UNIVERSITY OF SOUTHAMPTON

THE ADAPTATION OF THREE ASSESSMENT SCALES IN A COMPARATIVE STUDY OF SIX HOMES FOR THE ELDERLY TO DETERMINE THE IMPACT OF KEY WORKER SYSTEMS ON THE ETHOS OF THE RESIDENTIAL UNIT

A Thesis
submitted for the degree
of Master of Philosophy

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June 1986

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Abstract

The evaluation of specific inputs of care in homes for the elderly is an issue which has received considerable attention from both researchers and practitioners within the social work profession.

This descriptive study attempts to compare three homes for the elderly which operate a key worker system with three homes which do not, using three assessment scales adapted for use in a small scale project.

The three specific areas of comparison were:

(i) The daily practices within the home.

(ii) The levels of residents' self-esteem.

(iii) The levels of engaged behaviour in residents' lounges.

It was hoped by these means to measure the impact of this method of providing individualised care upon the organisation and the subjective and behavioural responses of the residents,

The adaptation of the assessment scale was not successful in the Analysis of Daily Practice and only partially so in the measures of self estemm and engaged behaviour.

The three measures appeared able to distinguish between homes which operated no system of individualised care from those which did. It was not capable of distinguishing between those homes which operated a key worker system from a home which planned care around a bath rota.

Preface

Introduction

This project, undertaken as part of a Personal Research Fellowship at Southampton University in the Department of Social Work Studies, was concerned with an assessment of the care of the elderly in six residential homes drawn from the same local authority. These homes were all generous in their support and co-operation. Pseudonyms have been used throughout the study in order to preserve confidentialty for all those involved.

The research was undertaken after consultation with both the Principal Training Officer and the Principal Officer responsible for Residential and Day Care for the Elderly from the local authority selected from the project. Throughout the project information, advice and encouragement were provided by Unversity staff, especially the first supervisor.

The researcher is employed by the same local authority at an Institute of Higher Education where she is responsible for the specialist teaching of those working with the elderly. The availability of assessment instruments which can be productively employed in small scale evaluation projects is therefore of great interest and provided much of the motivation to undertake this particular study.

Several of the homes, selected by the Principal Officer, had members of the management team who were or had been students on the courses run by the Institute of Higher Education and were well known to the researcher, others were unknown before the start of the project. The researcher was very aware of this potential source of bias throughout the study.

The Aims of the Study

The purposes of the project were three fold:

(i) To adapt a number of existing assessment scales for use by a single-worker in a short, intensive study.

(ii) To determine whether these revised scales were capable of discriminating between three homes in which a 'key worker' system was in operation and three homes which adopted other strategies for allocating care-staff hours between residents.

(iii) To examine the implication of this study for social service workers seeking to evaluate care inputs within their establishments.

The pursuit of the first aim required the researcher to complete the following tasks:

(1) To identify key areas of assessment by a review and evaluation of relevant data.

(2) To review the existing measures which might be employed in these areas,

(3) To select those measures most appropriate for use in a small scale, in depth study.

(4) To make, where necessary, adaptations to the measures used so that they were able to be used by a researcher, unsupported by assistants.

(5) To evaluate these adapted measures in a limited study consisting of six homes for the elderly.

The second aim was concerned with both the implementation of the measures and the interpretation of the assessment data and it necessitated two steps to be taken:

(1) To determine which homes for the elderly, from a sample of six, operated a 'key worker' system within the definition to be adopted in this particular study.

(2) To identify any clear distinctions which might be made between the 'key worker' and the 'non key worker' homes.

The final aim required the researcher to:

(1) discuss the value of the measures adopted.

(2) consider its general relevance for workers in the field.

The Project Presentation

The study begins with a historical review of the use of the key worker concept in relation to the elderly and establishes a working definition of what is meant by a key worker system. Chapter Two identifies those areas where evaluation would appear to be most pertinent. Chapter Three, the first of two chapters concerned with methodology, describes the measures available and the reason for selecting those adopted. Chapter Four describes the implementation of each measure and Chapter Five evaluates the assessment instruments. Chapter Six analyses the results obtained and compares those from key worker homes with those from non key worker homes. The final Chapter reviews the value of the measures adopted and considers its general relevance for workers in the field.

Chapter One

Introduction - the Development of the Key Worker Concept as it relates to the Elderly

The multiple health and social needs which often accompany ageing may require the services of a range of health and social service personnel. Since 1948 there have been continuous discussion about:

(a) the need to co-ordinate these services effectively, and

(b) the identity of the 'key worker' or who should assume this co-ordinating role.

From time to time various members of the caring professions have been proposed as suitable candidates for this task, usually followed by withdrawal from its demands in the face of more pressing claims. The need for such a person is not usually contested.

1.1 Co-ordinators proposed from within the Health Service

(a) The Medical Officers of Health. These were early favourites for the role. The Guillebaud Committee (1956) reviewing the cost of the Health Service recommended 'that all authorities who have not yet done so should review the working of their health and welfare services to see whether their efficiency might be improved and the interests of the patients better served by combining their administration under one committee of the council or under one sub-committee'. The report assumed that the welfare services would function in a subordinate, anxillary capacity in relation to the health service, headed by M.O.H.

(b) The General Practitioners. By 1960 Central Government was seen to moving be in favour of the general practitioner as co-ordinator. It was felt his long standing knowledge of the patient would enable him to detect early signs of deterioration. (Report of the Central Health Services 1960). Russell Smith, Under Secretary of Health in the same year argued 'The team should be active under the leadership of the family doctor who is in a position to call the various services into action when he thinks his patient has reached a stage at which the particular service is required'. This view is echoed in the Gillie Report which declared that the family doctor 'can best mobilise and co-ordinate the health and welfare services in the interests of the individual in the community and of the community in relation to the individual'.

Richard Titmus (1968) argued that there was little evidence that G.P.'s wished to assume this role and pointed out that consultations with elderly patients had actually declined since 1948. Staff shortages however were to clinch the argument against G.P. co-ordination of the caring team. The Mallaby Report (1967) pointed out 'the shortage of medical practitioners is such that they should not be charged with responsibility for services such as those provided under the National Assistance Act'.

(c) Health Visitors. As early as July 1950 a leader in 'The Medical Officer' suggested that 'If health visitors can be adequately trained and be recruited in sufficient numbers .... they are best fitted to prevent the disasters which at present unfortunately affect too many in later life .... one nurse in a district for all preventative health services is a sensible and economic way of securing adequate visitation without a multiplication of visitors'. However, they were not allowed if they wished to do so, to become key workers for the same reasons as the family doctor. There were shortages both of nurses to train as health visitors and of those who had completed their

initial training. The Jameson Committee (1956) states 'Their role with the family and aged who need no medical attention is more problematical .... she should have a recognised place in the scheme of official and unofficial help, called in wherever there is a health problem with which she can assist or her self calling for the help of the appropriate organisation when, as may often be the case, she is first on the scene'. Thus health visitors were given a specifically illness orientated role rather than the preventative one which had been envisaged.

The three co-ordinating roles described were of very different natures. Had the various suggestions been taken up the M.O.H. would have performed an impartial leadership role as committee chairman; the G.P., more actively involved with individual patients, would have been responsible for alerting and co-ordinating other services; while the health visitor would have performed the most direct service of all by personally monitoring those deemed vulnerable and, if possible, preventing any deterioration in their condition by ensuring appropriate interventions were made either by herself or another caring agency. In fact all these groups were finally deemed unsuitable to develop these co-ordinating roles because of staff shortages.

1.2 Co-ordinators proposed from within Welfare/Social Services

The Welfare Officer/Field Social Worker

If the Health Services were not equipped to undertake preventative work with the elderly those in the welfare departments were equally ill equipped. Peter Townsend in 'The Last Refuge' was critical of their performance during pre-admission interviews with elderly clients. The decision to admit was often reached after a very superficial examination of the facts, without thorough enquiry into the alternatives and without ensuring that the person concerned was in agreement with the decision to admit or that they properly understood what was involved in such a decision.

The Association of Directors of Welfare Services, presenting their evidence to the Seebohm Committee stated that elderly people 'posed the biggest social problem in this country'. The Seebohm Committee saw the social worker as playing a crucial part in assessing the needs of elderly for residential and domiciliary services. Prior to the re-organisation of the welfare services the group of social workers who had built up a special knowledge of the sick elderly were the Medical Social Workers. They worked at the interface between the Health and Welfare services and as Sheridan claimed were 'the best equipped person on the hospital staff to evaluate the social provision'. (Sheridan 1955).

The post-Seebohm re-organisation of welfare services with its commitment to a trained social work team seemed to offer few benefits to elderly clients. Brearley writing in 1975 pointed out that while the young were offered social work services the elderly were offered only social services. Efforts have been made to explain this reluctance by social workers to become involved with elderly clients. Greengross (1980) suggests that social workers 'find it very painful to become involved with those who may suffer and soon die, who may deteriorate and whose progress it is difficult to measure in terms of success'. Rowlings shared this view, 'Old age confronts us not just with death but with decline ... these very aspects of old age which they, the social workers, fear most for their future selves'.

Whether or not these fears are instrumental in the shunning of elderly clients by social workers, Hill (1980) has shown that student social workers are not enthusiastic about working with the elderly. He studied a sample of 187 social work students of which 66% had previously worked with the elderly. Only 40% expected to do so after qualification and only 28% of the students wished to do so. He said the acquisition of a professional qualification was seen as taking social workers away from work with the elderly and handicapped and into work with children.

There seems to be considerable evidence that social workers are ineffective in the role of welfare service co-ordinator. Stapleton (1979) in a Newham Study found that two fifths of those coming into care had received no domiciliary help and only a minority had received a full package. He concluded that old people were being placed in residential care even though solutions to their problems were available in the community. Similarly, Booth (1985) following a survey of the dependency levels of nearly 7,000 residents in four local authorities concluded 'The evidence presented suggests there is a substantial proportion of people living in homes for the elderly who are not so impared in their ability to cope with the practicalities of living as to require the sort of total care and support generally provided by residential homes'.

Means and Smith (1985) suggested that the local authorities have failed in three ways. They have 'failed (a) to reduce their reliance upon residential care, (b) to concentrate the domiciliary services upon those most at risk, and (c) to develop schemes which encourage 'family' and community support for frail and sick people. Qualified social workers proved reluctant to work with elderly clients'.

Residential workers became officially involved in the key worker debate in 1976, although the discussions were certainly not specifically centered around the elderly but were concerned with making the best use of the skills of both the field and residential social worker. The Residential Care Association and the British Association of Social Workers described their goal in Social Work Today (2:9:76). It was the provision of guidelines to field and residential workers as to how (a) they might co-operate in the best interests of the client, and (b) in the process consider boundaries between field and residential social work and the areas of overlap.

The ensuing report recommended that every person coming into care should have a named Key Worker who would have full accountability and responsibility for such factors as the evolution and maintenance of care plans, their implementation and monitoring and the calling of regular reviews.

The report advised that Key Workers should be selected from either field or residential staff, the choice dependant upon such factors as the purpose of the placement, the previous and current experience of the worker and organisational factors, in particular, staff resources. Emphasis was placed on the need for 'adequate supervision, consultation and support'.

The Key Worker System was, therefore seen as a device to obtain effective co-operation between the voluntary and statutory agencies concerned with a particular client, in particular, co-operation between field and residential workers. In some ways the basic problems of professional status and role were not solved by this device. The vexed questions of who did what when a client was received into residential care remained. The sources of the essential supervision, consultation and support were not always clear. Despite these problems this system was received with enthusiasm by some residential workers who saw it as a useful clarification and possible extension of their role and it has been adopted within some residential establishments including homes for the elderly.

The social work profession moved through a similar process to that of the Health Service. Both professional groups recognised that the elderly population presented a challenge because of the growing number of those who were both elderly and frail. If the available resources were to be administered effectively there was a need for increased co-ordination and planning. Both groups, despite this recognition, failed to devise effective strategies with which to undertake this task. The social work professional produced the 1976 guidelines in an attempt to effect greater co-operation between the residential and field work sectors and it is from this 1976 paper that the key worker systems described in this study are most closely related.

1.3 A Working Definition of a 'Key Worker' System

It has been shown in the previous sections that the co-ordinating roles discussed by both Health and Social Services varied from a largely administrative post proposed for the M.O.H.'s to the more practical, preventative role prescribed for the Health Visitor and the field social worker. By 1976 the concept of key worker had emerged within social services. This co-ordinating role had lost its high-level administrative pretensions and now described a worker who would occupy a central role in relation to a particular client.

The functions of the key worker would include:

(1) the monitoring of those seen at risk.
(2) the assessment of the client's need.
(3) the formulation of plans for therapeutic interventions.
(4) the co-ordinating of necessary services.
(5) the supervision of service delivery.
(6) responsibility to report back to a senior officer who would in turn offer supervision and support.

Having considered the historical development of the concept and after discussion with senior residential care officers the definition of a key worker system used in this study is as follows:

It is the planned delegation to a single worker of the responsibility of ensuring that an individual resident receives from the available services, those which are most appropriate to his/her expressed or perceived need.

Only those homes whose key worker system conformed to this definition were described in this study as 'key worker' homes.

1.4 The Debatable Value of a the Key Worker System in a Home for the Elderly

Barry Meteyard's critique of the Key Worker System in Community Care (16:2:84) raised important issues. He saw the Key Worker System as capable of being exploited in two ways; either as a vehicle of case management or case therapy, reflecting the basic social work dilemma between care and control. In practice he felt a successful Key Worker System must avoid either extreme and balance the needs of the organisation against the needs of individual clients.

Leaving aside the care versus control issue, some would contest that a key worker system is neither practical or therapeutic. The following arguments may be advanced against its use:

(1) The co-ordination of a wide range of care services ceases to be an issue on admission to residentical care so the main function of a key worker is lost.

(2) The evolution and maintenance of care plans and the calling of reviews are not part of standard practice in most homes for the elderly.

(3) 'Adequate supervision, consultations and support' is not available.

(4) Meteyard's use of 'therapy' as a function of key worker may be contested as implyng some inadequacy on the part of the elderly person admitted to care.

(5) Duty rotas may be organised in such a way that assignment of a particular resident to a particula worker is impractical.

(6) Staff/Resident ratios militate against intensive involvement with individual clients, especially those in the more 'able' category.

Despite these arguments many homes now use a key worker system as a means of allocating staff services between the residents. Among the reasons which may be advanced for its adoption are:

(1) It offers more personalised service to the residents by ensuring that at least one member of staff has a special concern for a particular resident.

(2) As a result of this relationship problems may be detected more speedily and remedial action taken.

(3) The residential worker's task is more rewarding because of the special relationships and has increased status because of the resultant special responsibilties.

(4) It recognises the existence of special relationships between staff and certain residents and builds this into a recognised care system.

(5) Because management delegates some care responsibilities supervision is more likely to be offered.

(6) Implicit in the key worker system is the belief that each resident may have special needs and preferences. Recognition of this will be a counter balance to the institutionalising propensity of residential care.

1.5 The Focus of this Study

If the arguments in favour of a key worker system in residential care are correct, the residential experience in homes which operate such a system should be demonstrably different. The home itself should be geared more finely to the needs of individual residents rather than to smooth running efficiency; the residents should reflect in their behaviour, both verbal and non-verbal, the increased levels of control, satisfaction and security which such a system seeks to offer.

These considerations led to the decision that this project would attempt to measure what, if anything, was different about key worker homes from non-key worker homes. This in turn pointed towards empirical action-based research which would yield information about the organisational practices within the homes and the quality of life experienced by the residents.

The following chapters will review the literature which lead to the adoption of certain types of measurement, their implementation and a discussion of the findings.

Chapter Two

A Review of Relevant Studies

2.1 The Nature of Current Residential Experience

It has been established that the purpose of this study is to examine the impact of the Key Worker System in providing an improved quality of life in homes for the elderly. That there is cause for concern has been demonstrated in various studies.

There are special characteristics of groups of elderly people in residential care. They are made up largely of females, (about 75%), most of whom are widowed or unmarried. In the 1982 study by the Polytechnic of North London of 100 Homes for the elderly, the average age of women was 82 and 79 for men. The men were less disabled than the women and recent admissions were frailer than those who had been admitted for ten years or more. Half the population were independently mobile, three quarters could dress themselves, four fifths could feed themselves and four fifths were continent. These properties were not constant, but varied from home to home, some homes having far higher proportions of confused and very dependent residents. There is no reason to suppose that a study of another 100 homes would produce identical results.

If it is accepted that all studies are limited however large their scale, but that the picture outlined above is not totally dissimilar to conditions as they exist in most local authority homes for the elderly, nothing in these figures quoted would lead one to expect the lack of variety in behaviour which has been observed in studies both in the United Kingdom and in the United States, all of which have shown the same depressing picture of social inactivity. (Godlove et al 1981, Hughes & Wilkin 1980, Meacher 1972, Robb 1967 and Townsend 1962).

For example, Tobin and Lieberman (1976) compared institutionalised older people with those living in the community. They described an institutional syndrome of low morale, negative self image, pre-occupation with the past, feelings of personal insignificance, intellectual ineffectiveness, docility and withdrawal, anxiety and fear of death. They addressed themselves to the problem of determining how far this syndrome might be attributed to the institutional environment. They found however, that 'most of the psychological qualities attributed to the adverse effects of entering and living in an institution were already present in people on the waiting list.' Concluding a follow-up study one year after admission they state 'the status of the old-timer appears to be largely a function of his status just before admission'.

The whole process of admission to care seems to involve changes in behaviour which cannot be directly related to the care regime. Godlove et al 1982 in an observational study of the elderly in four different care settings described their experience thus 'those long periods of silent inactivity was of a crushing boredom'. When they asked subjects whether they were ill at ease with people and whether they felt any desire to avoid contact with others. 33% of these in homes replied affirmatively to both questions. Similar results were obtained in American Studies, Fontana (1977) found residents didn't want to admit they 'belonged' there or associate with other residents. Tesch and Whitbourne (1981) found residents choose not to involve themselves with other residents because of the possible threat this posed to their privacy and independence. Interaction has also been observed as minimal between staff and residents, (Fontana 1977, Godlove et al 1981). Miles (1978) found a positive effect of admission to Nursing Homes, residents had a higher subjective rating of their health than a group of community based elderly subjects although Gray (1976) points out that the institutionalised elderly are without the physiotherapy and occupational therapy of everyday life.

The evidence seems to suggest that the whole admission process, beginning with the pre-admission decision making phase is potentially damaging. The residential social workers tasks is to attempt to help create a rich, stimulating environment despite the many bereavements suffered by those entering residential care. Langer and Rodin (1976) work demonstrated the beneficial effects of control enhancing treatment involving decision making and plant care. Elderly residents in a nursing home who were asked to care for their own plants were compared favourably with residents who were given a plant which was cared for by staff. Langer claims 'many of the consequences of old age may be environmentally determined and thereby potentially reversed through the manipulation of the environment'.

A C.P.A Report (1984) outlined the rights of residents. They were rights concerned with fulfillment, dignity, autonomy, individuality, esteem, quality of experience, emotional needs, risk and choice. The Report states: 'The quality of life in a home will be enhanced by inclusion of the widest possible range of normal activities, particularly those with which the residents have been familiar with in the past'. The high value placed on choice and variety of activity is typical of a report of this kind and it was in response to value judgements of this kind that engagement studies have been developed as a measure of welfare in institutions for the elderly.

From the studies cited above the following points may be demonstrated:

(1) That not all resident's behaviour may be attributed to the care regime in which he/she is placed. (Tobin & Lieberman 1976).

(2) That even the prospect of admission has a powerful effect upon self-image and behaviour. (Tobin & Lieberman 1976).

(3) That once admitted into a residential situation many residents express a preference for social withdrawal. (Fontana 1977, Tesch & Whitbourne 1981, Godlove et al 1981).

Despite these findings which detract from the argument that the quality of the residential experience is crucial to the well being of residents, other evidence refutes this and asserts:

(1) Improved physical care way result in an enhanced sense of physical well-being. (Myles 1978).

(2) In a postive environment some of the negative effects of ageing, emotional as well as physical, may be reversed. (Langer & Rodins 1976).

Bearing in mind the danger of wrongly attributing behaviour directly to the residential environment and noting the content of the CPA Report 1984 it was decided that three areas had been identified as relevant:

(1) The classification of organisational styles and their implications for residents.

(2) The level of morale and self esteem among elderly residents.

(3) The quantity and variety of activity apparent in the residential situation.

Not only have these been identified as important by social workers in residential care but there is also a substantial body of psychological and sociological theory which supports the selection of these topics and these will be explored in the second half of this chapter.

2.2 Theoretical Support for the Suggested Areas of Study

(a) The Classification of Organisation Styles and their Implications for Residents

Goffman is a name which has become closely associated with institutions. Although by no means the first to consider the effect of institutions on the individual, he offered a clear sociological framework from which to study their impact on the individual. It had relevance for a wide variety of institutions and has proved a theoretical model from which the analysis and measurement of regimes has been developed.

He introduced the concept of a 'total institution' which he defined as 'a place of residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life'. (Asylums 1961 Edition p XIII). He identified the four main components of a total institution as follows:

(1) Batch Living - where 'each phase of the members daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and are required to do everything together.

(2) Binary Management - total institutions consist of two groups, the managers and the managed,

(3) The Inmate Role - in which the individual undergoes 'role stripping' until he only has one role, that of an inmate. This is largely achieved by mortifications built into the admissions systems.

(4) The Institutional Perspective - from which defenses against the system are seen as evidence of guilt.

In order to survive this experience Goffman suggests four possible coping strategies these are, withdrawal, intransigence, lip service or colonisation and conversion.

Writing from a very different perspective, the work of Russell Barton, a consultant psychiatrist, had a powerful effect on British thinking. In 1959 he produced a book 'Institutional Neurosis'. The first part of the book is devoted to a description of the clinical features of the disease, these are, apathy, lack of initiative, loss of interest in the outside world, submissiveness and resignation.

Russell Barton identified seven clusters of factors in a mental hospital environment which might cause this condition. They consisted of loss of contact with the outside world, enforced idleness, bossiness of medical and nursing staff, loss of personal friends, drugs, ward atmosphere and loss of prospects. While expressing ideas which are very close to Goffman's, Russell Barton as a medical practitioner, was interested not in institutional analysis but in the establishment of a therapeutic environment.

Peter Townsend was directly concerned with the residential care of the elderly. 'The Last Refuge : a survey of residential institutions and Homes for the Aged in England and Wales', took four years to complete and was published in 1962. It was designed to draw to the attention of the nation, and particularly the government, the inadequacies and miserable conditions in which many elderly people ended their lives. Many of the details he describes are strikingly similar to the conditions in mental hospitals which had concerned Russell Barton.

Townsend included in his survey a Quality Scale, consisting of forty-eight items which he felt to be crucial in determining the level of care. It also included an Incapacity Scale of Sixteen items which was a pioneer in this type of measurement. Although the purpose of his work was to do away with institutions for the elderly he did recognise that some were less damaging than others and attempted to quantify these variations as well as considering the differing physical condition and ability of the residents. He identified vulnerable groups who were most likely to require residential care, the widowed, the divorced and the childless. He was adamant that alternative provisions should be made for those in need although did not discuss in any detail what these provisions should be.

Kleemeier, writing in the same year as Goffman's Asylums was published, was also concerned about the effects of institutions upon the individual. In his essay 'The Use and Meaning of Time in Special Settings', Kleemeier identifies three 'descriptive dimensions of special settings, They are:

(1) The Segregate/Non Segregate Continuum : 'the condition under which older people may live exclusively among their age peers, having little contact with other age groups.'

(2) The Institutional/Non Institutional Continuum : 'the varying degrees to which the individual must adjust his life to imposed rules, discipline, and the various means of social control used by staff.'

(3) The Congregate/Non Congregate Continuum : 'the closeness of individuals to each other and the degree of privacy possible to attain in the setting.'

There are very clear links with Goffman's concepts of Batch Living and Inmate Role, although he differs from Goffman in his insistence that one dimensional classifications are inadequate. Tizard et al 1975, also criticise what they describe as the 'stream-press' model which represented the institution as all consuming. Tim Booth (1985) elaborating the work of Tizard et al identifies four main sources of variation:

(a) Ideological Variation
(b) Organisational Variation
(c) Staffing Variation
(d) Variation in resident response

Kleemeier's work was significant therefore in that his concept of multi-dimensionality was re-examined and particularised to form the basis of several organisational measures.

Models which emphasise the interaction between the individual and the environment form another important strand of organisational theory. Henry Murray (1938) introduced the notion of environmental press, in which individuals reacted to their environment either with satisfaction of frustration, the nature of this re-action providing a fruitful field of behavioural study. The idea was then neglected until further explored by Stern, Stein and Bloom (1956). They developed an objective measure of environmental press, an aspect which had been relatively passed over by Murray who had concentrated on isolating psychogenic needs. Pace & Stevens (1958) worked on measures of environmental climate in a Higher Education setting. They based their findings on a consensus of student perceptions and found it an influential determinent of student behaviour.

Continuing to develop the idea of environmental press Moos and Houts (1970) writing about a psychiatric setting assert 'the press of the environment as the patient perceives it establishes the direction his behaviour should take if he is to find satisfaction and reward within the ward culture'. The work was later developed in relation to sheltered care for the elderly (Moos, et al 1979).

Lawton and Simon (1968) of the Philadelphia Geriatric Centre developed an 'environmental docility hypothesis'. This suggested that the greater the environmental press the less pronounced personal characteristics become. Using Murray's theory as a base this gradually emerged as the general social ecology theory of the ageing process. (Lawton and Nahemow 1973). They describe the ecology of ageing as 'a system of continual adaptations in which both the organism and the environment change over time in a non-random manner, either environment or the organism is capable of initiating a cycle of action, or of responding.' Both the environment and organism 'exist in an inextricable and mutually pervasive relationship' (De Long 1974). Old Age renders the person vulnerable because of reduced competence; 'not vulnerable in terms of receptor sensitivity, but in terms of their behaviour being controlled by environmental rather than interpersonal forces.' (Lawton and Nahemow 1973).

Lawton and Nahemow went on to develop a transactional model composed of five key factors.

(1) The degree of individual competence comprised of life maintenace, functional health, perception, cognition, physical self maintenance, instrumental self maintenance effectance and social role.

(2) Environmental Press - those elements which evoke a response when interacting with individual needs (Murray 1938). There are the objective aspects of environmental demand and support. Press is in itself neutral but is defined as positive or negative by the interacting individual.

(3) Adaptive Behaviour - what is or is not adaptive is determined by social norms, other environmental factors and individual values.

(4) Affective response - the internal emotional experience of the individual environment transaction.

