act toward things on the basis of the meanings that things have for them"* (Blumer 1969, p2).

Blumer argues that this is too simplistic a view on its own, which fails to separate out symbolic interactionism from other approaches. According to Blumer the key to symbolic interactionism is the source of the meaning of an object, developed by the interplay between the participants towards the object. Their action is symbolic because these processes use symbols, words, interpretations and language to convey meaning (Denzin 1989).
The second assumption is that:

> "T*he meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows"* (Blumer 1969, p2).

And lastly:

> "*These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters" (*Blumer 1969, p2).

The perspective of symbolic interactionism contributed to this study as I sought to explore people's experiences related to entering a care home with RNs. The participants' experiences arose as a result of considering care home admission and how they interpreted the significance of this event provided meaning and insight into their situation. It was imperative for me to understand from the participants' perspective what they believed about their world and their perceptions of what led to care home admission in order for me to understand their actions (Crooks 2001).

Whilst we can never fully understand how an individual interprets their reality, a symbolic interactionism approach assists in appreciating the interlinking between the individual and the context in which they exist (Cutcliffe 2000). According to Currie (2009), a symbolic interactionist approach allowed the elements of:

> "self, interaction, context and action to be explored"(Currie 2009, p28).

Symbolic interactionism allowed for deeper understanding of participants' decision making based on the meanings assigned to and the implications of care home admission for them, coupled with how their family/friends perceived the care home option. Of significance, was the complex interaction between the participant and their family. Participants had to comprehend and weigh up the available options whilst articulating their wishes to family members, which in some instances resulted in admission to a care home. The relationship between family members shaped and in some instances altered the eventual outcome. The use of the symbolic interactionist "*lens*" helped me to understand the participant's perspective, thereby providing an interesting insight into family dynamics and decision making.

The world exists separate and apart from the individual's perception of it, but it is the individual's understanding of the world in which he exists that influences behaviour (Blumer 1969). The environment in which people exist is dynamic with people constantly adapting to their changing circumstances and it is that process of adapting that influences their behaviour. Benzies and Allen (2001) consider that the most important aspect of symbolic interactionism is the inextricably linked nature of the individual and the ever-changing context in which they exist. Symbolic interactionism has the potential to improve our understanding of human behaviours and as such can enhance other theoretical perspectives (Benzies and Allen 2001). I was also mindful of my role as researcher in how I constructed participants' meaning (Benzies and Allen 2001).

In order for me to understand participant actions, it was important for me to see their world as they saw it (Jeon 2004). It was essential to comprehend what the participants knew about their world and what aspects they considered important. This was a key factor when considering the study design and made a symbolic interactionism approach of value to this study. Symbolic interactionism assisted in understanding human behaviour by highlighting the ever changing concept of self and the effect this had on their social interaction.

The theory of symbolic interactionism also influences the paradigm of social constructivism (Schwandt 1994). Constructivists believe meanings need to be interpreted in order for them to be understood (Schwandt 1994).

Kathy Charmaz, who studied with both Glaser and Strauss, advocated the use of the core principles of grounded theory but adopted a constructionist approach, in accordance with the belief that theory is constructed through a joint process between researcher and those being researched (Charmaz 2000, 2006).

3.5 Social constructivism

Constructivism or constructionism is an ontological position with as its basic tenet the socially constructed nature of reality, which denies the existence of an objective reality that can be known (Robson 2002). Schwandt (1994) suggests that the goal of constructivists is to:

> "*understand the world of lived experience from the point of view of those who live it"* (Schwandt 1994, p118).

Constructivists are of the view that human reality is socially constructed rather than existing objectively with the notion of multiple realities. Constructivists are not searching for an external reality, rather they seek to obtain greater understanding and shared meaning created through interaction between researcher and those being researched (Charmaz 2006).

The ability to interpret and fully understand the meaning attributed to the participants' words required the researcher, acting as a research tool, to work with the participant to construct meaning. However, researchers need to be mindful of the potential for bias from within their own preconceptions (Robson 2002, Silverman 2005). Bryman (2004) argues that the researchers own account of the social world are also constructs. Therefore, I was aware that my role was:

> "*To understand the multiple social constructions of meaning and knowledge*" (Robson 2002, p27).

Robson (2002) goes on to argue that reality can be constructed only by means of a conceptual system, hence there can be no objective reality because different cultures and societies have different conceptual systems. Charmaz

(2006) supports the constructionist position and assumes that any research study can only offer an:

> "*interpretive portrayal of the studied world, not an exact picture of it*" (Charmaz 2006, p10).

Charmaz (2006) argues that it is difficult for the researcher to remain detached and objective but also to obtain rich data that, she asserts requires a level of interaction, which precludes researcher detachment. The constructionist approach is not without its critics, including Glaser (2002) who does not dispute the validity of a constructivist perspective but attributes its usage to conducting qualitative data analysis rather than grounded theory. He discounts the relevance within grounded theory of the construction of data as an interplay and mutual interpretation between researcher and participant. Glaser argues that Charmaz's style of in depth interviewing tends to guide the interview and allows the researcher to convey their personal bias and or interpretations rendering the data constructivist (Glaser 2002). Instead of the passive, non structured interviewing, which should be prevalent in grounded theory, Glaser strives for an objective external reality which is discovered by a neutral observer. He goes on to argue that if grounded theory is applied correctly, it transforms the constructivist data, into objective, abstract data by the use of grounded theory methods, in particular constant comparison (Glaser 2002).

This study acknowledges the key role of the researcher as interpreter of the data and thus accepts an element of constructionism during data collection, which facilitated the collection of good quality data. I concluded that the incorporation of symbolic interactionism would assist me in understanding participant decision making and the constructionist approach would enhance the choice of grounded theory as the appropriate methodology.

Thus, the decision was taken that grounded theory was the most appropriate method. I then had to consider whose interpretation of grounded theory was in keeping with my own perspective and suitability to explore why people with minimal care needs chose to enter a care home with RNs. In the next section, I will outline some of the debate around grounded theory and the different emerging perspectives.

3.6 Whose grounded theory

The book "Discovery of Grounded Theory" (Glaser and Strauss 1967) developed the method of grounded theory analysis. Subsequent works by Glaser (1992, 1998), Strauss and Corbin (1998) expanded on the concept and provided further detail regarding the process to be undertaken. As a novice researcher when I commenced exploring the concept of grounded theory, I could appreciate the benefits of the method but I did find the works of Glaser and Strauss (1967), Strauss and Corbin (1990) and Glaser (1978, 1992) difficult to fully comprehend with regard to the concepts of coding and analysis. Work by Charmaz seemed to offer a more edifying explanation of the method and her interpretation of grounded theory assisted me to become familiar with the terms and concepts. Originally, I followed the constructivist approach described by Charmaz but was concerned that I was moving away from the original concept of grounded theory. The more I read other interpretations of the method the more comfortable and in accord, I became with the classic grounded theory, with the subsequent elaboration by Glaser.

Schreiber and Stern (2001, p97) expound the view that in order to conduct a grounded theory study there is a requirement to work with someone taught by one of the *"direct disciples"* of Glaser and Strauss. That was impractical to achieve in my situation, but I was fortunate to work with supervisors with considerable experience in the method who brought with them their perspective on the interpretation of grounded theory. My last supervisor, when undertaking her thesis, had been instructed by a supervisor whose doctoral thesis was examined by Glaser and who had subsequently worked closely with Glaser. This meant my supervisor was very conversant with the grounded theory methodology as interpreted by Glaser. Her understanding of the method and the assistance she provided helped me to develop confidence and a deeper level of understanding of grounded theory.

I adopted classical grounded theory as espoused by Glaser and Strauss (1967), with further clarification as provided by Glaser (1978, 1992) and Charmaz (2006), amongst others. I stayed as close to the original intentions as possible and incorporated the traditional core methods of theoretical sampling, data collection with simultaneous data analysis, constant comparison and data saturation. Thus ensuring the developing theories were "*grounded"* in the data.

3.7 Summary

This chapter has outlined the processes involved in selecting an appropriate methodology for the study. The advantages of a qualitative grounded theory methodology and the different interpretations of the method were explored. The concepts of symbolic interactionism and social constructivism were considered and how they influenced the study and my choices regarding whose version of grounded theory was adopted. Grounded theory is an inductive method suitable for use with any theoretical perspective and was suited to this study as I sought to understand human behaviour and explore participant decision making with the aim of developing theory in this area.

Chapter Four will explain the core methods associated with grounded theory and how they interrelate to form the cyclical process of theoretical sampling and constant comparison with analysis.

Chapter 4: Study design, sampling strategy and data collection

4.1 Introduction

As discussed in the previous chapter grounded theory has evolved by the work of the various exponents of the method. The use of the core concepts; theoretical sampling, data collection with simultaneous data analysis, constant comparison, data saturation and ensuring the developing theories are "*grounded*" in the data, are common to all grounded theorists to a lesser or greater extent. Critics of the methodology argue that some studies that purport to be "*grounded theories*" do not merit the title, often due to poor adherence to the core methods (Becker 1993, Glaser 1978) and as a result, the outcome is more descriptive than conceptual and fails to generate theory.

Whilst the central tenants of grounded theory method are inextricably interlinked it would be helpful to consider them separately and how they were incorporated into the study.

4.2 Study design and sampling strategy

This grounded theory study sought to understand why people with a minimal need for care, chose to enter and remain in a care home with RNs when their care needs could be met in other settings. I considered the best source of information would be obtained directly from care home residents, who met the inclusion criteria (detailed in Section 4.4). The following section will explain the sampling strategy and provide a brief profile of the participants.

Data collection in grounded theory can incorporate a variety of sources (Glaser 1978), interviews, observation, literature or other documents. This study utilised semi structured interviews and incorporated the relevant literature. Data collection within a grounded theory study is based on the concept of theoretical sampling which directed me to select individuals based on their ability to contribute to the research study (Glaser and Strauss 1967).

This study utilised both a purposive and theoretical sampling strategy to select suitable participants and to guide the interviews. Initially due to an absence of data to guide theoretical sampling, a purposeful sample was utilised, based on an identified inclusion (described below) criteria (McCann and Clark 2003).

4.3 Theoretical sampling

Theoretical sampling is unique to grounded theory and utilises the information obtained from the joint collection, coding and analysis of data, to inform the researcher as to what data to collect next and who is best placed to provide the information (Glaser and Strauss 1967).

Glaser and Strauss (1967) describe theoretical sampling as:

> "*groups or categories to study are selected on the basis of their relevance to the research question, theoretical position and most importantly the explanation or developing account*" (Glaser and Strauss 1967, p45).

In grounded theory, during data collection, the use of theoretical sampling may assist in identifying further participants, shape the topic areas for subsequent interviews, explore emerging categories and inform subject areas when searching the literature (Glaser 1978, Cutcliffe 2000, Jeon 2004). Currie (2009) and Chiovitti and Piran (2003) support the use of a comprehensive audit trail, clearly detailing the selection of participants and directing subsequent interviews. An audit trail was incorporated in the study, supported by memo's recording the participant selection process and documenting my thoughts and deliberations. Theoretical memos completed throughout the study directed theoretical sampling by encouraging me to document my thoughts and deliberations.

Initial participants were residents funding their own care in a care home with RNs, assessed as not being eligible for the Funded Nursing Care Contribution as they did not require RNs to meet their care needs and had been identified as being willing and able to converse with me. This purposeful sampling of participants was gradually replaced by theoretical sampling as the study progressed. The use of theoretical sampling aimed to identify topics and participants who were best placed to contribute to the study. Theoretical sampling provided the opportunity to explore topic areas as they presented during the interview. It supported the inclusion of important ideas and concepts from one interview to subsequent interviews and directed me to collect further data with a particular focus in mind (Charmaz 2006). An example of this was when it became apparent that participants were not aware that there were two different types of care homes, those with and without RNs. This led to further exploration of the topic area during subsequent interviews, to investigate whether the possession of this knowledge would have altered their choice of care home.

The simultaneous process of data collection with analysis served to identify gaps in the data (Glaser and Strauss 1967) and directed the sampling strategy. Within a grounded theory study, it is undesirable to determine the sample size at the outset (Cutcliffe 2000), as it may limit the researcher, which may result in a lack of awareness regarding the value and completeness of the data and affect subsequent data collection.

4.4 Study population

The study population comprised of people over 65 years of age, responsible for funding their own care in a care home with RNs. They had been assessed in accordance with DH (2007) guidance as not requiring care by RNs and for whom there were no other contraindications, which made them unsuitable to interview. One of the large national providers of residential care agreed that I could approach willing care home residents in five care homes with RNs, situated within the study area. The respective care home managers due to their knowledge of the residents, were asked to identify residents who met the inclusion criteria. They were also requested to advise me regarding any individuals who due to their present situation made it inadvisable for me to make contact, examples included residents who had become unwell or were cognitively impaired.

Forty-one residents, from the five participating care homes were identified as meeting the inclusion criteria as of 1st August 2009. Seven people were excluded as they had been identified by the care home managers as being cognitively impaired and it was therefore not appropriate to include them in the study. A further three people were not approached due to a change in their health needs which precluded their involvement and made it inappropriate to proceed. Of the remaining thirty one potential participants, contact was made with eighteen people during the four-month period August to December 2009.

Following initial contact, four potential participants declined to be interviewed. One potential participant changed her mind during the cooling off phase and left the care home shortly afterwards. Another potential participant who had initially given permission for the interview to proceed, had the arrangement cancelled by her son. The third potential participant became unwell in advance of the interview therefore the interview was cancelled. His wife, who was also a resident in the care home, declined to be interviewed, due to her husbands' ill health. A resident, who had initially agreed to participate, on the day, advised me that whilst she was in agreement with speaking with me, she declined permission to record the conversation or use any of the information obtained in the study. Despite my reassurances regarding the confidential nature of the study and how her responses would be anonymised, I was unable to allay her concerns. We chatted generally for a few more minutes and then I thanked her for her time and left.

One care home, as a prerequisite to my making contact with the potential participants, required that I speak to their next of kin to obtain permission to approach the resident, despite their having capacity to make their own decisions. The care home manager explained that he had not wanted to risk of upsetting family members by allowing me to approach their relative without their knowledge and consent. I documented in a memo, at the time my surprise at this request, whilst trying to understand the situation from his perspective. I concluded that he was guarding against potential criticism by the residents family for possibly subjecting their relative to avoidable distress. As requested, I made contact with three family members. One resident's son was unwilling for me to approach his mother, as he thought that she would be upset by the interview. The niece and the daughter of the two other residents were happy for me to approach their respective relatives and they both consented to being interviewed. In total eighteen people were given the information pack and of those six people declined, or their family member declined on their behalf to participate in the study.

Once a potential participant had been identified, the care home manager, senior nurse or administrator usually introduced me to the resident. In some instances, I was left to locate the resident and introduce myself. As I became better known within each home, I was granted a greater degree of freedom to approach people independently. Once we were introduced and once I had their permission, I proceeded to explain the study and responded to any their initial questions. The potential participant was under no obligation to engage with me at this stage, but all of the potential participants listened to my explanation regarding the research project. If the potential participant exhibited an initial expression of interest, an information pack was left with them for their consideration. The information pack contained an introductory letter explaining the study and inviting them to participate (Appendix 1), a Participant Information Sheet (Appendix 2) with a reply slip detailing aspects of the study, including their right to withdraw at any stage (Appendix 3). The ethical considerations of the research study are discussed in later in the chapter.

The potential participants were afforded the opportunity of a week's "cooling off" period to consider whether they wanted to be included in the study and discuss their involvement with family members. Before departing, I suggested a tentative mutually convenient date and time the following week to conduct the interview or to answer further questions. Assurances were given that they were not committed to this arrangement in any way and I would only make contact again with their full agreement. The potential participants were asked to complete the reply slip and return to the care home manager signifying either their agreement for me to finalise the interview arrangements or to decline participation. The information sheet (Appendix 2) had advised that although all steps would be taken to prevent the participant from becoming distressed it was suggested that it might be helpful to have someone, either a family member or someone from the care home staff, available at the end of the interview just in case they needed support. This offer was not taken up by any of the participants.

During the study, pseudonyms were used, when referring to participants or places to maintain privacy and respect their anonymity. Twelve participants were interviewed for this study; ten women and two men aged between 86 and 99 years of age. Five study participants were admitted to a care home from hospital with seven admitted from their own home. Participant selection was limited by several factors. Firstly, families who did not want their relative to be included in the study, participants who themselves chose not to participant and how the potential participant presented "*on the day*". On occasion interviews had to be rescheduled if it was not convenient for the participant.

The scope of the study did not permit access to the care home records so it was not possible to confirm how functionally able the participants had been on admission to the care home, compared to their level of physical functioning when interviewed. At the time of the interview, all of the participants were mobilising independently or with the assistance of a stick or frame. All participants appeared able to manage the majority of their personal care needs, with some needing assistance with washing their back and feet and getting in and out of the bath. This confirmed to me that these participants were appropriately included in the study as, confirming the accuracy of their assessment, that they did not require RNs for the provision of care.

The section above has described how people were initially identified to participate in the study. The cyclical nature of the core tenants of grounded theory does not dictate an obvious order as to how to describe the processes and their subsequent application in this study. Therefore, whilst I have tried to describe them in a sequential manner, the order they are detailed below does not reflect either their importance or the stage of their incorporation within the study. The next section will describe the concepts of data collection, theoretical sensitivity, the constant comparative method of data analysis and the use of memos.

4.5 Data Collection

The bulk of data collection for this study was through direct face to face interviews with care home residents using an interview schedule to guide the interview. Grounded theory method requires the gathering of sufficient rich data to provide a suitably detailed understanding of the topic area. Glaser (1978, p8) expounds the premise to treat "*all as data*" and supports the collection of data from as many appropriate sources as possible. Methods for data collection were tailored to maximise the opportunity for participants to share with me their experiences. When examining which would be the most appropriate methods to obtain data, it was important to consider the potential participants and identify whether there were any special considerations that needed to be taken into account (Lee 1993). Older adults may have been experiencing some form of sensory impairment, which may have restricted their ability to respond to postal questionnaires or telephone interviews (Wenger 2001).

Interviews are considered a key element in obtaining participant views (Robson 2002). There are a number of benefits of face to face interaction which affords a good level of participation and permits the researcher to tailor the discussion based on the verbal and non verbal responses received (Robson 2002). Therefore, the use of face-to-face interviews, which allowed the exploration of the subject from the perspective of the participant, was deemed the most effective method of data collection.

Lofland and Lofland (1984, p57) consider that data collection in grounded theory as a "*guided conversation*", permitting thorough exploration of the experience under investigation. Holstein and Gubrium (2003) describe the active interview whereby the participant holds the information the researcher needs and by virtue of discussing the "facts" they become altered by the emphasis the participant places on the information being conveyed. The dynamics of the interview changed with each participant and altered the nature and quality of the interaction due to the individual nature of the relationship that developed between the participant and researcher. Some people were more responsive, volunteering information that provided a fuller picture whilst others responded with short sentences and were perhaps less forthcoming and reluctant to elaborate on certain points.

Lee (1993) identifies three themes that he considers enable the researcher to approach the research of sensitive topics. The first theme challenges the researcher to be innovative in their approach to researching sensitive topics and to adopt methods that work for them. The second theme reinforces the bond of trust that has to exist between the participant, and myself, as researcher. This trust is based on the quality of the interpersonal engagement and the building of a mutually beneficial relationship over the course of our interaction. The final theme recognises the equal status and value of the participants within the research process. I tried to incorporate these basic tenants during my interviews to be able to maximise the potential for an informative interview. Care was taken to ensure that the participants were not coerced to disclose or discuss areas that they were uncomfortable with. The extent of information the participant shared with me rested entirely with them.

I was asking participants to focus on events that had been instrumental in their decision to enter a care home, which may have caused distress and I was wary of this during my interviewing. Throughout the interview, I was alert for indicators both in the participants' physical demeanour and in their voice for signs of discomfort or reluctance to discuss a particular topic. This wariness may have restricted how deeply I probed during the interview, as I was anxious not to cause upset. The language and terms used by both parties required clarity of meaning, minimising the risk that the researcher brings their own interpretation to the encounter. The term "*thick description*" (Morse and Field 1996, p200) encompassed the whole process not just the spoken words but also the context and the manner in which they were said. The tone, demeanour and stance that I took, acting as a research instrument, are all fundamental to effective informative interview (Morse and Field 1996).

Interviews were undertaken in the participants' care home in a location of their choosing, which in the majority of cases, was their bedroom. Depending on their preference, the door remained open or closed. The majority chose to have the door closed, which provided a private environment in which we were less likely to be disturbed. Access to a drink if required, was also ensured. Time was spent ensuring that the participant was comfortable, agreeing the seating arrangements, with participants' often wanting me to have the "*best chair*" in the room. The process often involved some rearranging of furniture to ensure our proximity, to facilitate good eye contact and to select a suitable vantage point for the recorder. Optimum positioning of the recorder was crucial, needing to be close enough to capture the conversation, without becoming intrusive, thus inhibiting the dialogue. The recorder worked without difficulty and was sufficiently sensitive to pick up even soft voices. Most participants did not seem to be affected by it once set up. I was concerned that it might cease recording and did on occasion check to ensure it was still functioning. I used the time required to set up the recorder to engage in general conversation, usually commenting on their room picking out a personal possession or photograph of interest. I was conscious that for the interview to flow well I needed to make the participant feel relaxed and comfortable in order to establish a rapport. Hopefully, this was facilitated by the participant, being in a safe environment amongst their possessions. My initial contact the previous week afforded me the opportunity to obtain a sense of their personality and provided me with an indication of how to approach the interview.

Prior to commencement of the interview, any remaining questions or concerns were addressed and when the participant was happy to proceed, the consent form (Appendix 4) was signed, signifying the commencement of the interview. Participants often, due to failing eyesight, preferred me to read the consent form aloud in advance of being signed. Many had expressed a natural reticence about being recorded and some found the volume of pre interview documentation they were required to read daunting. It was essential to provide written information to ensure participants were fully informed regarding the study and the extent of their involvement. Time was spent informing the participant that their responses would remain confidential and anonymity would be preserved. This was in accordance with the research ethics and the nursing code of conduct. Confidentiality did not extend to the disclosure of something of a criminal nature or any suggestion that the participant had been the subject of abuse and participants were fully appraised of this exclusion. The right to decline to participate in the project or to withdraw from the study at any time was explained and those who chose not to participate were not disadvantaged in any way.

Once the consent form had been signed, I commenced the interview by asking the participants to tell me about themselves and what had led them to be admitted to the care home. The intention was twofold, firstly to put people at ease and allow them to choose where to commence their story and secondly to set the scene to understand their life prior to admission to a care home. It was only later during data analysis did I appreciate the importance of this information. The description of the life before admission to a care home served to provide an understanding of the factors that had initiated the need for a change in their living arrangements.

During the interview, I tried to adopt an open and non judgemental, encouraging approach, by refraining from expressing a view which could be construed as disapproval with any of their statements. I prompted either for clarification purposes to establish whether I had understood what had been said or to develop an emerging topic but not to express an opinion. The open-ended interview schedule was designed to allow participants to express in their own words the reasons that led to their admission to a care home with RNs whilst providing a framework for questions. I was mindful that the participant could also feel obliged to say what they thought I wanted to hear. Assurances were given that there were no right or wrong answers. To minimise any risk of causing distress I tried to provide an atmosphere conducive to making the encounter as productive as possible. The interviews provided the primary source of data for this study and it was important that participants' views were fully incorporated.

The interview guide (Appendix 5) incorporated six broad subject areas relating to admission to a care home, which provided an aide memoir. Initially this was to ensure all areas were addressed, it then evolved in accordance with the principles of theoretical sampling, to direct the interviews into areas of theoretical relevance (Glaser 1992). This did not preclude any concerns the participants identified in being fully explored.

I took care during the interview to be alert to any signs of distress and either to divert the topic away from the difficult subject or to refrain from delving too deeply into areas that were could potentially cause upset. One participant advised at the commencement of the interview that she would become tearful when discussing the death of her husband but she opted to continue with the interview. During the interview, she did become a little tearful, but she quickly recovered and by the time I left, she showed no signs of distress. Time was spent at the end of all interviews to engage the participant in general conversation to ensure that they were not upset by the experience. It appeared that she, as had others, enjoyed the opportunity to tell me about her life and experiences and no one was left upset or distressed following an interview. Subsequent visits to the care homes where interviews had already taken place served as reassurance that no one appeared to have been adversely affected by agreeing to meet with me.