(5) Adaptation level - the state of equilibrium between environmental press and the individual, this is achieved when 'the stimuli are perceived by the individual as being neither too strong nor too weak.' Two types of adjustment are possible:

(a) assimilation in which the individual modifies the environment.

(b) Accommodation in which the individuals characteristics are modified to meet the environmental press.

The need to establish congruence between the elderly person and their environment in order to improve morale was emphasised in Kahana's congruence model (1974). Matching personal needs to environmental support concerned both Schooler (1974) and Sherwood, Morris & Barnhart (1975). These approaches all emphasised that the reduction of tension and the satisfaction of need leads to well being. This notion was contested by Davies & Knapp (1981 p. 128) who stressed ".....it has been argued by many psychologists that tension reduction as an

explanation of all behaviours is inadequate, and that it is imperative to recognise the part that tensions creation, exploration and search for stimulation play in determining affect and behaviour".

The power or exchange theory of Blau (1964) was related to the Elderly by Dowd (1975). Blau argued there were four power resources: money, approval, esteem and compliance. Dowd suggested that as money as a form of exchange was often inappropriate and their approval unsought the elderly resorted to esteem and finally to compliance. 'The relative power of the aged vis-a-vis their social environment is gradually diminished until all that remains of their power resources is the humble capacity to comply.'
(Dowd 1975 p. 587).

Davis & Knapp reviewing the British theoretical contribution described it as 'very reluctant to scratch the well polished veneer of simple description and comparison' (1981 p. 132). The insight of Goffman into the common features of institutional life has to be considered alongside the complementary view that institutions provide 'an array of environments some possessing significantly more institutional characteristics than others.' Apte (1968). Isolating the different characteristics which are instrumental in producing more or less institutionalised care regimes has been the concern of those producing measurements of these regimes.

<u>This review of the theory suggests six important questions which must be posed if the measurement is to be valid.</u>

(1) Are the resident's links with the community fostered or severed?
(Goffman 1961, Barton 1966, Townsend 1962, Kleemeier 1961).

(2) What degree of control and choice (i.e. power) does the resident possess? (Goffman 1961, Barton 1966, Townsend 1962, Kleemeier 1961, Dowd 1975).

(3) Are the care routines responsive to individual differences in residents' competence, personality and preferences (Murray 1938, Goffman 1961, Lawton and Nahemow 1973, Kahana & Coe 1969, Schoder 1970, Sherwood et al 1975)

(4) How far does residential life offer a private as well as a public dimension? (Goffman 1961, Barton 1966, Townsend 1962, Kleemeier 1961).

(5) What is the power balance between staff and residents and how is it maintained? (Goffman 1961, Barton 1966, Townsend 1962, Kleemeier 1961, Blau 1973, Dowd 1975, Lawton and Simon 1968, Lawton and Nahemow 1973).

(6) What is the nature and extent of communication between staff and residents? (Goffman 1961, Barton 1966, Townsend 1962, Kleemeier 1961).

(b) <u>The Level of Morale & Self Esteem among Elderly Residents</u>

The complex relationship between personality and ageing has been variously described. One approach which does not attempt to explain the relationship but rather describe the effects of ageing on the personality by identifying patterns of ageing is the typological model of ageing. Reichard et al (1962) described five patterns, mature, rocking chair, armoured, angry and self haters. Neugarten et al (1968) arrived at eight patterns. Reorganisers, Focused, Disengaged, Holding On, Constricted, Succorance-Seeker, Apathetic and Disorganised. Both these typologies describe general approaches to ageing.

Williams and Wirths (1965) were concerned with patterns of living which might be continued into old age, they were, the World of Work, Familism, Living Alone, Couplehood, Easing Through Life with minimal Involvement and Living Fully.

Mass and Kuypers (1974) focused on patterns of ageing and predominant life style. They identified ten life styles, Family Centred Patterns, Hobbeyist Fathers, Remotely Sociable Fathers, Unwell Disengaged Fathers, Husband-Centred Wives, Uncentred mothers, Visiting Mothers, Employed (work-centred) mothers, Disabled-disengaged mothers and Group-orientated mothers. These patterns show women to be more vulnerable to circumstantial change than men.

These various studies demonstrate that responses to the ageing process are varied and many of these different responses occur alongside a high degree of life satisfaction. All four studies showed considerable stability over the life cycle. The 'ageing stability' thesis (Glenn 1980) shows evidence that, after the early developmental stages, attitudes and values become relatively stable. Change is not exclusively confined to the young, however, and is likely to occur in relation to changing environments (Koln and Schooler 1973. Moos 1975).

McClelland's data was concerned with the way in which an individual constantly reacts to the environment. He described the individual as doing this in one of two ways, either by embracing the environment or rejecting it - McClelland identified these as 'approach' or 'avoidance' motives. (McClelland et al 1953). The nature of the response depends upon whether an environmental change promises to be negative or positive. The important motives will be those which are concerned with needs for achievement, affiliation and power. Environments which are congruent with the motives, the individual's traits (or habitual responses)and learned schemata, consisting of ideas, values, social roles, will afford the greater degree of psychological well being.

The work of such psychologists as Fromm (1947), Rogers (1959 & 1961) and Maslow (1959, 1970) all suggest that there is a 'core tendency' to seek self fulfilment and self actualisation through the realisation of inherent potentialities. These ideas have been used extensively in social work thinking although the theorists disagree as to the method of attaining the high level of personal satisfaction. Rogers sees it as achieved through the positive regard of others and through positive self-regard. Maslow, although agreeing that there is a tendency to self actualisation, sees this as an apex which can only be reached if at least some of the more basic needs are first met. Fromm also stresses the needs for relatedness and rootedness, the meeting of minds, which will create the environment from which the individual may achieve self realisation.

These views are at variance with the consistency theories of McClelland, Fiske and Maddi which stress the desire for continuity rather than fulfilment (McClelland 1953, Fiske and Maddi 1961).

The developmental theorists are concerned with the interface between core tendencies and environmental pressures. Havighurst (1959) describes a development task as one 'which arises at or about a certain period in the life of individuals, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks.'

Baltes and Willis (1979) identify three sources of development for the elderly person.

(1) Some experiences are age related, resulting from biological change, age stratification of roles and society's response.

(2) Other experiences are 'history graded' resulting from cohort and period effects.

(3) Some experiences are the result of life experiences peculiar to the individual.

The complex and individualised combination of these sources may be used to explain the wide variety in patterns of ageing.

The age specific tasks are described variously by theorists. Evaluation is commonly held to be important as the elderly person reviews his life in order to make sense of its various episodes (Erikson 1950, Butler 1963, Gould 1972, Newman and Newman 1979). This is seen as a more passive evaluation than that occurring in middle age, when evaluation often leads to remedial action. In old age one of the functions of this evaluation may be to provide a source of continuing positive identity in the face of possibly negative reality. (Clausen 1972).

Peck (1956) identified three areas in which the elderly need to show flexibility if the ageing process is to be negotiated positively.

(1) Self worth derived from a number of roles will be more enduring than that derived solely from the work role.

(2) Physical problems, described as bodily insults, must be transcended.

(3) Personal death must be accepted but nor allowed undue dominance.

Clark and Anderson (1967) describe five adaptive tasks which face the elderly.

(1) Recognition of ageing and definition of instrumental limitations.

(2) Redefinition of physical and social life space.

(3) Substitution of alternative sources of need-satisfaction.

(4) Reassessment of criteria for evaluation of self.

(5) Re-integration of values and life goals.

The value of these theories is to highlight the areas of concern which may attend the ageing process. They have been criticised by Kimmel (1974) as being 'armchair' theories, not rigorously tested by research. Developmental issues will differ depending upon the many variables which exist in the ageing population. Even if the existence of these developmental issues are accepted as realistic it still leaves considerable work to be done on the successful negotiation of these tasks by the individuals concerned if they are to function effectively in their environment.

Old age may be seem as a time of relative calm with fewer significant life changes than those encountered by the young adult. (Pearlin 1980). Life events of the elderly, however, tend to be of an irreversible nature. McCrae (1982) describes youthful events as gains and challenges, 'entrace' events, while old age brings threats and losses 'exit', events. McGrath (1970) outlines a number of threats which dog old age:

(1) The physical threat of injury, pain or dealth. The poor health or death of contempories may add to the personal anxiety experienced.

(2) The ego threat of injury and pain to the psychological self through role loss and declining status.

(3) The inter-personal threat of disrupted personal relationships.

The resources which defend the individual against these threat may be financial resources, health, education, social supports, self esteem and perceived mastery and control over events. (George 1980 and Perlin et al 1981). The reduction in personal resources may result in an increased susceptibility to environmental rather than intra personal pressures (Lawton and Nahemow 1973).

Changes in, or abandonment of, roles as a result of ageing are rarely a unilateral decision on the part of the individual but are part of a 'continuous bilateral negotiation between the individual and the social system as he moves into new positions through time'. (Bengtson 1973) Role transitions are smoother when individuals are adequately prepared and there is some continuity between old and new roles (Riley 1976) 'Anticipatory Socialisation' is important in preparing and identifying the nature of a change. Rites of passage are important in signalling that a transition is taking place. These are often absent for the elderly and where they do exist they may frequently be open to negative interpretations (Rosow 1974 & Blair 1973).

The symbolic interactionalists who are concerned with the process of attributing meaning, emphasise the social nature of man. Identify or self emerge through interaction with others and identity is confirmed both by significant others and by society generally. This self forms the core element around which human behaviour is organised (Hickman and Kuhn 1956). Consistency is achieved through memory, situational stability and habitual responses (Kimmel 1974).

Changes in objective reality do not automatically alter self perception Neugarten (1969) proposes that in later life the self becomes less dependent upon externals and acquires a greater interiority. Clark and Anderson (1967) suggest that because of the degree of personal change and role ambiguity associated with ageing the question, Who Am I?, assumes poignant relevance.

To summarise the following five points seem crucial to an understanding of ageing.

(1) People age in different ways, many of which appear to offer satisfaction.
(Mass & Kuypers 1974, Neugarten et al 1968, Reichard et al 1962, Williams & Wirths 1965)

(2) Ageing is a process which is environmentally as well as personally determined.
(Baltes & Willis 1979, Bengtson 1973, McCelland et al 1953).

(3) Humanist personality theorists see the drive for fulfilment as a core tendancy which is not obliterated by age.
(Fromm 1947, Maslow 1959, Rogers1950)
Others see the search for continuity and stability as a basic drive. (Fiske and Maddi 1961, McClelland et al 1953).

(4) Ageing presents the individual with a number of threats, changes and tasks which have to be negotiated.
(Baltes & Willis 1979, Butler 1963, Clark & Anderson 1967, Erikson 1950, Gould 1972, McCrae 1982, McGrath 1970, Newman & Newman 1979, Peck 1956).

(5) The preservation of a social identity during the ageing process is dependent on both personal and environmental factors.
(Clark & Anderson 1967, Hickman + Kuhn 1956, Kimmel 1974, Neugarten 1969).

Measurements of subjective well being must be considered critically in the light of these researchers. Three crucial components must be present if a measure is to be used in the context of a study of the possible impact of Key Workers on lives of elderly residents.

(1) It must allow for different reactions to the ageing process.

(2) It must be appropriate to the life stage and its special tasks.

(3) It must be capable of determining whether or not residents demonstrate a positive self identity in their residential setting.

(c) The Quantity and Variety of Activity apparent in a Residential Setting

There have been a number of studies which describe certain negative features of behaviour among elderly residents and attribute these to the effects of institutional behaviour. Some of these were included in 2.2 (a). Langer described such a state as 'mindlessness'. Its reverse was seen as a state of engagement, this in itself was seen to indicate an improved quality of life (Hitch & Simpson 1972, Gupta 1979 & Adams et al 1979).

A commonsense approach would suggest that if people are sitting around a room either gazing vacantly into space, talking to themselves, or asleep, then their quality of life is not high. This was certainly the view taken by Townsend 1962 deploring the quality of care offered to the elderly in residential care, it was re-iterated by Robb 1967 and Meacher 1972. Hughes and Wilkin (1980) found the situation 'apparently still as accurate today as it was when Townsend first described it.'

There is indeed a distinct lack of meaningful activity observed within all types of care provision for the elderly (Godlove et al 1982). The question which must be considered then, is whether this is a cause for concern or whether it is a natural consequence of observing a group which is composed of elderly and frail members. Unless there is good evidence to support the theory that this apathy is not inevitable there is little point in using engagement as a measure of the effectiveness of an input of residential care.

The psychological experience of ageing has been described in two contrasting ways. The Disengagement Theory (Cumming and Henry 1961: Cumming 1963) described ageing as the mutual disengagement of the individual and society. This was supported by Neugarten (1969) who stressed the greater 'interiority' of personality, the pre-occupation with the inner life as opposed to the outside world.

This idea suggests that with the imminence if death and the increased likelihood of disability, disengagement is advantageous both to society and the ageing individual who discards task orientated interpersonal roles and takes on more peripheral ones. This shift in roles frees the elderly person from the constraints exercised in the more highly interactive roles of middle age and protects society from the disruptions which are caused by the death of more highly participant members.

The alternative view known as the Activity Theory suggests that satisfaction depends on the validation of self concept through active participation in middle aged roles or their substitutes if these are no longer available because of age related events such as retirement or life events such as death of a spouse. (Lemon et al 1972 Longino and Kart 1982) Role loss is seen as a contributory factor to loss of self esteem. 'Older people are the same as middle aged people, with essentially the same psychological and social needs ..... The older person who ages optimally is the person who stays active and manages to resist the shrinkage of his social world' Havighurst et al (1968).

These are serious criticisms of both theories. It has been shown that activity may decline without loss of morale (Maddox 1970) Lemon and Associates (1972) and Longino and Kart (1982) found little proof that role involvement and role support were positively correlated with life satisfaction. Longino and Kart found a little support for making an association between social activity and indicates of well-being, conversely there was a negative association between formal group activity and life satisfaction.

The disengagement theory has been criticised by Hochschild (1975) because of its blanket assertion that engaged elderly people are either unsuccessful disengagers or in some way exceptional. He also challenges the notion because it presents disengagement as a single process whereas he feels it to be made up of many facets (for example, social, psychological or physical) which are not necessarily interdependant. Perhaps the most pertinent criticism of the theory is that it ignores the importance of individual responses to ageing and disengagement.

Shanas et al (1968) explores the idea that activities acquire a different value in old age. They suggest that 'Extensive social interaction may gradually be replaced by intensive social interaction involving fewer people'. Mass and Kuypers (1974) in a 40 year old study found some evidence that disengagement among older men was a reversion to a life style preferred as young adults which underscores the freedom which may be experienced with the loss of certain role constraints.

There is some evidence that disengagement is not always freely chosen. Dowd (1975) found that some elderly people no longer felt able to contribute and so withdrew Carp (1978) found that if the elderly were given increased opportunities of involvement, this resulted in hightened morale and longevity.

Disengagement, given much contradictory evidence, may most rationally be seen as one of the effects of ageing rather than as a process which is intrinsic to ageing itself. Particularly it is important when determining quality of life to distinguish between disengagement through personal preference and disengagement which is involuntary.

These two theories,, although illustrating the complexity of the field are not the only representatives of contemporary work on the ageing process.

A third theory, is that of the life course perspective. This stresses that each individual will experience ageing in a unique way which will be dependent upon both his previous life pattern and upon the present constraints under which he is placed. 'He ages according to a pattern which has a long life history and maintains itself, with adaptation, to the end of life' (Neugarten 1968). Baltes & Willis (1979) suggest three sources of development:

(1) The aged-linked experiences such as biological changes - age determined roles and social experiences.

(2) History graded experiences which are determined by the period context of the cohert.

(3) Personal ideosyncracies, such as marital status, employment experiences.

They suggest that chronological age becomes less important with time and that history graded and ideosyncratic events are emphasised.

The life course perspective theory seems to avoid some of the major problems encountered by the other theories because of its assertion that an elderly person's personality is only as similar to another elderly person as would be a middle aged person or a child to some one of similar age. There seems some evidence that individual differences become more pronounced with age, 'Those characteristics that have been central to the personality seem to become even more clearly delineated, and those values the individuals has been cherishing become even more salient' (Neugarten et al 1968). The North American longitudinal studies of Woodruff and Biren 1972 and Costa et al 1980 confirm high levels of stability in personality traits.

A critical appraisal of all these approaches would suggest the following argument may be made for the use of a measure of engagement.

(1) There is no reason to suggest that a group of elderly people will be any less diverse than any other group of similar age.

(2) That any uniformity of behaviour either in terms of passivity or group activity has been environmentally produced.

(3) That any study of engagement must be capable, therefore, of evaluating not only the level and nature of activity but also be able to relate this to its social context.

2.3 Conclusion

This chapter has demonstrated both from the evidence of field studies and the work of theorists in a variety of disciplines that the effectiveness of any input of care should consider three crucial areas. These areas include the organisational practices from which the input of care operates, some subjective assessment by residents of their experience of well-being and a measure of the level and nature of resident activity. The appropriate method of making such appraisals will be considered in Chapter 3.

Chapter Three

Methodology - Part I

3.1 Introduction

There has been some support for the adoption of the three areas of investigation isolated in Chapter Two. These were:

(1) psychological well-being - described as life satisfaction.

(2) engagement - defined as 'interacting with materials or people in a manner likely to maintain or develop skills and abilities' (Blunden & Kushlick 1974).

(3) the social environment of the home, with special reference to such aspects as privacy, choice, power and communication..

Goldberg & Connolly (1982), reviewing research into residential care conclude that 'Impact studies which combine observation of staff practices and residents' behaviour with residents subjective re-action to these practices are needed to test the appropriateness and effectiveness of different types of training of staff'. On this basis, when trying to ascertain whether the Key Worker input results in any measurable differences in the desired output, the general well-being of residents, it seemed crucial to make some measurements that involved both resident behaviour and their subjective response to their present life experience, as well as some attempt to define the nature of their residential environment.

Having defined the areas which might be usefully investigated the following decision had to be made:

(1) what type of measurement should be employed.

(2) whether or not an existing measure could be used.

Bland & Bland's (1983) review of recent research into Old People's Homes forcefully put the case for using scales developed by someone else who had done similar work before, thus avoiding 'waste of resources and the use of unreliable and invalid scales'. Indeed in a small study with limited resources this made good sense. Having accepted this the rest of the chapter will be devoted to the review of some of the available measures and the identification of appropriate ones for use in this study. Each of these three areas will be examined in turn.

3.2 Measurement of Institutional Regimes

(a) Bland and Bland (1983) in their review of measurement of regimes stated '..... there are two main approaches which have been taken. One American influence has been to start with a specification of important dimensions and to push this through to the development of survey questions which can yield a numerical score on a scale purporting to measure the dimension .....'. The alternative approach is to sort out into broad types without attempting to quantify or 'score the homes'. They quoted Thomas (1981) as an example of the second method.

They saw both approaches as less than perfect. The first was limited because it 'is apt to become sterile, pseudo-scientific and jargon-ridden'. The second was flawed because it 'is apt to produce impressionistic and ill-organised material, often anecdotal, with little theoretical base'. Bland and Bland inclined towards the second approach although they introduced strict conditions, 'The researcher must still base his system of categories on a set of underlying dimensions and be able to point to objective procedures which decides whether a case falls into this category or that'. The main differences between the two approaches became one of scoring rather than of data selection and collection. Since the second approach has not yet yielded measurements of an easily transferable kind it is the first, more systematic approach

which will be explored. Three types of measurement in this category will be described, those belonging to the needs-press model, those concerned with defining and measuring psycho-social milieu and the third concerned with organisational practices.

The Needs Press Model, based on the work of Murray was adapted by Moos, Gauvain, Lemke, Max and Mehren (1979) to form the Sheltered Care Environment Scale (SCES). It was concerned with three dimensions, Relationship, Personal Growth, System Maintenance and Change, They used a sixty three point scale of true/false items. These items were evenly divided between seven sub-scales concerned with cohesion, conflict, independence, self exploration, organisation and order, resident influence and physical comfort. There were three parallel forms:

(a) The real form
(b) The ideal form, and
(c) The expectations form.

These dealt with perceptions of the existing experience, the ideal experience and of the anticipated experience.

Its relationship to the work of Murray and the earlier work of Moos was evident. Its usefulness lay in its ability to explore the institutional environment through the eyes of various potential and existing participants. Their reactions would be determined by how far the environment was experienced as either satisfactory or frustrating. As far as this study is concerned the SCES would not seem to be sufficiently objective to distinguish between the various welfare inputs which make up the differing residential experiences in the six homes studies.

The second option available was the measure developed by Pincus (1968) and revised by Pincus and Wood (1970). Pincus produced the Homes Description Questionnaire (HDQ) closely reflecting the theoretical model of Kleemeier. Pincus and Wood went on to use the HDQ to compare the response of staff and residents. This yielded significant, if predicable, divergencies. This work differed significantly from that of Moos, it measured reactions to objective items of physical plant, rules and regulations and staff behaviour. Pincus did not attempt to describe and measure the inter-personal or the supra-personal environment and suggests that 'the characteristics of the resident population be treated independently of the factors that shape the environment.'

In so far as this approach focused more sharply on the objective differences which may exist within the residential environment it is closer to the type of measure required in the study. Interesting results had been obtained by the North London Polytechnic group (Wilcocks et al 1982). They had used a fusion of both the approaches described using a questionnaire based on the work of Moss (1979) and Pincus (1968). This present study required a measure capable of determining whether or not caring routines reflected the value system ideally implied by the implementation of a key worker system. This very specific information seemed to be best illustrated using the third type of measurement.

The favoured type of measurement is that concerned with organisational practices. All the measures to some extent concern themselves with the degree of social control implicit in various organisational systems. Ruth Bennet (1963) related Goffman's concept to the care of the elderly and produce an Index of Totality. This was a list of ten factors by which it might be determined whether an institution rated as having high or low totality.

The list was comprised of the following items: duration of residence; orientation of activities ; pattern of recruitment; the residential pattern; the system of sanctions ; the scheduling of activities; provisions made for disseminating nomative information; provisions made for allocation of staff time to observation of residents; personal property of residents and decision making about personal property. It was applied to various types of institutions (Bennet and Nahemow 1965) and later studies (Bennett & Eis dorfer 1975) found connections between high totality, the age of the institution and the lack of specific training of staff.

Coe (1965) developed another list of totality, this included items such as lack of privacy, rigidity of scheduling and limitation of access to personal property and the use of force by staff. He found that totality was associated with the depersonalisation and withdrawal of residents. Kahana & Coe (1969) using the index as a base in a study of a Jewish Rest Home found that a few clear rules offered an enabling structure. Kiyak et al (1975) completed further work on the Totality List in their study of the role of informal norms in determining totality.

In Britain the major work in the measurement of Totality was undertaken by King & Raynes (1968) and developed in a further study by King, Raynes & Tizard (1971). King & Raynes identified four dimensions which determined how far management practices reflected an institutional or an inmate orientation. These dimensions were:

(a) Rigidity of routine (whether or not it was responsive to special circumstances or special individual differences).

(b) Block treatment of inmate (whether or not activities occured en masse without adjustment to individul variations of pace or motivation).

(c) Depersonalisation (whether or not opportunities existed for privacy, self expression, initiative and personal possessions).

(d) Social Distance between resident and staff (whether staff and residents share in common social activities or whether these are segregated and formalised).

This measurement was first applied to Children's homes and later adapted for use in old peoples homes by Townsend and Kimbell (1975). This concentrated on three dimensions, the structure of routine, depersonalisation and social distance. Further work on the measurement was completed in homes for the mentally retarded by Raynes, Pratt and Roses (1979).

All these works, but particularly that of King, Raynes and Tizard (1970) were used by Evans et al (1981) to develop a schedule 'to assess the extent to which a home had adopted resident-orientated or institutionally-orientated practice in relation to four key areas:

(i) Resident Care
(ii) Resident Autonomy
(iii) Staff-resident interaction, and
(iv) Organisational Practices and Features

This third type of measurement was clearly focused in an area appropriate for the purposes of this study. It seemed designed in a way which might make it capable of highlighting whether care practices were in line with the ideology implicit in the key worker system. These might be demonstarted in practices offering freedom, choice, privacy and fostering the ability to make meaningful decisions about life style.

(c) A Description of the Analysis of Daily Practices Schedule

The Analysis of Daily Practices Schedule was adopted because, at the time (1984), it seemed to be the most sensitive instrument with which to measure the nature and quality of care-giving procedures; since that time Tim Booth's Institutional Regimes Questionnaire IRQ has been published. This is largely based on the work of Evans et al, but it has been adapted so that it can be completed by officers in charge with some written guidance. This would have avoided some of the problems encountered and these will be explored in the next chapter.

Despite its very obvious value, there were three real problems about adopting this schedule and these were all concerned with resource issues:

(i) The team of trained reseachers used in the Manchester Study could not be matched in number or in qualifications.

(ii) The time available was very different. The Manchester Study spent four to six weeks in each home, two days were available in this study.

(iii) The Manchester findings were corroborated by interviews with staff and residents. This multiplicity of methods would be impossible in this study because of both the restraints described above.

The benefits which were seen to outweight the problems described were:

(i) The schedule's purpose, to assess the extent to which the regime adopted resident orientated as opposed to institutionally orientated practices, was appropriate to this study.

(ii) It had been designed for a study of a similar size and with a not dis-similar purpose.

(iii) The questions had been shown to be meaningful, test scores reflected findings collected in the study through interview schedules.

(iv) Procedures for scoring were clearly stated and easy to implement; this had been demonstrated in the high level of inter-rater agreement.

(v) It had good face and content validity the four question sequences covering the essential aspects of theory identified in Chapter Two.

It was therefore decided to try in some way to overcome the difficulties and to use this measure in a way which would offer the valuable dimension to the present study.

3.3 Measure of Psychological Well-being in Residential Homes

(a) A Review of Some Tests of Psychological Well-being in Residential Homes

Whatever type of measure is used in attempting to gauge psychological well-being, it is attended by difficulties. A measure based on observed behaviour will be subject to all the biases of the observer through which he will filter his observations and subject to all the limitations of the contact on which that observation is based. Similarly, a measure based on self report will be limited by the self understanding of the subject and their willingness to reveal themselves to the outside world.

Six special concerns are present when attempting a study of this nature in homes for the elderly. First it is a very serious invasion of their privacy, already eroded by the residential experience. Not only does this give rise to ethical fears but

it may also reduce both the willingness of subjects to participate in the interactions (Pastalan 1968) and their capacity to do so (Aloia 1973). It would seem important, therefore, that interventions should be conducted with strict confidentiality and as privately as possible within an institutional setting.

Another problem, encountered in a population which includes many who are physically and mentally frail, is whether residents are able to register and understand the items to which they are asked to respond. Research on this problem is complex. Bot winick (1977) shows decline is greater in psychomotor than in verbal skills which deal with information. Shaie (1975) suggests that skills and information become obsolete rather than intelligence itself declining. Hayer & Plude (1980) indicate a slowing of perceptual processing and an age related reduction in the shere bulk of material that can be attended to. Bot winick (1978) noted that elderly people responded more cautiously and had a greater desire for certainty, although if time pressures were lifted the age decrements became less.

The immediate life experience of the residents may influence their ability to respond. The stress of admission to care may well cause a decline in their normal cognitive functioning. The degree of choice, preparation and the disruption experienced will determine the severity of the stress involved. (Schulz & Brenner 1977) At its worst, studies show that moves from home to institution or from one institution to another may result in physical, psychological and social deterioration or death (Schulz & Brenner 1977, Coffman 1981, Kowalski 1981). Tobin & Liebermen (1976) found that if residents survived the first year after admission they did not show evidence of psychological deterioration. Booth (1985) in a British study also found that mortality and length of stay were inversely related; survival rates rising consistently with the length of time spent in care.

Not only are studies of residents in Homes for the Elderly likely to be recovering from the stress of admission but a good proportion of them may well be near to death. Palmore and Cleveland (1976) outlining the theory of the 'terminal drop' suggest that many human functions 'tend to show a marked decline prior to death during a period ranging from a few weeks to a few years'. Booth (1985) asserts 'the implications of high rates of mortality in old peoples homes for the skills required of care staff, the morale of residents and for the character of residential life is an issue which has not yet received the attention it deserves'. There does seem a considerable weight of evidence, therefore, to suggest that many of the residents interviewed may be stressed and pre-occupied and that if interviewers are to be successful they will need to be undertaken at an unhurried pace.

A third area of debate must be the ability of the subject to stand back and review his own behaviour. An individuals ability to do this will vary considerably at any age but because of the many losses which accompany old age some have felt that they will be all the more likely to defend against reality. 'It is possible that in old age a person who is able to deny reality, in this case residential care, with reality of segregation and institutionalisation, and, at the same time is able to engage in compensatory, even escape type activity, may perhaps possess the most effective combination of traits'. (Oberleder 1962).

Tobin & Lieberman (1976) commented on the uses made of denial in their study of the elderly both prior and one year after admission to institutional care. They found denial had a positive function in defending against the anxiety of impending institutionalisation, denial in the realm of interpersonal conflict however, had negative implications for survival after admission. Lazarus and Golden (1981) suggest that 'when denial is partial, tentative, or minimal in scope it tends to be far less pernicious and often useful, permitting a mixture of denial, illusion and reality testing'.

Not only may a resident be defended against the reality of his situation but the meaning which he attributes to it may vary depending upon his life experience and amount expectation. Sherwood & Nadelson (1972) found that comparison with others tend to be an important reference among the elderly and would be an important determinant as to whether one felt oneself 'relatively deprived'.

In the end the discussion seems very little different than it would be for any other age group. Coleman (1984) asserts, 'a person therefore might not really know why he has low self esteem and his replies to questioning in this direction might be only a "rationalisation", the presentation of the most acceptable answer, or the one that comes to hand ..... The stand point adopted here is that the questions whether data of this kind has value can best be judged by the results.'

Another point which has exercised many reviewers of this field has been whether or not residents in homes for the elderly will be willing to give frank and honest answers (Willcocks et al 1982, Bland & Bland 1983). Booth (1985) raises two questions:

(1) How far do residents mean what they say?
What confidence can be attached to residents expressions of satisfaction and contentment with their lot when observers report widespread boredom, loneliness and frustrations?

(2) How far do residents say what they think?
If residential life encourages deferential attitudes, can their opinions be taken at face value as true accounts of their real feelings?

Goldberg and Connelly (1982) conclude hopefully 'that the more relaxed modern regimes which encourage choice and self-expression, together with sensitive methods of consumer research, may enable even very elderly people to express their

choices and feelings, both positive and negative - more freely'. At the present time it seems that the researcher has to assert that as consumer studies in other fields are considered not without value there is no reason why homes for the elderly should be considered exceptional, indeed one could argue that such studies could serve an educative as well as an illuminative purpose in giving value to the opinions of residents.

A fifth serious problem is how far the psychological well being of the resident may be seen as a direct response to the care environment. Tobin & Lieberman (1976) identify a residential syndrome previously described. However, Lieberman (1969) argued that some of the perceived negative effects of institutionalisation could be associated with the residents' personal characteristics and the effects of re-location rather than being directly attributable to the institution.

Although residential care may be shown to have detrimental effects in such areas as self definition (Kahana & Coe 1969) sources of self esteem (Rosner 1968) and cognitive task performance (Jackson 1974), it may also be argued that the process is two ways and that institutions are also partly shaped by the characteristics of their members (Moos 1974). This seems to be supported by Wilkin (1983) who found that homes with over 40% confused residents tended to adopt more institutionally orientated practices. Evans et al (1981) noted that resident orientated practices were easier to achieve in homes where the disability level was low. Booth (1984) concludes 'it is perhaps more accurate to regard institutional life as a continuous process of action and reaction with residents influencing the shape and character of the social environment which, in turn, influences their behaviour and well being'. Again, there is no

easy way to disentangle the dependent and independent variables so that these considerations must be taken into account when making interpretations of the data gathered.

Finally, any study which is concerned with psychological well being in a residential setting for elderly people will inevitably be dealing with material which is painful and distressing because of the stressful nature of relocation and the multiple losses both preceeding and accompanying admission. All the most widely used tests involve the use of an interviewer which immediately exposes them to further subjectivity, variability and makes them dependent, to a greater or lesser extent, upon the skills of the interviewer. Egan (1982) identifies interviewer bias as arising from cultural sources, from the interviewers accepted models of behaviour and from their life stage perspective. This personal contact therefore while enabling and enriching the experience for some subjects will present other subjects with a further disincentive to engage.

Although a possible solution to the problem of interviewer bias would have beenthe use of an independent rater, this was outside the resources available for this study. The use of video was considered too invasive since it would seriously threaten the residents' rights to privacy so was also excluded as a possibility on ethical grounds.

To summarise, serious criticism may be made of all measure of psychological well being. On a personal level they may well be intrusive, difficult to comprehend and ineffective in measuring what is felt as opposed to what is openly expressed. They may ask the impossible since subjects may be unable to make the type of judgements required and even if they are able they may well be unwilling to do so. The effectiveness of this type of measurement may also be questioned in the context of the evaluation of care inputs since it is impossible to attribute the feelings recorded directly to the immediate care experience.

Finally, most test require the extensive use of interviewing which introduces yet another source of bias to complicate a confused picture still further. Safeguards such as the use of an independent observer or a test - re-test format were beyond the resources of this study. Even had these restrictions not operated, the value of Testing and Re-testing is limited given the unstable properties of a population composed of the very elderly and the very frail.

Davies & Knapp (1981) review three of the most widely used measures of psychological well being. They begin by considering the work of Neugarten and colleagues. Neugarten had moved away from the examination of overt behaviour which could be interpreted in social terms as useful and competent and had focused instead on the individual's evaluation of both past and present life satisfaction and happiness. Previous work had reflected either activist and disengagement models of ageing. Neugarten, Havighurst and Tobin (1961) isolated five components to make up a measure of psychological well being in their Life Satisfaction Rating (L.S.R.). These factors were zest; resolution and fortitude; congruence between the desired and the accepted goals; self concepts and mood tone. Each of these components were rated on a five point scale made by two raters using four interview sessions with each subject.

This scale reflected the work of the fulfilment theorists, Peck and Erikson, it also embraces the self actualisation theories of Rogers & Maslow. By assigning low scores to both passivity and meaningless activity it avoided the bias of either an engagement and an activity interpretations of ageing. Its disadvantages were that it was not geared to an institutional population and would require skilled and prolonged interviewing over a wide sample in order to establish reliability and validity with such a group.

As a result of the time consuming and costly nature of the L.S.R., Neugarten et al (1961) were motivated to design two other life satisfaction indices one based on short self report questions (LSI-A), the other open-ended questions and check list items on a three point scale (LSI-B). Of the two the LSI-B has been used only rarely. Scores on both scales were seen to have reasonable validity when compared with scores of both the LSR scale and those of clinical psychologists. The LSI-A appears to have the greater face validity in relation to the theories of Rogers, Maslow and Maddi.

The LSI-A scale received considerable attention from researchers. Wood et al (1969) refined the scoring system and Adams (1969), Bigot (1974) and Knapp (1976) examined the various factors used to indicate psychological well being. It has been widely applied to a range of environments (Edwards and Klemmack 1973, Havighurst et al 1969 and Wolk and Telleen 1976).

Knapp in his review of these measures identifies two major defects in the LSI-A scale for use in British institutions:

(i) the similarity of environment among the population, and

(ii) the large number of those who would be too confused to make a valid response.

In the 1960's Bradburn developed his Affect Balance Scale ABS. This consisted of ten items, the first five representing positive affect and and the last five negative affect. The predominance of positive over negative affect was used to determine psychological well being. As the scale had been developed from self reports of middle aged men it did not reflect satisfaction with appropriate developmental tasks. Items one and three were directly related to Rogers positive self regard and item four related to activation. It was

demonstrated by Moriwaki (1974) that ABS and two sub scores discriminate between normal elderly and elderly psychotics and was also sensitive to the degree of role loss experieneed by elderly subjects. Bild and Havighurst found that it correlated 0.66 with Neugarten's LSI-A scale. Beiser (1974) amended the scale adding a third facet, that of long term satisfaction, clearly incorporating the developmental task perspective of Erikson and Rogers.

Peace, Hall and Hamblin used the scale on a sample of 155 elderly people who were all residents of old people's homes. They found comprehension a major problem with the elderly respondent and to the lesser extent with the interviewers. Negative items seemed to be more meaningful than the positive. The interviews tended to be long and difficult and they were not wholehearted in their support of Moriwaki's view that the ABS was the 'best predictor of psychological well being'.

Lawton produced a useful morale scale (1972 and 1975); his Philadelphia Geriatric Centre Morale Scale was especially designed for use with the very old. It concerned itself with a three fold analysis of morale, these were 'a basic satisfaction with oneself; 'a feeling that the people and things in ones life offer some satisfaction to the individual', and 'a certain acceptance of what could be changed'. The original fifty items were reduced to twenty two following the analysis of data obtained from three hundred residents from two types of residential provision.

The items had face validity in relation to the personality theories of Rogers and Maslow although Davies and Knapp felt that they did so in a less precise manner than the LSI-A. Like the ABS it did not attempt to assess age adjustment. Lawton was himself uncertain whether more positive views should have been included in order to determine whether or not positive and negative affect existed independently of each other.

The P.G.C. showed internal consistency and test, retest correlations of 0.75 and 0.91. Correlation with Neugarten's LSI-A was 0.57 when measured in a selected number of cases. The three dimensions identified by Lawton were not very different from those used by Schooler (1970) and Pierce and Clark (1973).

These scales although differing both in design and methods of data collection have clear shared strengths and weaknesses. They seem able to distinguish between these diagnosed by psychologists as psychologically well and the psychologically sick. They all tend to be time consuming and difficult to administer. Some critics, for example, Bland and Bland (1983), felt that their transatlantic origin also presented problems in British use. This might account for some of the problems experienced in the use of Bradburn's Affect Balance Scale by Pearce, Hall and Hamlin.

(b) A Description of Coleman's Eight Bi-Polar Self-Esteem Items

These very real problems led to the consideration of a British measure. As the title makes clear, the scale consists of eight sets of Bi-polar statements, such as 'I feel useful .... I feel useless'. The subject is asked to indicate which of these statements most closely reflects their feelings about themselves. If a choice is made they are asked the reasons for this choice and an example of the feeling, experience or behaviour on which such a response based is requested. Anyone refusing to make such a choice is given a neutral coding.

A similar study in the Netherlands had been carried out by married women between 30 and 50 but in one of the English studies the scale was completed by four trained psychologists, who tested subjects three times over the period of one year.

The results obtained were analysed by identifying sources of self-esteem. These were divided into seven categories:

(i) Family contacts
(ii) Other relationships
(iii) Health, independence
(iv) Interests and Hobbies
(v) Work Role
(vi) Inner Self
(vii) External Circumstances

The results of English studies showed that a higher level of self-esteem was found among elderly people living in the community. Over the year there was considerable stability in the level of self-esteem expressed although the sources were more variable. The analysis of sources of self-esteem was felt to have particular value in identifying the strengths and weaknesses of an item of social provision. An example was given in which a group of residents living in sheltered housing were contrasted with a group of residents in a residential institution. In the case of those in sheltered housing 'health' is frequently mentioned as a source of self-esteem where as residents of old peoples home mention 'interests' more frequently.

(c) Selection of Coleman's instrument for assessing satisfaction and subjectivity perceived sources of self-esteem in Elderly People

So far it has been established that any measure of self esteem must allow for individual variation in adjustment to ageing, it must be appropriate for the life stage and m ust be capable of determining whether or not residents demonstrate positive self esteem in the residential setting.

The problems of such measures have also been explored investigating as they do an area of great subjectivity and among a group who have every reason both to be defensive and defended. The scales reviewed by Davies and Knapp all had positive aspects but equally had problems in design, administration and interpretation.

The reasons for adopting Coleman's measure of self esteem was most importantly that it seemed to offer some possibility of identifying sources of self esteem in homes for the elderly and therefore, be capable of discriminating between those care environments which were experienced positively by residents and those which were experienced negatively. Given that care environments alone cannot compensate for all the losses associated with old age and institutionalisation, the key worker system, if effective, aims to provide the resident with support which, in turn, may allow him to find some continuity of experience and some feelings of self worth. It is the effectiveness of this form of worker intervention upon which, it was hoped, Coleman's instrument of measurement might throw some illumination.

Coleman's researches had already demonstrated that the instrument was capable of discriminating between those living in the community and those living in various care situations. It had not been possible to discriminate between those in sheltered housing and those in residential care in so far as the level of self esteem was concerned although differing sources of self esteem were identified and information of this kind would be equally valuable.

The eight items used in Coleman's scale seemed appropriate to the life stage. All of them were closely related to the adaptive tasks described by Peck, Clark and Anderson. They were also satisfactory in so far that they did not show any undue

bias towards either an activist or disengagement theory of ageing. It clearly offered scope for the expression of self regard and self actualisation as defined by Rogers and Maslow.

It shared the problems of data collection with the other scales described in the previous section, however, because it narrowed its focus, to measure only sources of self esteem, it was shorter. As the experiences of Peace et al had shown when working with a very elderly and frail population this was an important consideration. It also had the advantage of being designed for the British population and had already been used in an institutionalised setting.

The scale has not been as widely used as the others described but because self esteem has been seen to be under particular attack in the residential setting, its relevance outweighed this consideration. Although the key worker might be regarded as a new and rather weak social link it might well be crucial in preserving self esteem. Granovetter (1973) stresses the importance of weak ties. They need not be intimate and can be composed of relatively brief contacts and still perform a vital function in the diffusion of influence and information, offering mobility opportunities and offering access to community organisations. Moss (1973) showed that social relationships played a preventative role in health maintenance, another factor important in the presentation of self esteem. Anatonvsky (1979) suggested that social relations might provide supportive resources for coping that would lead to a general sense of control. If these benefits result from the use of key workers they might well be reflected in the responses made to Coleman's eight items.

Coleman's self esteem scales were developed in England for a multi disciplinary and longitudinal study of elderly people living in the community (Everett and Coleman 1982). A similar scale had been used and extensively tested in the Netherlands

(Coleman 1976), he stated "There were shown to be consistently high associations between self esteem and other indices of subjective well being used, subjective health attitudes to old age, absence of worries, absence of feelings of loneliness, satisfaction with past life." They also correlated with the variables to which one might expect them to correlate, thus, absence from feelings of loneliness related most to the family. Coleman recounted this as evidence both for the validity of the measure of self-esteem and of the indices of self-esteem be used.

To summarise it was decided to adopt this measure for the following reasons:

(1) It was designed for use with the appropriate population in a British Setting.

(2) It was a suitable length.

(3) It had recently been revised.

(4) It had been shown to be reliable in respect to both item correlation and stability over a period of time.

(5) It had good face and content validity.

(6) The method of scoring was clear.

3.4 Measure of Engaged Behaviour

(a) A Review of Measure of Engaged Behaviour

Observation studies, from which engagement studies are developed, have been used in the Health Service for over twenty years, albeit infrequently, to monitor the delivery of service to geriatric patients. (Norton, McLaren, Exton-Smith 1962, Wells 1980) Michael Meacher (1972) made the first observation study in residential homes for the elderly mentally infirm. He

observed residents for half hourly periods between breakfast and supper recording activities and conversations at half minute intervals.

In America McClannahan and Risley (1975) used observations techniques to measure engagement noting details of residents location, position/motion, speech and participation in activities or engagement with equipment, materials or other people.

Kuslick and his colleagues at the Health Care Evaluation Research Team at Winchester introduced the concept of engagement to the United Kingdom. (Kuslick 1974, Kuslick and Blunden 1974, Blunden and Kuslick 1975) this concept of engagement was influenced by, and to some extent derived from, the work with the elderly by Lindsley 1964, McClannahan 1973, McClannahan and Risley 1975.

'A Measure of Resident's Purposeful Activity in Two Homes for the Elderly' Lunt Powell, Jenkins & Felce (1976) described the methodology employed by the Wessex Team as follows:

(1) Observations were only made in communal areas.

(2) Engaged behaviours were defined as those involved in daily living activities, eating, health care routines, manipulating recreational materials, social interaction with other people and mobility of using a frame or handrail. Disengaged behaviour included touching but not looking at or manipulating materials and talking without attending.

(3) Recordings were made at fifteen minute intervals throughout the day, in different rooms, beginning with the first client on the left.

(4) In order to check reliability two observers were used making simultaneous but independent observations. reliability checks were made on every fourth observation. Inter-observer agreement on the number of people engaged was 97% and on the number of people present 99%.

The paper claimed that the measures, besides having a high degree of reliability, was sensitive in discriminating between situations of high and low activity. Its utility was 'the identification of areas of the home, and time of the day which have planned activities to engage the interests of the residents'.

The Institute of Psychiatry in the observation study 'Time for Action' set out to discover what happened to similar groups of people when they received care or services in four different types of environment. Wherever possible observations were made a continuous period between 10.00 a.m. and 4.00 p.m. Sixty five subjects were carefully selected so that each of the four groups should be at a similar level of dependency and not differ widely in terms of age or for the length of time they have been receiving the particular services. It was requested that observers in the various settings should be ignored.

In each setting three observers were used working in pairs observing a subject alternatively for periods of one hour. They were given observation sheets to cover each ten minute period and using symbols as a form of shorthand made a record every ten seconds.

A training period preceeded the commencement of the study. A consistently high level of agreement was a pre-condition of accepting this form of recording. In the event agreement was high and did not present any problems.

Both these engagement studies presented the researcher with serious problems:

(1) Both studies required at least two observers.

(2) The studies extended over a longer period than could be sustained by a single observer.

These resource issues will be discussed more fully when dscribing the selection of the sample in Chapter 4.4.

(b) A Description of McFadyen's Measure

Malcolm McFadyen (1984) has described a further variation on these observation methods. This was also derived from the behaviour analysis literature of Schaffer and Martin (1966). In this method, which again is a form of time sampling, each resident is observed once in each observation period. The length of this period is variable, McFadyen used thirty minute periods.

The activity recorded was the one in which the person was engaged at the commencement of the observation. Thirty seconds were allowed, if necessary, to clarify what the resident was doing. The level of engagement was subdivided into ten categories ranging from 'Self Help Independent' to 'Doing Nothing ? Watching'. A separate sheet was used for each resident observed and it included a brief written description to amplify the coding where necessary or desirable.

McFadyen, quoting Hall 1980, emphasised the need to train observers. He outlined four stages of training:

(1) An introduction to and discussion of the categories of engagement employed.

(2) Joint recordings made by trainer and trainee, discussing any differences in observations or classification.

(3) A period of simultaneous recording, without discussion after which the percentage of agreement would be calculated.

(4) Trainer and trainee would code each others observations and level of agreement again checked.

McFadyen reported that typically after training inter-observation agreement was over 90%.

He investigated the number of observations required to produce an adequate sample of behaviour and found this to be relatively small. An analysis of the engagement pattern of thirty residents on a psychiatric ward on twenty ratings gave a very similar picture to an analysis based on sixty ratings with rank order correlations for the measurement of non-engagement and active engagement 0.88 and 0.92 respectively. Similar results were obtained in an old people's home in an analysis of the engagement pattern of twenty-four residents based on twenty observations per person compared with fifty-four observations per person. He concluded that twenty observations offered sufficient stability from which it was possible to gain a reliable picture. He also noted considerable stability in the results obtained and two studies, completed with a six month interval, shared a rank order correlation of 0.63 and 0.71 (both significant at $p < 00.1$) for both non-engagement and active engagement measures.

His study showed that the time of day at which samples were made influenced the results. Non-engagement in all settings tended to peak after lunch however, despite these variations, when comparing two populations they retained their respective positions.

McFadyen has sought to answer the criticisms of engagement studies made by Davis & Knapp (1981). The cost of such studies had been s ource of negative comment, a criticism which he met by proving that fewer observations were required than had been general practice and that trained observers need not be employed. His work showed a relative stability of engagement patterns with temporal fluctations throughout the day. The afternoon was shown to be the peak time for leisure activities in both hospital and home settings.

Another problem, made in most critiques of engagement studies, is that looking at engagement versus non-engagement might not give an accurate picture of the quality of life, because the way in which the engagement is experienced by the individuals will be known will not be known. Maddi (1961 & 1962) makes the point that responses to stimuli vary in kind as well as in strength, what produces interest in one person may produce fear in another.

The recording methods used by McFadyen enables the observer to study an individual´s rather than a group´s response. The validity of the argument that engagement cannot be crudely equate with quality of life is accepted. He suggests that while increased engagement can be both positive and negative, enforced engagement being clearly suspect, there is a positive value in studying the levels of engagement when embarking on a process designed to de-institutionalise the physical and social environment.

(c) Reasons for Adopting McFadyen´s Measure

The arguments advanced in favour of McFadyen´s method of observing engagement, well supported by hard data, led to the adoption of this format of the purposes of this study. the particular merits, besides these already mentioned, were:

(1) It offered a detailed breakdown of the type of activity in which residents were engaged.

(2) It provided an opportunity to explore personal differences within the group.

(3) It provided a simple format which did not employ a large number of complicated methods.

(4) It offered a thorough but simple training plan.

(5) It only required one observer at any time.

3.5 Conclusion

This chapter has described how, after researching available measures, it was decided to adopt those devised by Evans et al 1981, Everett & Coleman 1982 and McFadyen 1984. The factors which largely influenced the choices made were:

(1) Ethical. The measures chosen sought to reflect a respect for privacy and to ensure that those involved were offered the opportunity of informed consent.

(2) Practical. The measures had to be capable of use within a limited budget.

(3) Methodological. The measures had to have been recently tried and tested and to have shown themselves capable of producing reliable and valid data.

The selection of the sample used in this study and a description of the test administration will be examined in Chapter 4.

Chapter 4

Methodology - Part II

4.1 Introduction

The importance of looking at the total caring practices within the home, at the same time as seeking to evaluate the impact of the key worker system on individual residents has already been stressed. Two limitations however, had to be accepted at the beginning of this study:

(a) All aspects of the residential experience could not be measured.

(b) Because of resource restraints only a small sample of homes could be investigated.

Consequently it was decided to adopt an in-depth pilot study which would yield the maximum data although over a limited range. Although the resources available allowed for the recruitment of one assistant it was essentially a single worker study. Despite the restrictions this imposed it was also of particular value given the third aim of this study, that of, identifying learning which might be of use to social service workers seeking to evaluate care inputs in their establishments.

After consideration it was decided that six homes would be investigated. This number was selected because it was manageable and offered the same base as that used in the much praised study by Evans et al (1982).

This chapter will explore the way the sample in each of three measures was selected and the way in which the test was administered.

4.2 The Measurement of Regimes

(1) The Selection of the Sample

In an attempt to try and ensure that the homes studied would have some similarity in their support networks and access to resources, they were all selected from the same County Council. These homes were selected by the Principal Officer responsible for Residential and Day Care for the Elderly within the County Council. She made her choice partly with regard for the proximity to the researcher's work base and also bearing in mind the requirement previously agreed, that three of them should be using a key worker system and three of them not. All Officers in Charge had been approached and had agreed to co-operate in the study.

At the outset three major problems became apparent. The first of these was that three homes, **The Beeches, The Cedars** and **The Rowans** were already known to the researcher. This meant the researcher received a more personal welcome and had a good deal of prior knowledge of the homes concerned. In the homes where the researcher was not personally known to the management team they were aware that the researcher was a tutor on a qualifying course for social service workers. Although, therefore, the uneven spread of information available to the researcher was a source of bias, her work role also provided an acceptable basis for a working relationship with the management teams of all the homes and greatly facilitated access.

The second factor which might prejudice the validity of the study was the differing physical environments in which both staff and residents had to work and live. The homes were of different ages, different sizes and the degree of privacy which

was available to residents varied considerably. A brief description of each of the six homes will illustrate the problem of making any direct comparison between them.

The Acorns has been open for fourteen years, It was purpose built. It is situated on a council estate away from the centre of a busy town. It houses sixty residents of whom twenty are in ten shared bedrooms. Residents have the use of two lounges, one of which is slightly larger than the other.

The Beeches is placed on a steep hill in a village which acts as a domitory for the county town. It is one of a number of social service properties in the same location. Opened in 1975 it has fifty five residents. There are five shared (double) bedrooms. It has five lounges, one large, one medium and three small. The

home is divided into four resident groupings and the four link areas between the groups, created for safety purposes, also are used by residents as seating areas.

The Cedars has been open for thirteen years, it takes a maximum of forty eight residents. It is situated close to the main shopping area in a small market town. It has seven shared bedrooms all housing two residents. The three lounges all have distinct functions. One is used as a television lounge, one as a quiet room and one as a smoke room. It has a large front hall which is also used as a seating area by a regular number of residents.

Situated in the grounds of the old work house which still stands, disused, **The Rowans** was opened in 1974. It is on the edge of a housing country town. It has fifty five residents and has similar accommodation to the Beeches. It has six permanent double rooms and two double rooms which are used by short stay visitors. Like the Beeches it has five lounges. All the lounges have television. There is also a large sun lounge which

is used by residents. Apart from the actual lounges there are four alcoves used as seating areas and there is an occupation and hobbies rooms which is used by residents as they wish.

The Sycamores is a converted Victorian house built about one hundred years ago. It has been used for its present purpose for well over twenty years. It is in a residential area of a large port and a few minutes walk away from local shops. It has thirty nine residents. At present it has only seven single rooms, the rest are shared. There are three lounges of the usual Victorian drawing room proportions and one small lounge.