I endeavoured to develop a trusting and reciprocal relationship between the participants and myself to facilitate the sharing of their story. Many downplayed the significance of their experiences and questioned how it could be considered of interest and of any use to me. Some even seemed to consider engaging with me as a responsibility. For example at the end of one interview, when I was thanking the participant for her time she stated:

> "*It is part of your job to talk to me and part of my duty to answer you*" (Mrs D).

I had been worried that she might have considered the interview a "*chore*" for her but was reassured when she said:

> "*It was certainly very nice and I felt quite excited really*" (Mrs D).

Her comments demonstrated to me that not only had she enjoyed our encounter, she considered that we were equal partners in the interview each with our part to play. I was very fortunate that so many older adults were willing to share their time and experiences with me to assist the study.

In accordance with the principles of grounded theory each completed interview was transcribed (further details of this process is addressed in Section 4.11) and any thoughts that occurred after the interview and during transcription were recorded and reviewed. This informed theoretical sampling and directed data collection with the aim of addressing the emerging categories and concepts. An aspect of theoretical sampling, according to Glaser and Strauss (1967, p46) was the link with the need for the researcher to be "*sufficiently theoretically sensitive*" to enable the refining of the categories that are instrumental in developing theory.

4.6 Theoretical sensitivity

Theoretical sensitivity relates to the researchers' ability to have insight, understanding and be able to give meaning to the data (Glaser and Strauss 1967, Glaser 1978, Strauss and Corbin 1998). Strauss and Corbin (1998) attribute theoretical sensitivity as defining the personal qualities of the researcher, in terms of what they bring to the study from their personal and professional experience and their ability to be aware of the nuances contained in the data. The ability to demonstrate theoretical sensitivity is an essential component of grounded theory but it is also difficult concept to achieve and to ensure I was working in a theoretically sensitive manner. Theoretical sensitivity relies on the ability of the researcher to conceptualise their thoughts and ideas and to think theoretically about the data. Theoretical sensitivity can provide the key to effective theoretical sampling and coding, the ability to establish the relationships between codes and categories and encourage abstract thinking (Glaser 1978). I was able to draw on my professional knowledge and previous experience to explore all possible explanations for what was occurring within the data and to guide analysis. Theoretical sensitivity was supported by the recording of my reflections in the form of memos and was incorporated throughout data collection and analysis.

4.7 Memos

Memos are notes that the researcher makes throughout the phases of the research process to record and explain theory as it is developed (Glaser 1978). Memos provided an opportunity to document reflections on the interviews and recorded my deliberations at all critical points throughout the study. Memos also enabled me to state my assumptions and preconceptions, with the aim of minimising the potential for bias. Glaser (1978, p83, Schreiber and Stern 2001) assert memos are the "*bedrock*" of theory generation. Memos assisted me in recording the methodological decisions taken regarding the study, throughout the duration of the study. Memos evolved during the study and demonstrated my development as a researcher. Early memos featured during data transcription, commenced as a simple description of events and developed into thought provoking, conceptual analysis relating to codes, categories and the emerging theory.

Memos were dated, filed for future reference, served to guide me during data analysis by documenting the development of the codes and categories, and helped to establish the relationship between categories (Coyne and Cowley 2006). Memos supported me throughout the development and refinement of the theory. Existing memos were reviewed, sorted, developed and integrated into existing memos, as well as informing new memos. The writing and refining of memos provided further data to be incorporated. An example of a memo and how it evolved during analysis is detailed in Table 5.2.

Tape recorded notes and reflections were made appertaining to completed interviews, usually sitting outside in the car after the interview had finished. An example related to notes made to describe the difficulties experienced in interviewing people of advanced years, often due to visual or auditory impairment. At its worst, these difficulties hindered the development of a good rapport with the participant and being able to engage in meaningful dialogue. One such encounter, due to the participants' hearing impairment had limited our dialogue despite our best efforts. I reflected in a memo following the interview that in hindsight perhaps he had not been suitable as a participant due to his hearing impairment, which prevented the interview proceeding with any flow.

Diagrams provided another useful tool to enhance my ability to conceptualise the linkages between codes and categories, document my thoughts and ideas and assisted me in developing a diagrammatic representation of the categories linked to the emerging theory.

4.8 Constant comparison

Constant comparison is a fundamental principle of grounded theory and is defined by Glaser and Strauss (1967, p21) as a "*strategic method for generating theory*". Using constant comparison in accordance with grounded theory methodology I commenced by comparing each line of interview data with other interview data, subsequently progressing to comparisons between codes and categories and further data as the interviews and analysis progressed. This involved going back and forth between the transcribed interviews, enabling the data to be synthesized, looking for similarities in the data and as concepts were developed, the relevant literature was incorporated and memos were written to explore my emerging thoughts and ideas. Constantly comparing the data during coding, formed the basis for theory development and enabled the theoretical refinement of the categories (Glaser and Strauss 1967). Theoretical comparisons led me to think about what was happening within the data and provided an opportunity for concepts and categories to emerge. Categories continued to be reviewed and refined as new data influenced ongoing analysis.

Data analysis in grounded theory directs the researcher to seek to identify patterns, commonalities and relationships through the examination of the data (Glaser and Strauss 1967). It was also important to seek out "*negative cases*" or examples which did not seem to fit into the categories. Data analysis formed part of the cycle of theoretical sampling and constant comparison that guided me through this process. Data analysis is discussed further in Chapter Five. Data collection continued until it became apparent that no new information was becoming evident and the data was becoming repetitive. This is referred to as data saturation (Glaser and Strauss 1967).

4.9 Theoretical saturation

Theoretical sampling within a grounded theory methodology steers the researcher away from precise numbers of participants, as theoretical saturation is not based on predetermined sample number (Bryman 2004, Glaser and Strauss 1967). Achieving saturation does not require the collection of all data on a phenomenon, rather enough to be able to develop themes and theories (Glaser 1992). Glaser (1992) states that one can never achieve saturation, as there is always the potential to locate new data. The dilemma for the novice researcher is how much can be considered sufficient. The concept of data saturation related not just to the quantity of data collected but also the quality of the data. Hence, as the key categories were emerging, I focused data collection on the data that were becoming important for the developing theory. It was this joint collection and analysis of data that helped achieve theoretical saturation and provided the evidence that during the last few interviews no new information, informing the generation of categories or their properties, was becoming apparent.

The basic tenets of grounded theory have been explored and their relationship to the study have been considered. It was also important to ensure that the participants in the study were adequately protected throughout the research project and not subjected to any avoidable risks.

4.10 Ethical considerations

All research carries with it risks associated with the impact of the study on participants. Even without a formalised process in place, researchers should be attuned to identifying and committed to ensuring the welfare both physical and psychological of their participants. Ethical approval was sought and obtained from University Insurance and Research Governance, local Research Ethics Committee and the local NHS Research and Development Committee. This study was working with potentially vulnerable adults and care was taken to ensure their welfare was of paramount importance from the outset. The ethical processes followed were designed to minimise the risk to the participants. Roster (2001) explains that ethical research should identify the procedures and risks the participants will be exposed to and advises that the consequences of the research need to be considered and whether they would want to continue having been made aware of the risks.

The majority of research institutions and professional associations have adopted a code of ethics (ICN 1996) to ensure an ethical approach is taken with regard to research studies. Good ethical research is based on the concepts of beneficence, which considers that research studies should identify some benefit for the participant or for society. This is balanced against the principle of non-maleficence, whereby the participant should not be harmed by participating in the research. Identification of the potential risks and benefits for participants is important to ensure their safety and their needs are fully considered. The greatest risk to the participants of this study was the potential for them to become upset recounting the circumstances that led to their admission to a care home. I was guided by the care home manager's knowledge of the resident, how they were likely to respond during the interview and the systems and processes in place in the home designed to deal with anything that might cause distress. As part of obtaining ethical approval, it was essential to have identified how participants would be supported should they become upset. In order to achieve this, in advance of the interview being arranged, it was suggested that the participant may want to identify a family member or someone from the care home staff to join them after the interview, but no one choose to take up that offer.

Another important aspect of the study was to ensure that the principles of voluntary, informed consent was given by a person competent to do so. This meant that participants had a right to have the implications of the research fully explained to them. They also needed to possess a level of cognitive ability to enable them to understand how the study would involve them and to give consent voluntarily without coercion. The researcher was responsible for ensuring the participants were not deceived in any way by the research and their views were accurately represented. All potential participants were provided with verbal and written explanation regarding the study, detailing what was expected of them should they choose to take part and their right to decline to participate or to withdraw from the study at any stage. The potential risks associated with interviewing vulnerable people regarding a sensitive topic were taken into account in both the design of the study and the flexibility in which the topic of entering a care home could be approached.

Lastly, participants have the right to confidentiality, including respecting their privacy and anonymity (Punch 1994, ICN 1996, Foster 2001). I had an obligation to protect the rights of all potential participants, involved in the study and to respect their right to confidentiality in accordance with the Nursing and Midwifery Council Code of Professional Conduct (NMC 2008). Maintaining confidentiality included my obligation to ensuring all the data was stored in a safe and secure environment.

4.11 Data management

All the interviews were recorded in full with the permission of the participant. Recording the interview offered a complete record of the conversation and permitted a thorough and multiple examinations of the data, both raw and transcribed. Following each interview, the recorded interviews were transcribed verbatim into a word document with wide margins allowing space to insert appropriate labels or codes. Each line of the transcripts was numbered for ease of identification. The audiotapes were replayed several times to ensure that the transcripts were recorded accurately and to fully familiarise myself with the data. During the process of transcription, I was able to visualise the conversations and to capture the context in which the comments were made. Where applicable, non-verbal communication, including laughs, sighs and any displays of emotions were incorporated into the transcripts. Memos were used to capture my thoughts or suggestions as they occurred to me during transcription of the interviews. Whilst transcribing the interviews was time consuming, it offered the opportunity to reflect on the conversation. It also provided an audit trail to demonstrate the robustness of the findings and counter arguments of researcher bias. Once the interviews were accurately transcribed, coding of the data commenced.

All documents, recordings and other person identifiable information were treated as confidential and stored in locked cabinets. I transcribed all the recorded interviews to provide me with the opportunity to not only listen to the data and reflect on the conversations, but also to see the dialogue in a text format. The files were saved onto a password protected personal computer that only I could access. To ensure anonymity, the audiotapes of interviews were labelled with a unique numerical identifier and did not carry names of participants. Hard copies of the transcribed interviews were kept in a locked cabinet. The list identifying the participants was kept separate from the interview transcripts, with the list of names only accessible by me. Computer files were password protected and the computer stored in a secure location. The data would not be used for other purposes without the permission of the participants and kept in accordance with University of Southampton regulations.

4.12 Summary

This Chapter explored the central tenets of a grounded theory methodology and the methods utilised. The initial purposive sample leading to theoretical sampling was explained. The concepts of theoretical sensitivity, the generation of memos and the constant comparison method were also considered. The ethical issues relating to conducting research with vulnerable people and the particular problems associated with this study were discussed. Chapter Five explains how data was analysed using the core concepts of grounded theory methodology.

Chapter 4: Study design, sampling strategy and data collection

Chapter 5: Data analysis

This chapter will explain the process undertaken to analyse the transcribed interviews, code the data and explore the generation of categories and their properties. Memos written throughout analysis will be referred to where appropriate. The key concepts of data analysis within a grounded theory methodology were documented in Chapters Three and Four and this chapter will explore how the data was analysed in accordance with the principles of grounded theory.

5.1 Introduction

The aim of grounded theory is to explain a problem by generating a theory, "*grounded*" in the data (Glaser and Strauss 1967, Charmaz 2006). The study sought to explore through interviews with willing care home residents why they chose to enter a care home with RNs when not clinically indicated. The aim was to generate theory, through the core concepts of grounded theory methodology, to explain why participants chose to enter a care home.

The process of generating theory is based on deconstructing the data through coding and then reconstructing the data into categories to facilitate the development of abstract concepts. The generation of substantive theory requires a cyclical process of data collection and data analysis utilising the constant comparison method. Theory generation required the identification of a core category, relating to factors that influence care home admission. Glaser (1992) considers the identification of a core category as the central point of grounded theory as it integrated all of that theory's various aspects. The core category should account for most of the data and relate to the categories

(Glaser 1978). The specifics regarding how data analysis should be undertaken within a grounded theory study are described through the works of Glaser and Strauss (1967), Glaser (1978, 1992), Strauss and Corbin (1998).

5.2 Grounded theory analysis

The process of data analysis in grounded theory is fundamental to the development of theory but the ability to generate theory is dependent on the quality of the data analysis (Glaser and Strauss 1967). Integral to and supporting the analytical process was the use of theoretical sampling, constant comparison, the generation of memos, the use of diagrams and by incorporating aspects of the relevant literature (Glaser 1978). The strength of grounded theory is the interrelationship between data collection and analysis, with the processes conducted simultaneously. Grounded theory analysis can be described as being more cyclical than linear and results in considerable overlap of the stages. It was important to commence coding immediately post interview and to incorporate through memo generation my thoughts and deliberations, which in turn influenced the theoretical sampling strategy.

Theoretical sampling directed the researcher to collect data based on the emerging ideas and categories. Theoretical sampling extended throughout the coding and analysis phases into the identification of categories. It then moved from comparing incidents, with incidents, to incidents being compared with each emerging category. Glaser (1992) warns against analysis taking place at the end of data collection, as this risks a failure to understand the relevance of the data for theory development resulting in a descriptive study not grounded theory.

Glaser (1992) considers coding as the fundamental analytic tool that will uncover an emergent grounded theory from the field of inquiry. Coding starts by labelling segments of data, with the aim of generating categories and according to Glaser (1992) involves:

> *"Conceptualising data by constant comparison of incident with incident and incident with concept to emerge more categories and their properties"* (Glaser 1992, p38).

Charmaz (2006) describes coding as attaching labels to sections of data that explain the data. Coding sorts and groups data to identify patterns within the data and initiated the development of theory (Glaser and Strauss 1967, Strauss and Corbin1998, Charmaz 2006). Glaser (1978, 1992) and Charmaz (2006) advocate the use of at least two phases of coding: Substantive coding and theoretical coding.

5.3 Substantive coding - 1st level codes.

Glaser describes the first stage of theoretical analysis aimed at developing codes from the data as "*open*" coding. The intention of this to categorise common concepts in the data by the use of "*line by line*" coding. I commenced coding, by reading through the transcribed texts line by line. The aim was to identify words or sentences, which defined a single incident and gave meaning to participant comments. Glaser (1978) stresses the importance of line by line coding as a mechanism whereby the fractured data can be fully conceptualised. Each line or incident of the data was assigned a descriptive label or code, which described and summarised segments of data into a more succinct format. I found it useful to work with a hard copy of the transcribed interviews during the initial coding process to facilitate the jotting down of ideas and tentative codes. Each phrase or concept was compared with others from subsequent interviews resulting in the identification of a new code, the renaming of an existing code to provide greater clarity or to incorporate a concept within an existing code.

The process of rereading and comparing the transcripts and the messages being conveyed was repeated over again to search for links and common threads. Analysing the content of each line and comparing lines of transcripts with other data sources enabled similarities and differences to be established between concepts. Where possible "*in vivo*" codes were used, which depicted the participants' own words and assisted in ensuring that the intended meaning was captured and concepts were drawn from codes taken directly from the data. An example was "*I take a day at a time*" which was both a comment made by a participant and an "*in vivo*" code. This served to reflect the way that a participant viewed her care home admission which had resonance with other participants. In vivo codes ensure that concepts emerge that have a direct link to the data. This comment linked with other similar comments "*I try to be happy wherever I am*" and "*I try to like things",* which all seemed to centre on the process of adapting to life in a care home but also demonstrated an attitude of mind. These participants may have expressed some reservations about their current situation but their positive attitude demonstrated a desire to adapt to their current situation. The descriptive nature of in vivo coding helped during the initial coding stages to ensure coding was reflecting the participants' narratives but led the way to a more theoretical approach to coding. The codes moved from the descriptive in vivo codes to a more conceptual code, entitled "*adapting*".

The code "*adapting*" also described as a "*gerund*". The use of "*gerunds*" as advocated by Glaser (1978) and Charmaz (2006), assisted in ensuring what Charmaz (2006, p49) describes as an "*insiders*" or emic view of the data.

Gerunds are usually a noun formed from a verb, which denotes action. For example, the gerund for the word influence becomes influencing. This was coded in several interviews to depict the factors that influenced decision making. Coding using “*gerunds*” to depict action and change helps the researcher focus on the participants’ words and actions and assists in conceptualising and achieving abstraction (Charmaz 2006, Glaser 1978). Another example was the influence the family had in persuading the reluctant participant to choose a care home. The use of a “*gerund*”, incorporated in the term “*influencing factor*” brings a sense of abstraction to the statement.

Assigning codes to the data was an evolving cyclical process involving comparing and contrasting incidents from other interviews. Codes were assigned to depict meaning and directed me to further data collection to address new questions, provide clarification or more substance to the data (Glaser 1992, Charmaz 2006). This resulted in various drafts of codes with their evolution documented through the use of memos. Although there are a number of data management databases on offer which purport to facilitate coding and tracking of data, I chose to manually code the data. This enabled me to remain close to the data and the coding process. A hard copy of each transcript was used to annotate the suggested code in a wide space alongside the transcript. Initially I did not restrict the number of codes utilised. I coded what seemed the most appropriate label and then later when re examining the data I identified commonalities within the data, leading to refining of the codes. As I identified similarities within the codes the number of codes began to reduce as I grouped the more frequently appearing codes into a “*code log”*. This enabled me to keep track of the codes and their relationship to sections of the data. The “*log*” was stored with the transcripts in a binder for ease of access.

When dealing with large amounts of data it is easy to lose sight of the messages being conveyed by the data. Some statements or phrases which may initially not have appeared relevant, later gained in importance following further interviews. I took the view that none of the data was irrelevant. Instead, some statements and observations appeared to be less relevant than others and were filtered out during the process of identifying the categories and their properties. Constantly comparing the data allowed the codes to be reviewed and refined until they captured the intended meaning and led to the development of categories that demonstrated relevance, fit and meaning (Glaser 1992). Care was taken to ensure the codes chosen fitted the data rather than forcing the data to fit the codes, to ensure they reflected the essence of the conversation.

An important aspect during the development of the codes was the ability to render the data more abstract by viewing the data as distinct from the participants, to enable the conceptualisation of the data. This was achieved by breaking down or "*fracturing*" the data, which facilitated the comparison and identification of sequences or connections within the data leading to the development of categories (Charmaz 2006). Glaser (1992) cites two important aspects of coding. The first reinforces the need for sustained constant comparison of the data and the second relates to the question that needs to be posed of all the data:

> "*What category or property of a category does this incident indicate?*" (Glaser 1992, p39).

Taking the story apart allowed me to focus on discrete entities contained within the data, whilst distancing myself from the memories of the whole conversation. Writing memos throughout the process summarised my impression of the data and assisted me in organising my thought processes. Coding the data helped to explore the meaning of what the participants were reporting and made it easier to identify commonalities within the data. I was looking for patterns, descriptions and relationships between phenomenon and trying to identify what "*sums up*" the pattern of behaviour (Glaser 1978, p94).

Table 5.1 shows an example of an excerpt from an interview demonstrating how the codes evolved during subsequent data collection and analysis. This participant had been discussing how she made the decision to enter a care home.

Line no	**Excerpt from interview with Mrs B.**	**Open code (1)**	**Open code (2)**
74	He (her nephew) said to me afterwards, did you hear the doctor says it is the best.	Decision making by others	Influencing factors
75	I said yes, I did. I don't know it, but I said that's fine, so I came here.	Making the decision	Rationalising Decision
76	You know I was living in my own home.	Previous living arrangements	Leaving the past
77	Of course, my husband sadly died 28 years ago, far too young and	Past life	Leaving the past
78	that is what life has in store for you	What life has in store	Adapting
79	and I realised even if I had, always had, someone into clean and before I went into xxx hospital. I had some care assistants coming in to help.	Care arrangements	Influencing factors
80	Because, little things bothering me, this fluid and one thing and another and I thought about it.	Reflecting on options	Influencing factors
81	I have a lovely big garden and I always had a gardener in to do the heavy work. I have loved gardening and	Previous living arrangements	Leaving the past

Line no	Excerpt from interview with Mrs B.	Open code (1)	Open code (2)
82	I thought to myself, I cannot go back home because if I could not do the things I wanted to it would depress me.	Decision making	Turning point
83	Even if I had someone living there permanently who was caring or something	Considering options	Rationalising decision
84	<u>I can't stand that, it is not me.</u>	Expressing her choice	Influencing factors
85	I was an only child, which I think makes you very independent	Defining herself	Self determination

Table* 5.1 *An exert from an interview showing generation of open codes

An important aspect during coding was to reflect on the significance of statements and to record the deliberations as memos. The following explores the generation of a memo and how memos can evolve over time with further data collection and analysis.

The statement shown in **Table 5.1** (line 84) "*I can't stand that it is not me*" refers to Mrs B's comments concerning her options. Initially it did not appear to be very significant and my associated memo interpreted it very much as an aspect of this participants' decision making without considering other aspects.

Table 5.2 shows the initial memo relating to the statement "*I can't stand that it is not me*" (Mrs B).

This participant is stating her preference for not having someone living in her home. She had considered staying at home with support but had discounted it as an option. This was her exerting her decision making ability.

Table 5.2 An example of the use of memos to explore a concept

The participant had when deliberating about entering a care home, considered but discounted the option of having someone live with her in her home. I had interpreted her statement literally and had not associated any particular significance to the statement. Further, into the coding process as my analysis became more developed, the statement began to engender new meaning during rereading of the transcripts. As I reflected on what she was saying and the possible interpretations of her statement, "*I can't stand that it is not me*" I realised that I had failed to capture accurately her meaning with the assigned code. This participant appeared to be not just stating that she had discounted the option of live in care, but reflecting on something of a more fundamental nature, which, related to her perception of life in her own home. I wrote another memo to try to capture this alternative interpretation, shown in **Table 5.3.** below.

She was sharing a deep seated dislike related to having someone in her home. "I can't stand that" is quite a forceful statement. What is it about having someone in your home that evoked such a negative emotion? The relationship is different, they would not be a "guest" subject to the usual restrictions. They would live there, having access to rooms and possessions, cooking in your kitchen. This person would be living in her home for 24 hours a day. Our conversation led me to believe that her house could accommodate a live in carer, so did not appear to be an issue of space. She goes on to link the comment to her being an only child and being independent.

This participant had already described how fond she was of her home, and having a live in carer would have afforded her the option of returning home. Instead, she had chosen to enter a care home rather than taking advantage of what would appear to be both a feasible and desirable option and enable her to return home. She had been widowed for 28 years and was used to living on her own and maybe for her it felt uncomfortable to have to share her house and living space with a stranger. She was a very polite lady and gave the impression of having high standards and may not have wanted the role of permanent hostess. It may not have been very relaxing for her to have someone in her home all the time. She would have had to share her home with someone she may not have had anything in common with or even liked.

How is that different to being in a care home? The care home represents neutral ground with a different set of acceptable behaviours. Carers knock before they come into the room and have clear boundaries about accessing possessions. There is a clear acknowledgment of the shared living arrangements and the hotel, type arrangement.

Table 5.3 Development of memo reflecting changing perspective

Another participant expressed a similar comment:

> *"It was only a two bed roomed bungalow. It would have meant turning one of the rooms into a sort of bed sitting*

> *room for a complete stranger. Really can't do with that*
> (Mrs G).

There appeared to be this aversion to live in care, which took a while for the significance of this view to be appreciated.

Another example of the development of a code relates to the statement in line 82 (repeated below):

> "*I thought to myself, I cannot go back home because if I could not do the things I wanted to it would depress me*"
> (Mrs B).

This statement seemed to reflect the participants' deliberation that had taken place prior to her decision not to return home and to choose to enter a care home. As indicated above, I initially assigned "*decision making*" as the code. However, on reflection it seemed too broad a concept and failed to differentiate between the types of decision making taking place. This participant was the second person to be interviewed and it was only after undertaking further interviews and rereading the data did I appreciate that the code did not reflect the subtleties of decision making occurring. It was during the coding of subsequent interviews, where similar concepts were repeated that the code "*influencing factors*" was identified. The code was amended to "*influencing factors*".

An important aspect of grounded theory is the ability to return to the field to obtain further data, based on the information identified from the analysis process. One example of this was when it became apparent at an early stage that participants were unaware that there were different types of care homes. It was appropriate, as part of the data collection to explore with participants as to whether the outcome would have changed had they known about the different types of care homes.

The phase of substantive coding led to the generation of a large number of codes. These codes needed to be refined to identify the most salient codes to be considered as categories (Glaser 1998, p72). The data fractured during the initial coding required reconstructing through the identification of categories or potential categories and their properties. This required me to move to a more abstract and selective way of categorising the data.

Incorporated during this phase was my need to recognise the importance of my own preconceptions and their potential to bias or influence the study (Glaser and Strauss 1967). I had to balance my knowledge of the subject area with an obligation not to make assumptions regarding the data and attempt to force data to fit into preconceived categories. My previous experience had led me to believe that care homes with RNs were for people who required care by RNs. Further, whilst they fulfilled a valuable service they were places that most people would not choose to enter unless there was an absolute need. It was important that I set aside that view to ensure that I could hear the participants' voice and be clear about the meaning of their words. I had to confront my preconceptions and values to ensure my own beliefs were not influencing the interpretation of the data.

Coding and data collection continued until the data did not seem to be providing any new information. The codes were refined to capture the intended meaning and accounted for all identified behaviours. Substantive coding moved to the next stage of selective coding.

5.4 Selective coding

Once I had identified, sorted and refined the "*open*" codes, I moved to explaining the larger, significant and more frequently appearing labels (Glaser 1992, Charmaz 2006). Rethinking the codes and establishing the interpretation of their meaning led to the identification of categories and their properties. Some codes exhibited more significance than others did and coding moved towards being "*selective*", focusing on those codes, which related to the core category (Glaser 1992). For example, "*rationalising decisions*", "*influencing factors*", "*accommodating decisions*" and "*accepting decisions*", due to their importance in relation to the research topic, were also identified as "*selective codes*". The importance of the different decision making styles grew in significance especially when taking into account the effect this had on the ability to settle into the care home. Only data that held relevance for the emerging theory continued to be incorporated. One of the most challenging aspects of analysing the data was trying to decide which potential categories were relevant to the study and which could be merged or expanded into other developing categories. This key stage of delimiting the theory required the integration of the potential categories and their properties.

Section 5.3 considered the following early "*in vivo*" codes "I take a day at a time", "I try to be happy wherever I am", "I try to like things". By using the participants' direct words described very aptly how some of the participants dealt with having been admitted to the care home. However, in order to move from descriptive incidents to concepts that are more abstract required the identification of a code that captured the above codes into a more succinct reduced, deliminated format. The utilisation of the gerund "*adapting*" achieved that aim and this concept, during the development of the categories became a property of the category "*settling in*".

5.5 Category development

In grounded theory the aim is to generate, by the use of constant comparison "*conceptual categories and their conceptual properties"* (Glaser and Strauss 1967, p35). The intention is to develop a hypothesis or a relationship between the categories and their properties (Glaser and Strauss 1967) state:

> "*A category stands by itself as a conceptual element of the theory and a property is a conceptual aspect or element of a category." (*Glaser and Strauss 1967, p36).

Glaser (1978) advised that this process required the incorporation of the key tenants of grounded theory, constant comparison and reduction, theoretical sampling, theoretical coding, the use of memos, diagrams and the inclusion of relevant aspects of the literature as data. The grounded theory process was designed to draw on the theoretical elements of the data. The codes identified during selective coding developed into properties of categories, with categories becoming the property of the core category. These conceptual codes serve as the "*building blocks*" of theory (Glaser 1978, p55).

I returned to the data to establish whether statements confirmed or contradicted previous data. Data often appeared to fit into more than one category. It was only by reading and re reading the transcripts and constantly and systematically comparing the data was it possible to establish relationships within the data. The process of describing and grouping the categories together assigned meaning to the statements. As the codes were developed, relabelled, refined and compared, the most salient areas became more apparent. Some codes had more significance than others had and needed to be explored as to their potential for category development. This led to the identification of some potential categories, which were scrutinised to discover whether they had the fit and relevance required to develop into categories or sub categories.

Throughout the process of analysis, categories and their properties became integrated. Categories were delimited and reduced by constant comparison which resulted in the main categories gaining in significance with an improved understanding of the relationship between categories. As the categories became integrated and reduced, only the most relevant remained, the categories themselves became saturated, resulting in nothing further to inform analysis. The aim was to develop a clearer understanding of the underlying patterns, as a precursor to delimiting the theory. As categories and their properties emerged, they developed in abstraction and become the core of the emerging theory. Throughout the study, theoretical memos were utilized to record my deliberations and make notes regarding various aspect of the process. This, informed category generation and posed questions of the data. Diagrams helped to identify the key linkages within the emerging categories. Throughout analysis and in accordance with the principles of grounded theory analysis, the relevant literature provided a source of data. Glaser (1967) recommends the use of the literature once the categories have been identified. Further reviews of the literature were undertaken to determine whether the findings from this study were reflected in other studies in order to add clarity, to develop the categories and the core processes becoming apparent within the study. The studies identified as a result of further literature searches will be discussed in Chapter Six and Seven.

The participants' stories recounted a life before admission to a care home, which on initial reading seemed, to be just setting the scene, without any particular significance. This topic area began to gain in importance and led me to explore aspects of loss associated with their past life and the grieving process. This was coded initially as "*previous life*" but was later changed to

the gerund “*leaving the past*”, depicting the physical change that had occurred. The concept of “*leaving the past*” suggested an element of having to move on and to make changes but in reality related to an event, which had initiated the change, in effect, a “*turning point*”. The use of a gerund to depict action and to signify a major occurrence in people’s lives also added significance to the data. Initially I considered whether the code “*turning point*” with the realisation that their lives will no longer remain the same, might have had the potential to develop into a category. However, further exploration concluded it was not robust enough to justify its identification as a category; instead, it became a property of a category. The extension of categories and the development of emerging theory continued until no new categories emerged (Glaser and Strauss 1967, Glaser 1978, Strauss and Corbin 1998, Charmaz 2006).
Two main concepts started to take shape within the data. Firstly, the importance of the period in advance of entering the care home. Whether this was due to a specific event or a more gradual change in their situation, it led to the realisation by the participant or their families that their previous life could not continue. The “*turning point*” signified the need for change. This guided me to the development of the category “*choosing the path*” which will be detailed in Chapter Six. The second category to gain in significance was the period post admission to the care home. This reflected to what extent the participant had settled into the new environment and was entitled “*settling in*”, detailed in Chapter Seven.

Following the initial substantive coding, the data analysis moves to the next more abstract phase of theoretical coding (Glaser 1978).

5.6 Theoretical coding

As the categories became more refined, theoretical codes specified possible relationships between categories developed during the coding process (Charmaz 2006). Theoretical codes are the second coding method according to Glaser (1992), are more abstract than substantive codes and provide a more theoretical way of thinking about the data. Developing theoretical codes assisted in bringing together all the data, codes and facilitated the identification of possible relationships between categories and conceptualising how the codes related to each other with the intention of "*weaving*" the fractured story back together (Glaser 1978, 1992). Theoretical codes must have "*grab and fit*" and are used to give form to the codes and assist in telling the story (Glaser 1978). Once the potential categories started to manifest I sought through the use of constant comparison, to establish their differences and similarities. The identification of "*negative cases*" is considered important by Glaser (1978) as well as, what influenced the category to change. The relationship between the other developing categories was also explored.

An aspect of developing theory relates to what Glaser identified as the 18 theoretical coding families that aimed to develop relationships between categories and their properties (Glaser 1992). Within the coding families Glaser (1978, p74) classified as the six C's, identified as the first general code and an integral aspect of theoretical coding. The six C's are causes, contexts, contingencies, consequences, covariences and conditions. Glaser (1978, p74) suggests that not all the codes are applicable and most studies fit into a causal, consequence or condition model. They provide a lens to view the data and enabled the fractured data to be brought back together again (Glaser 1992). Theoretical coding provided signposts to enable the relationship between codes and their labelling to be tested (Glaser 1978, Jeon 2004).

Theoretical codes offered explanations relating to the theory generated from the study and allowed for more in depth analysis of the core variable by identifying factors associated with entering and remaining in a care home with RNs. Grounded theory explained the why, how, where, when and under what conditions and with what consequences did the theory unfold (Jeon 2004). It was this ability to conceptualise which defines grounded theory as opposed to conceptual description, which fails to achieve the necessary level of abstraction and just describes experiences. Focusing on the relationship between the theoretical codes assisted in linking the data to the analysis.

Table 5.4 details the theoretical codes associated with the factors that link the data.

Theoretical Codes	**Choosing the Path**	**Settling in**
Causes	Change in situation leading to consideration of care home admission Turning point	
Conditions	Factors that contributed to admission Lack of support at home both actual and perceived. Family view that care at home is no longer sustainable	Ability to settle into the care home Made to feel welcome in the home Positive decision making

Consequences	Admission to a care home	Settling or not settling into care home
Contexts	Older adults living at home, requiring an increased level of support or following a medical event.	Whether the participant choose to enter the care home of whether the decision was made for them.
Contingencies	Circumstances necessary for care home admission to occur	Participant being able to settle into care home

This form of coding ends when it locates a core category and forms the basis of theory generation. (Charmaz 2006).

5.7 Core category

Analysis then focused on identifying the core category which tied the stages and phases of the theory together (Charmaz 2000) and established linkages between this and the other categories. Glaser and Strauss (1967, p 261) stress that a "*theory should fit the data*", it should work and be relevant within the area being studied. Identification of a core category is the central point of grounded theory (Glaser 1992) as it integrates all of that theory's various aspects and accounts for most of the variation in a pattern of behaviour, which is problematic and relevant for those involved. Glaser states that (1978, p95) the core category will emerge from among many and "*core out*". Glaser and Strauss (1967) explain that in order to discover theory the researcher:

> "*generates conceptual categories or their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept*" (Glaser and Strauss 1967, p23).

They go on to state:

> "*the concept is undoubtedly a relevant theoretical abstraction about what is going on in the area studied*".
> (Glaser and Strauss 1967, p23).

Glaser and Strauss (1967) argue that the concept does not change even if the facts do. This point is illustrated by reference to their study of care of dying patients. The theoretical category is "*social loss*" which is identified as the value of the dying person's loss to family and society. The nursing care received was dependent on how the nurses viewed the individuals' level of "*social loss*". Glaser and Strauss (1967) conclude that people with a perceived high level of "social loss" will receive better care than those with a low "social loss." This category of "social loss", which in their study relates to nursing care, can be applicable in other hospital settings. Glaser and Strauss (1967) predicted that those perceived as having a high "social loss" value would lead to better care than those with a lower "social loss" value. Glaser and Strauss (1967) conclude that a theory remains a theoretical category until disproved as theoretically no longer applicable and replaced by a better theory

Once the core variable had been identified, it guided further data collection and incorporated the literature relevant to the developing theory. Coding then focused on those variables that related to the core variable to further support and direct theory development.

5.8 Evaluating the quality of research findings

In order for the findings of research to be given credence, studies have to demonstrate their worth through a robust evaluation of the methods utilised to conduct the study. A school of thought suggests that qualitative studies should not be judged using the same criteria as used in quantitative studies (Guba and Lincoln 2005). Lincoln and Guba (1985) assert that all research, including quantitative, is subject to the inclusion of some “values” attributed to the researcher. These values can take the form of basic assumptions, perspectives, both personal and cultural norms and can influence the outcome of the research.

Glaser and Strauss (1967) were critical that grounded theory studies could be evaluated based on quantitative verification methods of validity and reliability. In preference to the terms validity and reliability, Glaser and Strauss (1967) adopted the terms credibility, plausibility and trustworthiness as concepts, which can enhance the quality of grounded theory studies. In order to evaluate whether a study is worthy of consideration require the ability to demonstrate what Glaser and Strauss (1967) and Lincoln and Guba (1985) articulate as the credibility of a study. They argued that detailing the strategies used for collecting, coding, analysing and presenting data could demonstrate the credibility of a study. Credibility can also be demonstrated by the use of direct quotes from participants and the use of the core principles of grounded theory to explain how theory was generated from the data. In this study, rigour and credibility will also be demonstrated in the manner in which the research was conducted and how the findings were presented. This will establish for the reader how the emerging (or substantive) theory fits the data, is relevant and can withstand scrutiny (Pope and Mays 2006).

The term credibility has similarities with internal validity and aims to depict how things really are and how they work as well as seeking the truth in the data.

Lincoln and Guba (1985) suggest two factors, which enhance credibility. The first involves carrying out the study in a manner that enhances the believability of the findings, answering the question, are the conclusions reached feasible? The second approach involves taking steps to demonstrate credibility, has the research been conducted in accordance with good research practice (Lincoln and Guba 1985, Bryman 2004)? One way of achieving credibility is by allowing the participants to guide the inquiry process (Chiovitti and Piran 2004), by investing sufficient time in the data and with them. I sought to achieve this by trying to establish a rapport during the "*interview*" by being interested in the participants' lives at the outset and providing a full explanation of the importance of the research study. At the end of each interview, I recapped the salient points discussed, to ensure I had not misconstrued their meaning and to afford the opportunity for any misapprehensions on my part to be corrected. The use of reflective memos (discussed in Section 4.6) detailed any non-verbal cues such as body language, mood or gestures, as well as my thoughts and impressions regarding the interview.

Lincoln and Guba (1985) suggest that getting the participants to check over the transcripts and the analysis will assist in establishing credibility. Guba and Lincoln (1989) as is Glaser (2002) are critical of the success achieved by this practice. Lincoln and Guba (1985) argue that this practice may lead to misleading assertions that the study possesses credibility. They cite a study whereby despite errors of fact, none of the hundreds of people member checking, considered their views had been misrepresented. This can be due to participants expressing agreement either out of politeness or in deference to what they may consider is the researcher's greater level of knowledge. The other factor according to Byman (2004) is that the bond established between participant and researcher may make them reluctant to be critical. Participants may also consider that they have already contributed to the research study and they may not want further involvement. Glaser's (2002) view is more emphatic as he asserts that grounded theory provides an abstraction of their voice not their actual words and as such, member checking cannot be used to establish credibility.

I chose not to ask the participants to read the transcripts as many had failing sight and may have found reading approximately 15 pages of transcripts daunting. Even those participants with the visual ability to read the transcripts may have considered it too much to ask, as they had already afforded me a considerable amount of their time. In the event that they had read and concurred with the content of the transcripts, it would have been a significant imposition to ask them to comment on my conclusions. Bryman (2004) suggests that even if research findings were put forward for comment, some participants may have found deciphering the language of research too daunting. There did not appear to be sufficient benefits to warrant the approach so this was not undertaken.

One of the key tenants of grounded theory is the need for the researcher to develop theoretical sensitivity, previously discussed in Chapter Four, which is also a key factor that can contribute to demonstrating the authenticity and credibility a qualitative study requires. I chose to either document my reflections, deliberations and decisions in a notebook that accompanied me throughout the study period or by recording my thoughts via my recorder and transcribing them later. The term "*reflexivity*" refers to the researcher's awareness of themselves as part of the data they are collecting and the ability to reflect on their own behaviour and the influence it may exert on the data (Hall and Callery 2001). Glaser asserts (1992, p8) that "*all is data*" and argues that the use of constant comparative analysis will treat bias as just another variable of the research and if conducted correctly, will remove bias in whatever form it presents. Hall and Callery (2001) expound the view that combining theoretical sensitivity with reflexivity and relationality can enhance the rigour of a grounded theory study. Relationality, according to Hall and Callery (2001) addresses the power and trust relationship that exists between researcher and participant as another mechanism by which the rigour of grounded theory study can be enhanced. I as the main research tool took into account my position as researcher.

Grounded theory methods produce an abstraction from time, place and people (Glaser 2002). He goes on to argue that grounded theory differs from qualitative data analysis, due to the use of a method that eradicates bias. Data is abstracted and not simply described (Glaser 2002). Despite Glaser's assertions that bias is eradicated by the use of grounded theory methods. Researchers need to be able to defend the robustness of the study in other ways.

In addition to credibility, Glaser and Strauss (1967) identified the terms plausibility and trustworthiness as further concepts to enhance the quality of grounded theory studies. Plausibility refers to the degree to which the research process and the theoretical findings fit reality (Hall and Callery 2001). Are the findings believable and can we trust them? In order to defend the robustness of the study, I provided a full explanation of my sampling strategy, the manner in which the interviews were conducted and subsequently coded, how my conclusions were reached and whether they were presented in a plausible way. By including the use of reflexive memos and supporting notes, documenting how the research process had been undertaken and by the identification of my views, deliberations and problems encountered during the study assisted in demonstrating the logical progression and cohesiveness of the research design.

Establishing transparency throughout data collection and analysis process allows the reader of the research to make their own judgements regarding the quality and trustworthiness of the research. My aim by utilizing the strategies outlined above was to enhance the rigour of the study and the trustworthiness of the findings (Holloway 1997, Cutcliffe 2000). Rigour can be enhanced by the use of a clear audit trail with an explanation as to the methodological decision making undertaken. Access to complete transcripts of the interviews provided corroboration of the participants' actual words and demonstrated how categories and concepts were identified leading to the development of the core category. The level of detail provided should be sufficient to enable judgements about the research process to occur (Strauss and Corbin 1998)

Glaser and Strauss (1967) and Glaser (1978, 1992) devised their own criteria for assessing the value of grounded theory studies. According to Glaser and Strauss (1967) any theory being developed must be understandable and:

> "*fit the situation being researched and work when put into use".* (Glaser and Strauss 1967, p3).

Glaser (1978, 1992) sets out four criteria required to achieve robust theory. Firstly, the categories of the theory have to "*fit*" the data. The theory should relate directly to and account for all the data and should not be forced to fit predetermined or preferred categories. Secondly, it is essential that the theory "*works*", enabling it to explain the variations in behaviour and interpret what has taken place in a manner that can be readily understood. Theories that fit and work will have "*relevance"* which is the third criteria. They can achieve this by allowing "*core problems and processes to emerge*", rather than the use of a preconceived theory. Cutcliffe (2005) suggests that the theory should be

> "*Sufficiently general to be applicable to a multitude of diverse daily situations within the substantive area, not just to a specific type of situation*" Cutcliffe (2005).

Lastly, a good grounded theory requires "*modifiability*" which recognises the ever changing nature of the social world and the responsiveness of good grounded theory to adapt to those changes (Glaser 1992, p5).

The above discussion has centred on the use of various criteria to judge the rigour of a study. Researchers sought through the use of terminology to provide legitimacy to qualitative methods to establish the robustness of a study equivalent to those in quantitative research. The goal of interpretive enquiry is to seek an understanding of an individual's social world and that can only ever be an approximation, it can never be an exact interpretation but by providing a clear explanation as to how the research was conducted can enhance belief in the study findings.

During the research study, I was careful to identify my own beliefs and perceptions, explain and justify my actions with regard to how the research was conducted and how my conclusions were reached. I supported the study with memo's and by incorporating the participants' own words. I also detailed the development of codes and categories. The strength in my approach rested with what I was able to bring to the understanding of why participants choose to enter a care home with nurses rather than a search for the complete truth. That does not mean that the measures described did not strive to ensure the study findings were as robust as possible.

Achieving academic rigour in grounded theory is dependent on being able to demonstrate a clear, coherent approach, which justifies the methods used, the decisions and actions taken. By maintaining a level of theoretical sensitivity throughout the study, the use of an audit trail, reflective memos and transparent decision making, enabled the reader to have confidence in the findings from this study.

5.9 Summary

This chapter described the key principles of data analysis in grounded theory. The principles of coding, from initial line by line coding through substantive and theoretical coding are explored. The processes of developing categories are also considered. An example of a memo is provided and how through the process of data analysis and constant comparison the memo evolved. The importance of being able to demonstrate quality and robustness within a grounded theory methodology was also discussed.

Chapter Six and Seven will present the findings from the data analysis and how they relate to the categories of "*choosing the path*" and "*settling in*".

Chapter 5: Data Analysis

Chapter 6: Findings: choosing the path

6.1 Introduction

This study sought to explore, understand and interpret the experiences of older adults when deciding to enter and remain in a care home with RNs. The next two chapters present the findings of the process of data analysis described in Chapter Five, including excerpts from the participant interviews with examples from the literature where appropriate to support the emerging categories. I will describe the generation of categories, their properties and address some key findings relating to the factors that influenced the decision to enter and settle in a care home with RN’s.

This chapter entitled “c*hoosing the path*” will explore issues relating to how and why the decision was made to enter a care home and who was instrumental in making the decision or assisting in the decision being made. Diagrams will be used as part of the analytical process to visually represent the conceptual relationship that developed amongst the emerging categories and their properties. Italics have been used to emphasize some of the key concepts.

6.2 Choosing the path

In order to fully appreciate the factors that influenced the decision to enter to a care home with RNs it was necessary to delve back into the pre-admission living arrangements. What had led to the conclusion that living at home was no longer a viable option resulting in admission to a care home with RNs? Smallegan (1985) speculates that no one’s first choice is to enter a care home:

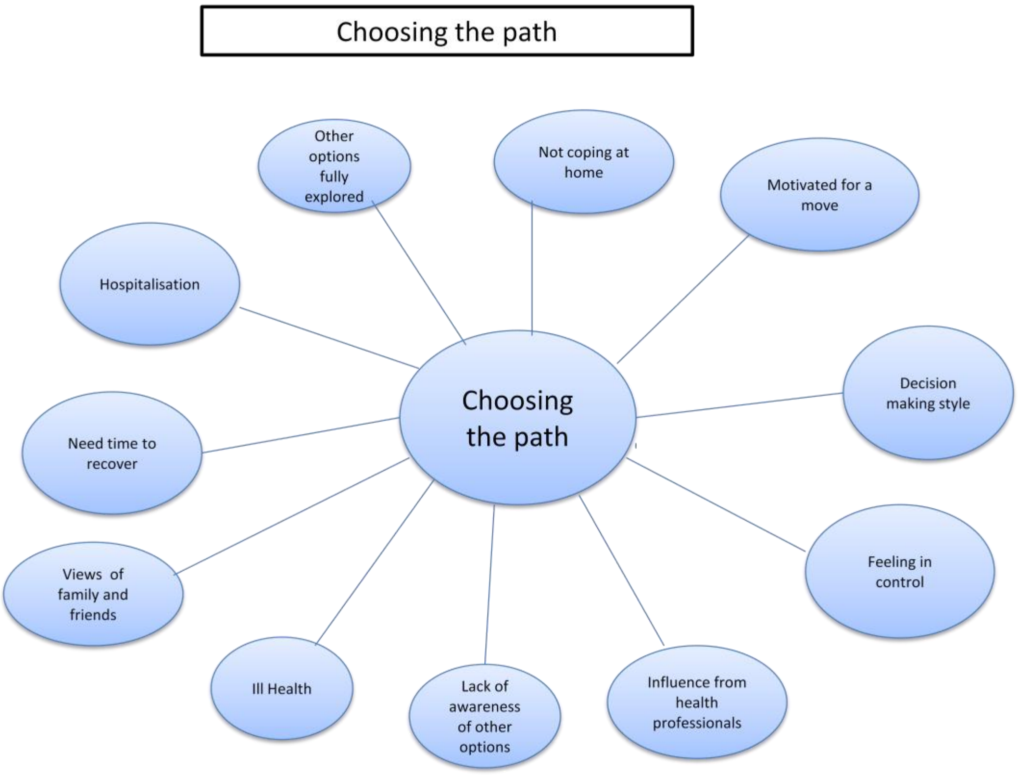
Chapter 6: Findings: "choosing the path"

> "*a decision to enter a nursing home is always a result of inadequacy – in finances, health, social supports, emotional strength or other ability to cope*" (Smallegan 1985, p364).