The Tamarisks, like **the Rowans** was built beside the old work house, twenty one years ago. It is situated in a city which serves as a large naval base and is in an area given over to public building. It faces a prison built like a castle, is flanked by the old, extensive work house and is backed by a large general hospital. It houses sixty residents in six four-bedded rooms, twelve double rooms and twelve single rooms. It has four lounges with clear differences in function. The main large lounge is on the first floor used by mentally alert residents, another lounge on the ground floor is used by residents who are confused. There are two smaller lounges, one is used as a television lounge and one as a quiet lounge.

From this brief summary of certain key resources it can been seen they differ widely. Even those details are difficult to interpret since some rooms are shared by married couples or siblings from choice, others are allocated on the grounds of necessity. On face value the two older buildings, **The Sycamores** and **The Tamarisks** are at the disadvantages of having far fewer single rooms and offer less obvious opportunities for privacy. The results of the study must be interpreted with these relative deprivations in mind.

The third factor which made the study less than straightforward was an initial confusion as to which homes were actually using a Key Worker System within the definition of this study. It was obviously important that there should be a balanced number of each type so that they could be constrasted.

Those identified initially as having a Key Worker System were **The Acorns, The Beeches** and **The Cedars.** Those who were without the System were the **The Rowans, The Sycamores** and **The Tamarisks.**

After two visits it became clear that the difference between the two groups was not as distinct as had been hoped.
A one page questionnaire was devised in order to clarify the situation.

It asked:

1) Do you have a Key Worker System?

2) If yes - how long has it been in existence?

3) Who initiated the system?

4) How are workers' allocated to residents?

5) What tasks are the special responsibility of the key workers?

6) What support is offered to key workers?

The response from **The Acorns** showed that a Key Worker System had been instigated three years ago by the previous officer-in-charge. It could not operate effectively because of two staff vacancies and sickness amoung existing staff. Care assistants were allocated approximately six residents each - all

male residents were allocated to a male care attendant. Their special responsibilities were concerned with more intimate details of physical care, such as bathing, weighing on Monday, general care of their clothing, referral to a volunteer when clothing needed marking and responsibility for chiropody appointments. Responsibility was also taken for residents shopping needs, though it was not clear whether this meant taking the residents shopping or shopping on behalf of the residents.

The support offered was that of encouragement and advice when needed. It was felt that the care assistants were very responsible and would always report any change in a residents condition.

At **The Beeches** a variation in the key worker system was used which they described as a family group system. Rather than allocating a number of residents to each care assistant they allocated two part-time care assistants and one domestic to a group of nine residents. This was felt to operate more smoothly because of the large numbers of part-time staff employed and the problem of care which existed under the system of one Key Worker to a group of residents. Only one member of the care team would operate at a time, but a key worker would in this way always be available to the individual resident.

The members of staff were allocated on a geographical basis - one care team to a group of rooms. Each care team was seen as having direct and primary responsibility for the physical, mental and social care of their residents but were accountable for their decisions to senior staff. Each family group related directly, for day-to-day matters, to a residential care officer for support and guidance. Approximately every 6 - 8 weeks each group had a supervisory session with the officer-in-Charge.

The Cedars operated a Key Worker System which had been in operation for about 4 months at the time of the study. The system was initiated by the officer-in-charge and largely

implemented by his deputy who used the setting up of the key worker system as part of a college project for Certificate in Social Service.

The allocation of residents was based on the bath list - since often close relationships developed in those intimate care procedures. As vacancies occurred on a member of staff's bath list through residents leaving the Home and through death, new residents would be allocated to them. This system was a flexible one so that either residents or staff who were experiencing problems with the relationship could ask for a re-allocation to take place. Procedures for making this change were not explained.

The key worker was seen as the care officer who was responsible for a group of care assistants. She would delegate to each care assistant the responsibility for a number of residents for whom they would be key person. This had some similarities therefore with both Home No. 1 and Home No. 2 - although it differed from both.

The support system for this scheme consisted of meetings between care officers - care assistants and residents so that the working of the scheme could be monitored by both those servicing it and by consumers.

Unlike the other other two schemes the primary focus of this scheme was social care and emphasis was given to increased social interaction between residents and care staff.

At **The Rowans** no Key Worker Scheme was in operation, although special care was devoted to the bath-list to ensure emotional fit.

At **The Sycamore's**, although designated as a home without a key worker system, the officer-in-charge described herself as operating a 'partial system'. It had been set up for one year and care staff were allocated to residents basically on the

grounds of compatibility - although when this didn't exist they would be allocated on an arbitrary basis. The key worker was seen as responsible for bathing, personal clothing and providing feedback to the care officers about any problems which might be experienced.

No formal supervision was offered but emphasis was placed on sharing information of particular relevance with care officers. Although the basic list of key workers duties were largely pratical, they were being encouraged to expand the range of residents activities. At the time of the study care assistants were planning to take their residents on a day trip.

The Tamarisks affirmed that they had no Key Worker System in Operation.

Although no home operated an identical system it became clear in discussion with staff at **The Acorns** that the key worker system had been allowed to fall into disuse following various changes and disruptions. This was confirmed by the officer-in-charge in his reply and also was born out in informal discussions with care assistants, many of whom appeared unaware of the existence of the scheme.

It was equally clear in conversation with care assitants at **The Sycamores** that there was enormous enthusiasm for the new venture and a real excitement about offering a new type of care, based on increased social involvement. It was, therefore, decided tp re-classify the homes, so that the homes that operated a key worker system were **The Beeches, The Cedars,** and **The Sycamores** and those not doing so were **the Acorns, The Rowans and The Tamarisks.** This revised grouping was felt to offer a more clearly defined sample, although there were still very real differences between the interpretation of 'key worker' by each officer in charge.

(b) Administration of the Schedule

Evans et al has designed this schedule to be used by the reseachers after considerable periods of observation and interviewing. They did not, as a result, appear to have paid undue attention to the wording of the questions. The assessors already knew that the purpose of the assessment was to distinguish homes with largely resident orientated practices from those with largely organisational orientated practices. The aim was clear 'to judge particular organisational practices and features according to their tendency to facilitate or limit resident freedom, to facilitate administrative efficiency at the expense of resident needs, to regiment resident and subject them to block treatment, limiting decision making powers, to maintain social distance between resident and staff'. (Evans et al 1981)

In this study it would have been impossible to complete the schedule on the basis of information collected in the two days within the home. The assistant who observed the levels of engaged behaviour had no relevant training or experience and it has already been noted that the researcher was liable to bias. The schedule could not therefore be completed in the way which was intended. Tim Booth, faced with the same dilemma of choosing between the excellent content and the unsuitability of the presentation for his use, set about designing an Institutional Regimes Questionnaire (Booth 1985). Re-designing the schedule was outside the limits of this study so that another means had to be devised.

The method finally adopted was by no means ideal but was felt to minimise some of the major problems. It was decided to complete three of the schedules in each home using one member of the management team and two other members of staff. To some extent this could be seen as reflecting the two way completion required in the original study although the process of reaching a consensus was not included, indeed, any disagreements were seen as providing an interesting source of additional information.

The management input was supplied by the officers in charge, except at the Acorns, where it was completed by a deputy. The staff members were, in all but two instances, care assistants. The exceptions were a residential care offier from the Beeches and a domestic from the Rowans. The staff members were selected by the officer in charge.

The form was completed in two different ways. The managers completed them independently while the residential care officer, the ten care assistants and the domestic were interviewed, the questions put to them verbally, where necessary re-framing them, and then scored by the reseacher. The reasons for adopting this dual method were:

(1) Managers could not always make themselves available and found it easier to complete in the evenings, often in their own time.

(2) Some of the questions were worded in a way which made it difficult to understand and therefore complete accurately without professional training, (e.g. 'Do staff avoid demonstrating infantilisation of residents in their attitudes to them?'), therefore some questions needed re-phrasing in simple English.

(3) By completing the non-management staff's forms through an interview it was hoped to gain a clearer view of actual practices than might have been the case if they had been asked to complete them independently and had sought the guidance outlined in (2) from senior staff.

(4) It was a long schedule which, to those unused to form-filling, would have been totally off-putting.

It was decided that although both the scoring instructions and the phrasing of the questions often suggested the 'right' answer that both managers and staff should be trusted to give as objective a view as possible and that, because they would feel personally responsible for different aspects of residents care, they would to some extent act as a corrective to each others' prejudices and preconceptions.

Evans et al (1981) had already identified the significance of the contribution both of the head of home and the quality of staff relationships in determining the quality of care. It was hoped that by comparing the answers of different members of the caring team within the home something of the quality of the leadership and of the team work would be made apparent. It was hoped that the lack of time available for observation was therefore to be compensated for by seeking three different perspectives within each home and making internal as well as external comparisons.

4.3 Measurement of Psychological Well-Being in a Residential Setting

(a) The Selection of the Sample

The limitations of this study must again be briefly stated.

(1) One interviewer only was available, a trained social worker of some experience, not a psychologist as in Coleman's English study, but a married woman between 30 and 50, as employed in the Dutch studies.

(2) Time constraints dictated that only twelve residents could be interviewed, allowing approximately thirty minutes for each resident.

No specific guidelines were given in the literature as to the precise nature of the population for which the scale was intended. It had certainly been used for elderly subjects in a

number of different settings. The scale was one which placed considerable demands on the subjects both intellectually and emotionally. If the short term memory was grossly impaired it would be impossible to hold two statements in mind while making the necessary judgement. Choosing between such statements as 'I am of importance to others' and 'I don't, count anymore' might be extremely painful and experienced as an intrusion or an attack.

The considerations described led to the decision that the selection of the sample could not be an entirely random one. It was decided to show each head of home the test and ask them to select twelve residents who they thought would be able to complete it. This produced interesting reactions. Almost unanimously it was agreed that it would be difficult to find twelve residents who would be able to complete the test. In every home this was eventually forthcoming but only after some consultation between other senior staff.

The basis on which the choices were eventually made were three fold:

(1) The capacity of the resident to complete the scale.

(2) The level of co-operation which might be obtained.

(3) The acknowledged need for the interviewers to see a cross-section of residents.

Clearly then this was in no way a random sample, nor was it claimed to be representative. All the homes were anxious for the researcher to meet their 'characters', many of whom were out spoken critics of the system. Those interviewed were not always judged by the staff to be in good mental health, they were suggested on grounds that they would be interesting.

Almost any method of selection would have had certain draw backs and this one offered the great advantage of placing the officer in charge in control. Their co-operation was vital and was consistently forthcoming. Only one resident who had been suggested refused to be interviewed. She had heard from her friend, interviewed earlier, that the researcher was selecting suitable candidates for euthana sia.

The two largest homes, the Acorns and the Tamarisks, had sixty residents. The smallest, the Sycamores had thirty-nine. The sample of twelve residents then, at worst, consisted of 20% and at best nearly 31% of the total population. This seemed to offer a reasonably substantial sample from which to make the measurement. Although not made a priority, in fact, the age and sex distribution between the key worker and non-key worker homes was very close. The youngest resident interviewed was aged sixty six, the oldest 100. Age was found, as in other studies, to be a poor indicator of either mental or physical capacity.

The sample therefore was a non-random selection made by the officer in charge in consultation with other senior staff. It consisted of at least 20% of the total resident population. Only one resident thus selected refused to take part and was replaced by another resident selected by senior staff.

The balance achieved between those who were fully able to complete the form and those who were not, remained unclear. The quality of the reponses obtained indicate a high number who did not participate fully and this will be discussed in Chapter 6.

(b) Test Administration

The time allowed for each interview has already been stated. This was not strictly observed and varied considerably from resident to resident. Some saw the scale as a welcome opportunity for a long chat, others were rather concerned about the use which was to be made of their replies. Others found it an upsetting experience, reminding them of their many losses.

It would have been very desirable to have interviewed each resident in complete privacy, this was certainly what had been envisaged. In reality this was not possible. In homes where most residents had their own bedrooms this was more likely to occur but at the Tamarisks only 20% of the residents had their own room and at the Sycamores this was even lower at 18%. These two homes together with the other large home, the Acorns, also had no private room available where residents could see visitors, which, where it existed, was usually on the ground floor, conveniently near the public lounges and ideal for interviewing. Even when privacy was available some residents, whose meagre energies were required for essential movement for meals and toileting, preferred to complete the scale in their usual seat in the lounge. The degree of privacy available may well have influenced the quality of the responses, although so too might fatigue, so the choice was by no means clear-cut.

In practice, then, residents were given a choice of remaining where they were or of going to their room, or at least to somewhere more private, wherever such an alternative was available. In some homes residents were encouraged to use their bedrooms during the day and those residents were more likely to be interviewed there. As these rooms contained photographs and other personal possessions, the atmosphere was more intimate.

At the beginning of each interview residents were told that the questionnaire was part of a study of life in old peoples' homes which hoped to identify how this life might be made as full as possible. Where residents were sighted they were shown the sheet, if visually impaired they were told it consisted of eight pairs of statements. It was explained that in each case they were asked to make a choice between the two responses. The interviewers then completed the form underlining the preferred response. After each point on the scale residents were asked once if they could give a reason for their choice. Whenever a reason was given it was written down and read back to the

respondent to check that it was accurate. On the eight occasions when two sources of self-esteem were mentioned in either a negative or a positive context both sources were scored.

The administration of the test was straight forward and had been clearly described by Coleman. The lack of privacy available to many residents, without considerable physical effort, created some difficulties. This was particularly the case when the respondent was deaf or partially deaf especially if eye sight was also failing. Sex and age differences between the two groups of homes had not emerged as significantly dissimilar, and taken overall, fluctuations in privacy were probably also equally spread since both key worker and non key worker groups included homes without a large proportion of single bedrooms or private interviewing rooms.

There is little doubt that given optimal conditions, that is, privacy which was available without physical exertion, the responses to the test would have been of a higher quality, by which is meant there would have been a higher number of reasoned responses. In retrospect the researcher is still doubtful as to whether or not privacy should have been made a condition of completion. This would have excluded a large number of those interviewed and thereby have rendered the survey respondents atypical of most residents in homes for the elderly.

4.4 Measurement of Engaged Behaviour

(a) The Selection of the Sample

The time allotted for the measurement of engagement was two days. An observer was trained in accordance with the training schedule outlined by McFadyen. A home, not included in the study, was used for the training sessions. The training took place

throughout one day and continued into the evening for final crosschecking. The inter-observer agreement was 96% by stage four of McFadyen's training Programme.

Several major decisions had to be made before the study took place since they were crucial both to the reliability and the validity of the study. The first concerned the number of observations which were required to provide an adequate sample of resident's activities. McFadyen found that an analysis of the engagement pattern of 30 residents based on 20 ratings gave a similar pattern to an analysis based on 60 ratings. He spaced his observations throughout a complete day, beginning at 8.30 am and proceeding at 30 minute intervals until 9.00 pm.

Complete coverage of the day was felt to be undesirable on several counts. It appeared to require an obstrusive surveillance when undertaken in a home for the elderly. In an increasing number of homes residents are encouraged to use their rooms as bedsitters and will often prefer to sit in them to be private. It seemed unacceptable to interrupt them at regular intervals in order to observe their level of engagement. Pastalan (1968) classified four types of privacy; solitude; intimacy and freedom from identification and surveillance. Intrusions of the type mentioned would be to trespass on more than one of these areas.

Another practical problem encountered was the frequenct use of many different seating areas. It was felt that one observer scoring every half hour could not possibly hope to cover thirty residents, which would require a rate of one observation per minute with no time to track the missing residents down.

After discussions of these problems with residential workers strong feelings emerged about the rights of residents to reasonable privacy. There seemed a lack of respect about recording details of personal care without full consultation of all the residents concerned. The very process of seeking this permission would in the short term create a highly artifical situation until the observer had become an accustomed figure, in two days there was no time for such an adjustment.

No such fears were expressed about recording activities in semi-public space such as the resident's lounges where visitors were an unremarkable occurence. It was therefore decided that the observations should be limited to these communal seating areas, the result of this discussion was to effectively limit the period during which observations could be made since, at mealtimes, the lounges emptied for some time before, during and after each meal. As the dining room was often the largest communal space, large group activities such as bingo, would take place there, again causing an exodus from the lounges. McFadyen warns that special events prejudice results and any obviously different or special day should be avoided. This precaution was taken but of course some chance occurences such as visitors were inevitable. Although these happenings are normal in most of the homes they invariably caused a rapidly increased level of interaction and in a brief survey of two days significantly influenced results.

(b) Test Administration

In order to make an effective comparison it was planned to observe for two hours in the morning and two hours in the afternoon. These hours would include the mid morning coffee time and would continue until lunch time. Observations would resume after the residents had re-assembled after lunch. There were some differences between homes in the timings of lunch and also the distance from the various lounges to the dining rooms. The observation times were therefore designed around these factors rather than following a rigid time schedule. Typically four hours between ten thirty and four thirty were observed. In the morning and afternoon sessions in McFadyen's study showed very obvious temporal shifts in behaviour. Early afternoon showing the least activity and late afternoon a peak in activity. These times were felt therefore to offer a reasonable cross section of resident behaviour.

Having established the periods in which observations should take place there remained two further decisions, (i) the frequency of observation and (ii) the number of residents who would be observed. These two aspects were closely linked to the problem of where the observations should take place. In the Acorns, which had two main lounges, there was little choice, but in homes like the Rowans there was a choice of five internal lounges and large sun lounge which was used in fine weather. Since the variation of provision made nonsense of any attempt to match lounge for lounge throughtout the six homes, it was decided to inform the officers in charge concerned about the purpose of the observations and ask them to allocate the observer to the lounges of their choice. There was little discussion of the grounds of their decision although most officers in charge indicated that they were trying to offer some variation in experience so that both lively and less lively lounges were observed.

One result of observing within various sizes of lounges was that the number of residents who could be observed were reduced. During one afternoon observation period at the Beeches the observer was sent to a small lounge with four occupants, all of whom slumbered. Towards the end of the observation period the observer was 'rescued' by an officer who moved her to a lounge in which there was considerable activity. It was decided not to score these later observations, since to introduce a fifth lounge in one home would even further cloud the issue.

The example quoted above was the only instance of a lounge with less than five occupants and this was the number selected so that over the course of the two days twenty residents would have been observed for a two hour period. This reduced by one third, the figure that McFadyen cited as reliable but as it offered comparison between large and small lounges this was felt to be a reasonable compromise. As residents frequently left the lounges for long periods in order that the size of this small sample should not become reduced even further it was decided wherever possible to observe eight residents. This allowed for the three who were absent for the longest periods to be discarded. This may well have resulted in a bias of the type of resident observed, since they may have been the less physically active. As this practice was constant throughout the six homes, however, it should not have adversely affected the reliability of the study for the purposes of making comparisons.

The two hour observation period was divided between eight residents, allowing one observation per minute, fifteen observations being made in all. In practice only the large lounges offered that number of residents so frequently the total number of observations made were less although number of scores for each resident remained the same.

With the exception of the afternoon of day one at the Beeches, when only four residents were present, five of a possible eight observations were used. Where more than five were completed the observations of the most persistent absentees were discarded. The format adopted was that the first fifteen observations were used from five residents observed over a two hour period at eight minute intervals in a lounge which had been selected by the officer in charge.

4.5 Conclusion & Summary

The sample consisted of six homes. In each of the six homes three members of staff would complete a schedule on daily practices within the home; twelve residents would be interviewed and asked to select items from Coleman's bi-polar measure of self-esteem; finally four lounges would be observed in each home for two hours over a two day period.

The research work would be carried out by two women, between 30 and 50 years. (This coincided with the workers employed in self-esteem studies in Holland). Both the researchers were trained teachers, the author was also a trained social worker. Neither had previous research experience.

The main adaptations were as follows:

(1) The Analysis of Daily Practices was to be completed by three members of staff occupying different work roles within the establishment without attempting any consensus. In the original study the scoring was done by the observers.

(2) Coleman's Bi-Polar measure was used in its original form but the researcher introduced a rule of one prompt only when seeking to secure a reasoned response. The researcher was not a trained psychologist.

(3) The time schedule for the study of engagement was much modified. McFadyn's 20 observations of 30 residents at half hourly intervals was changed to 15 observations on 5 residents at 8 minute intervals.

Although these amendments were to some extent the result of working with limited resources they were also a response to both the study's environment, and its population. The actual time spent on assessment in each home was as follows:

(1) Analysis of Daily Practice, approximately one and a half hours.

(2) Bi-Polar Measure of Self Esteem, approximately six hours.

(3) Study of Engagement, eight hours.

Thus the total assessment time was fifteen and a half hours and each test was capable of completion by a single worker.

The results obtained in this study will be discussed in Chapter five. Before moving on however, this appears an appropriate moment to mention the very high level of co-operation which was offered in all the six homes studied, without which it would have been impossible to continue beyond this point.

Chapter 5

Evaluation I

5.1 Introduction

The previous two chapters described the methodology and the next three will be devoted to evaluation with particular reference to the aims of the study set out in the preface. This chapter is primarily concerned with the first aim, that of adapting a number of existing assessment scales for use by a single worker in a short intensive study, although it obviously has implications for the other two as well. Each of the measures will be reviewed , noting any particular problems which were encountered.

The evaluation of these assessment scales has to be conducted in two areas. First it has to consider whether the measure itself is well constructed, reliable and valid, and, secondly, it has to address itself to the problems of adaptation and decide how well the test survived the changed usage to which it was subjected.

Copies of all three assessment instruments may be found in Appendix 5 at the end of this chapter.

5.2 An Evaluation of the Analysis of Daily Practices

The test itself seemed to present some problems which would have existed whether or not its usage had changed, as well as some which were probably covered in planning briefings in the original study but were not explicit; others directly caused by the adaptation. They have been briefly outlined below:

(1) The scoring system requiring Yes/No answers was straightforward but at times this seemed to be at the expense of clarity, e.g. 'Is there extensive use of sedation?', was scarcely illuminated by the Yes/No response as no baseline was provided as to what 'extensive' might

imply. Similarly 'Do residents have a choice of who bathes them?' would be dependent partly on the availability of choosen staff and a scale of -Always, Sometimes, Occasionally, Never, might have been more enlightening.

(2) At times the precise meaning of questions was unclear. 'Do staff routinely dress many residents?', might be simply a question about the number of residents requiring help or about the way in which such help was proffered. Similarly 'Can able residents choose when to get up?', might be answered differently depending upon whether or not the resident saw breakfast as essential or expendible. The precise meanings are unclear.

(3) Some items were open to a variety of interpretations, this was reflected in the high degree of subjectivity which typified the responses. Section B includes the item 'Have the majority of residents personalised their own room?'. Some guidelines were offered. 'Pictures and photographs don't count'. Seven out of eighteen responses were negative although this may well have been a result of how the 'many small personal items' were defined, especially if they consisted largely of pictures and photographs.

Section C, page 5 also presented similar problems. 'Do staff among themselves display accepting respectful attitudes to residents?' and 'Do staff avoid generalised terms for categories of residents?' were both questions to which the answer was dependent upon the sensitivity and level of awareness of the respondent. Negative responses might in fact reflect superior expectations rather than inferior provision.

(4) Some items seemed to reflect confusion about the testers expectations of group living and about what model of care would provide the optimum quality of life. At times they seemed to be adopting a 'hotel' model at others that of a substitute home. In Section A, page 2 the item 'Do residents receive food as soon as they sit down?' seemed inappropriate as this is not usually available in social eating situations. In the same section 'Are males/females toileted in separate facilities?', seemed in direct contrast since in most small group or private situations this would not occur.

(5) Some items ignored the importance and power of resident/resident interactions. In particular in Section B, page 4 two items illustrate this point 'Are all communal areas available to all residents?' and 'Can residents choose where they sit in lounges?'. The answer yes or no was here inappropriate as the important issue was clearly, where this was negatively scored, who was responsible for the embargo. The frequent response was 'No, but that is because of resident's insistence not staff's'. This territoral behaviour is common in group situations and so the question in relation to resident freedom becomes more complex.

Already it may be seen that the adaptation of the scoring system, requiring three responses from each home, created problems over and above those inevitable in attempting to score something as complex as the quality of care within a home for the elderly. This was necessary in order to reduce the demands made upon a single researcher with limited resources to manageable proportions. It was not without value in that it did highlight some of the problems inherent in the scale which might have been less apparent when scored in the way intended.

The previous five criticisms all raise serious doubts as to both the reliability and the validity of the schedule. When used for the purposes of this study other problems also arise. Evans et al besides judging organisational practices were also looking at what they describe as 'features'. Although very relevant to the total package of care as experienced by the resident they do not assist in determining whether or not key worker systems are able to mitigate the worst effects of institutionalisation. If it is assumed that these inadequacies in themselves constitute an organisationally orientated regime then the precise deployment of staff becomes irrelevant. There are three areas where this problem occurs:

(1) In those questions where the answers are determined by the quantity or quality of the physical resources, e.g. 'Can residents choose a private or a shared room?' or 'Are there facilities for residents to see visitors privately?'. The value given to these resources may indeed reflect something of importance about staff attitudes but their actual provision is something over which they have limited control. They were more truely a reflection of society's attitudes.

(2) Some questions are determined by the staff resources made available. Although creative management can do much to deploy staff in a way which is responsive to the needs of the consumers there are limits upon their ability to respond. The officer in charge at the Beeches replied to the question 'Can residents choose when they go to bed?' 'Yes' but added that there was often strong inter-resident rivally competing for staff attention. The question 'Do staff attend promptly when residents need help retiring?' was left unanswered amd she wrote 'Ideally yes, but realisitically with two members of staff for fifty five people, no'. Similarly the same issues were raised over the questions relating to batheing and getting up.

(3) Some items seemed to question the quality of the community services rather than the quality of care offered within the home. 'Can residents freely retain their own G.P.?' was generally accepted as ideal but as one respondent noted 'When this is possible, if the G.P. works in the same area as the home'. Similarly the items on page 7 'Are facilities, materials, teaching regularly available to residents (e.g. library servicem visiting teachers, etc.)?' may say as much about local community provision as the caring practices within the home.

These last three points all raise important issues about the responsibilities of officers in charge and their staff. How far are they responsible for not only caring for the residents in accordance with the residents expressed views but also for generating ressurces when they are not readily available? Whatever the answer to this question the items which fall into these categories seem to have limited validity in relation to whether caring practices in key worker homes are more responsive to individual needs than those in non-key worker homes.

The final difficulty which presented itself was the confusion in the scale about the exact status of the resident in relation to the staff. Some items seemed to assume that residents should be provided with time consuming services 'Are residents brought tea if they wish it?' and 'Are clothes generally kept in a good state of repair?'. Other items reflect the need for maximum freedon 'Do residents collect their own pensions?', 'Can residents stay out as long as they wish?'.