If her assumption is correct, what were the inadequacies experienced by the participants in this study that had triggered care home admission? Had there been other options open to them?

Figure 6.1 details the factors as identified by the participants that contributed to making the decision to enter a care home with RNs.

Figure 6.1 Choosing the path



Chapter 6: Findings: "choosing the path"

The study participants were admitted to a care home via one of two possible routes. Participants were admitted directly from hospital (5 participants) or as was the majority from their own home (7 participants). In two instances, participants had been admitted from hospital directly to another care home, where they had remained briefly prior to entering the current care home with RNs. These two participants have been incorporated within the admitted from hospital group. The common thread was a change in their circumstances, which led them to considering admission to a care home with RNs as a viable option.

During data analysis, I concluded that having an understanding of the period before admission to the care home had a bearing on the development of this key category. Most participants appeared keen to discuss their pre admission to care home self, sharing their life before residential care. Each story varied in the level of detail provided, with some participants describing their home and family situations and recounting specific events in their past. For example, their voluntary work with a national charity or stories about the decline of a local restaurant that a participant and her husband had frequented. I interpreted this disclosure as the participants demonstrating their previous independence, focusing on their status as a valuable member of society, as worker, spouse or parent, a self-sufficient entity in control and capable of running their lives. It was as if they were trying to preserve their identity and validate the importance of their life that existed before the care home, a life now lost (Gubrium 1993, Rowles and High 1996, Paterniti 2003).

The participants' discussion of their life before admission was initially coded as "*pre admission status*". However, this felt very clinical and failed to depict the actual change that occurred. The code "*leaving the past*" seemed to encapsulate the significance of what was happening for these people, akin to grieving for their life before. Following further examination of the data, this code was renamed "*turning point*" to respect the significance of their previous life but also to acknowledge the need for change. The "*turning point*" could be as a result of a health event requiring hospitalisation or a more subtle realisation indicating the need for alternative arrangements. For some, it may have been the culmination of months of struggling, with hospitalisation providing the impetus that initiated the need for change.

One participant described how hospitalisation had been the trigger for change. When asked why she had been admitted to the care home she stated:

> *"Because I needed a lot more looking after, than they* (family*) could give me. Or that the uniformed people* (carers) *could give me"* (Mrs D).

Hospitalisation is often a precursor to care home admission with participants acknowledging a decline in physical functioning perhaps resulting in a loss of confidence (McCauley *et al.* 1997, Penrod and Dellasega 1998, Wilcocks *et al.* 1987, Hoare 2004,Gilbert *et al* 2009). All of the participants had suffered from a period of ill health leading to hospitalisation. It would appear that although the participants perceived that they were less able, their functioning was still of a level that did not require care by RNs. Participants who had been hospitalised prior to admission to the care home transferred directly from hospital. This trend was highlighted by the Commission for Social Care Inspectorate (CSCI 2004) who identified that in some areas up to one third of permanent admissions to care homes with or without RNs were admitted directly from hospital. The impact of experiencing a health event and the unsettling environment of being in hospital can affect how people review their options.

One participant stated when asked about the decision she had taken to enter the care home and whether she had considered returning home with assistance stated:

> *"I wasn't in a fit state mentally or physically to start*
> *making those sort of arrangements even with help. So there*
> *just wasn't any question of it"* (Mrs G).

Peace *et al.* (1997) argue that decision making whilst in hospital is compromised due to poor physical health and reduced personal strength. The individual is susceptible if health and social care professionals are intimating that residential care is the best, if not only option. Many participants were not aware of the range of care options on offer. A study by Peace *et al.* (1997) reiterated that view, as did a more recent Counsel and Care study (2009). Both studies concluded that a considerable number of people are being discharged to a care home without being aware of the full range of options on offer to them.

None of the participants indicated that they had been offered rehabilitation in advance of entering a care home. They may have benefited from some rehabilitation to assist in their recovery, to improve function and possibly regain confidence. Department of Health guidance (2009) indicates that rehabilitation should be explored in advance of admission to a care home. The Community Care (Delayed Discharge etc Act) (DH 2003b) recommended the use of intermediate care "step down" beds with the intention of bridging the gap between hospital and long term care. The Department of Health funds delayed discharge grants payable to local social service departments to develop improvements in care services to support the transfer of patients out of hospital (Bryan 2010). These initiatives are primarily available to people who are in receipt of local authority funding. Those funding their own care, whilst not explicitly excluded, may miss out, due to not being in receipt of local authority services.

Due to a constant demand for hospital beds, pressure is placed upon participants and their families to organise a discharge destination within a very short period of time (Bryan 2010). In the financial year 2004 to 2005 the average length of stay in hospital was just over seven days, which may not allow patients time to recover from the event that caused hospitalisation and to reflect on their long term care options (Bryan 2010, Peace 1997). Participants appeared to be of the impression that their choices were between care at home or residential care. The CQC (2009) annual report highlighted that self funders may not be afforded the opportunity to fully consider their options with appropriate advice and support in advance of discharge. This, possibly results in a poorer standard of treatment than those in receipt of local authority funding, a view echoed by the Counsel and Care study (2009). Victor *et al* (2001) concluded that 15 percent of older adults admitted to long term care recovered sufficiently to have been able to return home had it not been that they had already given up their home.

Participants explained their rational for entering a care home, which varied, from wanting to convalesce:

> *"I literally came in for some convalescence"* (Mrs B).

and:

> *"That was the plan (*convalescence*) then I just stayed here"*
> (Mr K).

To feeling that they were unable to continue to function at home:

> *"I was in and out of hospital, I realised that when I came out of hospital, I physically couldn't do anything"*
> (Mrs G).

Another participant stated:

> *“I collapsed and then I decided I couldn’t go back to shopping and cooking I finally decided I couldn’t do it any longer*” (Mrs I).

These participants had clearly articulated their reasoning for entering a care home. Their rationale for coming to these conclusions was multifaceted, with not all factors applicable to everyone.

The previous participant statements, related to those who had been admitted to a care home with RNs from hospital. Amongst those admitted from hospital there appeared to be a clear indication that the participant was involved in the decision making despite the potentially compromising nature of their hospitalisation. A different pattern of decision making seemed to exist for those who were admitted from their own home. There was a move away from the participant being the decision maker to that role being undertaken by family members. An exploration of decision making styles will be considered later in the Chapter.

On participant who had been admitted from home, clearly stated:

> *It wasn’t my decision”(*Mrs F*).*

Another participant expressed:

> “*My niece was worrying about what was going to happen to me. I think I could have carried on for a while*”
> (Mrs E).

As discussed previously, it is not always a single factor that results in admission to a care home. One of the properties of the category “*choosing the* *path*", related to the various "*influencing factors*" identified during data collection. These were outside or within the participants' control and either contributed to the decision or served to hinder the decision making process. **Figure 6.2.** Below, depicts a diagram detailing the factors that influenced decision making as identified by the study participants. These factors are explored in greater detail further on in the chapter.

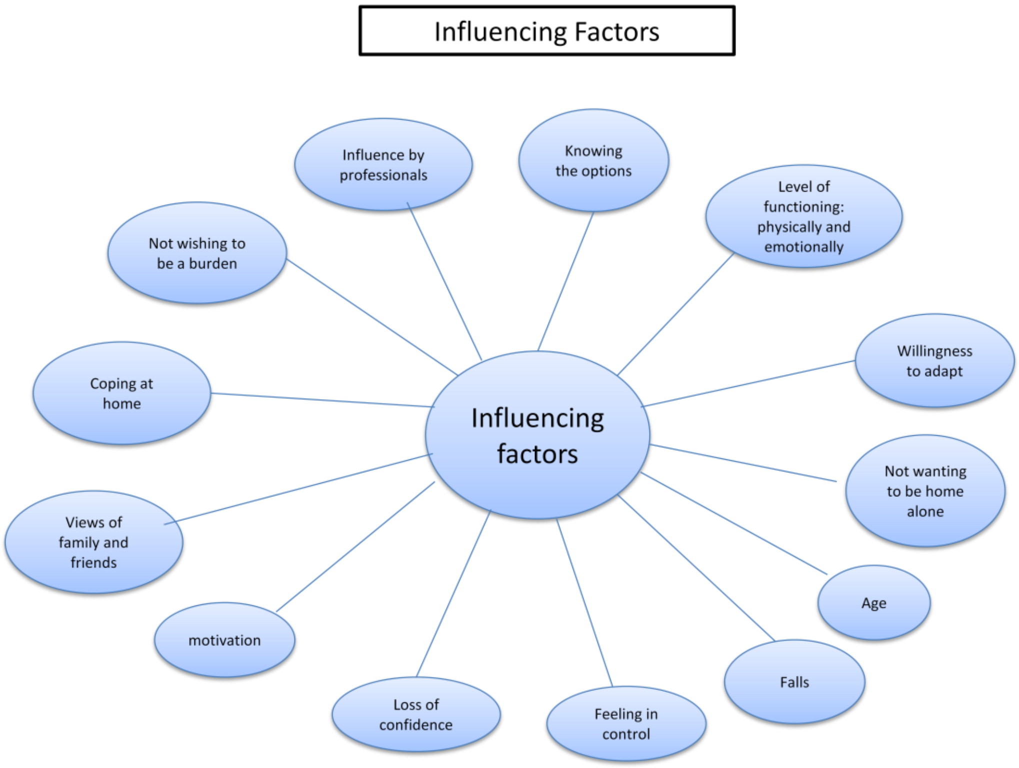


Figure 6.2 Influencing factors

According to a study by Peace *et al*. (1997) older adults are less likely to enter residential care if a number of conditions are present. Availability of good informal support with sufficient income to maintain, adapt or enhance support at home or the availability of good community services. A study by the Joseph Rowntree foundation (2006) found that by providing "*that bit of help*" assisted older adults in remaining independent at home. This low level input was described as providing assistance with minor repairs, lunch clubs and help to attend appointments. Other studies have identified physical and mental health problems, requiring 24 hour care or supervision as reasons for admission (Bebbington *et al*. 2001, Smallegan 1985). Boggatz (2009) highlights the example of the "*perceived threat*" as being a factor in care home admission. Older adults were wary of returning home, as they had perceived that other problems could beset them, which included the risk of falls, further ill health and loneliness. One participant cited as a reason for admission to care was that she was experiencing falls at home. A study by Gilbert *et al* (2009) found that patients admitted to hospital following a fall were less likely to return home.

Concerns about being able to cope at home was the trigger for one participant who entered the care home with her sister. They had been living separately but were both experiencing difficulties and chose to move to the care home together. Another participant had decided that he was not managing at home and chose to enter the care home. According to Willcocks *et al*. (1987) problems associated with informal support networks accounted for one in five of admissions.

Some of the study participants were experiencing difficulties with their mobility, requiring the use of a walking aid, but not to the extent that it restricted their ability to move around the care home. Other studies have highlighted carer stress as another major reason, as was lack of patient motivation with fear of crime, abuse and loneliness cited by a small number of people (Bebbington *et al*. 2001, Fraher and Coffey 2011).

Participants identified the need for company as one of the reasons for entering a care home. One stated:

> *I don't like being alone* (Mrs I).

and another:

> *I couldn't have stayed there on my own* (Mrs J).

Care homes can offer companionship, which may be lacking for some people living alone. A socially unconnected person who has never married or has been widowed may enter a care home without physical or mental impairment simply because they want the companionship which may have been missing at home (Willcocks 1987, Fraher and Coffey 2011).

Participants appeared to be unaware of the different options on offer in advance of entering a care home (Fraher and Coffey 2011, Counsel and Care 2009). One factor identified was the apparent lack of information and advice provided to the participant and their family with regard to the various residential and non residential facilities available. Participants' not being fully apprised of their options was a concern for me, with my clinical background and my personal ethos of informed decision making. Irrespective of whether participants had settled into the care home or not, being afforded other options may have had a dramatic impact on their life, but non more so that those participants who had not settled in their care home. If advice and support is not available from health and social care professionals, participants or their families who are computer literate may search the internet for information regarding care homes.

A range of websites exist that offer assistance and information. Searching the internet does not always provide what is required as I discovered when I entered the phrase "*looking for a care home*" into two well known search engines. Apart from the funded adverts, I did not always locate advice on how to choose a care home. When I narrowed the search to my local area, I then came up with a selection of care homes, an entry link to the local authority site and a local care home association. One search engine came up with a link to CQC and Age UK, but the other one did not. Being able to access information is dependent on having access to a computer and a degree of computer literacy. Those people without internet access may not know who to approach for assistance. All hospitals should have a patient advocacy liaison service (PALS) who should be able to provide advice and assistance but this is again reliant on people being aware of their existence.

Studies have identified that decision makers are often family members but that doctors and other health care staff also exerted considerable influence. In some circumstances, they may be considered the main decision maker. A major UK study concluded that health and social care staff were instrumental in the decision making regarding admission to residential care, to the detriment of the resident (Wilcocks *et al*. 1987). Hospital staff should be a source of information to patients and their families and can exert considerable influence either intentionally or inadvertently. A comment made early in the admission, can affect the decision to enter a care home.

At times, hospital doctors appeared to influence the decision making process although the extent of their influence is unknown. Some participants credited a doctor with either suggesting the care home or giving it their seal of approval. Stewart and Roter (1989) explored the patient and doctor relationship. They acknowledge the continued existence of the traditional paternalistic model as one of their four types of patient and doctor interactions. The paternalism model, whereby the level of patient control is low and the level of control by the doctor is high can result in a greater level of acceptance of the authority of the clinician (Stewart and Roter 1989). An example of this comes from one participant who had been in hospital following a period of ill health and had made the decision to enter a care home on discharge from hospital. She had considered returning home with support but discounted that option. Her nephew had been to look at three care homes and had expressed a preference in the one that was ultimately the discharge destination. The doctor who was present during one of these discussions appeared supportive of this particular care home:

> *"and the doctor was there and he nodded and said it is the best, and so they thought that if the doctor says that, it is not too bad" (Mrs B).*

His apparent approval served to substantiate the choice and reinforce the decision although the extent of his knowledge regarding the suitability of this home was unknown. Another participant also indicated that the doctor had contributed to the decision to enter a care home but it was unclear as to the extent of his influence. During coding and analysis, the above sentence was originally coded as "*decision making by others*". However, that failed to separate out the different decision makers, professional, family, friends, and their level of influence. The doctor did not make the decision, his involvement only extended to confirming the impression that this participant and her relative had also reached. He did exert some influence over the decision making as evidenced by their placing some importance on his validating their choice. The regard paid to his input was difficult to gauge and ultimately may not have altered the decision. The code was amended to "*professional influence*."

Other health and social care professionals also have an important role in directing participants and providing appropriate advice and support. Older adults who do not have resources to finance their own care may be eligible for assistance from the local authority. Local authorities will allocate a care practitioner to undertake an assessment of needs (Community Care Act 1990).

The assessment determines an individual's needs and how these could best be met. Without a comprehensive assessment, individuals may not be aware of their options or financial entitlements (Community Care Act 1990, National Care Forum 2009). The assessment should take into account personal wishes, including whether an individual wants to remain in their own home. The assessment should also identify whether there is a need for care in a care home or other supported living options. Once an individual's needs have been identified, the local authority care manager has a role to discuss with the patient and their family the available options and work with them to put an appropriate package of care in place. This may include admission to a sheltered living facility or a care home with or without RNs.

One participant acknowledged assistance from a social care professional whilst in hospital. This participant lacked family members who could have assisted him. He reported that a social worker had helped to locate a suitable care home. The remaining participants may not have been in receipt of practical assistance whilst in hospital. However, from my experience either a member of the ward nursing or the local authority staff would have had to identify whether each participant was responsible for funding their own care on discharge. The extent of this initial contact may have just taken the form of a question to establish whether the participant was responsible for funding his or her own care and once known, there may not have been any further involvement by the local authority.

Lack of support at this stage may disadvantage people who may be unaware of their entitlements. For example, they may not be aware that they can have the value of their property disregarded for the purpose of paying care home fees for up to 12 weeks. The Department of Health introduced the 12 week disregard to provide an opportunity for care home residents to have time to consider whether a care home is the correct option in advance of having to commit to residential care and potentially sell their home (DH 2008). The Local Authority is responsible for funding the care home fees and the value of the house is not taken into account during that period. If people are not aware of this option they are unlikely to take advantage of it (DH 2008).

Local authorities due to funding constraints have chosen to focus their resources on people whose care needs have been assessed as being substantial or critical. This suggests that those individuals whose care needs have been assessed as not being substantial or critical may not be eligible for local authority care (Wanless 2006). This policy of only supporting people with substantial or critical needs had been initiated by 72 per cent of councils (CQC 2009). There is evidence that providing social care for people with lower needs can delay the use of high level social care such as care homes (Wanless 2006). A CQC report (2009) takes the view that as the population ages and financial pressures increase, access to publicly funded care will become further restricted. In such circumstances, it is particularly important that people have access to good support and information regarding the available options (CQC 2009).

Identification of the "*turning point*" for someone in hospital was easier to identify than that of an older adult in his or her own home. Participants who had been admitted from their own home described a different scenario regarding when the "*turning point*" was reached and who was responsible for the making the decision regarding long term care. Wanless (2006) reports that a social care inspection survey in 2004 showed that the majority of people want to stay in their own home or a smaller home with support. The survey also indicated 21 per cent indicated their preference was for a care home (Wanless 2006, p58). A study of community care services, by Davies *et al.(*2000, cited in Wanless 2006, p60) of people with care needs, concluded that out of a total of 333 responses, 41 per cent were against admission to a care home. A further

25 per cent were strongly against care home admission and 26 per cent preferred not to be admitted to a care home. In total 92 per cent of the study population reported that they were against residential care.

Care at home may be a viable option for many people. However several studies have concluded (Nolan *et al.* 1996, Efraimsson *et al*. 2001) home care needs to be well planned to ensure that it supports patients and their families both practically and emotionally. There is a tendency that too much responsibility falls to informal carers. The study participants, whilst not having extensive care needs, seemed to have lacked support from family members to provide assistance to enable them to remain at home. The choices between care at home or residential care may involve what Peace (1997, p43) considers to be personal trade-offs. Some of her suggestions present as being very stark, such as "*personal care versus personal neglect; security versus privacy; company versus solitude; warmth and regular food versus familiar places and objects*", implying that care at home cannot deliver a good standard of care. In my experience it is not inevitable that those at home will be faced with unsuitable care, to any greater extent than can be experienced by residents in a care home. Peace *et al*. (1997, p47) defines residential care as "a *place in which to care or be cared for*". It is easy to associate care in the physical sense, but does care only relate to assistance with activities of daily living? Should it extend to encompass providing a place of safety and the provision of companionship?

It has already been suggested that the study participants were not always the decision makers when it came to considering admission to a care home. One of the important factors to feature in the data related to the role of the participant and their family in making the decision to enter a care home. In several instances, the participant did not consider that they had made the decision to enter care, with that role being undertaken by family members, often the participants' daughters, with varying input by the participant. The decision may also have been made, jointly with the participant. Family members were not interviewed for this study but an indication of the level of influence they exerted over the decision could be gauged from the data provided by the participant interviews. Although by law (Mental Capacity Act 2005) no one is able to make decisions for a person with capacity, in reality family play a crucial role in exercising their powers of persuasion. One participant who considered she was managing at home stated her niece had wanted to get her settled and was the driver for the admission into the care home. A study by Reuse (2005) demonstrated the sense of relief felt by family members at getting a loved one settled. Families may consider they are acting in the best interest of their relative. Arling *et al.* (2010) in their study regarding the potential for older adults to return to the community following admission to a care home highlighted the importance of having a family member who was supportive of the decision to return home.

Lack of involvement in the decision making process is not unique to this study (Wilcocks *et al.*1987, Netten 2001, CQC 2009) nor to this country (Nay 1995, Penrod and Dellasega 1998, Nolan *et al*. 1996, Sommes *et al.2008,* Fraher and Coffey 2011). Care home residents in Australia, United States of America and France have reported similar experiences (Nay 1995, Penrod and Dellasega 1998, Nolan *et al*. 1996, Sommes *et al.2008*). Findings from CQC (2009) indicated that almost half of users of adult inpatient services were "*definitely*" not involved in decisions about their care to the extent they wanted. Half the 19 participants in the study by Nay (1995) indicated that they had made the decision to enter care, with many having expressed the view that there was a lack of alternatives to entering a care home. Somme *et al*. (2008) interviewed 3538 randomly selected residents in long term care facilities across France using a 139 question, questionnaire to determine level of involvement in the admission process. Only 38 percent of residents considered that they had been part of the admission process. A study (Penrod and Dellasega 1998) carried out in North American explored the experiences of family members who had to admit a close family member to a care home. The participants in the study were reliant on public funding and the medical staff were identified as being, the real decision makers as they were the gatekeepers to accessing public funding. Penrod and Dellasega (1998) reported carers cited the lack of other options offered to them and the inevitability of the process as being areas of frustration.

Participants and their families can make the decision to live together to mutual benefit. One example was the participant who had made the decision about nine years ago to combine her resources with her daughter and son-in-law and purchase a property together where they could all live. She reported:

> "*I had my own bungalow and sold the bungalow, at my daughter and son in law's request"* (*Mrs D*).

This participant reported that they had purchased a large eight bed roomed house and she spoke with fondness of looking after her grandson and singing him songs to help him go to sleep. It appeared from her conversation that at the time this arrangement proved to be mutually beneficial. However, as time went on and for reasons that she appeared not to want to elaborate on this arrangement ceased to be viable. Her comments indicated that when she went into hospital the opportunity had presented itself for her to be admitted to a care home. She reported that she:

> "*needed more looking after, than they (her family) could give me*" (Mrs D).

It proved difficult to obtain further details regarding the precise reasoning for her not being able to return home. This participant presented as being physically able with the assistance of two walking sticks and reported that she required some assistance with washing and dressing. This level of need could be easily managed in the community. She suggested that the hospital had indicated that she could not return home. She reported:

> *They said,(*staff at the hospital*) my people really hadn't got the time to look after me properly so they thought if I came out into a care home it would be better for me and for them and it was*" (Mrs D).

This participants' daughter was working and it had been suggested that she did not have the time to assist her. She indicated that she had carers coming into the home but that for whatever reason the level of input was inadequate to allow her to remain at home.

In this study, various factors were identified from the data as influencing the decision to enter a care home. As mentioned previously all the participants were aged between 87 and 99 years of age. Advanced age in conjunction with a diagnosis of dementia and stroke was identified as a contributory factor with regard to admission to a care home (Connolly and O'Reilly 2009). Whilst the study participants could be considered as being in the older age group, they did not appear to display the symptoms of stroke or dementia. This raises the question: What affect if any, does age have as a factor for care home admission? A study by Willcocks *et al*. (1987) of local authority care homes, depicted residents in residential care as being characterised by women aged, in their 80's living alone prior to care home admission. Although Willcocks *et al'*s (1980) study is now over 30 years old, the participants shared similarities with my study participants, as does a more recent study (PSSRU 2010) citing 84 years of age as the average age for care home resident.

6.3 Decision making

As detailed in Chapter Five, the coding process led to the development of several codes that seemed to suggest different types of decision making used during the process of admission to the care home. They were coded as “*rationalising decisions*”, “*accommodating decisions*” and “*accepting decisions*”, which seem to typify the types of decision making experienced by participants and provided some insight as to how decisions were reached. In advance of entering a care home, some participants appeared to have thought through the available options and identified difficulties associated with remaining in their own home. Several participants reported that they were actively in charge of the decision to enter a care home with some assistance from others.

“*Rationalising decision*” was assigned as the appropriate code that seemed to incorporate both fit and relevance, to describe the decision reached by the participant. They were able to justify, to themselves and others, why they had made the decision they did. All of the participants classified as “*rationalising decision*” makers had been inpatients in hospital in advance of entering a care home and had suffered a period of ill health. Some participants reported that they lacked confidence in being able to manage at home. Other examples of “*Rationalising decisions*” included one participant who reported:

> “*I collapsed and then decided that I couldn’t go back to shopping and cooking. I finally decided I couldn’t do it any longer*” (Mrs I).

Another participant had decided when in hospital that she wasn't going to be able to return home:

> *"I was in and out of hospital. I physically couldn't do anything. I couldn't be at home. It would have meant either getting a live in companion or going through all the palaver of getting somebody coming in regularly every day. The whole thing seemed to me to be quite impossible and I discussed it with my step daughter and we decided the best thing to do was to clear the lot and to settle down." (*Mrs G).

However, one participant was "*keeping her options open*" (Mrs B), as she had not yet sold her house and was waiting to see how things went.

The second type of decision making that seemed to occur was "*accommodating decisions",* whereby the participant had not chosen to enter a care home but had acquiesced to please a family member. The decision to move according to the participant was not theirs, rather that of a key family member. However, they were not averse to the idea and had gone alone with the plan whilst retaining an element of control.

An example related to one participants' admission to a care home following her husband's death. The admission was not as a result of her lack of physical functioning, rather an acceptance of her husband's assertion that she would not be able to manage on her own. She seemed happy to comply with this view. The decision to enter a care home was organised by her husband in advance of his death. He had been unwell with cancer and had been admitted to the care home for his last few weeks of life. She gave me the impression that she had been happy to defer to her husband's assertion that she would be unable to manage on her own at home, so came into the care home in accordance with his wishes. She shared with me that her husband had taken responsibility for the running of the house and all the associated paperwork, which she acknowledged she would have found difficult to deal with should she have remained at home. She had never had to manage the financial aspects of living at home, as her husband had been responsible and she lacked the knowledge and confidence to undertake the tasks. She reported that she had settled well and seemed content in the care home:

> "*I couldn't have stayed there on my own. My husband saw to everything right up to the last. H used to have a wodge of papers every year to see to. Gas and water and all that jazz" (Mrs J).*

She goes on to justify the decision:

> *"Couldn't have done it. He was jolly good with all that head work. I couldn't have managed anyway without him" (Mrs J).*

I debated whether this participant had "*rationalised*" the decision but in reality, the decision did appear to be her husband's with her acquiescence and so the code was amended to an "*accommodating decision*".

Participants were considered as adopting an "*accommodating decision*" when despite not wanting to move into the care home, they had conceded to family pressure regarding the move. They could still claim that they had been involved in the decision making but they were not the driving force. They too had rationalised the decision making but not to the extent of a "*rationalising decision*" maker. An "*accommodating decision*" implied a level of control in the decision making process. Participants had weighed up the options and had decided that the decision although not necessarily theirs was something they were in agreement with.

Some participants appeared less happy with the decision taken and although they appear not to have refused to enter a care home, they were expressing a greater degree of dissatisfaction with the decision than those whose rationale fitted in "*accommodating*" category. The third style of decision making emerged from participants who had not wanted to enter the care home and from their perspective, were coping at home. One participant had reported her daughter was worried about her and so had agreed to enter the care home to please her daughter. Initially I considered that this was a "*Rationalising decision*" as she was rationalising the decision to enter the care home. On further reflection, I concluded that she would not have made this decision if it had not been for her daughter's concerns. Her daughter's wishes were influencing her but in a different way than if the decision had been hers. Her statement "*see another side to it*" was her way of pleasing her daughter's wishes to prevent her family from worrying about her. This did not fit as an "*accommodating decision"*, as although she was accommodating her daughter's wishes she was not happy with the outcome of the decision and reported that she had not wanted to come into the care home. I therefore concluded that this decision was more in keeping with an "*accepting decision"* making style.

The code "*Accepting decisions*" encapsulated decision making that was made by a family member but the participant was less in agreement with the decision than had been the case for an "*accommodating decision*". The participant had reluctantly accepted the decision despite their assertion that they could have continued to manage at home. There was an element of resignation surrounding their decision, implying less control over the decision and as a result, they appeared less satisfied with the outcome. One participant was very

reluctant to discuss the subject in detail and appeared to me to be very unhappy with the decision to enter the care home. This participant asserted that she had been managing at home and it was her daughter-in-law who had arranged for her to be moved to the care home. It was clear from her statement, “*It wasn’t my decision” (*Mrs F*),* that participants in these instances had not considered they were in control of the decision to enter a care home. Admission to the care home for this group of people was dependent on the family member being able to persuade the participant that this was the correct decision. The ability to convince someone of your point of view is very much dependent on the relationship between the two parties. In other situations, the older adult may have been able to persuade family of their ability to remain at home and in a different set of circumstances being able to remain at home may have been the chosen course of action. Families may have had their own reasoning for wanting a relative in a care home. Some participants thought they were coping at home, a view, perhaps not similarly interpreted by their family. Participants and their family seemed to be experiencing differing levels of understanding regarding how they were managing at home and what was an acceptable solution to the problem. Families did not appear to be hearing what participants were saying about not wanting to enter a care home.
Another example of an “*accepting decision*” making style was typified by statements like the one from one participant:

> *“I could have lived more on my own but my niece, I think wanted me away settled*”(Mrs E).

And she continues:

> “*My niece was worrying about what was going to happen to me. I think I could have carried on for a while*”
> (Mrs E).

Carers may consider that the responsibility associated with looking after an older adult in their own home is more that they consider they can manage (Penrod and Dellasega 2001) and admission to a care home may be seen as requiring less input by the carer, especially if they are separated by a geographical distance. Bringing them geographically closer to family and entering a care home may make supporting the older adult easier.

Table 6.1 demonstrates the development of coding for an "*accepting decision*" making style.

Line no	**Excerpt from interview with Mrs C**	**Open Code (1)**	**Open Code (2)**
10	But I didn't make the decision. To come here, no, because I had these falls.	Decision making by others	Influencing factor
25	My daughter said to me I know you won't want to, but I think the time has come for you to leave the house.	Decision making by others	Accepting Decision
28	But it does come to a time when you have to, you know, see another side to it, to everything and she had asked someone, about,	See another side	Accepting decision
30	She had thought about me if I was secure in a home. They haven't got to worry about me.	Thinking about family	Influencing factor

Table 6.1, shows the development of coding that led to the identification of the assigned codes

These decision making types also reflect the amount of control over the situation experienced by the participants. Control can take several forms. It is not simply the control exerted by the care home over residents, which will be discussed in the next chapter but also the level of control the participants had in their own lives and decision making.

Being in control of our lives and having a say in critical decision making is something valued by most people and loss of control has been identified as having negative health consequences (Willcock *et al*. 1987).

A study by Bailis and Chipperfield (2002) claimed that:

> "*perceived control is a cause and not merely a consequence of enhanced health in later life*" (Bailis and Chipperfield 2002, p531).

They suggest that control is maintained by not striving against negative events. Work by Thompson *et al.* (1998) around the identification of "*primary control strategies*" depicts how people shape their environment to suit their needs. When the ability to shape one's environment is compromised, Rothbaum *et al*. (1982) describe the need to draw on "*secondary control strategies*". These refer to the way people reinterpret their situation to enable them to deal with what is occurring. Accommodating negative life events, for example having to enter a care home, rather than fighting against them helps retain at least a perception of control. Wilcocks (1987) states that some participants will over claim their involvement in the decision making as a coping strategy to avoid what they perceive as rejection by society and their family.

A technique some participants appeared to use to be able to retain control of their situation (more) was a process of rationalising the decision by using "*primary control strategies*". I have incorporated these two conceptual labels to explain how participants used both the decision making style and the control strategies to remain in control of the decisions taken. One participant had made the choice to enter the care home and had deferred her decision as to whether she would chose to remain in the care home leaving her in complete control of the situation.

Another participant, who had entered the care home on the death of her husband had rationalised her decision by agreeing with her husband that she would not have been able to cope at home. Thus she drew on her "*secondary control strategies*" both by adapting to the death of her husband and the resultant admission to a care home. Both participants appeared to be in control of their situations in their own way.

It would appear, that the most difficult combination of decision making and level of control to reconcile, relates to participants having entered the care home reluctantly. The lack of control over the decision making coupled with what was perceived as little control over decisions taken within the home served to make adjusting to the situation more difficult. One participant had entered the care home, as her niece did not consider she was coping at home. The decision to enter the care home was not hers, as she believed that she was managing at home. This was coded as an "*accepting decision*" to reflect her reluctance to entering a care home. This participant was also finding it difficult to settle into the care home.

A study by Maloney *et al*. (1996) interviewed people living in community based settings and care homes with RNs in the United States. Participants were older adults who needed assistance with at least three activities of daily living with exception of those who were living in a retirement community who were self caring. Maloney *et al*. (1996) suggested four types of decision making related to long term care. The first group is where the individual makes no plans for long term care and waits for crisis and are referred to as "*scramblers"*. This type of decision making tends to result in the patient having very little input into the decision. The second type was those entitled, "*reluctant consenters*" who were prompted to act by others. The third type act as a result of a "*wake up call*", following a near crisis. The last type is the most proactive as they think about the future and plan for their long term care needs. "*Advance planners*" trade off independence with flexibility and this type according to Maloney *et al*. (1996) refer to those who enter a retirement village type settings in advance of the need for care.

The participants in this study tended to be a mix of "*scramblers*" as family appeared to take the decision on their behalf and those who had received a "*wake up call*" and made their decisions as a result of being admitted to hospital.

An important aspect of this study was to explore why participants had chosen to enter a care home with RN's. Only two participants reported that they were aware of the two different types of care homes, those with or without RNs. It was not possible to determine from the interviews, whether a member of the family acting as decision maker, understood the difference between a care home with and without RNs. Even those participants who had been very informed and involved with the decision making had not appreciated the distinction between the different types of care homes. One participant reported that her stepdaughter had been a nurse and had assisted her in making the decision regarding choice of care home. Whether her step daughter had been aware of the distinction between care homes with and without RNs is not known. This participant was very actively involved in the selection process, having viewed four homes from a shortlist provided by her step daughter. She based her decision on a positive feeling when looking around this home due to '*nice*' staff and being made to feel welcome. She explained that despite visiting four homes:

> *"We had the choice of one. I went to one….we were taken around by the manager and then I saw the entertainments officer who I didn't like on sight. The manager I was not awfully keen on and half way around, he said to my step daughter "oh she is alright isn't she. I think we will have to put her on another floor". That meant he was going to show me rooms on a floor with people who were slightly off and he realised that I wasn't slightly off and he made a mistake"* (*Mrs G*).

This telling account was coded as an "*influencing factor*" as it helped her to decide which care home would not be suitable. This nursing home manager appeared to be struggling to accommodate the older adult into his care home. He had incorrectly assumed that as this older adult had not presented with a physical disability, she had cognitive impairment, which was why she was considering admission to a care home with RNs. Also of interest is that he chose to converse with a relative rather than addressing the participant directly, indicating perhaps that he had already "*categorised*" her without taking the time to get to know her. This participant reported that even if she had been aware of the different types of care homes, it would have not altered her decision making as she had based her choice on the impression of the home and the care staff rather than on other categories. A very comprehensive 56 page "*Counsel and Care*" care home handbook is intended for families carers and professionals mentions residential and nursing care homes as options but fails to provide further information regarding the different groups of patients that is catered for in each type of home (Counsel and Care, 2010). Age UK have a very detailed checklist, of things to consider when entering a care home and one item in the list asks

> "*Is the home registered to provide the level of care you need* (Age UK checklist, Appendix 6)?

The checklist fails to suggest the importance of identifying this information and how it can be accessed.

Entering a care home can be a momentous decision often taken at a time when people are least able to give it due consideration; for example, following a period of illness or bereavement (Nihtila and Martikainen 2008). Only one of the participants indicated that they had received professional support to assist them in making the decision to enter a care home. People contemplating admission to a care home should be supported in understanding the implications both financially and psychologically. The majority of assistance often came from family members, but they may lack the knowledge and experience to be able to provide meaningful assistance or lack the signposting to where appropriate advice can be located. Health and social care professionals have a key role to play in assisting patients work their way through the complicated process.

6.4 Summary

The interview data indicates that the participants had in advance of being admitted to a care home with RNs considered themselves settled in their environment not anticipating or wanting to move from their homes. Various factors altered the stability of their arrangements resulting in the need to reconsider their options. All the participants had experienced a "*turning point*" in their lives, requiring them to "*leave the past*" and to reconsider their living arrangements.

Participants had to "*choose the path*" that would meet their needs. Participants entered the care home from hospital or from their home. The study identified three styles of decision making. The "*rationalising decision*" makers, whereby the participant was in control of the decision, had weighed up their options and made their choice supported by family. The next type of decision maker was the "*accommodating decision*" maker who was not the primary decision maker, as that role fell to family members. They were overall in agreement with the decision. Lastly, there were the "*accepting decision*" makers. These participants had not wanted to enter a care home but had been persuaded by family to accept admission. The participants had "*chosen the path*" or in some instances, the path had been chosen for them.

The next chapter will consider the second influential category related to the participant arriving at their destination and their ability to settle into the care home and enjoy what the home has to offer.

Chapter 7: Findings: settling in

7.1 Introduction

The previous chapter explored from the perspective of the participants, the factors that influenced the decision to enter a care home with RNs. The "*turning point*" signified the need for a change in living arrangements identified by either the participant or their family. The participants, by choosing to enter a care home with RNs or having had the decision made for them, had "*chosen the path*" they were to follow for the next, perhaps final, phase of their lives.

This chapter will describe the second category entitled "*settling in*" and the properties identified in the data, supported by the literature, which focus on the changes and challenges experienced by participants in entering a care home. The strategies utilized in adapting to and coping with the new environment and the degree that the participant felt in control of their new life will be discussed. Some advantages and potential disadvantages of care home living are also explored.

For most participants the journey from living in their own home to entering a care home has been a final one with few opportunities to reverse the decision and return to their previous accommodation (Peace *et al*. 1997). Arling *et al* (2010) in their longitudinal study undertaken in the United States, identified, the period within 90 days from admission as being the optimum timescale for achieving a discharge from a care home. After this period, care home residents become too settled in the care home, thus reducing the potential to return home. Entering a care home reflects a major life event for older adults, of which they often had little previous knowledge or opportunity to prepare for. Studies have shown that the first four weeks after admission are the most stressful with feelings of abandonment and helplessness (Hodgeson *et al* 2004, Kao *et al* 2004) which can result in increased confusion and depression (Hodgeson *et al* 2004).

Figure 7.1 details the factors identified that affect the settling in process.

Figure 7.1 Settling in to the care home

7.2 Settling in

The process of adjusting to life in a care home involved coming to terms and dealing with various aspect of the change. It is dependent on when the participant considers they have "*settled in*". The use of the term settled is a subjective one as the participants were not asked specifically whether they considered they had settled into the care home. I interpreted from their responses as to whether the participant was indicating that they were either settled or not settled in the care home or a stage in between. "*Settling in*" became a code that had encompassed several other codes and appeared to encapsulate the participant view of having entered the care home. "*Settling in*" constitutes more than just moving into the care home, it requires an acceptance of the need to accept the change and adapt to the new life. It becomes not just a question of moving in rather the ability to move on from their previous life. The timescale required to achieve this varied from participant to participant and for some may never be fully realised. Ellis (2010) argues that transition takes at least 6 to 12 months, potentially longer and was often achieved by the resident on a subconscious level.

Participants in this study either entered the care home from hospital or, as was the case for the majority of the participants from their own home. Moving house can be considered one of the most stressful life experiences. Irrespective of whether admitted from hospital or home, several studies have demonstrated that the impact is no less severe for an individual entering a care home (Dellasega and Mastrain 1995, Nolan and Dellasega 2000, Melrose 2004).

Whilst a stressful experience, for most people, a move is usually viewed as a positive choice incurring positive benefits. When undertaken following hospitalisation, a traumatic event, or reluctantly, the impact is heightened and the ability to adapt and cope may be adversely affected (Nolan and Dellasega

2000, Fraher and Coffey 2011). The change may mean moving from a much loved home with the loss of a majority of their possessions to occupy a single room they may not have had the opportunity to view prior to admission. This room may become the focal point of life in the care home where they could spend the majority of their time. A study by Davies and Nolan (2004) concluded that older adults and their relatives enter a care home largely unprepared for the reality of care home life.

An example of this was a comment from one participant who had not seen her room in advance of her move:

> *"No, I didn't see this until I came in and the first thing I said was "isn't it dark" of course with these windows, this is the tail end of the building. Very nice and modern*" (Mrs G).

Participants expressed a sense of sadness and regret on having to leave their previous home, with the associated memories referring to aspects of their home that they had held in particular regard. One participant exemplified this when she fondly described her:

> "*lovely panelled hall*" (Mrs C).

and wistfully stated:

> "*so all my things have gone*" (Mrs C).

This appeared to me to be an acknowledgment of her grieving for the loss of her home and her possessions.

> *"You work hard for it all through the years, you know and then you have to give everything up"* (Mrs E).

Having a sense of home is important to preserve self-identity (Peace and Holland 1994). Rowles (1993) argued that moving people from their home should be avoided due to the importance of an individual's home. He referred to this as the loss of "*spatial identity*" associated with the disappearance of familiar spaces and the potential loss of established social networks (Fried 1977). A grounded theory study by Stern and Kerry (1996) described the experiences of people who had lost their home due to fire and the overwhelming feelings of grief they experienced. The extent of which was not appreciated by others who failed to comprehend the significance of the loss of a home. The impact of leaving their home to enter a care home with RNs may not be of the same magnitude as the loss of possessions through fire, but that does not devalue the sense of loss experienced nor the need to grieve for cherished items.

Care homes encourage residents to bring personal items but warn against bringing objects of value due to the risk of them being damaged or stolen. Most participants displayed personal items in their rooms. These were obviously held in high esteem as they often drew to my attention either a photograph or other item on display during the course of our conversation. The potential to bring items of symbolic value helped participants settle in their new environment (McCracken 1987, Mikhail 1992). Some participants had bought larger items with them and I was shown examples of a favourite chair or chest of drawers. Mostly the possessions brought from home were smaller, photos and other memorabilia. For example, one participant took pleasure in showing me some wonderful photographs of her mother who had been a nurse during the First World War. Whilst having treasured items is beneficial to help create a homely environment, the concept of home relates to more than buildings and tangible possessions and placing a value on what home meant to participants may be more difficult to define.

Being invited into someone's home confers certain responsibilities and acceptable levels of behaviour, distinct from entering public buildings. Home, for most people is considered a sanctuary, where we can be ourselves. The freedom exists to do what we want, when we want and exert control over our environment. Care homes, irrespective of their efforts, will never achieve the same sense of personalisation, level of freedom and privacy (Willcocks *et al*. 1987). Care homes are arranged physically and organisationally to be semi public facilities. As well as trying to achieve a home like atmosphere for the residents, they also function as a work environment for the carers and other care home staff. This raises the question as to whether a care home has the prerequisites to be considered as "*home*" (Willcocks *et al*. 1987).

Participants were rarely afforded the opportunity to visit prospective homes in advance of the move. The majority of participants had been reliant on friends and family to select the care home and to ensure that it would meet their needs. This approach was successful for many of the participants who either worked closely with family members to ensure a good selection or could rely on family judgement. A symbolic interactionism study by Reuss *et al*. (2005) into understanding families' experiences of moving a loved one into a care home highlighted that both prospective residents and their carers benefited from good preparation in advance of the move. However, the transfer to a care home does not always go to plan. One participant reported a distressing incident when she related how the proposed move from hospital to a care home was changed without notice. Her move to a care home with RNs was brought forward by two days, without warning or explanation. Neither the participant or her family were consulted, a situation that she naturally found extremely distressing. Her nephew, who had wanted to accompany his aunt to the home, to help her settle in, was not aware of what had transpired until after the event. The first he knew of the change in arrangements was when he returned home from work and listened to his telephone messages. The participant explained that despite her protestations:

> "*So they* ***bundled*** *me off here in a car and then my nephew didn't know I was in here until the evening when he got a message on his answering machine*" (Mrs B).

The Oxford Dictionary of English (2005) defines "*bundled*" as "*to send forcibly, hastily, or unceremoniously*" The participants use of the term "bundled" seemed closely aligned to the above meaning and the manner in which she said it, appeared to demonstrate to me that the incident and the way in which she was treated still rankled with her. The hospital had disregarded her request to wait for her nephew and went ahead with the transfer. The sense of indignity that she felt that day was still evident when recounting the event, four months later.

She went on to explain:

> "*I felt a bit strange, all alone as it were, no one knew where I was but they met me at the door and there was sister O and a very nice nurse and they got me comfortable here and settled*" (Mrs B).

The care home was welcoming and seemed to have done all they could to help her settle in, but the ordeal appeared to have left its mark and did nothing to assist her in coming to terms with the move. A study by Dellasaga and Nolan, (1997) and my recent experiences confirmed that unfortunately this would not have been an isolated incident. Care homes have an important role to play in ensuring new residents are made to feel welcome on admission to the care home and during the early days whilst they become acclimatised to the new environment (Nolan *et al*. 1996, Ellis 2010). None of the other participants reported difficulties associated with their discharge, but this was not posed as a specific question. In my experience hospital staff are under constant pressure to free up much needed beds to accommodate new admissions, therefore they may lose sight of the human experience and how it feels to be sidelined when it comes to the final discharge preparations. Hospitals are often faced with unpalatable choices when the numbers of patients requiring an inpatient admission exceed the number of available beds. I am regularly involved when hospitals are on "*black alert*" signifying serious bed shortages and the wholesale drive to move people out of hospital to accommodate new admissions.

There is evidence that the length of time patients remain in hospital following a health event has reduced. The average length of stay reduced from just over eight days in 2001 to 2002 to just over seven days in 2004 to 2005 indicating that people were being discharged earlier in their post recovery stage (Bryan 2010). It could be argued that it is perhaps too early in some instances as the number of people readmitted to hospital rose from five and a half per cent in 2002 to 2003 to over six and half per cent in 2005 to 2006. This suggests some people may be discharged when not fully recovered or without sufficient care in place (Bryan 2010). As well as evidence of shortened hospital stays there is data suggesting, there are delays in people being discharged from hospital with a quarter of all hospital delays in 2005 attributed to social services departments (Bryan 2010). The above figures do not specifically relate to those who are responsible for paying for their own care, as my experience has shown that people responsible for funding their own care are considered easier to discharge as they are not reliant on local authority funding and therefore not subject to the same delays as those waiting for funding approval.

The potential to ensure a smooth transition from hospital or home is essential to alleviate distress and assist the participant in being able to settle into the care home. Participants may require different levels of support and interventions throughout the transition period, having to adapt to life in the care home, which would have varied significantly from their previous life in their own home. Admission to a care home for many is the final phase of their life and just as in each previous phase, such as starting school, finding work and getting married it required a period of adapting both in an emotional and practical sense. Entry to a care home required participants to become accustomed to a new environment, routine and having to share their living space with strangers. These major changes all occurred at a time of their lives when older adults were possibly least able to adapt, perhaps following a period of ill health or when physical and cognitive abilities are declining. One participant, when asked whether she had seen the care home in advance of moving in, stated:

> *Well after L had decided that, she brought me in to see it. It was alright, you know. I am afraid I can't be bothered with that, I got to the age now* (Mrs E*).*

Nolan *et al*. (1996) outlined four factors, which they considered contributed to a successful transition into a care home. They related to:

- *Anticipation* – how well planned the through the decision was;
- *Participation* - the level of active involvement by the older person and their family;
- *Explanation* – the extent to which other options were explored and the rational for the move fully discussed;
- *Information* – the degree to which all those concerned were given sufficient information to make informed decisions.

A Counsel and Care study (1992) identified four most commonly cited aspects of residential living that concerned people. These related to the care home regime, the amount of personal freedom, social relationships, quality of care and the physical environment. Patterson (1995) considered that the availability of social support mechanisms could assist during the settling in phase. Social support can come from family, friends, other care home residents and care home staff, with the lack of essential support hindering the ability to settle. One participant offered assistance to another less able resident she had befriended.

A study by Oldman *et al*. (1998) interviewed residents in care homes with and without RN's. The majority of participants in Oldman et al's (1998) study having accepted the move as inevitable and sought to adjust and some felt enthusiastic but a smaller number continued to resist the move and living in the home.

The interview data suggested a relationship between the types of decision making explored in Chapter Six and the participants ability to settle into the care home. Those participants who appeared to be in charge of the decision, labelled "*rationalising decision*" makers were also those who had settled reasonably quickly into the care home. One participant enthusiastically stated:

> *I just liked it here. I like the staff here, I think they are wonderful, never find a better place* (Mrs I).