This independence/dependence tension expressed in items concerned with physical care was also expressed in items relating to the social/emotional interaction between staff and residents. In some instances the staff are seen as the course of much social benefit 'Do staff eat regularly with the residents?', 'Do residents discuss personal matters with staff?', 'Do staff regularly communicate with residents for social purposes?' In other items the need for independence is stressed 'Does a residents' committee exist?'. 'Does a formalised complaints procedure exist?', 'Do residents organise any functions themselves?'.

In practice, of course, the status of the resident will to some extent depend upon the perceived capabilities of the resident and this is accepted in some questions 'Do most able residents know the name of some staff?' In others the Yes/No response which does not allow for qualification of this kind must make the scoring unreliable. In this study where it is hoped to establish whether or not key worker homes provide a more individually orientated service this over-generalisation within the schedule is particularly damaging.

The previous discussion highlights two problems:

(i) that of attempting to measure the quality of care while excluding examination of the inter-personal and supra-personal environment.

(ii) that of devising a measure capable of discriminating between subtle differences of regime and also capable of producing a score.

Despite the quantity of negative comments which have been generated through this consideration of the schedule the fact remains that at the time of making this study it was by far the most appropriate measure available. The extent

to which the imperfections described influenced the results will be explored in the next chapter. It undoubtedly suffered as a result of the changed usage to which it was subjected, most markedly by producing three scores for each home which made interpretation extremely difficult.

5.3 An Evaluation of the Instrument of Assessing Self-Esteem & Subjectivity perceived Sources of Self-Esteem

The inexperience of the researcher was very apparent in this section of the study. A planning visit to each of the homes concerned, prior selection and notification to the residents involved would have been both reassuring and more genuinely respectful. However, some of the difficulties were the result of the very painful nature of the questions posed. After some residents had completed the scale it seemed necessary to spend some time talking in order to allow time for them to recover their composure.

A sad but not a typical set of responses to the scale was obtained from a lady at the Cedars. She felt useless 'because everything is done for me'. She had little enjoyment in life although she felt staff did all that they could, for example, giving resident outings in the mini bus. She felt she could do a lot; when she was able to get away from the home. She had no aims because what she wanted most was to return to her flat but she knew she couldn't. She had no relatives so felt she didn't count anymore. She felt unsure of herself, she gave no reason except she wouldn't like to say she was confident. She said she was as bright and alert as ever and again she did not give a reason. She indicated she had little hope for the future, again not giving a reason, but simply repeating 'not much hope'.

This illustrates some of the main problems encountered:

(i) When asked to give a reason for why she got little enjoyment out of life she instead made a reservation. This defensive behaviour was commonly encountered. A total of forty reservations were given after positive choices had been made and eighteen reservations were given after negative choices.

(ii) Obvious inconsistences abounded. In this example when making the positive choice that 'I am still capable of doing quite a lot', instead of mentioning a reason for such a statement the resident re-iterated that the home made her useless and if she was out she would be alright. This was refuted in the Choices statement that followed when she saw she knew she could not return to her flat.

(iii) Her reaction to the statement, 'I am as bright and alert as ever' was to state emphatically that this was the pole to be choosen. She ignored the prompt for a reason. This was a common reaction. Only five people stated sources of self esteem for this item, although most replies were positive. In all the homes where dementia was known and feared this question was very threatening.

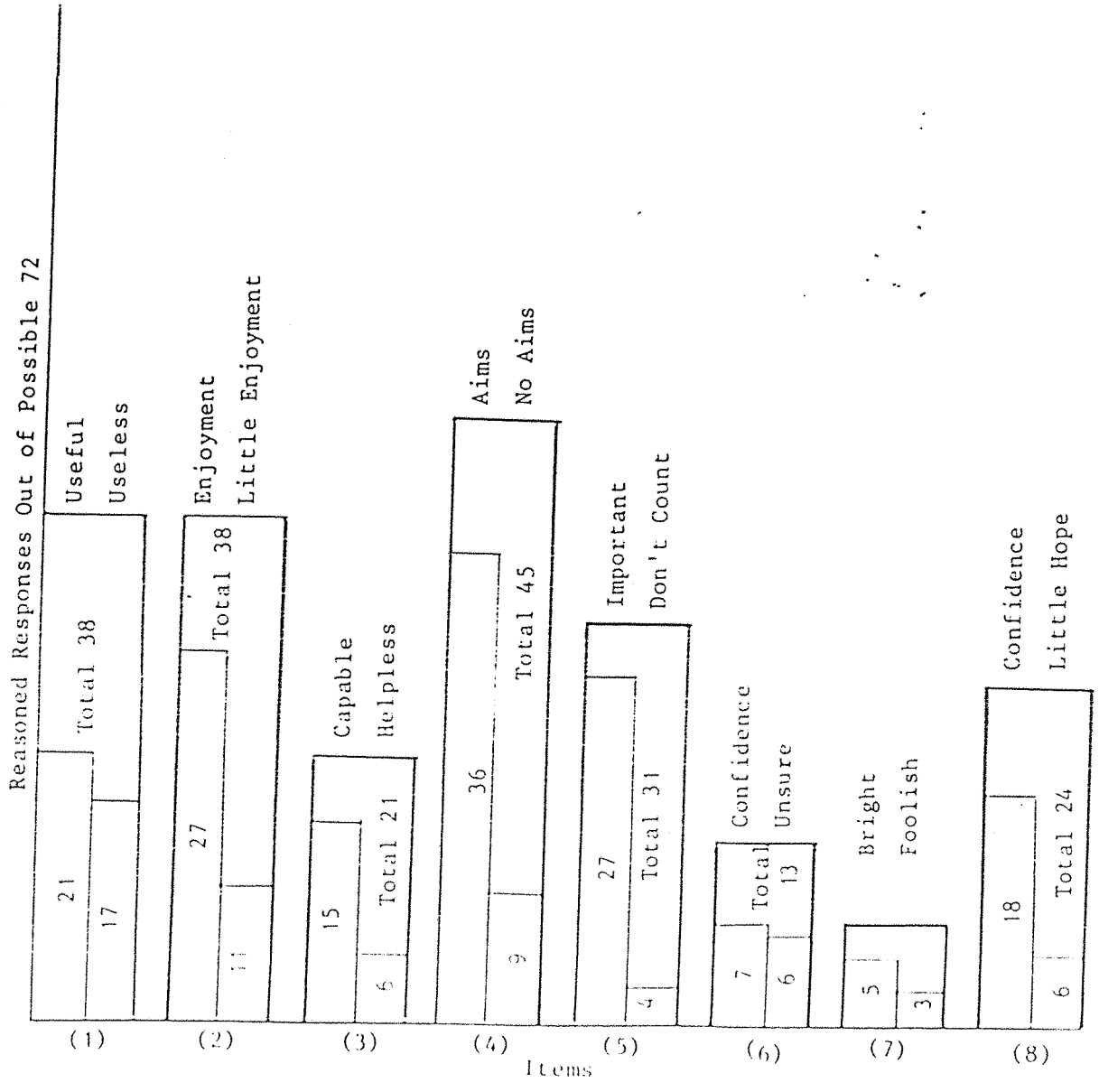
(iv) Her final repetition of 'not much hope' was very desolate. She had already given reasons why this might be the case in answers to other questions. She ignored the prompt. When respondents were depressed in the way this lady clearly was many of the questions seemed to emphasise their problems so that they were unable to offer another dimension by describing the positive or negative sources of their self-esteem.

This lady was of only of the average age for this study. The problem was compounded when interviewing the very elderly. One lady of ninety six at the same home, who had become blind, said she was useless because she was isolated from others because of her blindness. She was unable to enjoy herself because she could no longer see, Her only aim was for a clear ending, passing peacefully away without any trouble to anyone. She felt of no importance, everyone had died except for one nephew. She was now unsure of herself 'I am losing confidence, I have always been a decided and confident person, but I am getting on'. She looked to the future with confidence. "Yes I am looking forward to my death, life is really a trial'.

These problems, although real and by no means isolated, were not the most common. Two hundred and twenty eight positive replies and fifty five negative replies were accompanied by no comment what so ever. Various reasons may be found for this, lack of skill of the part of the interviewer, lack of privacy, problems of communication, problems of comprehension, or emotional blocks. No doubt all of these factors played some part in this pattern. The very limited conversational range recorded in the lounges when experienced from day to day must to some some extent have caused a loss of conversational skills.

Table 5.1 shows that the spread of reasoned responses was by no means evenly distributed throughout the eight bi-polar items.

Reasoned Responses to Bi-Polar showing the number of both negative and positive replies



The following points were of special interest:

(1) Item 4 concerned with future orientation elicited the greatest response (62.5%) and often highlighted differences between residents. One lady of ninety six at the Beeches requested that neither of the statements about the future should be underlined 'In a way when you are getting old you haven't got much future though you can still plan things and can still give advice'. She was a happy lady with two daughters whom she felt loved her. She said 'Life is still sweet. I've got a lot to be thankful for, I am quite sensible.' For less fortunate and less articulate residents these questions would be abruptly dismissed after a brief point of the finger to which ever statement seemed most to reflect their feelings.

(2) Item 8 also concerned itself with the future but did not share the same response rate (33.3%). This may have resulted from its position at the end of the scale when concentration was flagging or because it had been preceeded by two items for which there was little response (See Table 5.1). The word 'confidence' may have also been hard for many of the residents to respond to with any decisiveness. It did at least allow some imaginative leaps to take place. It drew a variety of responses including hopes of winning the pools, avoiding marriage, looking forward to Christmas and living to be ninety four.

(3) The statements which were responded to least were the statements about Confidence and Alertness (6 and 7 in the scale). Only six reasons were given for either negative or positive responses compared with twenty six responses to the aims of life statements. This would seem to indicate that these statements presented particular problems for the residents interviewed. A typical response to the choice was a resident at the Sycamores who requested that 'bright and alert' should be underlined. No reason was not given but the comment made was 'you tell them straight'.

(4) There was a marked preponderance of positive as opposed to negative responses (145 positive to 62 negative). Interestingly they were equally divided between the key worker and non key worker homes. Many explanations might be offered for this. It might be that the expression of negative feeling was not felt to be safe, this would support Dowd's suggestion that all that remained of residents power resource would be their humble capacity to comply. (Dowd 1975).

The main problems encountered which affected the reliability of the study were as follows:

(1) There was no effective way of taking account of those statements selected but with reservations. These do not fit comfortably in to the Coleman's scoring system. They are detailed in Chapter 6, although interpretation was difficult. This demonstrates the difficulty of using a polarised as opposed to a graded scoring system.

(2) Another problem was to decide what weight, if any, to give to those choices which offered no accompanying explanation. again figures for these have been given in Chapter 6. No further interpretation was possible other than to note the balance of positive rather than negative comments. These responses often appeared defensive equivalents of remarks of the 'doing nicely', 'mustn't grumble' type. Conveniently these categories were very evenly distributed between the key worker and non key worker homes so far as the positive elaborated responses are concerned, in the negative responses rather more came from non-key worker homes than from key worker; thirty five as opposed to twenty.

(3) Another difficulty encountered was that although asked for the reasons of their choice some answers included more than one source of self esteem. The way in which sources are categorised may be found in Appendix 5b(ii). Two examples may be found at

the Rowans. One resident said he had much enjoyment out of life because he was very well and also because he went out every weekend. Although the unifying factor was that he was well, the external circumstances were also important. Similarly another resident insisted they were capable of doing quite a lot. 'As I have a hiatus hernia I am helpless in a way, but I can do things with my hands, willpower makes me do things.' Again this mentioned two sources of esteem, heath and independence and inner self. In cases like this both sources were scored. There were eight instances of two sources being mentioned.

(4) Question Four relating to Aims in Life achieved a high response rate. The system of scoring however, did not always discriminate accurately between negative and positive responses. This is particularly well illustrated by the Rowans who had only two unelaborated responses to this question.

The responses were as follows:

Resident (1) positive

'That can be put both ways'. (Indicating positive response). 'Hoping life is going to improve a bit'.

Resident (2) - negative

'I'm stuck here with nothing much to do except sewing and knitting'.

Resident (3) - negative

'I've got to do as I'm told now'.

Resident (4) - positive

No reason.

Resident (5) - positive

'To live a bit longer, I enjoy being here they don't interfer with you'.

Resident (6) - negative

No reason.

Resident (7)- positive

'The clearest aim would be to get out of it (life)'.

Resident (8) - positive

'I intend to live until 94'.

Resident (9) - positive

'I don't want to live too long but as long as I can help myself I don't mind'.

Resident (10) - negative

'There's not much when you are in a chair all the time'.

Resident (11) - positive

'I don't want to live to be more than eighty'.

Resident (12) - positive

'I want to live as long as I can'.

From this it can be seen that Resident (1), (7) and (11), although giving positive responses and reason which can be coded using the categories provided, are not really very positive in tone. This seems to cast some doubt on the validity of this question at least as it scored in this study.

Question (8) seemed to be more capable of discriminating accurately. Among those giving reasonsed responses at the Sycamores, the scoring seemed to reflect more closely the tenor of the reasons.

Resident (1) - negative

'I shouldn't think there will be much more future'.

Resident (4) - no choice made

'I take each day as it comes and I don't have any plans'.

Resident (6) - positive

'I now look forward to the future with confidence, you can be happy here'.

Resident (7) - positive

'When I'm called I'll go - promoted to glory'. (Age 94).

Resident (8) - positive

'I don't feel miserable'.

Resident (10) - negative

'You can't say much else ... I've got a bad cold'.

Resident (11) - positive

'I take it as it comes, life is as you make it and I'm, reasonably contented'.

Resident (12) - negative

'Put that (little hope for the future) in capital letters. 'I've lost my wife, lost my children and the way I'm living, living in here ... helpless in here'.

Although more accurate the reasoned response rate to these statements were only seventeen as opposed to the twenty six for Question Four.

(5) In key worker homes in sixteen instances residents were unable to decide between questions, in the non key worker homes the number was twelve. These seemed to be a reflection of the individual rather than a persistent difficulty experienced with any particular question. Sometimes it was a sympton of confusion - Resident (4) at the Sycamores, made responses such as 'I couldn't give you a direct answer to either - I just take things as they come.' 'I can't answer that .....' 'I can't plan.' 'I take each day as it comes ....' She had an impaired long term and short term memory. Some times it was a genuine refusal to adopt such a polarised view of the statements.

In conclusion the reliability and validity of this measure had been tested both in Dutch and English studies although this study seemed to throw some doubt on the scores obtained from statement 4. There was no way of including the not inconsiderable number who could only agree to statements with reservations or, the smaller group of residents who found the Bi-polar statements did not accurately reflect their experience. Non-response was less of a problem and confined to a relatively small number of residents all of whom provided reasons. By far the greatest problem was that of obtaining reasoned responses. This seemed to have been achieved very successfully in other studies so was a particular source of disappointment in this study.

How far many of the difficulties encountered were a direct result of the measure being used by a researcher who was not a trained psychologist is impossible to determine. A repeat study might have clarified this issue, but, even had the resources been available, determining a suitable time lapse between testings would have been problematic. No formal figures were kept but it was noted, when in contact

with the homes some months after the completion of the study, that several of the participants from each home had already died. If one accepts the theory of terminal drop (Palmore & Cleveland 1976) this 'marked decline prior to death' must profoundly affect the assessment process.

5.4 An Evaluation of the Measurement of Engagement

In this measure, as in the other two, restrictions because of the size and scope of the study, presented problems. Ideally close matching should have occured between the key worker and non key worker homes since there is considerable evidence that environmental factors may be of crucial importance in determining resident behaviour. Three such factors must be mentioned before considering the measurement in more detail.

(1) The variation in the size of the lounge was bound to influence the interaction. The researchers into living spaces shows that size and layout are crucial in the formation of friendship (Lipman 1967 and 1968). Lipman and Slater (1975) defined a friendly sitting space as (i) being small enough for all the interactions to be conversationally comfortable, (ii) that it should be infrequently visited by staff, (iii) when interactions occur they should be supportive and accepting and (iv) lounges should be without many gibberish - prone residents, they favoured some segregation of the rational from the confused.

It was hard for the observer to categorise lounges in this way so that comments on size is all that has been attempted. (See Table 5.2 below:

Table 5.2

Lounges in which observations took place

Beeches		Acorns	
Day 1 a.m.	Large Lounge I	Day 1 a.m.	Smaller Lounge
Day 1 p.m.	Small Lounge	Day 1 p.m.	Large Lounge
Day 2 a.m.	Large Lounge II	Day 2 a.m.	Smaller Lounge
Day 2 p.m.	Large Lounge	Day 2 p.m.	Large Lounge

Cedars		Rowans	
Day 1 a.m.	T.V. Lounge	Day 1 a.m.	Medium Lounge I
Day 1 p.m.	Quiet Lounge	Day 1 p.m.	Small Lounge I
Day 2 a.m.	Quiet Lounge	Day 2 a.m.	Medium Lounge II
Day 2 p.m.	T.V. Lounge	Day 2 p.m.	Small Lounge I

Sycamore		Tamarisks	
Day 1 a.m.	Medium Lounge	Day 1 a.m.	Quiet Lounge
Day 1 p.m.	Medium Lounge	Day 1 p.m.	T.V. Lounge
Day 2 a.m.	Medium Lounge	Day 2 a.m.	Large Lounge
Day 2 p.m.	Small Lounge	Day 2 p.m.	'Confused' Lounge

(2) The degree of privacy within the homes varied greatly both in the allocation of private, bedroom, space and in their distribution of semi-public communal areas. This was a particular problem when seeking to make comparisons. Schwartz & Proppe (1969 & 1970) contend that when the physical space provided does not allow for privacy residents create their own by social withdrawal. This was corroborated by Ittleston, Proschansky & Rivlin 1970, specifically in relation to bedroom space. Bedrooms were more likely to be used as sitting rooms the fewer the number of occupants. The Tamarisks with sixty residents and only twelve single bedrooms could offer far less opportunity for privacy than the Beeches with fifty five residents and only five shared bedrooms. It might be expected therefore that the level of interaction would be higher at the Beeches whether or not a key worker system was in operation. Superficially, there seemed to be a closer comparison to be made with the Sycamores which had only seven single rooms to be shared among thirty five residents, the same proportion, 80% sharing.

(3) The disparity between the size of the homes would make direct comparisons difficult, for example, comparisons between the Tamarisks and Sycamores. Curry & Ratcliff (1973) found large homes were more likely to isolate residents from the community and from interaction with other residents and staff.

All these points raised very real questions about the validity of this type of observation as a means of determining whether or not a key worker system improved the quality of life as opposed to some other crucial differences between the establishments studies.

These difficulties all indicate the need for continuous evaluation in homes for the elderly. A before and after study in a home introducing a key worker scheme would have overcome many of the problems outlined although interpreting the results and generalising from them would still be difficult in such a complex and fluctuating environment.

The actual scoring of the observation was not as straight forward as had been hoped. The pre-study training sessions had revealed no major problems. When implemented on a wider scale certain problems with the coding, outlined in Appendix (5c), emerged. Scoring often involved making choices and also in coding behaviour in a misleading way. These activities resulted in a lack of precision and an ideosyncracy in the scoring which affected the reliability of the study in the seven following ways:

(a) The observation sheet included both a written description and a column for scoring the type of engagement (See Appendix 5(E) and while these allowed the observer to show two activities were taking place similtaneously, only one of them could be scored. An example would be if someone was driking a cup of coffee and watching television. This could be scored as SHI (drinking coffee) and L (watching television). To score both would create statistical chaos.

(b) The distinctions between Self Help Independent (SHI) and Self Help Dependent (SHD) were difficult to determine. The observer correctly scored SHD when residents were given coffee by staff and SHI for a resident who was sitting drinking it. It was a mere chance which of these activities were taking place at the time the observation was made.

(c) The seemingly clear cut categories invited the observer not only to record detailed behaviour but also called for an interpretation of the behaviour. The Beeches offered an example of this problem. Residents (1) on the afternoon of the second day was scored as engaged in Leisure (L) and other activities (O) throughout the afternoon. In fact she was winding wool around her fingers, playing with her ring and the buttons on her cardigan and pleating material. A similar problem was found in the Cedars recordings. A resident spent much of a morning trying to send other residents to lunch, she seemed to think she was at home and wanted her visitors to

leave. In the first case it was only in retrospect that it was questioned whether the residents behaviour at the Beeches should have been scored as deviant she had seemed quite contented and occupied although not meaningfully so. In the second case the resident was scored as behaving deviantly because the content of what she was saying was irrational despite the fact it was conducted in a socially acceptable fashion and certainly gave the outward appearance of social interaction. If the observer had been placed where she could not hear the full conversation or had been scoring moving from room to room as McFadyen's observers presumably had, she too would have been scored as being at Leisure.

(d) The non-engaged categories were a source of some concern since the observer found it very difficult to distinguish whether residents were asleep or doing nothing. It was also hard to decide when a resident was watching or doing nothing? (W & W? DN). It was felt a symbol DN?A (Doing Nothing? Asleep) would have been more helpful.

(e) The distinction between passive and active behaviour was questioned by the observer. In the Beeches, where 33.1% of the leisure activities were knitting the observer felt that staff encouraged this to the extent that residents would have to exert themselves to avoid this 'leisure' activity. The scoring reflected a positive involvement that may or may not have existed.

(f) Another problem encountered in the engaged category of behaviour was in the distinctions between Self Help Independent, Leisure and Other. Smoking was counted as leisure but drinking squash, eating apples and sweets were scored as others. Drinking coffee was described as Self Help Independent. These activities were scored in a uniform way throughout but they are not espcially rational distinctions between what are all pleasant time-passing activites.

(g) Speaking, was included in the leisure category and this was also a dubious categorisation in some instances. Although most of the interactions were between residents and these were generally conversational, the second largest group were between residents and staff. These interactions were very largely a response to an environmental cue such as 'thank you' when passed a cup of coffee. The Sycamores had the highest number of residential staff interactions. Of the sixteen recorded nine appear to have been conversational in tone while at the Cedars the number if only four. Fairhurst observing staff-resident talk in a Geriatric Hospital had described four main types of interaction: time out talk (conversational); ceremonial talk, used to punctuate tasks; superlative talk, full of unwarranted praise and encouragement and persuasive talk, based on the concept of the staff as guardian. He found that ceremonial talk, used for the smooth execution of tasks was the most commonly observed. This was found to be true generally in this study. To describe this type of interaction as leisure seemed inaccurate, however, revision of the coding as all these problems emerged proved too difficult. If another study were undertaken these categories would need to be clarified.

In conclusion two major problems were encountered:

(1) the scoring which had appeared clear cut during the training sessions in practice proved less than perfect.

(2) The very different settings in which the observations took place also made direct comparisons between homes problematic.

5.5 Conclusion

This chapter has critically examined the use made of the three measures in this study of six homes of the elderly. It has alerted the reader to problems of interpreting the scores which have been obtained. The restrictions of sample size discussed in Chapter four, when added to the limitations of study design described in this chapter, present a rather depressing picture.

The adaptation of the assessment scales for use by a single worker was successful in so far as they were all completed in the time allotted and yielded useful data. The major problems encountered which might be directly related to the adaptation were as follows:

(1) The problem of scoring the three responses to the Analysis of Daily Practice was unresolved.

(2) The measure of self esteem yielded a disappointing number of reasoned responses which might reflect the inexperience of the interviewer.

(3) The effect of reducing the number of observations in the Measurement of Engaged Behaviour is not known. In retrospect McFadyen's method of testing out the effect of reduced observations should have been repeated in a pilot study before proceeding further.

Booth (1985) has already provided a solution for the first problem by providing a new scale and both the remaining difficulties could be avoided in future studies by the more generous allocation of time to the pilot phase of the research.

Appendix 5(a)

Aims: to judge particular organisation practices or features according to their tendency to facilitate or limit resident freedom, to facilitate administrative efficiency at the expense of resident needs, to regiment residents and subject them to block treatment, to depersonalise residents by eroding individual differences to limiting decision-making powers, to maintain social distance between resident and staff.

Coding: within each category, the extent to which that practice is institution-orientated or resident-orientated is assessed on the basis of observations and interviews with resident staff. Each question is to be answered according to what happens generally in the home. For each question, Yes = 0 and No = 1. Total 78 questions.

(A) RESIDENT CARE (21 questions)

Yes / No

(1) Do residents have a choice of when they are bathed?

(2) Do residents have a choice of who bathes them?

(3) Can able residents bathe without permission?

(4) Can residents bathe in private (apart from a necessary staff helper).

(1) Are residents toileted according to their individual needs? (Routine toileting at set times, code 1). **Yes / No**

(2) Are residents toileted in private (apart from staff helper)?

(3) Are males/females toileted in separate facilities?

(4) Is each toileted resident attended throughout the procedures by only one staff member? (Conveyor belt system, code 1).

(1) Is there a choice of meals?

(2) Do residents receive food as soon as they sit down? (If residents have to wait until everyone is seated), code 1).

(3) Can residents eat with whom they wish?

(4) Do staff eat regularly with the residents?

(5) Are there facilities for the disabled to feed themselves?

(1) Can residents choose when to go to bed?

(2) Do staff attend promptly when resident needs helping retiring?

(3) Is there extensive use of sedation? (Yes = 1, No = 0). **Yes / No**

(1) Can able residents choose when to get up?

(2) Can disabled residents choose when to get up?

(3) Are residents brought tea if they wish it?

(4) Do staff routinely dress many residents? (Yes = 1, No = 0).

(5) Is breakfast available for residents as soon as they get up?

(B) RESIDENT AUTONOMY (21 questions)

(1) Do residents choose what to wear each day?

(2) Do residents choose the new clothes allowed them by the Local Authority?

(3) Are facilities provided for residents to buy/order additional clothes if they wish?

(4) Are clothes generally kept in a good state of repair?

(1) Can residents choose a private or shared room? **Yes / No**

(2) Can residents visit their own room at will?

(3) Is there reasonable privacy for residents in their own room? (If observation windows/staff don't known, code 1).

(4) Have the majority of residents personalised their own room? (Pictures and photographs don't count; evidence must consist of furniture, rug/bed or many smaller personal items together).

(1) Do residents collect their own pensions?

(2) Can all residents spend their money as they wish? (If money controlled by matron, or if restrictions are placed on certain residents, code 1).

(3) Do staff help the disabled/mentally inform residents to buy what they wish?

(1) Are ambulent, lucid allowed to go out of Home without persmission or without informing staff?

(2) Can residents stay out as long as they wish? (If curfew, code 1).

(3) Do staff often accompany disabled/mentally infirm?

(4) Are relatives freely allowed to take out residents? Yes / No

(1) Do residents have access to tea making facilities?

(2) Do residents have control over communal TV/radio?

(3) Do residents have access to telephone?

(1) Are all communal areas available to all residents? (If segregated, code 1).