The "*rationalising decision*" makers believed their decision to be the correct one and were adapting to the new environment.

The second group of participants were those who had agreed to the move to satisfy family members. They were in agreement with the decision even though it may not have been their idea, were identified as "*accommodating decision*" makers. Overall, they had settled into the care home well and were pleased with the decision even though the move had been initiated by others. An example came from one participant who had entered the care home with her sister, at her instigation confirmed:

> "*very happy here, not discontented*" (Mrs L).

The final group identified participants were those who had been against the move but had been persuaded by family members and appeared to have deferred to their decision making. This group were categorised as the "*accepting decision*" makers because the participant seemed to have had the least input into the decision making process and appeared not to be fully in agreement with the decision. They consequently seemed to be the least successful in settling into the care home. Several participants were adamant that they could have managed at home. Another example came from one participant who expressed her dissatisfaction with the care home. She stated that she disliked the care home on admission:

> *"When I first came in I said, I don't like it here, but you get used to it"* (Mrs E).

She went on to say:

> "*If I had said I don't like this, because I think sometimes there is something in a place, you think well I don't like it. But I thought well maybe things would get better"* (Mrs E).

I asked her whether it had improved and she replied:

> "*Um well, yes, because, no I get to know people. I can't get to know people very quickly you know, but um, I am okay, two ladies up there I got to know them*" (Mrs E).

Of greater significance was her comment later on in the interview:

> "*Sometimes I think it is not so bad you know, and then another time, I think oh, for goodness sake please take me, you know*" (Mrs E).

I probed for more information about why she felt that way, she admitted that she had reconciled herself to her situation but she still seemed to me to be unhappy in the care home. She reassured me that there was no suggestion that she was being mistreated, rather she had not wanted to come into the care home as she was of the view that she could have continued to manage at home. Her niece had persuaded her and she remained unhappy with the decision seven months later. She had tried to engage with the activities within the home but she found them not to her liking and she expressed dissatisfaction with the food. The only positive seemed to be that she had made friends with a couple of the residents. This participant's closest relative was her niece and her family. Her son was in America and she had not seen him for several years. It appeared that she was reliant on support from her niece to the point of not being able to refuse her request to enter the care home.

The process of adapting to the transition into a care home may reflect an individual's personal ability to adapt to changes as well as the circumstances associated with the transition (Ellis 2010). All participants discovered their own method of adapting to life in the care home either by embracing what the care home had to offer or coped by existing in the shadows. One participant had her own way of dealing with life, which had enabled her to settle into the care home.

> "*We can either lie down and die or we can pull ourselves up by our bootstraps and we get on with it*" Mrs B.

From another participant who had not settled into the care home:

> "*I thought well maybe things would get better*" (Mrs E).

The potential to settle into the home could be attributed to the participants' ability to adapt and cope with the changes they faced. Folkman and Lazarus (1980) have suggested that coping mechanisms can be classified into two major categories, problem focused and emotion focused. Problem focused coping is based on efforts to improve the situation by implementing changes to address the problem, where as emotion focused refers to thoughts or actions with the aim of relieving the emotional impact of the stress. In reality, the authors suggest a combination both problem and emotion focussed strategies are utilized dependent on the conditions being faced, the options available and our own personality. Participants relied on their problem solving skills to enable them deal with the situation; the emotion focussed aspect was dealt with by perhaps avoiding thinking about the issue or as one participant said:

> *"I try to be happy wherever I am*" (Mrs C).

The coping strategies utilized formed part of the individual being able to adapt to the situation with people who are "*successful adapters*" making the situation work for them, allied to our being able to cope and adapt.

An aspect of adapting can relate to keeping in contact with friends and neighbours, which can be difficult to achieve if the care home is not near the previous home or inaccessible by public transport. Participants cited proximity to family as influencing their choice of care home. An example from one participant:

> "*My daughter in law fixed me up here to be nearer to them*"
> (Mrs F).

And another view:

> *"My niece lives up the road"* (Mrs E).

There is a risk that residents in care homes can lose connections with their previous life and social circle. An example came from one participant who had moved from where she had lived previously to be near her stepdaughter, but as a result had lost contact with her circle of friends, resulting in her increased dependency on her stepfamily for visitors and contact outside the home. This participant had initially been discharged from hospital to a care home near her home as a temporary measure. When asked as to why she had not wanted to remain in the care home near her previous home she responded:

> *"Well there was no point because if I stayed there in my own home environment and been more or less dependent on friends and neighbours to for, I don't know to buy me a reel of cotton. They were even there some little distance away from my own home. Geographically it simply wasn't on from that point of view*" (Mrs G).

This sense of isolation could be exacerbated in participants who had moved away from their previous circle of friends. Understandably wanting to be nearer to family or friends influenced decision making and was often the reason for choosing a particular care home. This was cited as a reason for care home admission in studies by McAuley and Travis (1997) and Reed *et al*. (1998). Other factors identified as important, were proximity to the wider community and amenities, being within walking access to shops and accessible for families and friends (Reed 1998). Within the densely populated county that the study took place in, there are care homes both with and without RNs in the vicinity of all the care homes who participated in the study making proximity to a care home less likely to be a stand alone reason for the choice of care home. Participants tended to choose or have chosen for them homes that were close to family or friends. The beneficial nature of achieving this, is extended according to Reed *et al*. (1998) if residents can claim even a tenuous previous association with the care home. It was not necessary to have previously even visited the home, Reed *et al*. (1998) concluded that just knowing of the home's existence was sufficient to gain the benefit. One participant was very familiar with the care home, as it had been where her husband had died and was where he had arranged in advance of his death for her to be admitted. She reported that she was very settled in the care home.

A Counsel and Care study (1992) highlighted that the vast majority of care home residents wanted visits from families and friends. Their study indicated that 16 per cent did not have any family and seven per cent had family, who did not visit. Thirty three per cent received visits approximately monthly or less, 37 per cent were in receipt of weekly visits and seven per cent of the study participants had daily visits from family members.

An aspect of settling into the care home related to the participants ability to engage with others and establish a network of friends and acquaintances (Reed 1998). Participants spoke about whether or not they had made friends within the home, which for some had proved quite difficult. Many opted to eat their meals in their rooms either at their own instigation or at the suggestion of the care home staff, which may have limited opportunities for interaction.

> "*the last few days I haven't been down to the dining room, they brought it up to me. They think it might be better for me to be quieter up here and I think it was*" (Mrs D).

Some participants seemed to have more engagement with staff rather than other residents. An example was one participant spoke about her relationship with the staff in the care home:

> "*We can laugh and talk about things. It makes a change for them, to be able to communicate about things*" (Mrs B).

This participant associated herself with the care home staff, suggesting that she was one of a few residents who were able to converse with the staff. This is in keeping with another study, which indicated that residents tend to prefer to establish relationships, although they may be tentative, with staff rather than other residents (Reed and Roskell Payton 1995) unless there already exists a common bond such as religious or occupational affiliation. Residents in a study by Willcocks *et al*. (1987) stated that staff were too busy or not interested to talk. Busy homes, with task oriented staff focussing on residents physical needs may lack time to interact with residents who only require minimal assistance with activities of daily living. Much of the participants' contact time may be with housekeeping staff serving meals or undertaking domestic tasks.

Participants may experience loneliness despite being surrounded by people, with the potential to interact and converse with others an important activity in a care home (Andersson *et al*. 2007). However, if participants are finding it difficult to make friends or do not consider they have things in common with their fellow residents, this may contribute to feelings of isolation. Participants may not have anything in common with other residents, except their age.

Participants varied to the extent in which they chose to engage with the activities within the home. An example was from a participant who expressed her dislike of engaging with activities within the home, to the extent that not only did she choose to take her meals within her room she rarely joined in with activities. She said:

> *"Actually I am not one for mixing with people,*
> *I think they have had to accept that. They try*
> *to draw me into thing" (*Mrs C).

Some participants chose to move around the care home when they thought there was a reduced risk of meeting other people: One participant described her nightly sojourns down the corridor:

> "*When I have been sitting here for a long time,*
> *so in the evening when it is dark I often walk*
> *all the way up the corridor and look out the*
> *window and sometimes you see little baby*
> *rabbits running about. I like to see them and*
> *then I walk back down again. Then when I*
> *come in, I think I will go again all the way up*"
> (Mrs C).

She went on to state that had there been anyone in the room at the end of the corridor she would return to her room, not wanting to be obliged to engage in conversation.

Despite a care home's best endeavours some participants choose not to engage with the activities on offer within the home, which may limit the potential to get to know people. An interesting example was one participant who had been in the home for ten months but had not really spoken to any of her fellow residents. She had a hearing impairment, but not to the extent that it affected our conversation. She had expressed concern that she might not be able to hear what the other residents were saying or what was worse from her perspective, she would not be able to understand what people were saying to her due to any speech difficulties they may have had. This concern had prevented her from meeting people:

> "*My hearing is so difficult and a number of the people here have hearing and speech difficulties and I haven't been able to sort out those who are speaking clearly and those who don't. I don't want to embarrass them or me. I go down if there is anything in the entertainment line that interest me, but there again unless I am sitting quite close to the organiser or whoever is giving the speech, I can't pick up what they are saying. Because people don't speak clearly a lot of them. I am not criticising people. It is the way they learnt to speak, I suppose. That is a little bit of a difficulty but I am perfectly happy"* (Mrs G).

Care homes with RNs will usually have residents with a high level of disability both physically and cognitively, which may make interaction difficult. Some participants found it difficult to have contact with significant levels of disability as it may remind them of their own mortality. A recent (PSSRU 2010, p26) study concluded that the level of dependency in all care homes is increasing. One participant commented:

> *"I feel so sorry for some of the people here but none of us know what life has in store for us" (Mrs B).*

The previous chapter discussed the importance of having control over our environment and the decision making process, which assists us in being able to cope with the new environment, adapt to changes in routine and the shared nature of a regulated care home environment. There is another more negative form of control that care home residents may experience. There is a subtle distinction between the requirement for the care home to have in place a routine which facilitates the efficient, smooth operation of the care home and the form of social control that limits people's independence and self determination (Foucault 1965, Goffman 1961). Some participants intimated that there was a level of compliance expected within the care home. One participant stated:

> *"It is okay as long as you behave yourself and don't cause problems*" (Mr A).

This statement suggested the need for a certain level of conformity within the home. There was reluctance on his part to elaborate on this but this could be a real cause for concern. This man had indicated to me that he had no close family and few visitors so if he had issues regarding his care he would not have anyone with whom he could voice his concerns. All care homes as part of their CQC registration are required to have a complaints process in place, as a mechanism to enable care home residents to express any concerns regarding their care. Residents may be reluctant to complain in case there are subjected to subtle sanctions, such as a delay in responding to a request for assistance or the threat of eviction (Peace 1997).

This view of disempowerment is not new; Foucault (1965) argued that institutions use direct and indirect, explicit and implicit power to control groups, which lack power. Residents without family and friends or other contacts from outside the home may lack power to be critical of the system or have a mechanism to voice any concerns. Critics of institutional care (Goffman 1961) refer to the danger of the development of "*total institution*" whereby due to their detachment from wider society they can be subject to corruption, mismanagement and dangerous care practices. This also extends to the way staff behave towards residents as they can get drawn into uncaring and unevaluated practices, especially if they do not develop empathetic relationships with the people they are looking after (Goffman 1961). Staff in the care homes can view residents as a homogenous group and subsequently depersonalise the relationship, failing to acknowledge residents as individuals. The seminal works by Goffman (1961) and Foucault(1965) depict extreme examples of control. These were the product of large institutions, which no longer exist, their demise occurring during the 1970's and 1980's. However, the negative aspects of institutional life are still prevalent today, as the ingredients described above are still present. A recent Panorama programme (BBC 2011) exposed severe abuse of young adults with a learning disability and remind us of how easily what should be a caring environment can transcend into one where abuse is the norm. Vulnerable adults are at risk of abuse every day in care homes, especially, those without families and with little contact with the world outside the care home. Those with cognitive impairment may find it difficult to have their complaints believed and investigated. A key aspect of my role is to be involved with investigating allegations of abuse in a care home with RNs in conjunction with the Local Authority Adult Protection Team. These are regular occurrences often addressing serious issues of abuse.

Hockey and James (1993) refer to the process of infantilisation that can occur in a residential care setting. They argue that this is a response to dependency and prevalent in residential homes. One participant who thought the activities on offer were not very interesting expressed this view. In advance of our meeting, she had been involved with a group of other women in making smoothies. It had not gone to plan, as the young girl in charge of the process was not sure how they were made and the whole process became somewhat impromptu and a bit messy:

> "*If there is anything on, like this afternoon, that girl and another one of them they think up these things to do*" (Mrs E).

She went on to say:

> "*Sometimes you think, a bit babyish. You don't want anything like that, but that is just me*" (Mrs E).

The ethos of care home should establish policies, which try to emphasise resident choice and the importance of a home like environment (CQC 2009). Participants were at liberty to move to another care home, if their current home does not suit their needs. However, a prospective move requires giving a notice period, usually about a month to the home. Participants would be reliant on family to assist with finding alternative provision and then facilitating the move, all of which is impractical for those without family to assist them. One participant provided an example of having moved home with assistance from her family because she had been unhappy with the care home:

> "*I didn't like the other place, they weren't gentle.……but they didn't look after me as nicely as I get looked after now*" (Mrs D).

She reported to be much happier with her current home.

The length of time a participant had resided in the care home did appear to assist in the ability to settle into the care home (Ellis 2010). Those who remained unhappy with the decision were those who had not been actively involved and had not been in agreement with entering the care home. Institutional care has been charged with creating dependency, encouraging loss of identity, preventing self determination and stifling individual autonomy

(Peace *et al*. 1997, Townsend 1962, Richardson 2001). In my experience, there are some very good examples of care homes that afford residents a good quality of life and allow them to maintain their independence but conversely there are some homes whose ethos can restrict independence and individual autonomy.

Participants found ways to be treated as more than just passive recipients within their environment (Gubrium 1975, Paterniti 2003). Goffman (1961, p159) argued that residents develop an institutional "*underlife*", an informal way people attempted to survive the system and ensure that their personal needs were met. Participants appeared eager to share their past life with others as it had been so willingly shared with me, when the opportunity presented itself. Engaging with others helped to reaffirm their identity and confirm their status as not just care home residents, but as individuals with important stories to tell. Often, once the recorder was switched off, the participants proceeded to discuss other items of interest. One participant was very proud of her father who had served at the Somme and had been decorated by the French Government. Another participant shared with me that she had swam competitively when she was a teenager. Photographs were a great point of interest, both for me to use as an "*ice breaker*" but also encouraged the participants to share some of their life with me. I made a point of asking about a particular photo, which usually led to an explanation of most of the photos on display all of which provided me with a more in depth understanding of the participants.

Another key issue that emerged from the data was the concept of loss. Loss can be interpreted in several ways. It can link in with the loss of control described earlier or relating to the loss of possessions, home and social networks (Nay 1995). Another aspect is the loss of independence that comes with loss of physical and social functioning. A study relating to loss experienced by people affected by multiple sclerosis (MS) (Edmonds *et al*. 2007) identified that the ability to be able to deal with loss or changes in physical abilities related to their being able to successfully adapt to the loss. The findings suggested that throughout a deteriorating condition such as MS there was a need to juggle constantly positive and negative factors. These findings may be applicable to an older group of people who are trying to balance the loss of independence with positive experiences associated with being in a care home.

Several participants highlighted the importance of maintaining their level of physical functioning. Many made a concerted effort to walk as much as they could to facilitate this. Several participants considered they were less physically able as they had been previously. An example was from one participant who reported that prior to her admission to the care home, she had been physically able to walk the ten-minute journey from her home to the care home, up to six times a day, when her husband had been unwell. This participant had been in the care home for 23 months and she reported that since admission, her mobility had declined and she doubted whether she would have been able to undertake the journey now.

Another example was a participant who suggested that in the seven months she had been in the care home her level of functioning had declined. She stated:

"*You forget all about how you worked at home*" (Mrs E).

One participant reported that after she had been hospitalised, but prior to her admission to her current care home, she had more physically able than she was currently. She explained:

> *"In those days I was able to walk quite easily. I can't do that now. That wasn't a problem for me from a physical point of view"* (Mrs G).

A study by Richardson *et al*. (2001) explored the changes in physical functioning of 138 care home residents over a 12 month period. They concluded that 10 per cent experienced improvement in their level of physical functioning over the period but the majority showed deterioration (30 per cent) or remained stable (60 per cent). The findings demonstrated that care homes have a vital role to play in helping residents to maintain function. Another UK study by the Department of Work and Pensions (2001) concluded that those funding their own care were significantly less dependent than publicly funded residents were on admission, in terms of both physical functioning and cognitive impairment. This appeared to suggest that people responsible for funding their own care, present on admission to the care home, as being more physically able.

Some participants were accepting of the need to be admitted to a care home and had adapted better than others to the change in their circumstances. There was an acknowledgement that their lack of physical ability precluded them being able to undertake some activities considered crucial. An example by one participant showed a level of pragmatism to new living arrangements when she stated:

> "*I cannot go back home because if I couldn't do the things I wanted to it would depress me" (Mrs B).*

Although many factors influence the ability to settle into a care home of paramount importance is the quality of care and treatment being received. Good care in a friendly atmosphere will assist in the settling in process whilst poor care with unfriendly staff will impede that process. My experience has shown that a change in care home manager can do much to upset the dynamics of a care home, lowering the standards of a good home or improving the perception of a home with a poor reputation. Many older adults considering admission to a care home may not have any previous experience to help inform their decision making and may be reliant on media depictions of life in a care home.

7.3 Marketing of care homes and the image portrayed

The media has a part to play in the way care homes are represented. Television drama although not meant to portray accurately life for the majority of people, does tend to portray life in a care home in a particular way which could contribute to the lack of understanding on behalf of prospective care home users and their families. The advertising used by care homes represents an inviting image, designed to encourage admission (Packard 1980). Their brochures often depict happy smiling people portrayed as being reasonably fit and well. Prospective care home residents may have an image of life in a care home and the reality may not match their expectations, which can affect an older adults' ability to settle into the care home (Ellis 2010).

A recently viewed television drama depicted care home residents who were all functionally independent until the inevitable murder occurs (Midsomer Murders 2000). The care home was referred to as "*a residential nursing home*" and appeared to be staffed by RNs. Viewers may have concluded that despite the residents being able to look after their own personal care requirements they required an environment staffed by RNs. Although dramas of this nature tend to be creative with the facts, as their intention is to entertain, mediums such as television influence people's perceptions and may distort the reality of life in a care home. Most care homes with and without RNs are home to people who require assistance with their activities of daily living either due to physical or cognitive decline. Portraying care homes as being for functionally able people could mislead people who may lack knowledge regarding care homes and could encourage admission. It would assist potential care home users for the media to adopt a more factual representation when depicting life in a care home.

Care homes either tend to be under single private ownership, multiple private ownership or as part of a large private group or charity. Private homes rely on advertising to market themselves and to encourage people to come and view the home. The majority of care homes in the UK operate as private businesses and with the exception of those with a charitable affiliation, aim to make a profit for their owners and shareholders. Some areas have a surplus of beds in premium priced care homes and there is often competition to fill these beds. The ability to maximise profits is dependent on the home maintaining full occupancy, which can potentially lead to care homes admitting people with minimal care needs. It suits care homes to have a residents with a range of clinical needs and having functionally able residents reduces the workload for staff (Townsend 1962). There is little incentive for care homes to dissuade the more functionally able resident, as it enables them to maintain bed occupancy, reduces staff workload, whilst being able to command the same level of fees. Advertising relies on the subtle power of subliminal messaging to deliver the message we may not realise we are receiving. Care home marketing is no different as they are endeavouring to sell their product to whoever would like to buy (Packard 1980).

Care homes are primarily within the control of private companies, which limits the control the NHS can exert. The failures associated with Southern Cross group, one of the largest providers of care home care in the UK, clearly demonstrates the risks of dependency by the state on private ownership (2011, **Appendix 7**).

Care homes can present themselves as very attractive facilities. One of the care home resembled a hotel, with an entrance hall akin to a hotel lobby where people sat and read their papers, chatted with passers by, both staff and other residents alike. Residents were able to have their hair styled by the in-house hairdresser, have refreshments, and engage as much as they like with others. Some homes also offer a range of entertainment options. Residents can choose to fully participate with the activities on offer in the home or retire to their room if they want privacy, confident in the knowledge that support is available if required. All care homes are registered to a minimum standard with CQC, but not all care homes offer the same level of facilities with many of the more attractive features only available in the more expensive homes.

All purchasers of care in care homes whether they represent local authorities, PCTs or private individuals are purchasing from the same group of registered care homes. Local authorities with their bulk commissioning potential tend to pay less for placements, than those purchasing for individual use and as discussed in Chapter Two there is evidence that self funders are subsiding state provision (NCF 2009). The care home market in the UK has moved away from public ownership to being largely the domain of for profit private companies. There needs to be a greater awareness of the type of care offered by care homes to be able to advise older adults appropriately.

As I discussed the study with colleagues and supervisors, various anecdotal information came forward regarding the positive benefits associated with entry to a care home. One story related to a colleague's mother who was adamant about wanting to enter a care home, despite her family's initial misgivings and their belief that her needs could be met in her home environment. She was eventually admitted to a care home and it was reported that she had settled well into the home and by all accounts was flourishing. Examples such of this strengthen my belief in the importance of considering the individualised nature of needs and the variety of ways they can be met rather than trying to apply a “*one size fits all*” mentality.

7.4 Summary

This Chapter explored the ability of the participants to settle into the care home. The potential to achieve a smooth transition from having “*chosen the path*” to entering a care home to being settling into the care home was dependent on several key influencing factors both within and outside of the participants’ control. Part of the success, appeared to be dependent on the extent the participant considered they had participated in the decision making process and were prepared for and in agreement with the move. The role of care homes was also considered and how the media serves to influence our perception of residential care.

Chapter 8 will discuss the link between the two categories identified in the last two chapters to form the theory of “*crossing the bridge*”. The conclusions from the study and the ways the findings could be applicable for practice will also be discussed.

Chapter 8: Discussion, application for practice and conclusions

8.1 Introduction

There is and will continue to be, a rise in the numbers of older adults, in the UK, with increased dependency, requiring long term care. The challenge facing health and social care services is to be able to provide appropriate long term care within a climate whereby both the availability and the cost of good quality care becomes a factor.

This study sought to understand why older adults with minimal care needs choose to enter a care home with RNs. Data was collected via face to face interviews with care home residents supported by relevant literature. The previous chapters identified two main categories; “Choosing the path” and “Settling in” which encapsulated the main concepts identified from the data, related to entering and remaining in a care home with RNs. This chapter focuses on the theory of “*Crossing the bridge*”, which charts the journey from independent living to becoming a care home resident and explores the core category linking the data. My reflections of the research study and the implications for practice will be discussed. The study conclusions and recommendations for further research will also be detailed.

The literature identified a dearth of information regarding decision making by older adults when faced with being admitted to a care home. The NHS will need staff with the knowledge and skills to effectively manage this rising demand and to assist older adults make appropriate informed choices for their long term care. Entering a care home for most people is a life changing experience often resulting in a permanent move; therefore, it is imperative that it is the right choice for older adults and their families. This study provided an insight into the decision making utilised by older adults and their families, which resulted in admission to a care home with RNs. The theory will be supported where appropriate by relevant literature. It is important to understand the factors influencing decision making and to identify what can be done to support older adults when confronted with making decisions regarding long term care.

The "*theory of crossing the bridge*" links together the concepts of "*choosing the path*" and "*settling in*" and identified a number of factors associated with the transition from independent living to care home resident.

8.2 The theory of crossing the bridge

This theory brings together the two categories exploring the factors that influenced decision making associated with choosing to enter and subsequently remain in a care home with RNs. Prior to considering the option of entering a care home with RNs, participants or their families experienced what appeared to be a "*turning point*", whereby the realisation dawned that their previous care arrangements were no longer meeting their needs or in some instances the needs of their families. The "*turning point*" may have been related to an acute event such as being admitted to hospital but it could equally have reflected a series of minor incidents that culminated in the view that a change was required. If the decision to enter a care home was taken following an acute episode of ill health, this realisation can come as an unwelcome shock at a time when an older adult may not be equipped to make such a significant decision. Research has demonstrated that participants may have to make life-changing decisions, perhaps before they have had the opportunity to fully recover from ill health or to consider the all the available options and make an informed decision (Laing and Buisson 1999). Whatever the reasons leading to the "*turning point*", the result was a need to consider alternative care options. Participants had to "*choose the path*" that would best suit their long term care needs. The consequence of their situation resulted in admission to a care home and the need to make adjustments to enable them to settle into their new life.

The impact of the decision for the participant can be put into context by visualising this aspect of the journey as "*crossing a bridge*" from their previously independent life into the unknown world of a care home with RNs and all the changes associated with the move. The journey across the bridge was not the same for everyone. The circumstances that culminated in reaching the "*turning point*" and the starting point along the path varied as did the numerous influencing factors. Some were within the participants' control and others external to them, which influenced how participants coped with "*crossing the bridge*" to became settled into the care home. For a few participants the "*crossing*" could be described as still being in progress as some had not yet settled. There appears to be interconnectedness between participants' past life, present expectations and future aspirations that influenced how this stage of their lives was experienced and how easily the bridge was traversed.

The study focussed on participants, who had been assessed in accordance with DH guidance as not requiring care by RNs, indicating that their needs could be met in an alternative setting. All the participants could potentially have been supported in their own home, as they were functionally able but for some there appeared to be reluctance or lack of motivation to remain at home. The study highlighted a lack of awareness regarding the different types of care homes on offer but even if they had been in possession of this knowledge, it might not have altered their decision to enter a care home with RNs. Often the choice of care home tends to reflect proximity to family and other factors personal to them and was not as a result of the presence or absence of RNs.

The decision to enter a care home is a complex one with numerous influencing factors. The participants exhibited a tendency to follow one of three approaches to decision making. The first related to participants having made the decision to enter a care home having considered the options. The next approach, related to the decision to enter the care home, which had been instigated by family members but with the agreement of the participant. Lastly, family members were largely responsible for the decision to enter a care home, without the participant being in full agreement. It appeared that some participants had acquiesced to please family members.

Several participants articulated how they perceived the extent of their control over the decision making process. One participant stated, after acknowledging the assistance by family, she had received, "*the decision was mine*" (Mrs B). Other participants were happy for family to take the lead so whilst their actual level of involvement may have been perceived as being less than that of the participant described above they still considered that they were integral to the decision-making and as a result expressed satisfaction with the outcome. Being fully involved for some people was not critical to their ability to be satisfied with the outcome and consider an element of ownership with the decision. Many participants were content to let their family member make the arrangements on their behalf and had settled into the care home. Several participants considered that entering a care home was the correct decision for them at this time in their life.

Those who were in agreement with the decision either in an active or passive capacity tended to settle into the care home as opposed to those whose admission to the care home was undertaken reluctantly. Several of the participants believed they could have continued to manage in their own homes and expressed the view that they had been persuaded by family members to enter the care home. This group was identified as adopting an "*accepting*" decision making style in order to please family. This group gave the impression of being the most dissatisfied with the decision and appeared not to have settled into the care home.

The category choosing the path encompassed the factors that had arisen as a result of the "turning point" and how the decision had been reached and who had been in control of decision making. The findings from this study indicate that family members appeared to exert a high level of influence, and in some instances could be considered as the primary decision makers when considering admission to a care home. The views of family on occasion were at odds with that of the participant and for some, resulted in what appears to have been a reluctant agreement to enter a care home. It is easy to imagine older adults and their families debating the option of entering a care home with some older adults being more successful than others in convincing family members of their ability to continue to manage at home, perhaps with enhanced support. Others like the participants in this study seemed to lack the ability to persuade family members of their ability to remain in their own home culminating in admission to a care home.

The data highlighted an apparent lack of awareness by the participants of the care options on offer, with many assuming the choice was between being at home or in a care home. This uninformed position seemed to direct people into a care home with RNs when the participants' clinical needs could have been met in an alternative setting, e.g. at home with increased care, a care home without nursing or one of a range of "*sheltered*" options.

The second category identified from the data related to the extent the participant had adjusted to life in a care home and the level of satisfaction with the decision. Those who reported that they had settled into the care home appeared to have successfully crossed the bridge and were adapting to life in a care home. In contrast, those participants who had not been in full agreement to enter the care home appeared not to have settled into the home, several still asserting they could have managed at home. Despite the incongruity of the decision from a clinical perspective, those participants who considered they were involved in the decision making process, had settled well into the home and appeared to be satisfied with the decision.

The merits of the decision to enter longer term care if considered in the wider context of preservation of physical functioning, use of scarce resources and potential impact on public budgets is a debate which is currently being addressed as part of the recently published "*Fairer care funding*" report (2011). The negative impact on the decision to enter a care home in advance of clinical need may only become apparent once personal resources reduce resulting in dependency on public funding. Local authorities (LA) are under no obligation to fund at the rate payable by the resident, which could potentially result in the older adult being transferred to a less expensive home (DH 2001b). My experience suggests that there are three options available when local authorities become responsible for meeting the needs of older adults who want to remain in their care home. The care home could reduce the rate it charges in line with LA rate. Secondly, the LA could fund at their agreed rate, with members of the family agreeing to pay the difference in the LA rate and the care home rate as a "*top up*" to allow an older adult to remain in the care home. Lastly, the local authority agrees, based on the clinical risk of moving someone who may be nearing end of life, to fund in full the care home fees to enable the resident to remain in the home.

The study participants currently have the financial resources to fund their care, which affords a level of choice perhaps not on offer to those reliant on public resources. There is a potentially negative aspect to this, as decisions taken without the advice and support on offer for those assessed, placed and funded by local authorities may later be regretted. Financial resources are not the only factor, to be taken into account, when considering residential care. Due to rising numbers of older adults requiring care, potential shortages of affordable provision and increased costs of residential care facilities are real considerations, which will affect how effectively care can be delivered.

Figure 8.1 depicts the journey from identifying the need for a change in current care arrangements, to moving into a care home and becoming settled. It links the influencing factors to the two main categories and demonstrating the interrelationship between the key areas.

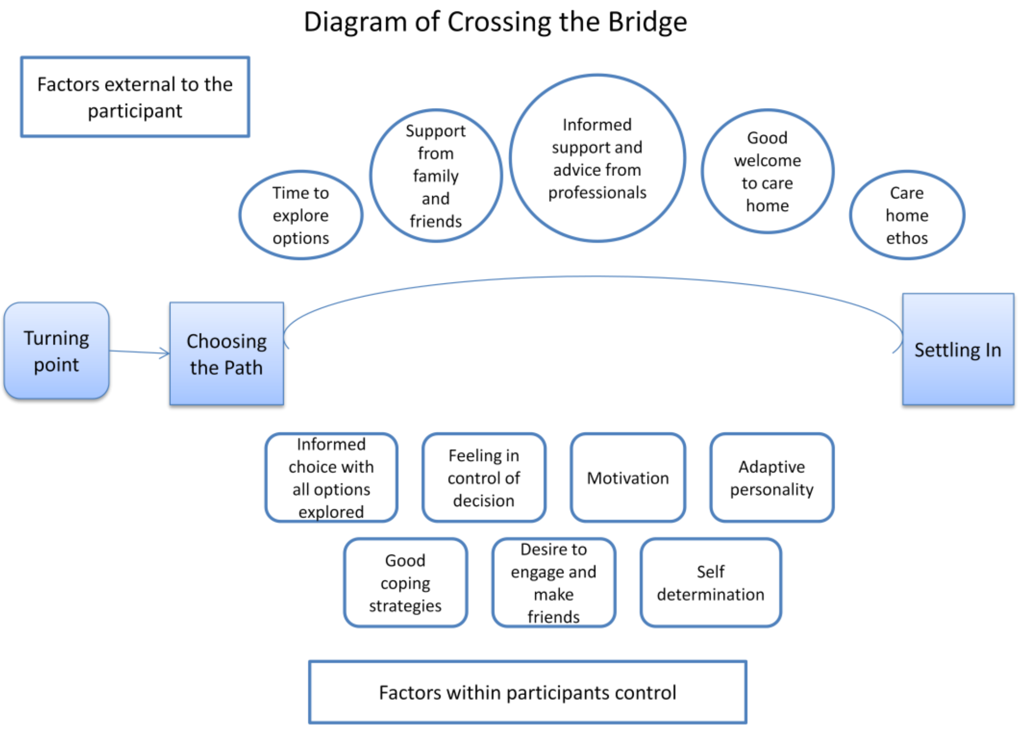


Figure 8.1 Crossing the bridge

The diagrammatic representation of the bridge suggests the extent and variability of the deliberations and difficulties experienced by the participant from making the decision to enter a care home to becoming settled and enjoying life. The two categories of "*choosing the path*" and "*settling in*" are situated at either end of the bridge to demonstrate the link between the start and end of the journey. The boxes above and below the bridge, represent the factors identified by participants which influenced their ability to make decisions regarding long term care. The boxes situated above the bridge represented the influences that tend to be beyond the control of the participant. These factors exert significant impact on the ability to make an informed decision regarding entering a care home and affected the potential to settle into the care home.

The factors were divided into those that influenced decision making related to entering a care home versus those that affected how easy it was to settle into the care home. Not all the factors apply to everyone in equal measure, but all had the potential to facilitate or hinder decision-making and affect the journey across the bridge. One of the influencing factors related to the quality of the support and advice from professionals, which afforded the participant the opportunity to make informed decisions based on the available options. This referred to the quality of the input from professionals and served to determine to what extent the participant considered they received appropriate information and advice. The availability of appropriate advice and support did appear to be limited. Allied to the provision of advice was the time afforded to the participant and their family and friends to be able to consider their options and make the right decision for them. This was probably more of an issue for those participants transferring from hospital where the pressure on beds would be greater than for participants being admitted from home, as would the availability of time to consider their options.

One of the most influential factors was the degree of support and guidance the participant received from family and friends. Family members often took the role of primary decision maker and their influence was key both in deciding to enter the care home and subsequently in the older adults' ability to settle into the home. Whether the participants considered themselves in control in either the actual or perceived sense of the decision making, affected how easy it was to settle into the care home.

Other factors identified, as being outside the participants sphere of influence, related to the ethos of the care home, the way the home welcomed the new resident and how they supported the participant in being able to settle into the care home. The manner in which the care homes address these issues are key determinates which affect the ability to settle into the home. Like all institutional settings, an element of structure and control is essential to enable homes to run efficiently but it is important that this still allows residents to remain in control of their lives.

The boxes "*below the bridge*" highlighted the factors identified as being within the participants control and reflected their own personal abilities and preferences. For example, one of the key influencing factors related to the concept of "*self determination*". Several of the participants were able to make their own decisions without having to defer to others, which would have made their ability to settle into the care home easier than for those whose decisions were being made by others, perhaps with only their limited involvement. Having the opportunity to be aware of the options on offer and to be able to exert an element of choice would enhance an individual's sense of self esteem. The participants' level of motivation and ability to adapt and cope with the new environment, also featured within the participants' own control. There was an interrelationship between how willing they were to engage in activities within the home and the way the care home was managed which influenced the ability to settle into the home.

The theory of "*crossing the bridge*" explains the process taken throughout the decision making phase and the potential to settle, once in the care home. The theory may potentially be applicable not only to entering a care home, but could account for the process of becoming settled irrespective of which long term care option is chosen. Major decisions that influence our lives are undertaken many times, for example, when we go to school, get married and seek employment. The same care and informed decision making should be afforded to this phase as the others ensuring that the participants' voice is heard and their preferences taken into account. Too many older people seem to be passive recipients rather than active participants in decisions regarding long term care (NCF 2009, p20, Fraher and Coffey 2011).

The dearth of studies that considered decision making or explored it from the perspective of the older adult is surprising due to the large number of people entering care and the long term implications of the decision. There is a need for robust studies within this area of research to understand how care for older adults can be provided and whilst studies in other countries can provide insight into this area, some of the issues identified are not always relevant to the UK. Several studies have explored decision making from family perspective or the experiences of family members having a relative enter a care home (Davies and Nolan 2004, Sandberg *et al*. 2002, Smallegan 1985), but very few have examined decision making in the UK from the perspective of the care home resident.

As part of the preliminary literature review a study undertaken in the United States by Grando *et al* (2002) highlighted to me the need for a study in this area. This was a two part study conducted to consider the reasons why people with "light" care needs entered a care home. Initially twenty care home residents defined as being independent with most activities of daily living, were interviewed as to why they had chosen to enter a care home with nurses. Reasons for admission included the lack of knowledge regarding the options, having experienced a health event, not wanting to live alone and a perceived inability to self care. Simultaneously a longitudinal study tracked over 7000 care home residents for 12 month period following admission to determine how stable their care needs were over time. The authors identified that 16 per cent of care home residents could have been cared for at home and of those 50 per cent remained in the light care category a year later. The Grando *et al* (2005) study undertaken in the United States and used Medicaid records rather than interviews but the findings suggest a reason for admission to a care home with nurses due to a lack of knowledge about long term care options has resonance with my study.

A recent Irish study (Fraher and Coffey 2011) also concluded that there was poor communication with and minimal participation by the participants with regard to decision making. This study used a hermeneutic phenomenological approach to interview a purposive sample of eight long term care residents who had within the previous three months moved to a care home. The findings identified several similarities with mine as to reasons for admission and the lack of information and informed decision making. It appeared that family members exerted considerable influence and as with my study some participants were happy to be in the care home whilst others were not. There was no suggestion however that these participants had minimal care needs and did not require this level of care.

My study adds to the limited existing body of knowledge as it considers the view from the care home resident and highlights the importance of the older adult being central to the decision making. I have tried to provide sufficient explanation and justification for the decisions taken and the paths chosen throughout coding to demonstrate the theoretical development of the categories. The core concepts of grounded theory as espoused by Glaser have been adhered to, as far as possible. I offer this study for others to judge whether the study achieved its aims, its conclusions have resonance with practitioners and the study has achieved fit, workability, relevance and modifiability.

A perceived change in need provides the context in which the participant finds themselves, either as a result of an acute event or a slow deterioration. This "*turning point*" caused an alteration in their ability to continue with their previous care arrangements and resulted in them "*choosing the path*" which in this instance has led to admission to a care home. A range of options such as rehabilitation, enhanced support at home, improved package of care or alternative care arrangements such as sheltered housing or an extra care arrangement could address the circumstances or conditions that led to this decision. The consequence of not being able to offer suitable alternatives could result in admission to a care home with RNs which although may suit some participants may not be ultimately a good long term care option. The participant "*crosses the bridge*" to becoming a care home resident with a view to "*settling in*" to their new environment.

8.3 Reflections on the study

Undertaking the study was an extremely enjoyable yet challenging experience. Several areas feature as worthy of mention. During the design phase of the study, when reading and evaluating the different research paradigms and methodologies, the suitability of grounded theory for this study became apparent. I could see the numerous benefits of the method outweighed the criticisms, but did struggle to grasp fully some of the complexities. It felt at times like a voyage into the unknown, requiring a considerable amount of time to read and reread the works of Glaser and Strauss (1967) and others to become conversant with the method. I was fortunate to have as my final supervisor someone with considerable knowledge of grounded theory, who was able to steer me through the intricacies of the method. Grounded theory methods, including theoretical sampling and constant comparison afforded me the freedom to explore the concepts, developed through theoretical abstraction that led to the identification of the core category and the generation of theory. The flexibility of the method allowed me to re-evaluate my thoughts and explore concepts from the data that had hitherto not been apparent. Grounded theory also provided a system for managing the large amounts of data that had accumulated and permitted me to focus on the key aspects of developing theoretical abstraction and conceptualisation from the data. Grounded theory afforded me the opportunity to explore a topic of interest and develop substantive theory using a method respected by professionals, which had received international recognition as a robust and trusted method of conducting research.

An issue not initially apparent, related to my dual role as researcher and practitioner, and my failing to appreciate fully the implications attributed to both roles. As a senior clinician, I was used to conversing with patients regarding a range of subjects. I was also of the view that older adults usually enjoy having someone take an interest in their lives and as such believed that there would not be any difficulties in getting people to speak with me. I had underestimated the difference in the relationship that existed between patient and nurse in the in the clinical role, compared to the equal relationship that exists between researcher and participant. My first two attempts at conducting an interview raised some concerns regarding researching older adults. Details of my initial attempts at conducting interviews have been described in Chapter Four and served to highlight the dilemma, associated with my first interview and a potential participant happy to converse with me but not in agreement for the information she had shared with me being used for the study.

The next interview was with a man with a severe hearing impairment. The interview was conducted to the best of both our abilities but the conversation never really flowed. Following this inauspicious start to the data collection, I became apprehensive about the interviews, worrying about potential difficulties in recruiting participants into the study and whether once recruited, they would engage with me. I was also concerned that the topic of the interview may cause distress to the participants. Fortunately, my anxieties were allayed as subsequent interviews passed without incident. Undertaking the study helped me to development professionally both as a clinician and as researcher and enabled me to consider how the findings of the study could improve clinical practice.

The premise of grounded theory research is to enter the field with as few preconceptions as possible. The researcher seeks to study an area of interest, which in my case had been identified through my clinical practice. I chose to explore why people with a minimal need for care entered a care home with RNs. Although, I was able to obtain some insight into this question, this was not the issue that was of paramount importance to the participants. It is central to a grounded theory study to identify what is "*the main concern or problem for the people in the setting*" (Glaser 1978, p94). What became apparent was the extent the participant was in charge of the decision and whether, they were in agreement with entering a care home. The element of control exerted over the decision to enter the care home seemed to influence the ability of the participant to settle in the care home. Whilst it is desirable when considering the wider health and social care resource debate, to encourage older adults not requiring RN care to seek other arrangements, what mattered to participants was whether a care home was the right option for them.

8.4 Implications for practice

This study makes an important contribution to our understanding of the factors that influence decision making when considering entering and remaining in a care home with RNs. The study will benefit health and social care practitioners in understanding the decision making styles utilised by families and what influenced decision making. The need for good communication with prospective care home residents and the importance of their understanding the range of available options and how older adults can be supported in making the choice that is correct for them.

The study highlighted areas where existing practice could be improved to benefit older adults considering long term care. An area that was not explicitly stated, but was implied by the participants, related to the provision of rehabilitation. Several participants did identify the need for further time to recover from their period of ill health, which has similarities with the accepted definition of rehabilitation. In my opinion, the importance of allowing older adults time to recover from an event and work towards regaining their function cannot be underestimated. There needs to be more robust processes in place to ensure an individuals potential for rehabilitation and reablement is considered in advance of decisions regarding long term care (Hoare 2004, DH 2009).

Older adults should be offered the opportunity to enter a therapeutic programme to try to improve their level of functioning, restore confidence and provide an opportunity to consider the range of options on offer. Associated with this was the apparent lack of informed advice and support regarding long term care options, provided to older adults by health and social care professionals. I was aware from my own experience that amongst professionals, knowledge of the range of community services available and the different types of care homes is deficient. I have observed where a casual remark by a senior clinician early on during the period of hospital admission is sufficient to direct someone into a care home with RNs when there may be other more appropriate options. Health and social care practitioners need to be aware of the impact their words may have and use this influence wisely.

This study can assist health and social care professionals realise and develop their advisory role. Key staff require sufficient knowledge regarding the type and range of long term care options, available to enable them to advise patients and their families. If health and social care professionals lack the knowledge and skills themselves then it is incumbent on them to direct older people and their families to where they can obtain appropriate advice. The options can range from remaining at home with enhanced care input, consideration of supported living or to enter a care home and of interest to this study, a care home with RNs.

Older adults responsible for funding their own care should not be disadvantaged when it comes to receiving sufficient information regarding the range of entitlements on offer. They should be given the opportunity to access the same assessments and information as those reliant on publicly funded care. The preferences of older adults should be taken into account where possible as should the importance of a choice of options being offered from which to make an informed decision. Older adults may require an advocate to work on their behalf, to support them in taking a more proactive role and to ensure their voice is heard during discussions regarding long term care.

The study indicated that families are often instrumental in the decision to enter a care home and their view is sometimes at odds with that of the participants. There may be a belief that in order to remain at home requires a greater level of input from family members to provide the day to day assistance and support required. Care homes may be perceived as requiring less direct family input and may ease some of the responsibility faced by family members, whilst delivering care in a safe environment. In my view, families may be more receptive in assisting to maintain an older adult at home if there were a range of options which offered support and assistance to family and friends. Carers also require access to information regarding their entitlement to a carer's assessment and other available benefits.

Some participants considered that it was the practical management of their home that they either found difficult or were of the view that they lacked the skills to address if they remained at home. Managing a home requires considerable input, but there are options available such as the use of court appointed deputies who can manage finances, take care of the day to day running issues and ensure repairs are undertaken. Practical assistance through the delivery of "*ready meals*" and other groceries as chosen by the older adult, with carers employed to accompany older people out for shopping trips or to visit friends and family. Care at home may not be suitable for everyone. Some participants despite having the cognitive skills and physical ability may lack the motivation to live alone as reflected by those participants who despite being physically independent were satisfied with the decision they or their family had taken to enter a care home.

A popular option which removes the responsibility for building maintenance exists through sheltered housing with extra care or retirement villages for those people who want to live in an "*own home*" environment. The growth of the extra care housing market and the range of different community options will assist people to maximise independence but with increased level of support if and when required.

If a care home is considered the best option then assistance from health or social care professionals should be available to ensure the correct care home environment is chosen. This does not extend to recommending particular homes as most care homes with or without RNs operate as private businesses and health and social care professionals have to guard against recommending a particular home or suggesting a care home which may not be suitable. They can however provide information regarding a range of care home or supported living options and offer support in making the right choice to suit individual needs. Making decisions regarding long term care, irrespective of which option is chosen is very difficult to arrange from a hospital bed without assistance from family, friends or health and social care professionals. Ideally, admission to a care home should be undertaken in a planned way rather than as a result of a health event. Older adults need to be encouraged to plan for their future needs in the event of illness or infirmity. More could be done to publicise the range of options available locally with the media using their influence to accurately portray long term care.

There will continue to be a requirement for a range of options depending on individual clinical need and personal circumstances but older adults need to be appraised of the range of options in order for them to make informed choices. The findings from this study can have practical applications to assist in developing robust systems to support best practice related to long term care.

Four main areas have been identified, that could be implemented locally to improve practice. The role of the NHS Funded Health Care Team could be enhanced. The work of the NHS Funded Health Care Team, of which I am involved, could focus on being the central point for older adults and their families. The role currently exists to co-ordinate an assessment to determine an individual's eligibility for NHS CHC or FNC. An aspect of the role could be to provide advice, assistance and training on the range of available options to health and social care staff. Enhancing the role of the NHS Funded Health Care Team would provide a key advisory role and address many of areas outlined above. The team could provide the link between hospital and the community, with nurse co-ordinators taking the lead to ensure all rehabilitation and treatment options are explored in advance of discharge.

It has been identified that many professionals seem to lack the knowledge and skills required to support and advise older people and their family. The need for a regular programme of training for health and social care staff to ensure they were apprised of the available options. The majority of people who were dissatisfied with the decision to enter a care home had been admitted from home. People considering admission from home may lack professionals who they can turn to for advice. Training could be given to community nurses to assist them in supporting people in their own home and how to access, admission avoidance schemes and occupational therapy assessments which can help adapt the home environment to make remaining at home more viable.

Development of slow stream rehabilitation units for those individuals who are not able to tolerate or do not require intensive rehabilitation. Older adults might benefit for extra time and support to enable them to consider their options, regain physical functioning and restore confidence. This could be incorporated within a under utilised community hospital or within a care home with enhanced resources to offer slow stream rehabilitation. The study by Hoare (2004) highlights the dangers of older adults being admitted to a care home from hospital and my study supports the need for rehabilitation or reablement options to be fully considered in advance of making decisions regarding long term care.

Lastly, the publication of a leaflet, detailing the local resources for older adults, what is on offer and how services can be accessed, would assist older adults and their family's obtain important information. A leaflet could be developed in conjunction with the PCT's, Public Health Directorate and Health Promotion unit and be distributed to GP surgeries, health centres, clinics and libraries.