(2) Are other areas (e.g. kitchen) open to residents?

(3) Can residents choose where to sit in lounges?

(C) RESIDENT-STAFF INTERACTIONS (9 questions)

(1) Does matron/deputy regularly chat to residents?

(2) Do residents discuss personal matters with staff?

(3) Do staff regularly commmunicated with residents for social purposes? (If communication mainly instructive/ information, code 1).

(1) Are residents generally addressed only by their Christian names? (Yes = 1, No = 0). **Yes / No**

(2) Is matron known to most residents by her name? (If title only, code 1).

(3) Do most able residents know the names of some staff?

(1) Do staff among themselves display accepting respectful attitudes to residents? (If critical, hostile, or distant, code 1).

(2) Do staff avoid generalised terms for categories of residents (e.g. the 'babies, the 'incontinents')?

(3) Do staff avoid demonstrating infantilisation of residents in their attitudes to them?

(D) ORGANISATIONAL PRACTICES AND FEATURES (27 questions)

(1) Are pre-admission visits by prospective residents a general occurrence?

(2) Does matron/staff generally visit prospective residents at home?

(3) Are new residents introduced to staff and other residents?

(1) Does a residents' committee exist? **Yes / No**

(2) Do staff and residents meet to discuss issues?

(3) Are issues brought for decision to residents by matron?

(1) Are there regular staff meetings?

(2) Are care staff involved in admission, case conferences, etc?

(3) Do staff control their daily work routines?

(1) Does a formalised complaints procedures exist?

(2) Does an informal opportunity for complaining exist?

(3) Can residents complain to SSD management without acting through matron?

(1) Can residents freely retain their own GP?

(2) Do residents see VMD by appointment or on request? (If en masse or with group regimentation, code 1).

(3) Is there evidence that minor medical problems are properly treated? (e.g. if ill-fitting dentures, inadequate spectacles, hearing aids, etc., code 1). **Yes / No**

(1) Are the furnishings pleasant and varied? (If furnishings uniform, regimented, code 1).

(2) Are facilities adequate for disabled residents? (e.g. adequate hand-rails, room for wheelchairs, colour coded doors, lift, etc.)

(3) Are pleasant gardens surrounding the home?

(1) Are visiting time unrestricted?

(2) Is the number of visitors unlimited?

(3) Are there facilities for residents to see visitors privately?

(1) Are regular outing/functions a feature of the Home (at least once a month)?

(2) Do residents organise any functions themselves?

(3) Are residents consulted before outings/functions are decided upon?

(1) Do residents undertake tasks in the home (e.g. cleaning, own small laundry)? **Yes / No**

(2) Do many residents undertake individual activities?

(3) Are facilities/materials/teaching regularly available to residents (e.g. library service, visiting teachers, etc)?

Appendix 5(b)(i)

Eight Bi-Polar Self-Esteem Items used in England (Everett & Coleman 1982)

(1) I feel useful - I feel useless.

(2) I get little enjoyment out of life - I get much enjoyment our of life.

(3) I am still capable of doing quite a lot - I am quite helpless.

(4) I have no aims left in my life - I have a clear aim in my life.

(5) I am of importance to others - I don't count any more.

(6) I am rather unsure of myself - I have confidence in myself.

(7) I am as bright and alert as ever - I have become rather foolish.

(8) I have little hope for the future - I look to the future with confidence.

Appendix 5(b)(ii)

Sources of Self Esteem : Categories into which valid examples of self esteem were coded

(a) FAMILY : reference to family relationships

Any reference explicit or implicit, to family members, related by blood or marriage, whether functional relationships were referred to or not, was included in this category.

(b) OTHERS : reference to other interpersonal relationships

This category included any reference to others which could not be construed as being solely a reference to family members.

(c) HEALTH : reference to lack of infirmity

This category included reference to good health (including reference to remaining alive) and to 'essential' household and bodily activities (shopping, cooking, cleaning, washing, etc) : activities which, if the individual were not able to do himself, would have to be done for him by someone else.

(d) INTERESTS : reference to hobbies, interests, activities

Reference to all forms of activities and occupations were included in this category (knitting, gardening, reading, travelling, etc). except for the 'essential' activities of daily living included under the previous category.

(e) WORK : reference to work role or specific role in organisation

In addition to paid employment, this category included reference to voluntary work (e.g. for old people's club), activities on committees (e.g. parish committees) and tasks or roles fulfilled in particular organisations.

(f) INNER SELF : reference to inner characteristics

This category included reference to characteristics related to the individual's personality, and also reference to the individual's values, principles and attitudes to life (religious and non religious).

(g) EXTERNAL Circumstances : reference to environmental and societal circumstances

This category included reference to external circumstances in the individual's life, whether specific to the individual as the physical environment in which he lived, or of a more general nature, for example reference to societal conditions.

Appendix 5(C)

Definition of Engagement Categories

SHI = Self-Help Independent:	Any self-care activity carried out without staff assistance.
L = Leisure:	Any non-deviant active behaviour judged by O to be for the person's amusement or occupation. Watching television included here.
Wk = Walking:	Walking.
O = Other non-deviant behaviour:	Active behaviours not falling to the above categories.
SHD = Self-Help dependent:	Any self-care activity carried out with staff assistance.
W = Watching:	Showing 'passive' interest in some identifiable event in the physical or social environment.
DB = Deviant Behaviour:	Behaviour judged to show delusional hallucinatory, or unwarranted aggressive quality, e.g. physical aggression, talking to self, undressing inappropriately.
A = Asleep:	Asleep.
DN = Doing Nothing:	Showing no involvement or interest in the environment.
DN?W:	Observer unable to decide between categories DN and W.

Appendix 5(D)

Codes for Verbal Interactions

R < -------- > R:	Two-way interaction between residents.
R < -------- > S:	Two-way interaction between resident and staff.
R < -------- > V:	Two-way interaction between resident and visitor.
R -------- > R) R < -------- R)	One-way interaction between residents.
R -------- > S) S < -------- R)	One-way interaction between resident and staff.
R -------- > V) V < -------- R)	One-way interaction between resident and Visitor.

Chapter Six

Evaluation II

6.1 Introduction

This chapter will focus upon the second aim of this study, that of determining whether the revised measurements were capable of discriminating between key worker and non key worker homes.

All three measurements presented the researcher with problems related to scoring which were explored in the previous chapter and the results will be interpreted bearing these in mind.

6.2 The Analysis of Daily Practices

The scores of each home will be briefly examined before discussing whether or not any meaningful comparisons may be made between the key worker and non key worker homes. These are summarised in Table 6.2(i). It must be emphasised at this point that a low score indicates a positive rating and a high score a negative rating. The detailed scoring for each home will be given separately.

Table 6.2(i)

Total Scores for Each Home (out of possible 78)

(N.B. Low Score = positive practices, High Score = negative practices).

Key Worker Homes	Officer in Charge	Staff (1)	Staff (2)
Beeches	8	20	12
Cedars	19	17	9
Sycamores	18	20	27

Non Key Worker Homes	Officer in Charge	Staff (1)	Staff (2)
Acorns	26	25	24
Rowans	8	23	25
Tamarisk	26	26	32

Table 6.2(ii)

Beeches - Analysis of Daily Practices - Detailed Score

	Officer in Charge	Staff (1)	Staff (2)
A. Resident Care (21 Questions)	3	8	4
B. Resident Autonomy (21 Questions)	1	3	3
C. Resident/Staff Interactions (9 Questions)	0	2	1
D. Organisation Practices and Features (27 Questions)	8	20	12
Total (out of 78)	8	20	12

(i) The Beeches. Most noticeable in this home's score is the difference between the officer in charge score and that of her two staff members. This is largely explained by her method of completion. She alone ticked the 'Yes' box to the question 'Do residents have a choice who bathes them?' but she added 'Usually one of their key workers, they are able to change if they wish', an operation which would require considerable courage on the part of the resident concerned. Rather amusingly she alone thought she was known to residents by her name - her staff both said she was called Matron. The

question 'Are the ambulent and lucid allowed to go out of the Home without permission or without informing staff?' illustrated the problem of interpretation. The officer in charge ticked the Yes response but added 'If going out we like to be notified because of the fire risks'. One of her staff members asked the 'No' box to be ticked adding 'they always tell us because of fire'. Clearly the practice of informing staff is used but it is not seen as a form of control but as a safety measure. To some extent the numerical scoring is a positive handicap in that it clouds the issues rather than clarifying them. In the original study this problem would not have occurred because of the very different method of completion.

Table 6.2(iii)

Cedars - Analysis of Daily Practices - Detailed Score

	Officer in Charge	Staff (1)	Staff (2)
A. Resident Care (21 Questions)	7	8	5
B. Resident Autonomy (21 Questions)	2	5	4
C. Resident/Staff Interactions (9 Questions)	2	1	0
D. Organisation Practices and Features (27 Questions)	8	3	0
Total (Out of 78)	19	17	9

(ii) The Cedars. At this home the situation was reversed, the officer in charge submitting the most critical score. He felt that staff did not avoid generalised terms for categories of residents or avoid infantilisation of residents. He noted a lack of a residents committee, said staff and residents did not meet to discuss issues and that issues were not taken to the residents for discussion. There was no formal complaint system. Visiting was not unrestricted, residents didn't organise functions or undertake tasks in the home. His score differed

most markedly in the Organisational feastures and practices section showing considerable criticism of his own management practices. His scores in the other three sections were much in line with the other two staff.

Table 6.2(iv)

The Sycamores - Analysis of Daily Practices - Detailed Score

	Officer in Charge	Staff (1)	Staff (2)
A. Resident Care (21 Questions)	8	10	10
B. Resident Autonomy (21 Questions)	5	5	7
C. Resident/Staff Interactions (9 Questions)	1	1	2
D. Organisation Practices and Features (27 Questions)	4	4	8
Total (out of 78)	18	20	27

(iii) The Sycamores. One of the care assistants at the Sycamores answered in a strongly negative way, separating her from her nearest staff score by seven points. Again four of these are accounted for in Section D, (Organistional Practices and Features). She felt staff were not consulted closely by management. There were no regular staff meetings, no involvement in admission or case conferences and no control

given over daily work routines. There was support for the last comment but not for the first two. This score is deceptive because in the interview she was very excited about the way the home was changing, she felt, for the better. She mentioned in particular that facilities for residents to see visitors privately were about to be improved, that regular outings and functions had started and residents were beginning to undertake tasks in the home. They were all scored negatively because this process was still at an early stage. She was, in fact, an example of enlightened attitudes resulting in very negative scoring.

Table 6.2(v)

The Acorns - Analysis of Daily Practices - Detailed Score

	Officer in Charge	Staff (1)	Staff (2)
A. Resident Care (21 Questions)	13	14	10
B. Resident Autonomy (21 Questions)	4	6	6
C. Resident/Staff Interactions (9 Questions)	1	1	1
D. Organisation Practices and Features (27 Questions)	8	4	7
Total (out of 78)	26	25	24

(iv) The Acorns. This home returned very similar scores from all members of staff. It scored most negatively in Section A dealing with resident care. There was little choice over batheing, almost none over meals and hardly any over getting up. It showed markedly less freedom within the home for residents to move around at will.

These figures are open to a number of interpretations. They might be seen as indicating:

(a) A well informed, united, caring team, reflecting similar values.

(b) A uniformly institutionalised group of carers who did not question the caring procedures.

(c) A particularly realistic set of responses that described precisely what happened, as opposed to what others might see as desirable.

The adapted method of scoring did not allow for exploration of these possibilities.

Table 6.2(vi)

The Rowans - Analysis of Daily Practices - Detailed Scores

	Officer in Charge	Staff (1)	Staff (2)
A. Resident Care (21 Questions)	4	9	10
B. Resident Autonomy (21 Questions)	3	5	8
C. Resident/Staff Interactions (9 Questions)	0	1	1
D. Organisation Practices and Features (27 Questions)	1	8	6
Total (out of 78)	8	23	25

(v) The Rowans. Like the Beeches the officer in charge's score was out of line with the staff members. He scored 8 while both other members of staff score was 23 and 25. This score showed the greatest deviation in Section D. Both his members of staff thought that a residents committee existed but he said they had choosen not to have one. The most pronounced differences in the final section were those dealing with functions, outings and activities within the home. The care assistant scored these all negatively, the domestic scored four out of six negatively while the officer in charge scored them positively.

Table 6.2(vii)

The Tamarisks - Analysis of Daily Practices - Detailed Scores

	Officer in Charge	Staff (1)	Staff (2)
A. Resident Care (21 Questions)	7	9	10
B. Resident Autonomy (21 Questions)	7	5	9
C. Resident/Staff Interactions (9 Questions)	1	1	0
D. Organisation Practices and Features (27 Questions)	11	11	13
Total (out of 78)	26	26	32

(vi) The Tamarisks. Like the Sycamores one staff member was consistently more critical in every section other than Section C. Her final score was separated by six points from the officer in charge and the other care assistant, who both scored 26. To some extent this high score reflected the way in which she responded to questions. She scored 'No' to the question 'Do residents have a choice of when they are bathed?' but added 'They do have the opportunity to refuse a bath or postpone it'. She felt there was no reasonable privacy for residents in their room, staff only knocking if they had their family with them.

The most noticeable feature of this assistant's response were the very distinct differences between the care practices employed in relation to the confused and non-confused. These differences were noted in Sections dealing with toilets, feeding, going to bed, clothing, money and shopping. She also made two significant mentions of resident control. She claimed one resident controlled the television and that residents were in control of the seating and movement was not acceptable to them within the lounges.

Interpretations of the Disagreements between Staff Members' Scores

The number of disagreements between the members of staff within a home was based on their responses to each individual item of the Analysis not on their final overall score. The Acorns, the home with least variation in the final score in fact had the same number of disagreements as the Tamarisks and more than the Beeches. In fact the number of disagreements showed remarkedly little variations. (See Table 6.2(viii) below).

Table 6.2(viii)

Number of disagreements scored in each home

Home		Number
Beeches	(Key Worker)	22
Acorns	(Non Key Worker)	26
Tamarisks	(Non Key Worker)	26
Rowans	(Non Key Worker)	27
Cedars	(Key Worker)	28
Sycamores	(Key Worker)	31

What is noticeable is the relatively high number of disagreements scored at the Sycamores. This was a home which had relatively recently changed their officer in charge. Staff were clearly stimulated by the change but also, at times, uncertain of how to respond to questions in a situation which was still relatively fluid.

In looking at the differences within the six homes these seemed to spring from three main sources:

(1) The different interpretations of the items made by different staff members. These differences were often more apparent than real.

(2) The different levels of critical examination to which the home was subjected by different members of staff. These differences were more real and have been illustrated by examples of both officers in charge and care assistants.

(3) The level of sophistication of the respondents. The very low scores of officers in charge could be seen to demonstrate their awareness of the 'right' answer even if, at times, their qualifications of the response almost negated their reply.

Comparisons between the Key Worker and Non Key Worker Homes

So far it has been demonstrated that there was considerable disagreement between members of staff within a home as to how they would rate their Daily Practices. This must seriously call into doubt the validity of using this adaptation of the socring system and thus make any true comparison between the homes solely on the basis of these scores impossible.

The actual scores obtained however are of interest, particularly those of the officers in charge, since they were ultimately responsible for the care practices within the home, although therefore, for this reason often most prone to bias. Their scores, in rank order were as follows:

Table 6.2(ix) Rank Order of the Officers in Charge Scores:

Home		Number
Beeches	(Key Worker)	8
Rowans	(Non Key Worker)	8
Sycamores	(Key Worker)	18
Cedars	(Key Worker)	19
Acorns	(Non Key Worker)	26
Tamarisks	(Non Key Worker)	26

Tim Booth (1985) has made the scores of the officers in charge the basis of his measure of regimes because of their crucial role within the establishment. Bland & Bland (1983) also stress the importance of the officer in charge and cite them as one of the reasons why it is so hard to match the groups of residents being compared in a research project. 'Often officers in charge do exercise influence over what they will or will not accept and this affects both discharges and admissions'.

Certainly the officer in charge score to some extent reflected the subjective assessment of the researcher, whose sources of bias have already been made explicit. As may be seen from the scores given above there was no clear distinction between key worker and non key worker homes; the Beeches (Key Worker) and the Rowans (Non Key Worker) both sharing the positive score of 8.

These two homes shared certain physical similarities. They were of a similar age and size, both pleasantly set in attractive gardens with a reasonably good outlook. They were both in a small pocket of social welfare buildings in what was, otherwise, a residential area. They each had a large number of lounges and less formal sitting areas and few shared bedrooms compared to others in the study.

Both officers in charge had some things in common. Both had completed the Certificate in Social Service and had other members of staff undergoing the same training so that care policy was a live issue and under constant review. There was no key worker system at the Rowans within the definition of this study, because the officer in charge, having considered this method of allocating care had rejected it as impracticable because of the rota system. What did operate was a bath rota list which was carefully compiled with special reference to the stated and observed preferences of both residents and staff. This linking of intimate, physical care to special attractions between the carer and the resident was common to most homes but was accorded more official recognition at the Rowans. It did not entail the same degree of delegation of care which the key worker system demanded because its special function was seen as the identification of special need and did not extend into recruiting resources to meet this need.

The reasonably good physical resources as well as the professional training of the officers in charge would have been, in part, responsible for the positive score obtained in this Analysis. It suggests that the professional orientation of the officer in charge may greatly influence the type of care on offer. This suggestion may be illustrated by contrasting the most positive key worker home (the Beeches - Score 8), with one of the two most negative homes (the Tamarisks - Score 26).

Differences were marked, not only in the physical environments but also in the priorities of care presented by the officers in charge. The officer in charge at the Tamarisks saw good physical care as a top priority in a home in which she felt she had a very high proportion of very physically and mentally frail residents. She placed great importance on nursing as opposed to more socially orientated skills. She felt she offered her residents a secure refuge in which they would most probably remain until death. It is impossible to know whether her priorities were a response to the resident population or whether, as Bland & Bland suggests, the population was a response to her concept of care.

This view of care was very different from that of the Officer in charge at the Beeches, with whom she shared a nursing background. At the Beeches Residential Care was considered only one option open to the elderly residents. This officer saw one of her most important tasks as the assessment of residents so that they might arrive at a decision as to which was the best package of care to meet their particular needs. This might be located either in or out of the residential situation.

The two larger homes shared the most negative score of 26 these were the Tamarisks and the Acorns. These were separated by 7 points from the Cedars and 8 points from the Sycamores. The Cedars and the Sycamores were separated by 11 and 10 points from the two most positive homes. These gaps were rather different from the perceptions of the researcher. Although the Tamarisks and the Acorns were rated by the researcher as having fewer resident orientated practices, the gap between the two middle ranking homes and those at the top seemed unrealistically wide. Some reasons for this have already been discussed. Both these middle ranking homes were enthusiastically developing new care policies and both felt lively and interesting places.

This additional information, largely gathered during informal conversations with the officers in charge has been quoted because it seems to some extent to support the scores obtained from the officers in charge and therefore support the validity of the analysis. Certainly it seemed as if those homes which were actively involved in developing care strategies for individual residents, even if they were not based on a key worker system offering care, scored more positively than those which were determined by the degree of the physical and mental disability in the residential population.

There is a danger of over interpreting these results and of assuming that the more positively scored homes were therefore 'better' for every resident. What it does mean however, is that those Heads of Homes whose care strategies were designed to accomodate individual needs developed daily practices which were markedly different from those which did not. This measure was not capable of distinguishing between key worker homes and the Rowans who also had a personally-orientated care strategy, at least not on the basis of the officer in charges' responses.

The staff scores of the home are also of interest. These are now totalled to produce a joint score for each home and read as follows:

Table 6.2(x) Rank Order of Other Staff Scores:

Home		Number
Cedars	(Key Worker)	26
Beeches	(Key Worker)	32
Sycamores	(Key Worker)	47
Rowans	(Non Key Worker)	48
Acorns	(Non Key Worker)	49
Tamarisks	(Non Key Worker)	58

Using these scores the key worker homes achieved the most positive scores although the differences was least pronounced at the Sycamores where the system was newly established and the officer in charge relatively new.

This positive scoring in the key worker homes may indicate that care assistants within these homes are encouraged to take a more individually orientated view of residents and this is reflected in their responses. Certainly the key worker system did demand much greater knowledge and discussion of particular residents.

The very high negative score obtained by the Tamarisks is partly explained by the policy of segregation within the home. Care strategies were markedly more regimented for those who were classified as confused than those who were not and the Analysis was not written to cope with a two-tier system of care.

It would be wrong, either in the case of the officers in charge or the other staff, to forget all the difficulties in scoring outlined in the previous chapter. This explains why one of the main sources of interest in this analysis proved to be in the written and verbal comments which were added to supplement the tick. The schedule had been designed to be used as a discussion document around which to arrive at consensus, so that differing interpretations of questions could always be clarified. As in this study the researcher scored or the officer in charge scored without consulting other staff members this clarification was lacking.

It was of interest that Evans et al noted that in their study there was little, if any, disagreement between the observers. Staff members in this study did not even agree in their answers to such seemingly objective questions as whether or not a resident's committee existed or whether there was a regular pattern of staff meetings.

As the staff were responsible for implementing many of the care activities described in the Analysis the residents must have experienced some inconsistencies. This must raise the question as to how far one can make broad generalisation about the quality of care within the home or whether in the end each residents' experience is unique. It is for this reason the other individually orientated measures have been included in this study. It also highlights both a strength and weakness in the use of an outside observer. They are able to form a clear broad outline but are often unaware of smaller details and inconsistencies which may importantly influence the ethos of residential life.

Conclusion

Four concluding points only remain to be made:

(1) The use of the measure was valuable as a learning experience in which the problems associated with this type of measurement were explored.

(2) The adaptation of the Analysis to its new usage was inadequate and claims for the results must be therefore be tentative.

(3) The figures broadly suggest that the two largest homes would seem to be the most institutionally orientated.

(4) The key worker regimes were at least as individually orientated as the best of the non key worker homes.

The method adopted did avoid the danger that the personal bias of the researcher would influence these results; in this way only can it claim superiority to the parent study.

6.3 Results of the Measure of Self-Esteem

This section will consider the findings for each home and then a comparison will be made between the results of the key worker and the non key worker homes.

Two areas will be focused upon for particular attention. These will be:

(1) The distribution of responses, these will be divided between the following categories:

(a) positive responses without a stated source;
(b) positive responses with a stated source;
(c) qualified positive responses (i.e. those where a positive pole was chosen but then a reservation was made);
(d) negative responses without a stated source;
(e) negative responses with a stated source;
(f) qualified negative responses (i.e. as for (c) but referring to a negative pole);
(g) explained non-response (i.e. no choice was made but the reason for doing so was explained).

(2) An analysis of the sources of self esteem, these will follow the Coleman groupings which are:

(a) Family contacts;
(b) Other relationships;
(c) Health/Independence;
(d) Interests and Hobbies;
(e) Work Role;
(f) Inner Self;
(g) External Circumstances.

Key Worker Home Results

The distribution of responses for the key worker homes is summarised in Table 6.3(i) Distribution of Responses in Key Worker Homes:

Table 6.3(i)

Distribution of Responses in Key Worker Homes

	Beeches	Cedars	Sycamores	Totals	%
Positive Response without Source	38	40	37	115	40
Positive Response with Source	39	26	27	92	32
Negative Response without Source	4	4	5	13	5
Negative Response with Source	4	7	11	22	8
Qualified Negative Response	2	2	3	7	2
Explained Non-Response	1	5	6	12	4
Totals	96	96	96	288	100

(a) The Beeches

(i) Distribution of Responses (See Table 6.3(i))

Just over 80% of the responses in this home were positive without any qualification, of these, just over half were positive responses with a source provided, this was the highest score in this category for any home.

There were few unqualified negative responses, just over 10% of the total responses. Approximately 44% of the poles were selected without a reason being given. The problem this presents for interpretation has already been noted.

Two people in this study made explicit problems which would affect completion. One said 'I have become rather forgetful' the other 'I don't always hear right'.

(ii) Number of References to Particular Sources of Self-Esteem

The table below illustrates the distribution of references made to particular sources which will than be discussed in detail.

	Family Contacts	Other Relationships	Health/Independence	Interests/Hobbies	Work Role	Inner Self	External Circumstances	Totals
Positive Responses	4	3	7	4	7	10	4	39
Qualified Positive Responses	1	0	2	0	0	1	0	4
Negative Responses	0	0	5	0	0	0	3	8
Qualified Negative Responses	1	0	1	0	0	0	0	2
Totals	6	3	15	4	7	11	7	53

Table 6.3(ii) Number of References to Particular Sources of Self Esteem at the Beeches (Key Worker Home)

These will be considered in decending order or frequency.

(1) Health and Independence

This was a major concern for the resident interviewed. The balance of comment was positive but only just. It was used twice to qualify a positive item as well as the reason for selecting a negative pole five times.

(2) Inner Self

Mentioned in eleven out of fifty five responses, this was a strongly positive response. It was used only once negatively to qualify the choice of a negative pole.

(3) Work Role

This was always commented on in connection with a positive response. It always referred to useful tasks undertaken within the home.

(4) External Circumstances

This was mentioned with equal frequency, however, unlike Work Role, it was used in three out of seven occasions to support the choice of a negative pole. The positive remarks referred to the good quality of care they felt they received, the negative to the difficulties associated with the residential experience. One said 'You can't say you enjoy it ....'. Another resident referred to the deterioration of her financial situation.

(5) Family

Out of the six times families were mentioned, they were only once used negatively to qualify a positive response.

(6) Interests & Hobbies

All references to this were positive and included reference to knitting, handicrafts and Church, it was once used to express a general interest in events.

(7) Other relationships

These three references were made about resident/staff relationships. On two occasions they were to explain the choice of 'I am of importance to others'. One said 'Matron and the girls, they are really kind' another 'I am to the staff if that is anything to go by'. It was also used it to explain her enjoyment of life 'I pull their (the staff's) leg and they pull mine'.

Evaluation

(i) The Response

This shows the highest rate of reasonsed response obtained in the study. There was a largely positive selection of poles.

(ii) The Sources of Esteem

Inner self was by far the most important source of self esteem. Relationships with family and others, when mentioned was positive although they did not feature largely in the responses. Reference to the residential experience was balanced towards the positive. Interest and Hobbies, unlike the Coleman study, featured very little in the responses. Health and Independence was the major concern and was quoted as a source of both enhanced and diminished self esteem.

(b) The Cedars

(i) Distribution of Responses (See Table 6.3(i))

69% of the responses were positive without qualification but in only 27% of these were the sources of self esteem stated. Nearly 20% of the responses were negative and 12% of thse gave a source. This was the highest number of negative poles with sources scored throughout the six homes.