The leaflet could also be incorporated into the information packs provided to all patients on admission to hospital. These various approaches could take forward the areas identified by the research study and work towards developing more evidence based practice for long term care.

8.5 Recommendations for further research

Due to resource constraints, this study was limited as to what areas it was able to address. In retrospect, it became clear from the data that the views of key family members, instrumental in the decision making process, may have aided understanding of the factors involved and offered a more balanced view. Whilst extending the study would have been a useful adjunct, it was discounted as the study protocol had to be focused to allow the study to be completed within the time frame of the Doctorate of Clinical Practice, but could be considered for further research. Instead, the focus of the study was on care home residents, with the aim of obtaining information from their perspective, pertaining to the factors that had influenced decision making, thus providing the basis for future studies in this area.

It would have been of interest to explore the views of older adults who returned home following a period of inpatient care and what factors had influenced the decision. Also of relevance, could be the consideration as to why some people were unhappy with the concept of live in care. Another area for further research may be to explore that if participants do experience physical decline in a care home what measures could be taken to ameliorate the impact and maintain function.

8.6 Conclusions

Through my clinical practice I had identified that older people were being admitted to a care home with RNs when this was not clinically indicated. This study sought to explore this phenomenon and identify the factors that were influencing decision making.

The study identified that either due to a physical event or as a result of a gradual change in the needs, the participant or their family had identified a requirement for a change in their care arrangements. The "*turning point*" represented the critical point at which, robust advice and support, delivered by well informed health and social care professionals, can ensure older adults have the opportunity to consider the full range of options on offer. The potential for rehabilitation should be fully considered as should the potential for the home environment to be adapted to accommodate remaining at home.

The consequences of entering a care home when not clinically indicated or without the express wishes of the older adult could potentially have adverse quality of life and resource issues. Older adults should not be disadvantaged because they have resources to pay for their care and they should be entitled to the same range of assessments and benefits as those who are funded through public resources. Support is crucial for older adults to feel fully engaged in the process of "*choosing the path*" that meets their needs and the needs of family members. Many people do not want to enter a care home and it is this group of people who should be empowered to have their voices heard and be supported to remain in their own homes where possible. In order to achieve this, health and social care professionals need to have access to evidence based knowledge and be encouraged to develop skills to assist participants and their families in a timely manner make decisions that are right for them. The theory of "*crossing* *the bridge*" is not solely applicable to entering a care home as it could extend to other long term care options.

Our growing numbers of older people will challenge us to find ways to maintain and promote independence whilst providing high quality appropriate care. The decision to enter a care home should be taken as a result of informed decision making with assistance from appropriate professionals following a full appraisal of the options. Decisions should be made appropriate to needs and personal choice as to how older adults wish spend their final years. What is of importance is the ability to deliver the right service provision based on clinical need to meet the aspirations of the older adult. This can only be achieved by all health and social care professionals being able to offer informed support and advice in a timely manner, whilst ensuring older adults remain central to the process.

Appendix 1: Letter to prospective participants

UNIVERSITY OF Southampton
School of Health Sciences

Building 67

University of Southampton

Highfield

Southampton

SO17 1BJ

Dear

You are being invited to participate in a research study that I am undertaking at the University of Southampton as part of my clinical doctorate programme.

I am a senior Specialist Nurse working with older adults. I am interested in speaking with people who have been admitted to a care home where Registered Nurses are employed. I would like to hear about your experiences and the factors that led to your decision to enter your care home.

If you think you would like to speak with me to discuss your experiences, please read the attached information sheet which offers more detail about the study. If you are interested in taking part in the study or want to know more, please complete the enclosed “Reply Slip” and return it to me, via the care home Matron. Returning this form will allow me to contact you and respond to any questions you may have. It does not mean you are committed to take part in the study in any way.

If you join the study I would like to reassure you that your confidentiality will be maintained at all times, unless during the course of our discussion, anything comes to light of a criminal nature or a perceived risk to yourself or others.

If something of concern is disclosed it may be necessary to alert the Local Authority Safeguarding Adults team.

Thank you for reading this information and please be assured that if you decide not to participate in the study you will not be disadvantaged in any way.

If you have any further queries or would like to discuss any aspect of the study I am happy to telephone or visit you to talk to you about the study.

Yours sincerely

Alice Stevens

Researcher

Appendix 1: Letter to prospective participants

Appendix 2: Participant information sheet

UNIVERSITY OF
Southampton
School of Health Sciences

Participant Information Sheet

1. Invitation to join the study

You are being invited to take part in a research study. Before you decide whether you wish to participate in the study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear to you or if you would like more information. It is important that you take time to decide whether or not you wish to take part.

Thank you for reading this.

2. What is the purpose of the study?

The purpose of the study is to find out about the views of people who have recently been admitted into a care home where Registered Nurses are employed. I am interested in exploring your experiences and to understand what led to the decision to enter this care home.

3. Why have I been chosen?

You have been chosen as you have, within the last year, entered a care home where Registered Nurses are employed and you have been identified as not requiring a Registered Nurse to deliver your daily care needs.

4. Do I have to take part?

It is up to you to decide whether or not to take part. You may receive no direct benefit from taking part in the study, but there is the potential to influence the assistance people receive prior to making the decision to enter a care home. If you do decide to take part or wish to ask some questions you will be given this information sheet to keep and will be asked to return a reply slip to me, Alice Stevens, the researcher. Returning the reply sheet will allow me to make contact with you and to answer any questions you may have. If you then agree to take part you will need to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the care you receive.

5. What will happen to me if I take part?

I will arrange to meet with you at a mutually convenient place, date and time in your care home. At this meeting I will ask you to talk about your experiences and to identify the factors that led to the decision to enter your care home.

I have considerable experience of talking about difficult subjects, and will try to make this as pleasant an experience as possible. With your permission, the interview/discussion will be audio recorded to enhance accuracy of reporting your story and to ensure that I can concentrate on listening to what you are saying without having to take notes. The interview information will only be used by me and anything that identifies you will be kept confidential. If any of your statements are used in the final report, they will not include anything that could identify you or the care home you are living in.

A signed consent form will need to be completed prior to the start of your participation once I have answered all your queries. Anything you disclose during the interview/discussion will remain confidential to the study and be anonymous in any reporting, unless during our discussion anything comes to light of a criminal nature or a perceived threat to yourself or others.

The interview/discussion should last approximately 45 minutes and breaks may be taken at any point during our discussion. The interview can be stopped at any time without you needing to give a reason.

It is appreciated that talking about the reasons that led to your admission to your care home might not always be comfortable. We hope that the discussion does not cause you any distress and all practical steps will be taken to prevent this. It would be helpful for you to identify someone who would be supportive to you should you need them following the interview.

6. Will my taking part in this study be kept confidential?

If you consent to take part in the research, your name will not be used and you will not be personally identifiable in any study reports. Your confidentiality will also be maintained unless during the course of the study there is any perceived threat to yourself or to others in which case I will inform you before any necessary action is taken. This principle is informed by the Nursing and Midwifery Council Code of Professional Conduct. I may wish to use the information you provide for further analysis in the future but your anonymity and confidentiality will be maintained.

The procedures for handling, processing, storage and destruction of the data match the Caldicott principles, which mean that only people who need to have access to the information are able to see it. The Data Protection Act of 1998 will also be adhered to. The data will be kept on a secure computer and in locked cabinets and will not identify you by name. My university supervisors and I will be the only people who will have access to any of the information provided. The tapes will be destroyed on completion of the study in line with university guidance.

7. What will happen to the results of the research study?

It is anticipated that the final report of the study will be completed before October 2010. Summaries of the report will be available to you from me at the School of Health Sciences, University of Southampton.

8. Where can I seek independent advice about being involved in a research study?

Provision for independent advice about being involved in a research study can be gained form:

Professor Judith Lathlean

Research Director,

University of Southampton

School of Health Sciences

Building 67

Highfield

Southampton

S017 1BJ

Tel: 023 8059 7967

9. What do I do if I need to complain about the conduct of the research?

If you have a concern or a complaint about this study you should contact Susan Rogers, Head of Research and Enterprise Services, at the School of Health Sciences

(Address: University of Southampton, Building 67, Highfield, Southampton, SO17 1BJ ;

Tel: +44 (0)23 8059 7942;

Email: S.J.S.Rogers@soton.ac.uk*).*

If you remain unhappy and wish to complain formally Susan Rogers can provide you with details of the University of Southampton Complaints Procedure."

10. Who is organising and funding the research?

This study forms a major part of a Clinical Doctorate Programme at the University of Southampton. This study is solely for my professional and educational development and is not related to the work I do within Surrey Primary Care Trust. I am paying to undertake the degree myself, in my own time without any sponsorship by an external organisation. My employers, Surrey Primary Care Trust are supportive of the study but are not involved in sponsoring the project.

11. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity.

The research project has been reviewed and given favourable opinion by the Surrey Research Ethics Committee and Sussex Research Consortium. It is being supervised by experienced researchers at the University of Southampton.

12. Contact for further information about the study

The researcher is based at the School of Health Sciences, University of Southampton. Their contact details are as follows:

Alice Stevens - Chief Investigator	023 8059 8230
Dr Sue Green - Senior Supervisor	023 8059 8230
Dr Magi Sque - Second Supervisor	023 8059 7970

University of Southampton
School of Health Sciences
Building 67

Appendix 2: Participant information sheet

Highfield

Southampton

S017 1BJ

Tel: 023 8059 7967

THANK YOU FOR TAKING THE TIME TO READ

THIS INFORMATION SHEET WHICH IS YOURS TO KEEP.

If you wish to ask any questions or to take part in the study please complete the Reply Slip and post it back to Alice Stevens, Address: University of Southampton, School of Health Sciences, Building 67, Highfield, Southampton, SO17 1BJ, in the addressed prepaid envelope OR give the completed Reply Slip to your Care Home Manager.

Appendix 3: Reply slip

Reply Slip

Could you please read and complete the following information if you would like to proceed.

Do you have any questions or concerns about the study that need answering before you are able to decide if you wish to participate?

Yes / No (Please circle whichever is appropriate)

If yes, please provide a contact number to enable me to telephone you to answer any questions or discuss any concerns you may have.

Appendix 3: Reply slip

Telephone number………………………………………………

If you do not have any questions or concerns and are happy to proceed with arranging a mutually convenient day and time to conduct the interview please complete the questions below.

I want to proceed with arranging the researcher to come to interview me.

Yes / No (Please circle whichever is appropriate)

1. Do you have a particular day or time that you would like me to come to the home to meet with you?

……………………………………………………………………

2. How would you like me to contact you to arrange an appointment?

By telephone on the following number…………………………

By letter……………………………………………………………

Appendix 3: Reply slip

Through the care home manager……………………………

Thank you for your time in completing the above reply slip. I want to ensure that you have had sufficient time to be sure that you wish to be involved in the study. I will not be in contact with you until you have had at least a week to be sure that you want to participate in the study.

Appendix 3: Reply slip

Appendix 4: Consent form

UNIVERSITY OF
Southampton
School of Health Sciences

Consent Form

Title of Project: An exploration of admissions to Care Homes with Registered Nurses

Name of Researcher: Alice Stevens

Please initial the box along side each statement indicating that you have read the statement and are in agreement with the content.

1. I confirm that I have read and understand the information provided to explain the above study and have had the opportunity to consider the information, ☐

ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without care or legal rights being affected. ☐

3. I agree to my responses being audio taped during interviews. ☐

4. I agree for extracts of my conversation to be reported in research papers but my name will not be used and I will not be personally identifiable in any study reports. ☐

5. I understand that my confidentiality will be maintained unless during the course of the interview there is information of a criminal nature or a perceived risk or threat to me or others, in which case I will be informed by the researcher before any necessary action is taken. ☐

6. Should I lose capacity to consent during the course of this study I understand that I will be withdrawn from the study and that any information already provided with consent will be retained and used in accordance with the consent obtained. ☐

7. I agree for you to use the information I provide for this study for further analysis in the future. ☐

8. I understand that it may be helpful to have someone available at the end of the interview to offer support, should I require it. ☐

9. I agree to take part in the above study. ☐

If you have a concern or a complaint about this study you should contact Susan Rogers, Head of Research and Enterprise Services, at the School of Health Sciences (Address: University of Southampton, Building 67, Highfield, Southampton, SO17 1BJ ; Tel: +44 (0)23 8059 7942;

Email: S.J.S.Rogers@soton.ac.uk*).*

Appendix 4: Consent form

If you remain unhappy and wish to complain formally Susan Rogers (contact details above) can provide you with details of the University of Southampton Complaints Procedure.

Name of participant	Date	Signature
________________	_________________	___________

Name of person taking consent	Date	Signature
______________	__________________________________	

When completed, 1 for participant; 1 for researcher site file

Thank you for your assistance

Appendix 5: Interview guide

Interview Guide

To be read out by the researcher prior to the commencement of the interview.

Thank you for agreeing to speak to me. I would like to explore your reasons for entering a care home where Registered Nurses are employed. I expect the interview to take no longer than an hour of your time, but we can stop at any point should you wish to do so for a break or if you wish to end the interview.

If you are in agreement, I would like to audio tape record our discussion. This will enable me to have an accurate record of what you are saying and for me to be able to listen to what you are saying without having to take notes.

If you wish to do so you can end our conversation at any time without giving a reason. You do not have to discuss any topic that comes up in conversation that you feel uncomfortable talking about.

If you are happy for me to proceed with the interview please sign the consent form.

Main areas to be considered:

- How long have you been living in your care home?

Appendix 5: Interview guide

- Where were you living before you were admitted into the care home?

- Were you living on your own or with your family?

- Please describe the circumstances leading up to your admission to the care home?

- Please describe any assistance you require in undertaking activities of daily living (for example washing and dressing, eating and drinking, going to the toilet).

- What influenced your decision making to enter your care home? Did anyone help you make the decision to come here?

- What are your observations on having made this decision?

Appendix 6: Care UK – Care home checklist

The following is a condensed version of the Care home checklist available on the website.

Care home checklist

Location and building

☐ Where is the home?

☐ Will visitors be able to get there easily?

☐ Are there transport links near by?

☐ Are facilities such as shops, pubs, parks and places of worship within easy reach?

☐ How accessible is the home?

☐ Will it be easy for you to enter and leave the building, and move between rooms and floors?

☐ How good is the wheelchair access?

☐ Is there a lift?

☐ Does the home feel clean and inviting?

☐ Are there any unpleasant smells?

☐ Do the rooms feel hot and stuffy or cold and draughty?

☐ Is there a relaxed and friendly atmosphere?

☐ Will you feel comfortable chatting and socialising in the home’s public areas?

☐ Are chairs arranged in groups or round the edges of the rooms?

☐ Is there a quiet living room for reading, as well as one with a television?

☐ Are the rooms a good size?

☐ Will you have a room to yourself?

☐ Is there any choice of rooms to accommodate preferences such as sun, shade or quiet?

☐ Do the rooms have en suite facilities or basins?

Appendix 6: Care UK- Care home checklist

☐ Will you be able to bring your own possessions such as pictures, plants and furniture?

☐ Does the home allow pets?

☐ Will you be able to settle into the home?

☐ Would you prefer a larger or smaller home?

Day-to-day life

☐ Are there telephone facilities you can use in private?

☐ Can you access the internet, either in your room or on a shared computer?

☐ Are books and newspapers available?

☐ Does a mobile library visit?

☐ Does the home arrange outings to the shops, entertainment venues or places of worship?

☐ Are there any physical activities such as exercise groups or gardening?

☐ How will you be told about upcoming events?

☐ Are you encouraged to stay active and do as much as you can for yourself?

☐ Are external doors kept locked?

☐ Can you go outside for fresh air when you want to?

☐ Are you allowed to make choices about your daily routine?

☐ Will you be able to rise and go to bed when you choose?

☐ Can you choose which clothes to wear each day?

☐ Are there any restrictions on visiting times or numbers of visitors?

☐ Where can you spend time with your visitors?

☐ Are there facilities for visitors to stay overnight?

☐ Are young children welcome?

☐ Is the home right for your cultural and religious needs?

☐ Are there members of staff who speak your language?

☐ Can the home meet your dietary needs?

Appendix 6: Care UK- Care home checklist

☐ Are there other residents from a similar background to you?

☐ Is there a choice of food and when and where it can be eaten?

☐ How are special diets catered for?

☐ Can you prepare food and drink for yourself?

☐ Do existing residents enjoy the food and can you try it?

☐ Are details of the complaints procedure readily available?

☐ Are you encouraged to give feedback?

☐ Is there a residents' committee?

☐ Do you have access to advocacy services?

Your care needs

☐ Is the home registered to provide the level of care you need?

☐ Do the other residents seem to have a similar level of need to you?

☐ What will happen if your needs change or increase?

☐ Does the home have bathing facilities that meet your needs?

☐ If you need help with bathing, who will provide this?

☐ Can you choose how often you have a bath or shower?

☐ Are toilets available in all parts of the home?

☐ Are they equipped with handrails and other mobility aids?

☐ Are you helped to the toilet when you need to go, if necessary?

☐ When are incontinence pads and catheters used?

☐ Do you have your own GP and access to other health services such as opticians and dentists?

☐ Who decides when a check-up is needed?

☐ How will the home let friends and family know if you are taken ill?

☐ How many staff are employed per resident?

Appendix 6: Care UK- Care home checklist

☐ How are they trained?

☐ Is there a manager on duty at all times?

☐ What is the turnover of staff?

Contracts and fees

☐ Can you see a copy of the home’s brochure?

☐ Can you see copies of recent inspection reports?

☐ Can you see a copy of the home’s contract/written conditions?

☐ What are the home’s fees?

☐ Is it clear how the fees are structured and calculated?

☐ How are NHS nursing care payments accounted for?

☐ How are fees collected?

☐ Do self-funding and local-authority assisted residents pay the same rates?

☐ Is a top-up payment required for local-authority assisted residents?

☐ Are extra items not covered by the basic fees clearly identified and accounted for?

☐ What arrangements are there for handling your personal money?

☐ How are your valuables kept secure?

☐ What are the notice conditions in the contract?

☐ Are any fees payable after a resident’s death?

☐ How quickly does the person’s room have to be cleared out?

Appendix 7: Guardian article on Southern Cross

Southern Cross's incurably flawed business model let down the vulnerable

The collapse of Southern Cross has re-ignited the debate over the role of private finance in the care-home sector

Richard Wachman Guardian.co.uk, Saturday 16 July 2011 00.08 BST

Residents sit outside a Southern Cross care home in Camberwell Green in south London. The company collapsed earlier this week after landlords took back the leases to its 750 care homes. Photograph: Paul Hackett / Reuters/Reuters

Southern Cross will soon cease to exist, as landlords take back leases linked to the firm's 750 care homes because it can no longer afford the rent. New operators will be brought in and Southern Cross will be remembered as a financial failure that heaped shame and ignominy on the sector. But how did it come to this? Britain's largest care homes operator, with 31,000 residents, was once a force in the land.

It's easy to see why. Not so long ago, running care homes for the elderly and sick seemed an easy way to make money in a country where the population was greying at a faster rate than anyone could remember. Most elderly residents were bankrolled by local authorities, offering private-sector operators a steady stream of income from the taxpayer.

Interest rates were low, allowing companies to borrow to expand their estates at a time when banks were falling over themselves to furnish loans. Councils were feeling generous and agreed annual fee increases ahead of the rate of inflation, making it simple for operators to cover their costs.

Against this background, Southern Cross prospered. A former executive remembers: "It sounds corny, but it really did seem we were in a land flowing with milk and honey."

By 2003, the company owned more than 100 homes and was attracting the attention of investment bankers. "You could see the firm was going places – management was ambitious and as it grew, so did the financial returns," said the former executive.

Appendix 7: Guardian article on Southern Cross

A year later, US private equity group Blackstone acquired Southern Cross in a deal worth £167m. Ludicrously, as it turned out, Blackstone supported a sale-and-leaseback business model that was all too common at the time.

Under this system, Southern Cross's operating company and property assets were separated. It was blatant financial engineering but it made sense on paper: acquisitions could be financed by spinning off the bricks and mortar into a different company, selling it on to property investors and then using the proceeds to buy more care operators.

Blackstone's biggest transaction was the £564m purchase of NHP, a property company that owned the leases to many of Southern Cross's homes. Blackstone later sold NHP for £1.1bn to a fund backed by the Qatar Investment Authority. As with other deals, Southern Cross's Middle Eastern landlord insisted on upwards-only annual rent increases, of around 2.5%.

As long as the boom lasted, Southern Cross was able to generate large amounts of cash and invest in its homes to make them attractive to local authorities. The sale-and-leaseback model worked fine when property prices were heading north: property players were happy to invest, and Southern Cross was willing to agree to upwards-only rents as it could borrow at cheap rates.

But after the financial crisis, Southern Cross was hit by a triple whammy: falling property prices put the brakes on what proved to be a reckless expansion programme; tough economic conditions saw local councils freeze or lower fees for residents; and worst of all, the company was now locked into rising rents at a time when income was being squeezed. It was a recipe for disaster.

Even during the best of times, profit margins in the care homes business are thin; as long as occupancy rates remain comfortably over 85%, a company that leases its homes from landlords can make good profits. But below that level, it becomes harder to break even, leaving businesses vulnerable to relatively small changes in the trading climate.

Research has shown that Southern Cross's occupancy rates fell every year from 2006. And it cut capital expenditure in its homes, hitting standards of care for residents, making them less appealing to local authorities.

A version of the sub-prime crisis was hitting the sector and other operators felt the pinch, with several seized by creditors. Barclays Capital, for instance, took over Care Principles, a company that looked after patients who had been sectioned under the Mental Health Act.

Appendix 7: Guardian article on Southern Cross

At Southern Cross, deteriorating standards of care were seeping into local media reports. By 2009, Southern Cross homes were attracting the attention of the Care Quality Commission. A report in the Observer last month disclosed that nearly 30% of the group's 581 centres in England had been served with improvement orders by CQC inspectors.

The tide had turned against Southern Cross for another reason. Local authorities were trying to care for more elderly and frail people in their own homes, so by the time they arrived at residential centres, their condition had deteriorated to include dementia, immobility and incontinence, which are more expensive to care for. Southern Cross was forced to take on more overheads as revenues declined, and all the while there was the ticking timebomb of a rising rent bill, which had reached £230m a year by January.

Blackstone left long before the bust. It floated the company for £640m in 2006 and sold its last Southern Cross shares a year later. In total, the private equity firm made a profit of £1.1bn on its original investment. Others were left to pick up the pieces.

Jamie Buchan, the chief executive who took over two and a half years ago, never really had a chance. He was reluctant to talk about what had gone wrong yesterday, but in May he told the Financial Times: "I've never come across this lease structure before. The model doesn't work through hard times."

The failure of Southern Cross has re-ignited the debate about whether private-sector operators can be trusted to provide social care. Unions, such as the GMB, are certain the idea is a bad one. Amanda Gearing, a regional organiser in the West Midlands, says: "Residential services should be left to local authorities, not companies with shares listed on the stock exchange. They will always put profits before people." Labour party stalwarts, like Michael Meacher, agree.

But Peter Hay, president of the Association of Directors of Adult Social Services, says: "Not all private care is bad. Private companies have pumped in £19bn of investment in the last 20 years. You would never have got that from the public sector. Also standards are getting higher. In 1991, I remember a local authority home where there were six men to a bedroom and 12 sharing a bathroom. These days having your own room and facilities is becoming the norm."

But Emily Thornberry, shadow health minister says: "Social care cannot be left to uncontrolled market forces."

Appendix 7: Guardian article on Southern Cross

She and others believe better supervision is vital. But surprisingly, no body in the UK seems to have direct responsibility for ensuring private care companies avoid risky business models of the kind that sank Southern Cross.

Health minister Paul Burstow says the new NHS regulator, Monitor, could perform such a role. At the Department of Health, officials are working on proposals to require care home operators to take out bonds underwriting the continued care of their residents in the event of their financial failure.

These are steps in the right direction, but more needs to be done because one thing seems sure: without tighter regulation and better policing, there will be more Southern Crosses.

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