5% of the items received an explained non-response. Some importance was expressed over the polarisation required. One resident refused three times to make a choice; to the Useful/Useless pole, he replied 'a bit of each, there isn't a lot you can do'. To Little Enjoyment/Much Enjoyment, he responded 'Neither is true, I am not unhappy, I make the most of life'. Similarly the Aims/No Aims he said 'No particular aims but I want to do the best thing I can'. Another resident replied to the Hope/No Hope choice 'Neither the future doesn't lie in our hands'. Faced with the choice between little or no enjoyment another said 'I get normal enjoyment, if people were kind it would make a difference'. She was referring at the time to other residents.

Just over 51% of all the responses offered either a source of self esteem or a qualification of the pole chosen or explained why no reason was given.

(ii) Number of References to Particular Sources of Self Esteem

Table 6.3(iii) analysis the response made.

	Family Contacts	Other Relationships	Health/Independence	Interests/Hobbies	Work Role	Inner Self	External Circumstances	Totals
Positive Responses	1	4	3	4	3	8	3	36
Qualified Positive Responses	0	0	3	0	0	0	1	4
Negative Responses	3	0	2	0	0	5	2	12
Qualified Negative Responses	0	2	0	0	0	0	0	2
Totals	4	6	8	4	3	13	6	44

Table 6.3(iii) Number of References to Particular Sources of Self Esteem at the Cedars (Key Worker Homes)

These are discussed below:

(1) Inner Self

This was most frequently mentioned source of self esteem, used positively eight times and negatively five times. There was a good deal of acceptance of life as it came. This was expressed in positive replies 'It allL depends what you look for in the future, que sera sera', 'I let the future come to me now ....'. 'I am fairly happy, I've got no complaints'. These suggested some resolution of the life stage tasks.

(2) Health and Independence

This was mentioned eight times, five of which were either in support in a negative pole or to qualify positive statements. Blindness, forgetfulness, poor eye eight and shell shock were all specific causes of difficulty. Positively people spoke of their ability to do things for themselves, this was expressed with varying degrees of enthusiasm, reflecting differing expectations of residential care. One said with satisfaction 'Re. self care, I bath myself', another said 'I have to do everything for myself'. Negatively another said 'I feel I have to be here to be looked after ....'. Another complained 'I am useless because everything is done for me'.

(3) Other Relationships

These were mentioned positively six times either to support a positive pole or to qualify the choice of a negative pole. They often referred to freindships within the home 'I am important to some people here'. 'I am important to Mrs H.'.

(4) External Circumstances

Again these were commented upon six times, half positively, half negatively. The negative statements referred to the residential experience 'This place makes me sick, looking at the people', another saying she had little enjoyment elaborated 'We don't get much but they do what they can taking us out in the mini-bus etc'. Positively several referred to the benefits of the group experience 'I have a laugh and a joke'.

(5) Interests and Hobbies

These included doing the pools and reading. They were mentioned four times.

(6) Family Contacts

These were also mentioned four times, once positively, the other times regreting that they no longer existed 'I don't think I count now, 'I've got no one left. They are all gone .... I only have one nephew'. Another just asked the researcher to underline the negative pole saying in explanation 'no relatives'.

(7) Work Role

This was mentioned three times and either referred to doing things for themselves , over and above what was expected of them or to tasks performed for other residents. No one mentioned household tasks undertaken within the home such as washing up.

Evaluation

(a) The Response

There were less positive comments at the Cedars than at any of the other key worker homes and also considerably less than at the Rowans. Apart from the Tamarisks this home had the highest number of positive responses which were unsupported by any source.

This home had the highest number of elaborated negative comments. Unlike the Beeches no gratitude was expressed to staff and residents did not seem to feel under any obligation to express a cheerfulness they did not feel.

(b) Sources of Self Esteem

Inner self was again by far the most common source of self esteem. All the other sources were mentioned but only infrequently. Family contacts afforded a positive source for only one resident.

(c) The Sycamores

(i) Distribution of Responses (See Table 6.3(i))

28% of the responses were positive with a source provided. 38% of the residents selecting a positive pole offered no explanation for doing so.

The Sycamores had the third highest number of unsupported negative choices surpassed only by the Acorns and the Tamarisks. This home also had the highest number of explained non-response, 6% of the total, a position shared by the Acorns. Several of these responses were received from the same resident who was very confused and found making choices impossible, she made several comments like 'I can't plan', 'I take each day as it comes and I don't plan'.

Altogether exactly 50% of the responses were eithout any stated source of self esteem.

(ii) Number of References made to Particular Sources of Self Esteem

	Family Contacts	Other Relationships	Health/Independence	Interest/Hobbies	Work Role	Inner Self	External Circumstances	Totals
Positive Responses	2	4	1	5	4	8	3	27
Qualified Positive Responses	0	1	2	0	0	1	1	5
Negative Responses	1	1	3	0	0	4	2	11
Qualified Negative Responses	0	0	1	0	0	2	0	3
Totals	3	6	7	5	4	15	6	46

Table 6.3(iv) Number of References to Particular Sources of Self Esteem at the Sycamores (Key Worker Home)

The sources of self-esteem referred are as follows:

(1) Inner Self

Again this is the most mentioned source of self esteem. Although used predominantly to support positive choices of poles, the feeling expressed were widely divergent 'I've got confidence, God will be good', 'I

shouldn't think there will be much future and 'I just go on living from day to day'.

(2) Health and Independence

This was used mostly in connection with negative responses '.... it comes back to general health ....'. Although one old lady of 94 boasted 'I've got a wonderful memory'.

(3) Other Relationships

This was mentioned six times together with External Circumstances. Four of these comments were positive 'I've got good friends here and see good friends every fortnight'. Others were less happy 'there isn't a lot of life here' (refering to other residents).

(4) External Circumstances

Life in the home was referred to positively three times 'This place suits me, where my food is cooked for me', 'I get much enjoyment now, its jolly here'. Another said 'You can be happy here'. The negative comments contrasted sharply 'I get no enjoyment - I am here all day'.

(5) Interests and Hobbies

These were the second most frequently stated source of self esteem. Knitting was mentioned by several residents, obviously a source of pleasure. Crochet and Church were mentioned once by the same resident.

(6) Work Role

Again this was a positive source of self esteem. They referred to completing tasks within the home and helping others 'I help them wash up the crocs in the morning in the kitchen', and 'I help out a little bit'.

(7) Family Contacts

These were mentioned only twice positively. 'I do help my children out with a couple of shillings'. Again this was not a very obvious source of self esteem.

Evaluation

(a) The Response

Only 50% of the responses provided the researcher with a source of self esteem to support their choice of pole, although a number abstained because they did not like the way the questions were polarised. Although not the worst response rate it was disappointing. Like the other two key worker homes the balance of remarks made was positive.

(b) Sources of Self Esteem

As in the other key worker homes, Inner Self was the most frequently mentioned, it provided the most frequent source of both positive and negative comments. All other sources of self-esteem were referred to as frequently although Hobbies & Interests were mentioned five times, this was the highest score throughout the study, the other two key worker homes scoring four.

Summary of Key Worker Home Results

The rate of response which were accompanied by sources was as follows:

Beeches	56%
Cedars	51%
Sycamores	50%

The balance of replies were positive and there was found to be a significant difference between the positive and negative replies. (See Appendix 6.3(i)).

Non Key Worker Home Results

The distribution of responses for the non key worker homes is summarised in Table 6.3(v).

	Acorns	Rowans	Tamarisks	Totals	%
Positive Response without Source	39	33	42	114	39
Positive Response with Source	16	33	14	63	22
Qualified Positive Response	7	14	6	27	9
Negative Response without Source	13	6	18	37	13
Negative Response with Source	11	7	11	29	11
Qualified Negative Response	4	3	5	12	4
Explained Non-Response	6	0	0	6	2
Totals	96	96	96	288	100

Table 6.3(v) Distribution of Responses in Non Key Worker Homes

Each home will now be considered in detail.

(a) The Acorns

(i) Distribution of Responses (See Table 6.3(v))

Just over 75% of the responses in this home were positive of which 17% were responses with the source of self-esteem stated. 7% were positive with qualifications. The negative responses accounted for 25% of the score of which 11% stated the source. Therefore there was proportionally more information about the negative as opposed to the positive choice of poles. Qualified negative responses accounted for just over 4% of the score.

Explained non-response was as frequent as that at the Sycamores and more frequent than any other home, it was 6% of the total score. One resident was responsible for two of the abstentions, refusing to make a choice between, Aims and No Aims saying ' You can't make this choice it depends how you are feeling that day'. The Bright and Foolish item was also unanswered saying 'I am up the Pole'. Another also refused twice, this time the items which remained unanswered were Useful/Useless 'When you are old you can't do much', and Capable/Helpless, 'Neither, in between, I am capable of doing quite a lot but I'm hindered by age and arthritis'. Thus the difficulties for them was that sometimes the questions seemed in appropriate, sometimes impertinent (Up the Pole was said aggresively) and sometimes far too extremely stated.

Under 40% of the responses stated any source of self esteem.

(ii) Number of References to Particular Sources of Self Esteem

Table 6.3(vi) illustrates the distribution of references made to particular sources of self esteem.

	Family Contacts	Other Relationships	Health/Independence	Interest/Hobbies	Work Role	Inner Self	External Circumstances	Totals
Positive Responses	1	3	1	2	2	4	3	16
Qualified Positive Responses	0	0	5	0	0	1	1	7
Negative Responses	1	1	3	0	1	5	1	11
Qualified Negative Responses	0	0	0	0	0	3	1	4
Totals	2	4	9	2	3	13	6	38

Table 6.3(vi) Number of References to Particular Sources of Self Esteem at the Acorns (non Key Worker Home)

The figures for sources will be considered in order of the frequency to which they were referred.

(1) Inner Self

As in the key worker homes this was most frequently mentioned but, within three homes the balance was less

positive in that there were only clear cases where this was positively referred to without reservation and five times when it was negatively referred to without reservation.

Some were cheerfully confident 'Yes plenty of confidence, I can carry on'. Several felt defeated by age referring to the Unsure/Confident item one resident said 'I should scribble that right out, I have no confidence in myself'. Another was more cautious' No not confidence altogether, because I get upset about things'.

The sense of impending death was noticeable in a number of remarks in response to both positive and negative poles. 'I don't want to die yet' (positive) 'Yes at my time of life' (negative) 'Aim to get to Heaven' (positive) 'No when I was 14 and 16 but not now' (negative). All these were in response to the Aims/No Aims item. Similar responses were made to the final Little Hope/Confidence poles, 'I am getting to the age where I am no use to myself or anybody else but I am not afraid' (negative).

(2) Health / Independence Poles

This was not a source of positive self esteem except for one lady who asserted 'I am quite capable of doing anything'. Others felt useless because of arthritis, a 'bad' leg and because of feeling physically dependant. Five used health and independence to qualify positive comments and three as a source for negative choice.

(3) External Circumstances

This was referred to six times, half the responses were positive, one negative and two as qualifications, once to a negative and once to a positive pole. Positive remarks were made about the residential situation. 'Yes, very satisfied with life here'. 'I enjoy it, its quieter'. Another choose a negative pole with the qualification 'except parties here and what happens here, I don't want enjoyment'. the negative pole was explained by 'since here (I've been) useless because you don't have to do anything.'

(4) Other Relationships

This was mentioned negatively three times and positively once. Positive sources mentioned a former employee, friends and staff 'I get enjoyment because they are all so kind to us'. One lady contended that you did not count to people any more 'not when you are old'.

(5) Work Role

This was mentioned positively twice by the same resident who said proudly 'I work here'. The negative comment was wistful 'I wish I could get around and do some dusting'.

(6) Family Relationships

These were mentioned twice only. One lady said they no longer existed 'Everyone has passed on.' Another lady said 'I feel my life has meaning because of my children'.

(7) Interests and Hobbies

Mentioned twice, once by a lady who love gardening, another who loved 'little chats' with people.

Evaluation

(a) The Responses

The number of positive responses without sources compares favourably with other homes but the positive choices with sources stated are fewer than the rest of the homes apart from the Tamarisks.

(b) The Sources of Self Esteem

Inner Self was the most frequently mentioned but was cited as the source of a negative pole five times and of a positive pole only four times. All sources of esteem were mentioned positively but very infrequently.

(f) The Rowans

(i) Distribution of Responses (See Table 6.5(v))

69% of the responses were positive of which exactly half also stated the source of self esteem. 13.5% of the responses were negativ, of which 7% also stated sources. This was the lowest rate of negatve comments in any of the six homes apart from the Beeches. There were 14% qualified positive responses, the most in the study, and 3% of qualified negative responses.

There were no instances of explained non-response. Just over 60% of the replies stated some source of positive and negative self esteem.

(ii) Number of References to Particular Sources of Self Esteem

These are shown in Table 6.3(vii).

	Family Contacts	Other Relationships	Health/Independence	Interests/Hobbies	Work Role	Inner Self	External Circumstances	Totals
Positive Responses	3	3	2	5	4	12	4	27
Qualified Positive Responses	3	1	4	1	1	2	2	14
Negative Responses	0	1	2	0	0	3	2	8
Qualified Negative Responses	0	0	0	1	0	2	0	3
Totals	6	5	8	7	5	19	8	59

Table 6.3(vii) Number of References to Particular Sources of Self Esteem at the Rowans (Non Key Worker Home)

These will now be discussed in descending order of frequency.

(1) Inner Self

The use of this source of self esteem was twelve times out of nineteen times used to elaborate a positive pole. The Unsure/Confidence item produced some very positive replies. 'Yes I have, if I've made up my mind to do something I would do it.' 'If they ask me to do anything I don't want to I'd soon tell them off.' 'Now, since I've picked up again', 'I'm very firm if I

don't want anything I won't have it and I won't change my mind and I can stick up for myself'. 'I've got to have confidence to look after two ladies', (this was a resident who cared for his wife and another arthritic lady, both he and his wife died shortly after). 'I would say I've got a lot of confidence, "I know what is right and what is wrong.' The only negative score for this item was a lady who said 'No, I've got no confidence in myself'.

There were two reservations to the positive pole, three negative responses and two reservations to the negative pole. One negative response underlining 'I feel useless, said 'You are only part and parcel of the economy', (referring to the position of being a resident in an old peoples home).

(2) Health and Independence

This was mentioned positively without qualifications only twice, otherwise it wasused to qualify positive statements (four times) and negatively twice. One lady choosing 'Much Enjoyment' said 'they won't do anything for you here you have to look after yourself'. The same lady responded to the Capable/Helpless item saying 'because I have a hiatus hernia I'm helpless in that way, but I can do things with my hands, will power makes me do things'. Another resident replying to the same item said she was still capable 'because I can wash and dress myself'. One lady of 100 said 'At the moment I feel useless because I can't do anything and I can't go out'.

(3) External Circumstances

THE REPLIES TO THIS ITEM WERE DIVIDED, FOUR USED THE SOURCE TO DEMONSTRATE POSITIVE SOURCES OF SELF ESTEEM, TWO TO QUALIFY POSITIVE RESPNSES AND TWO TO EXPLAIN NEGATIVE CHOICES. THE POSITIVE RESPONSES INVOLVED

going places with her son, going out every weekend, seeing the family and comparing conditions favourably to war-time. The qualifications and negative responses all concerned the lack of variety and activity in rsidential life 'I'm stuck here with nothing to do except knitting and sewing'.

(4) Interests and Hobbies

Mentioned positively five times, as a qualification to a positive response once and once to qualify a negative reply, the balance was clearly positive. With the Sycamores it received the most positive attention and was mentioned more frequently than in any other home. Sources mentioned were sewing, knitting, reading books, and writing and reading the newspaper.

(5) Family Contacts

These were used either positively (three times) or to qualify a positive comment (three times).

(6) Other Relationships

These were mentioned positively three times once to describe friends from the community twice to describe fellow residents who were helped by the resident. It was used once to qualify a positive choice and once negatively.

(7) Work Role

This was mentioned four times as a positive source of self esteem and once to qualify a positive statement. Positive sources were drying-up, helping with chairs and twice, caring for other reisdents.

Evaluation

(a) The Responses

The response rate to items giving sources of self esteem was the highest in the study, 4% higher than the Beeches, the top scoring key worker home. The balance of both the total response and those with sources was positive.

(b) Sources of Esteem

All sources were mentioned but Inner Self was by far the cost important source of positive self esteem. The replies were exceptionally vigorous and independent.

(c) The Tamarisks

(i) The Distribution of Responses (See Table 6.3(v))

This home had the highest number of unelaborated positive responses, nearly 44%, also the most inelaborated negative respnses, nearly 19%, thus, 63% in all made only unsupported choices.

There were fewer positive responses with sources stated than elsewhere, 14% and the most negative responses, 11%, a position shared with the Sycamores and the Tamarisks.

This home therefore provided the study with the least substantiated information of any in the study. Six residents were able to explain their reason for not making any choice. They included responses like 'I don't do a lot' and 'I feel bored unless I am doing something intellectually stimulating'.

(ii) Number of References to Particular Sources of Self Esteem

Table 6.5(ix) gives a detailed breakdown of elaborated responses.

	Family Contacts	Other Relationships	Health/Independence	Interests/Hobbies	Work Role	Inner Self	External Circumstances	Totals
Positive Responses	5	2	3	0	0	2	2	14
Qualified Positive Responses	0	0	1	0	1	4	0	6
Negative Responses	1	0	4	0	1	4	1	11
Qualified Negative Responses	0	1	0	0	1	3	0	5
Totals	6	3	8	0	3	13	3	36

Table 6.5(ix) Number of Referneces to Particular Sources of Self Esteem at the Tamarisks (Non Key Worker Home)

These results are now examined in more detail.

(1) Inner Self

The drift of remarks in this section is negative. Only two elaborated positive choices are made as opposed to four negative and this source is used to qualify positive comments four times and as a qualification of negative comments only three. The two positive sources stated 'I enjoy myself very well', the other 'I am not a miserable person'.

Age was the special source of complaint for one lady who made two of the negative comments in this category 'Now I am eighty four, age is a great thing. I am now not so confident' and 'Age comes into it a great deal. No, my brain is not the same. I am not the same'.

Another resident also found age had deprived her of aims 'I did have aims once but not now'. She also expressed insecurity, asked if she was (Unsure or Confident she choose Unsure saying 'How do you know what is going to happen'.

(2) Health and Independence

This again was a negative source of self esteem for four residents, a qualification of a positive response for one and a positive factor for three.

Complaints included arthritis, blindness, inability to stand and inability to walk.

(3) Family Contacts

This was responsible for the greatest number of positive responses with reasons given, five in all, it only once was a source of negative self esteem. The negatve response was by a man who said 'I've just lost my wife'. Others included a reference to a brother, a daughter and to families. Two of these responses were made by the same lady who gave families as the reason for choosing both Much Enjoyment and Importance to Others. It was mentioned more frequently in this than in any other home.

(4) Other Relationships

These were mentioned three times, all positively either in support of the choice of positive poles or to qualify a negative one. Two of these respnses were jokes, both made by men. The men whose wife recently died said he had No Aims 'Unless I can meet a rich widow', the other man said he had an aim 'Not to get married again'. The only serious response was a lady who said she enjoyed helping other people at the home.

(5) Work Role

This was used once to qualify a positive response. A man said he would be capable of doing quite a lot if he were given something to do. One lady asked how she could get enjoyment 'sitting - sitting'. Another lady said despite not standing she was able to get quite a few things done.

(6) External Circumstances

These were mentioned twice positively in connection with aims, both were about leaving the home. The resident said the aim was to go to Canada, the other to be moved from 'here'. The negative response also concerned the home, 'There isn't much to do here, it is very quiet apart from music on Monday and Tuesday'.

(7) Interests and Hobbies

These were not mentioned at all either positively or negatively.

Evaluation

(a) The Responses

These were largely negative and the results were particularly disappointing in terms of the number of sources of self esteem identified.

(b) Sources of Self Esteem

The only source which was not mentioned was Interests and Hobbies. Family relationships were the only relatively frequent source of positive comment. Health and Independence and Inner Self were the two most frequently cited sources of negative self esteem.

Summary of Non Key Worker Homes

Taken as a whole there was found to be no significant difference between the positive and negatove replies (See Appendix 6.3(b).

The percentages of responses for whcih reasons were provided were as follows:

Acorns	40%
Rowans	60%
Tamarisks	37%

Comparison of the Measure in Self Esteem in Key Worker and Non Key Worker Homes

The Key worker homes scored more highly overall on every positive item apart from family contacts. The home which scored the smallest total number of positive items, the Tamarisks, scored most highly in this section. This might suggest that families assume added significance in situations which are stressful.

The situation becomes less clear cut when individual scores are examined. The rank order of positive items scored was:

Beeches	39
Rowans	33
Sycamores	27
Cedars	26
Acorns	16
Tamarisks	14

These figures would tend to suggest that different levels of self esteem existed within the homes but they did not follow a clear key worker versus non key worker divide. What is clear, however, is that the key worker homes all achieved good or middle rank scores. The two largest homes (sixty residents each) scored the least number of positive items.

Problems of administration and scoring have been explored and the fact that these scores represent a disappointly small number of clear cut, explicit sources of self esteem. Where these responses do occur it is particularly noticeable that high scoring homes show Work Roles, Interests and Hobbies and Inner Self as major sources of self esteem, the low scoring homes show far less mention of Inner Self and almost none of the Work Roles and Interests and Hobbies. The findings for Interests and Hobbies were similar to those in Coleman's study but the other two findings were dissimilar. These scores were of particular interest because of the obvious links with the study of engaged behaviour. (See Table 6.5(i) and 6.5 (ii)

In some ways the most telling figure is the 283 responses that were made with no reasons given. Other reseachers have commented on residents reluctance to discuss their situation and feelings openly. Perhaps the reasons for this may be found in responses such as that made by a resident at Sycamores, 'You don't get a lot of pleasure in a place like this. There are a lot of strangers but not intimates. A lot often are weak in the head'. This sense of isolation and alienation is not conducive to the full and frank discussion of painful areas which this measurement requires.

6.4 Results of the Measure of Engaged Behaviour

The special feature of the behaviour observed in each home will be briefly described and these will each be accompanied by a table showing:

(1) The distribution of behaviour throughout the four observation sessions.

(2) The location in which the observation took place.

(3) The score expressed as a number and also as a percentage in order to illustrate more closely the way the behaviour was distributed throughout the observation periods.

(i) The Key Worker Homes

(a) The Beeches. (See Table 6.4(i))

The Beeches had a high level of leisure activity although this was not particularly varied. The most common past-time was conversation, which constituted 53.5% of the leisure score. Wool work, in this case knitting, was also a popular past-time accounting for 33.1% of the remaining score.

This high score in leisure activities overall is more remarkable as Day One afternoon was spent in a small lounge in which only one item of engaged activity was scored, the rest falling into the passive, non-engaged or gone out categories. This pattern did not persist on Day Two. The observations on the second day were made in the large lounges and here the afternoon proved to move lively than either of the morning sessions. The visit of an ice-cream man to the home, the buying and eating of ice creams and the conversation this generated accounted for some of the liveliness.

Table 6.4(i)

Distribution of Behaviour throughout Observation Period

At the Beeches (Key Worker Home)

BEECHES	ENGAGED BEHAVIOUR								PASSIVE BEHAVIOUR				NON-ENGAGED						DEVIANT BEHAVIOUR		CONE OUT	
	SHI		L		WK		O		SHD		W		A		DN		W?DN		DB		CO	
	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%
Large Lounge Day 1 a.m.	4	33.3	42	33.1	4	66.6	4	66.6	3	100	9	34.6					2	11.1			7	13.5
Small Lounge Day 1 p.m..			1	0.7							8	30.8	27	7.5			4	22.2			3.5	67.3
Large Lounge Day 2 a.m.	1	8.3	61	48	2	33.3					3	11.5	4	11.1			2	11.1			2	3.8
Large Lounge Day 2 p.m.	7	58.3	23	18.1			2	33.3			6	23.1	5	13.9	1	100	10	55.5	13	100	8	18.4
Totals	12	99.9	127	99.9	6	99.9	6	99.9	3	100	26	100	36	100	1	100	18	99.9	13	100	43	99.9

(b) The Cedars (See Table 6.4 (ii))

This home again showed a high level of leisure activity although watching television replaced knitting as the second most popular activity. In common with all the other homes, except the Acorns, conversation was the most popular past-time and most of this was between the residents. This home scored the highest level of verbal interaction between residents. After Sycamores it also scored the highest level of interaction between staff and residents.

No deviant behaviour was scored although there was a relatively high level of sleeping, much of which occurred on the afternoon of Day Two in the T.V. lounge where there was a lot of dozing between snatches of conversation and watching television. This was in marked contrast to the lively conversation observed in the quiet lounge on the first afternoon.

The explanation for some of the difference in behaviour between the two afternoons may have been the presence of a visitor this generated conversation throughout the study. Watching television generally did not stimulate residents but tended to send them to sleep. Recent research in a Hampshire home found that a high level of undiagnosed deafness meant that few residents could actually hear normally transmitted television (Tierney 1986). This may have accounted for the televisions' deadening effect; the background sound it produced might also make conversation between those using a hearing aid almost impossible.

Table 6.4(ii)

Distribution of Behaviour Throughout Observation Period

At the Cedars (Key Worker Home)

CEDARS	ENGAGED BEHAVIOUR								PASSIVE BEHAVIOUR				NON-ENGAGED						DEVIANT BEHAVIOUR		CONE OUT	
	SHI		L		WK		O		SHD		W		A		DN		W?DN		DB		CO	
	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%
T.V. Lounge Day 1 a.m.	1	11	30	22.4	4	40	2	50			16	34	8	20.5	2	100	1	100			5	26.3
Quiet Lounge Day 1 p.m..	2	22	42	31.3	2	20	2	50	1	25	8	17	7	17.9							6	31.6
Quiet Lounge Day 2 a.m.	6	67	10	7.5	4	40			3	75	19	40.4	7	17.9							8	42.1
T.V. Lounge Day 2 p.m.			52	38.8							4	8.5	17	43.6								
Totals →	9	100	134	100	10	100	4	100	4	100	47	99.9	39	99.9	2	100	1	100				

(c) The Sycamores (See Table 6.4(iii))

The Sycamores scored the highest percentage of engaged behaviour of any of the homes. Not only was the level of activity higher but the range of activity was greater than any other home except the Tamarisks who did not match variety with quantity.

Conversation again was an important activity. The afternoon of the second day was particularly lively, partly because of the arrival of a visitor with a dog which stimulated conversation both with and about the dog. Television watching was the second most favoured occupation and there were two recorded instances of this generating interaction. On one occasion it provoked a reminescence between two residents about the first World War and in the second two residents grumbled together about the poor quality of programmes. These were the only examples of television stimulating residents. There were few single rooms at the Sycamores so television watching had to take place in the public lounges. In the better resourced homes serious viewing tended to take place in resident's bedrooms.

There was the highest recorded level of verbal interaction between resident and staff recorded in the study when the content was recorded however, it was not of a social nature but task orientated revolving around practical help with daily living, collecting pensions, medical treatment and listening to residents ailments. This was true of all the homes and realistically intimate conversations were unlikely to take place in busy lounge areas.

Both knitting and reading papers played their part in leisure activities. In this home knitting was not a routine occupation handed out to residents, whether or not they were interested or able to comprehend the activity.

Another interesting observation was the level of mobility in this home in which residents actually walked about far more than in any other home. This might be the result of the home layout which, because it was an old converted house, was not dominated by dauntingly long corridors.

Harris & Lipman (1984) in their study of social process and space usage in Children's Homes noted how social expectations were expressed in spacial terms. The five modern homes in the study all had bedrooms located down corridors often at some distance from public living space, this would seem to suggest that frequent movement between the two was neither expected nor facilitated.

This home had less non-engaged behaviour than any other and no deviant at all was observed. Several of the residents interviewed in the self-esteem study were found to be confused so this can have had little to do with the actual mental condition of the residents and must, to some extent, be attributed to the quality of the environment.

Table 6.4(iii)

Distribution of Behaviour Throughtout Observation Period

At the Sycamores (Key Worker Home)

SYCAMORES	ENGAGED BEHAVIOUR								PASSIVE BEHAVIOUR				NON-ENGAGED						DEVIANT BEHAVIOUR		GONE OUT	
	SHI		L		WK		O		SHD		W		A		DN		W?DN		DB		GO	
	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%
Medium Lounge Day 1 a.m.	13	61.9	30	20.7	5	20.8	4	36.4	2	50	2	69	6	23.1	3	25	1	11.1			7	36.8
Medium Lounge Day 1 p.m..	3	14.3	31	21.4	11	45.8	4	36.4			4	13.8	9	34.6			5	55.5			10	52.6
Medium Lounge Day 2 a.m.	5	23.8	38	26.2	2	8.3	2	18.2	2	50	13	44.8	11	42.3	1	8.3	1	11.1				
Small Lounge Day 2 p.m.			46	31.7	6	25	1	9.1			10	34.5			8	66.6	2	22.2			2	10.5
Totals	21	100	145	100	24	99.9	11	100.1	4	100	29	100	26	100	12	99.9	9	99.9				

(ii) The Non Key Worker Homes

(a) The Acorns (See Table 6.4 (iv))

In this home less engaged behaviour was scored and more passive and non-engaged than in any other home.

The range of activity was limited to television, talking and a little reading. As already noted this was the only home where television watching overtook conversation in frequency. There was a little reminescing once in the morning of the first day about a dog someone used to own and in the afternoon someone mentioned a cat she used to have. Someone else admired the roses in the garden. One resident made a joke, obviously long remembered, 'Its full of emptiness' she said referring to her tea cup, she might well have referred to the environment.

The willingness of residents to respond had there been any stimulus to do so was illustrated by the flurry of activity and conversation caused by a small swarm of wasps which were collecting by the window of the lounge.

No visitors happened to call at anytime during the observations and this accounted for some of the lack of liveliness and interest.

Table 6.4(iv)

Distributon of Behaviour Throughout Behaviour Observation Period

At the Acorns (Non-Key Worker Home)

ACORNS	ENGAGED BEHAVIOUR								PASSIVE BEHAVIOUR				NON-ENGAGED						DEVIANT BEHAVIOUR		GONE OUT	
	SHI		L		WK		O		SHD		W		A		DN		W?DN		DB		GO	
	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%
Small Lounge Day 1 a.m.	6	35.2	9	21.4	1	11.1	3	20	7	43.7	12	37.5	10	12.7			1	6.6			26	47.3
Large Lounge Day 1 p.m..	10	58.8	11	26.2	3	33.3	5	33.3	2	12.5	9	28.1	30	38			3	20	1	7.7	1	1.8
Small Lounge Day 2 a.m.	1	5.9	12	28.6	4	44.4	1	6.6	4	25	9	28.1	6	7.6	3	50	6	40	9	69.2	20	36.4
Large Lounge Day 2 p.m.			10	23.8	1	11.1	6	40.0	3	18.8	2	6.3	33	41.7	3	50	5	33.3	3	23.1	8	14.5
Totals	17	99.9	42	100	9	99.9	15	99.9	16	100	32	100	79									

(e) The Rowans (See Table 6.4(v))

The home had a high level of verbal interaction both between resident and resident and between resident and staff. The morning of the first day was a rather quiet time but after that the lounges were all lively. On the afternoon of the first day the level of interaction was raised by a visitor who talked to all the residents, helping one less able resident to eat a peach and passing around sweets. An ice cream man was expected and this was a source of speculation and interest.

The morning of the second day was uneventful although conversation was animated. The Head of Home was subject to some disrespectful conjecture as they wondered when he would finally get around to some repair!

The afternoon of the second day was quite hectic, again a visitor was present, residents were leaving the lounge to go to Bingo sessions and a cat was present. The cat ruthlessly deprived a resident of her accustomed seat, the cat's removal was discussed, but never occurred. One of the residents remarked 'that cat is smiling he must be having pleasant dreams'. The very real value of animals in a residential setting in terms of stimulation was again demonstrated. One confused lady spent the afternoon doing nothing much except to sit and cuddle a teddy bear.

This was a home with a high level of stimulation and activity was correspondingly high. In common with the Beeches no one was recorded watching television in this study.

Table 6.4(v)

Distribution of Behaviour Throughout Observation Period

At the Rowans (Non-Key Worker Home)

ROWANS	ENGAGED BEHAVIOUR								PASSIVE BEHAVIOUR				NON-ENGAGED						DEVIANT BEHAVIOUR		GONE OUT	
	SHI		L		WK		O		SHD		W		A		DN		W?DN		DB		GO	
	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%
Medium Lounge Day 1 a.m.	9	50	15	14.1			2	40	5	31.2	5	17.8	29	40.8	7	100	2	16.6	1	20		
Small Lounge Day 1 p.m..	7	38.9	31	29.2	4	44.4	2	40	10	62.5	13	46.4					3	25			5	21.7
Medium Lounge Day 2 a.m.	2	11.1	27	25.5	2	22.2	1	20	1	6.3	7	25	25	35.2			6	50			4	17.4
Small Lounge Day 2 p.m.			33	31.1	3	33.3			3	10.7	17	23.9					1	8.3	4	80	14	60.9
Totals	18	100	106	99.9	9	99.9	5	100	16	100	28	99.9	71									

(f) The Tamarisks (See Table 6.4(vi))

This was a home in which the range of activities was wide although the frequency rate was low.

The morning of the first day was spent in the quiet lounge, little happened except a small stir caused when tea was served. Two residents sat and talked about another resident and there was a sad incident in which a new resident was rebuked by an established resident because she had used a footstool which was the personal property of the other. She said 'I am very sorry I thought it belonged to the home', and left the room. Another confused lady was criticised for not reading the paper when she had been given it and then losing it.

In the afternoon the conversation was more good natured. This observation was in the T.V. lounge where residents talked, knitted, crocheted and watched the television.

The morning of the second day was uneventful but in the afternoon the observation took place in the 'confused' lounge. Despite a visitor residents either sat banging, clapping or asleep. Two of the five residents observed were distressed. One kept asking where he was going and answering himself, another begged repeatedly, 'Please help me, please help me, where are my children?', between episodes of clapping and banging. The behaviour in this lounge produced the highest deviance scores of the study. It was impossible to know whether this reflected a difference in admission criteria or because the deviant behaviour became more pronounced in the segregated lounge.

The conversational level among residents was much higher than at the other larger homes, the Acorns. The contribution made by visitors was the highest recorded, while staff/resident interactions was the lowest in the study.

Table 6.4(vi)

Distribution of Behaviour Throughout Observation Period

At the Tamarisks (Non-Key Worker Home)

TAMARISKS	ENGAGED BEHAVIOUR								PASSIVE BEHAVIOUR				NON-ENGAGED						DEVIANT BEHAVIOUR		CONE OUT	
	SHI		L		WK		O		SHD		W		A		DN		W?DN		DB		GO	
	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%	No:	%
Quiet Lounge Day 1 a.m.	4	33.3	15	16.3	5	50	5	62.5			4	19	22	45.8	14	58.3	5	23.8			1	6.7
T.V. Lounge Day 1 p.m..	7	58.3	35	38	5	50	3	37.5	3	30	2	4.8	5	10.4	1	4.2	7	33.3			8	53.3
Large Lounge Day 2 a.m.	1	8.3	30	32.6							10	47.6	21	43.7	9	37.5	6	28.6	9	23.1	2	13.3
Confused Lounge Day 2 p.m.			12	13					7	10	6	28.6					3	14.3	30	76.9	4	26.6

Comparison between the Key Worker and Non Key Worker Homes

The Incidence of Specific Behaviours within Each Home

Table 6.4 (vii) provides a detailed breakdown of all the observed behaviour and expresses it as a percentage of the total number of observations within the home. In Key Worker Homes leisure activities are seen to form 51.2%, 47.7% and 51.6% of the observations as opposed to 17.7%, 38.2% and 32.3% in non key worker homes.

Other very different scores are those for self help dependent. Key worker homes score 1.2%, 1.4% and 1.4% while non key worker homes register 6.5%, 5.8% and 3.5%. Even more striking however, are the difference in the watching figures and here the order is reversed. Non key worker homes score only 6.5%, 5.8% and 3.5% whilst key worker homes here scores of 10.5%, 16.7% and 10.3%. Those scored Asleep also show marked differences, the key worker homes' figures are 14.5%, 13.9% and 9.3%, those for non key worker homes are 32.2%, 25.6% and 16.8%. The difficulty in distinguishing between these various categories have already been discussed and these wide variations may well illustrate problems of reliability in the measure rather than any real differences within the homes.

Table 6.4(vii)

Specific Behaviours, Percentages to the Total Observations within Each Home

	ACTIVE ENGAGEMENT				PASSIVE ENGAGEMENT			NON-ENGAGEMENT		
	SHI	L	WK	O	SHD	W	A	ON	W?ON	DB
Beeches	4.8	51.2	2.4	2.4	1.2	10.5	14.5	0.4	7.3	5.2
Cedars	3.2	47.7	3.6	1.4	1.4	16.7	13.9	0.7	11.0	0.4
Sycamores	7.5	51.6	8.5	3.9	1.4	10.3	9.3	4.3	3.2	-
Acorns	6.9	17.1	3.7	6.1	6.5	6.5	32.2	2.4	6.1	5.3
Rowans	6.5	38.2	3.2	1.8	5.8	5.8	25.6	2.5	4.3	1.8
Tamarisks	4.2	32.3	3.5	2.8	3.5	3.5	16.8	8.4	7.4	13.7

Analysis of Leisure Categories within the Homes

Table 6.4 (viii) gives a breakdown of the frequency of various leisure activities within the home.

(1) Watching Television

Differences in the viewing patterns of the residents have already been noted and these are linked in some degree to access to television in their bedrooms. Problems of audibility have been discussed earlier. In the Beeches there had been a management decision to encourage private as opposed to public viewing.

(2) Reading

There is a negative correlation between the television viewing and reading figures. At the Beeches where there is no public viewing recorded, the reading score is 13.2% at the Rowans it is 12.3%. The Sycamores have a reading score of 10.7% and a viewing score of 15.4%, while the Acorns, where residents spent the majority of their observed leisure watching television, have a reading score of 7.3%. The lowest score is at the Cedars where reading scores only 3%. Again for many people reading would be seen as an activity best pursued in the quietness of their rooms so too much weight cannot be placed on these figures. No figures were available but poor sight or blindness was a net infrequent problem this too would affect this score.

(3) Speaking

The residents of the Rowans spent the majority of their observed leisure activities in conversation with each other, 80.2% in all. This was considerably higher than the other homes.

(4) Wool Work

The residents of the Beeches were frequently knitting and this was actively encouraged as a defense against mindlessness. This raised the serious problem of the different values which may be attached to behaviours which all qualify as engaged. There is a qualitative difference between knitting for great-grand children and being handed out a dishcloth to knit or a ball of wool to wind.

(5) Others

The activities which were scored under 'Others' included activities such as tidying up, eating, helping other residents. These occurred with the greatest frequency at the Tamarisks, 7.6% and at the Sycamores 6.0%. They were infrequently scored elsewhere. Because of their diversity and relative infrequency they are hard to interpret.

Table 6 .4(viii)

Percentages of Total Number of Leisure Observations

	Watching T.V.	Reading	Speaking	Woolwork	Others
Beeches	NIL	13.2	53.5	33.1	NIL
Cedars	23.7	3.0	72.5	NIL	0.8
Sycamores	15.4	10.7	57.7	10.1	6.0
Acorns	46.3	7.3	43.9	NIL	2.4
Rowans	NIL	12.3	80.2	6.6	0.9
Tamarisks	7.6	9.8	66.3	8.7	7.6

Analysis of Verbal and Non verbal Interaction with the Homes

A breakdown of the number of interactions is given in Table 6.4(ix). Factors here to be borne in mind when interpreting these figures:

(1) The Beeches score is depressed because 25% of the observer's time was spent in a small lounge with four sleeping residents.

(2) The Tamarisks score was deceptive because of the very verbal nature of the confusion observed in the 'confused' lounge.

(3) Visitors, both human and animals generated conversation and these fairly chance visits did not occur at the Acorns during the time of the observations. The score for the Acorns is limited to staff/residents and resident/resident interactions which are, as already observed infrequent.

The key worker homes all scored quite well in these categories but unlike the leisure categories the home to reach the highest score is the Rowans.

Table 6.4(ix)

Analysis of Verbal and Non-Verbal Interactions (Number of Observations per Home)

Home	R ⟷ R	R ⟷ S	R ⟷ V	R ⟶	N.V.	PETS	TOTAL
Beeches	54	5	9	0	0	0	68
Cedars	75	15	8	0	1	0	99
Sycamores	60	16	3	2	0	1	82
Acorns	12	6	0	0	0	0	18
Rowans	64	9	12	0	0	0	85
Tamarisks	54	3	13	0	1	0	61

Conclusion

The key worker homes perform well throughout this section of the study. The Rowans, of the three non key worker homes perform as well as the best of the key worker homes.

The Tamarisks although showing a good range, also show a relatively low incidence of leisure activities. These figures are influenced by the policy of segregating confused and non-confused residents. The observer spent 25% of the observation time in the 'confused' lounge observing largely devant behaviour.

The Acorns, on the two days of the observations was an uneventful monotonous place. The largest single set of observations were in the 'Asleep' category which formed 32.2% of the total observations.

Once more the key worker homes demonstrate a consistently good level of engagement and their score is only matched by that of the Rowans. Again the two larger homes have the least positive score.

6.5 Evaluation of the Degree to which these three measures were able to discriminate between the various care regimes

The level of agreement between the three measures may be illustrated by comparing three sets of results from the measures used. This is set out in Table 6.5(i) in which the Head of Homes score from the Analysis of Daily Practices is set along side the positive self esteem scores and the percentage of engaged behaviour.

See overleaf for Table 6.5(i).

Table 6.5(i)

Rank Order	Heads of Home Score in the Analysis of Daily Practice	Score	Rank Order	Stated Sources of Positive Self Esteem	Score	Rank Order	% of Engaged Behaviour	Score
(1)	Beeches	8	(1)	Beeches	39	(1)	Sycamores	71.2
(1)	Rowans	8	(2)	Rowans	33	(2)	Beeches	60.8
(3)	Sycamores	18	(3)	Sycamores	27	(3)	Cedars	55.9
(4)	Cedars	19	(4)	Cedars	26	(4)	Rowans	49.7
(5)	Acorns	26	(5)	Acorns	16	(5)	Tamarisks	42.5
(6)	Tamarisks	28	(6)	Tamarisks	14	(6)	Acorns	33.8

This table shows complete agreement between the ranking of the Heads of Home response to the Analysis of Daily Practice and the number of stated sources of positive self esteem obtained from the residents of these homes.

The percentage of engaged behaviour does not so nearly reflect the other scores. Although the two homes with the least positive scores remain at the bottom of the table their position is reversed.

If the failure to offer sources for the negative poles selected in the measure of self esteem may be interpreted as negative, passive behaviour and this is compared with the percentage of non engaged and deviant behaviour observed in each home and again these are compared to Head of Homes scores, a comparison of negative scores may be obtained.

Table 6.5(ii)

Comparison between the Head of Home score from the Analysis of Daily Practice, the number of negative poles selected without a stated source and the percentage of non engaged and deviant behaviour.

(See overleaf for Table 6.5(ii))

Table 6.5(ii)

Rank Order	Analysis of Daily Practice	Score	Rank Order	No. of Negative Poles without Source	Score	Rank Order	% of Non-Engaged deviant behaviour	Score
(1)	Tamarisks	28	(1)	Tamarisks	18	(1)	Tamarisks	46.3%
(2)	Acorns	26	(2)	Acorns	13	(2)	Acorns	46.0%
(3)	Cedars	19	(3)	Rowans	6	(3)	Rowans	34.2%
(4)	Sycamores	18	(4)	Sycamores	5	(4)	Beeches	27.4%
(5)	Beeches	8	(5)	Beeches	4	(5)	Cedars	26.0%
(6)	Rowans	8	(6)	Cedars	4	(6)	Sycamores	16.8%

This table again shows agreement in placing the Tamarisks and the Acorns together in having the most negative scores. The rank positions between the other four homes shows little consistency.

The conclusion which may be drawn from these figures is that:

the three measures were able to distinguish between homes which operated no system of individualised care from those which did. It was not capable of distinguishing between those homes which operated a key worker system from a home which planned individualised care around a bath rota.

There was also some evidence that where more than one worker was specifically assigned to a particular resident (The Beeches and the Rowans) the practices of the homes could be seen to be more closely geared to individual needs and the levels of self esteem among the residents was higher. (See Table 6.5(i)).

Appendix 6.3(a)

Rank Correlation Chi-Squared Test

The Key Worker Positive and Negative Scores were re-grouped under the following headings to see if they were significantly different.

(1) Social Contact (comprised of Family Contacts and Other Relationships).

(2) Personal Well-Being (comprised of Health and Independence and Inner Self).

(3) Activities (comprised of Work Role and Interest and Hobbies).

(4) External Circumstances (this grouping remained unchanged).

These figures were based upon the Total Score for all three homes:

	Positive		Negative		Total
					$\frac{(O - E^2)}{E}$
S.C.	18	17.2	5	5.8	23
P.	37	41.9	19	14.1	56
A.	27	20.2	-	6.8	27
E.C.	10	12.7	7	4.3	17
Total	92		31		123

$\chi^2 = 13.782$

χ^2	10% (3) = 11.34
χ^2	0.5% (3) = 12.84

χ^2 0.10% (3) = 16.27

At the 1% level and up to the 0.5% level there is a significant difference between the two columns (positive and negative).

Appendix 6.3(b)

The Non Key Worker Positive and Negative Scores were re-grouped under the following headings to see if they were significantly different.

(1) Social Contact (comprised of Family Contacts and Other Relationships).

(2) Personal Well-Being (comprised of Health and Independence and Inner Self).

(3) Activities (comprised of Work Role and Interest and Hobbies).

(4) External Circumstances (this grouping remained unchanged).

These figures were based upon the Total Score for all three homes:

	Positive		Negative		Total
S.C.	19	14.9	3	7.1	22
P.	22	29.1	21	13.9	43
A.	15	12.2	3	5.8	18
E.C.	9	8.8	4	4.2	13
Total	65		31		96

$\left(\frac{O - E^2}{E} \right)$

$\chi^2 = 10.863$

χ^2 1% (3) = 11.34

χ^2 2.5% (3) = 9.35

χ^2 5% (3) = 7.81

χ^2 10% (3) = 6.25

At the 1% level there is no significant difference between the two columns, positive and negative.

Chapter Seven

Evaluation III

7.1 Introduction

This study sought to evaluate the effectiveness of the use of key workers in providing a better quality of life in homes for the elderly. The underlying assumptions behind such a system are two fold:

(1) that residential staff input is a crucial factor in determining residents well-being.

(2) that the way this care is organised will materially influence its effectiveness.

These assumptions were supported by sociological and psychological theory, both of which stress the importance of the interaction between the individual and his environment in determining his quality of life. The study therefore adopted measures which would:

(1) describe the nature of the environment.

(2) determine whether there were significant differences in residents behaviour in response to different care regimes.

(3) measure any marked differences in life satisfaction with various residential care situations.

The study only examined key worker systems indirectly and objections to such an oblique approach might be:

(1) The existing key worker systems were not adequately described.

(2) The precise importance of such a system to residents was not explored, for example, no resident ever mentioned their key worker, in any connection, during the interview with the researcher.

(3) The importance and value to staff was also unexplored. The system was discussed only at the Sycamores where it was still a relative novelty, it was not a focus of discussion at any of the other homes.

The definition of key worker used in this study was deliberately broad since if a narrower definition had been used the researcher would have found it difficult to identify homes which conformed sufficently to be able to form a study sample. The looseness of the definition used had to reflect the multiplicity of ways in which this concept has been interpreted. In fact the measures used in this study could not distinguish between a home where carers were made responsible for reporting need from those where they were also responsible for making provision for that need. What did emerge as crucial however, was the commitment to provide an individualised service for every resident and the precise method of achieving this end was far less important. Evidence to support this statement was provided in Chapter 6.

This final chapter will briefly evaluate the effectiveness of each measure and explore what are the points of general interest for social services workers.

7.2 A Discussion of the Value of the Measures Used

The difficulties of implementation and interpretation have been discussed. They arise from three main sources:

(1) Resource problems which affected all stages of the study.

(2) Adaptation problems arising from the limitations imposed by (1).

(3) Interpretation problems arising partly from (2), but also from the use of unmatched samples, size of home was a particular difficulty in this connection.

This section will now seek to identify the positive contribution of each of the measures used.

(1) Analysis of Daily Practice

Six important questions were posed on pages 25 and 26 which were felt to be important in the measurement of a care regime. Despite the many problems encountered in the adaptation of the scale the following questions were explored satisfactorily if not exhaustively.

(a) What degree of control or choice does the resident possess?

(b) Are the care routines responsive to individual differences in resident's competence, personality and preferences?

(c) How far does residential life offer a private as well as a public dimension?

(d) What is the power balance between staff and residents and how is this maintained?

The two questions less satisfactorily answered were 'Are the resident's links with the community fostered or severed?' and 'What is the nature and extent of communication between staff and residents?'. Both were clearly important topics. The first question pre-supposed that residents would still have links with the community and that these could be fostered or thwarted by the residential social worker. Neither of these pre-suppositions were totally true and the analysis could only indicate the intention of staff not their performance. The second question was far more successfully explored in the study of engaged behaviour.

The score obtained from the Head of Home was of particular interest because of the very clear correlation between their score and the degree of positive self-esteem expressed by residents which seems too consistent to be co-incidental, although generalisations from so small a study are always dangerous.

The researcher found the discussion which took place during the completion of these forms with non-management staff, of great interest. What was very impressive throughout all six homes was the high level of personal involvement and commitment to the elderly people with whom they worked.

(2) The Measure of Self Esteem

Three demands were made of this measure on page 33 of this study. They were:

(a) It must allow for different re-actions to the ageing process.

(b) It must be appropriate to the life stage and its special tasks.

(c) It must be capable of determining whether or not residents demonstrate a positive self identity in their residential setting.

All these three demands were to some extent met by the measure used. Some of the questions were very threatening to elderly people in the residential setting and only received a limited response, but in many cases a very clear picture of the client's position emerged. The use of a bi-polar measure was questioned by residents and equally by the reseacher since at times it had an inhibiting effect, however, it provided a stimulating challenge for a number of clients.

The researcher found this part of the study both a painful and moving experience. The various approaches adopted by residents to the life tasks with which they were confronted provided a rich learning experience. It was illuminating because evidence could be found to support most of the reactions to ageing described in Chapter 2. This provided the motivation for the extensive use of quotation used throughout this study. Any stereotyped view of ageing would be diifficult to maintain after such interviews.

(3) The Measure of Engaged Behaviour

The chief requirement of this measure was that it 'must be capable, ..., of evaluating not only the level of activity but also able to make some judgements about its motivation', (page 38). This study shows that the measure used was equal to this demand. Although some lounges had sleepy afternoon periods after lunch, residents did seem to respond positively to stimulation.

Leisure activities were enthusiastically reviewed in the self esteem measure which seemed to support these observations. The greater the novelty of the event the greater was the level of stimulation observed. Relatively unusual treats such as ice-cream and sweets were more stimulating than tea and coffee. Television usually lulled a resident to sleep while a visitor generated conversation, animals produced a ripple of pleasure and reminiscence.

These measures , then, despite the problems already explored, did produce a wealth of data which contributed to an interesting descriptive study. No single part of the assessment could have been omitted without impoverishing the study considerably. The very success of the exercise in fact produced problems in trying to analyse and then correlate the many different types of information.

7.3 Implication for Social Service Practice

(1) The Analysis of Daily Practice

The researcher received feedback from some of the homes studied that this assessment device had provoked a great deal of useful debate. The areas of disagreement between members of staff of the same home were obvious examples of the need for greater consultation and information giving to take place. This analysis might prove a useful tool in the review of caring practices within a home.

(2) The Measure of Self Esteem

This provided considerable insight into the impact of the ageing process on an individual resident. It was a valuable learning experience for the researcher as well as providing important clues about the individual's response to the residential experience. Not only might such an assessment provide a useful insight into resident need but it would also have clear value as part of a staff training exercise.

(3) The Measure of Engagement

Extensive literature quoted in this study showed this to be a valid measure for determining the richness or impoverishment of the residential environment. The indications are, that many residents, given the choice, do not enjoy doing nothing. This measure is useful because it can be used to determine both where a need for stimulation exists and the success of any intervention aimed at providing it.

(4) The Total Assessment Package

Undertaking three types of measurement undoubtedly creates a great deal of work so that question must be put, even if this is desirable, is it necessary? The answer for this study was in the affirmative. All the individual measures were so beset with problems that individually only very limited weight could be placed upon them. It was the very clear pattern of results which gave force to the arguments that an individually orientated care policy afforded greater client satisfaction. For other situations the solution might be different.

7.4 Further Research

Issues which were outside the scope of this study to explore but which had clear relevance to much of the data discussed were:

(a) The influence of the size and geography of the home on resident self-esteem.

(b) The impact of the wider environment on the quality of life within the home.

(c) The effect of various types of staff training upon service delivery within the home.

None of these topics are previously unexplored but they so constantly reoccurred throughout the study, exerting a powerful but unmeasurable influence upon the residential ethos that they would seem to warrant further investigation.

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