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Positive Nurse-Resident Relationships a Focused Ethnography in a Nursing Home

Rosemary A. Costigan
University of Rhode Island, rcostigan@ccri.edu

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POSITIVE NURSE-RESIDENT RELATIONSHIPS:
A FOCUSED ETHNOGRAPHY IN A NURSING HOME

BY

ROSEMARY A. COSTIGAN

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE

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OF
ROSEMARY A. COSTIGAN

APPROVED:

Dissertation Committee:

Major Professor: Donna Schwartz-Barcott

Alicia Curtin

George Willis

Nasser H. Zawia
DEAN OF THE GRADUATE SCHOOL

UNIVERSITY OF RHODE ISLAND

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Abstract

More than 1.4 million Americans reside in long term care facilities across the United States. Social and professional relationships are an integral component of everyday life within these environments. Few studies have systematically examined positive relationships that exist between residents and nursing assistants in long term care.

A focused ethnography of a nursing home, one known for the quality of life experienced by its residents and located in the northeastern United States, was used to examine the nature of (1) interactions (2) positive relationships (their development and maintenance) between residents and nursing assistants, and (3) supportive environmental factors. Peace House (a pseudonym) was one of 30 nonprofit, continuing care facilities operated in the US by an order of Catholic Nuns committed to the care of the elderly poor. Participant observation took place primarily in public spaces over a four-week period. Interviews were conducted with ten Caucasian, English speaking and cognitively alert residents, including 9 women, 1 man and ranging in age from 74 to 103 and residing on a skilled nursing unit. Schatzman and Strauss's fieldwork notation system was used to record and analyze data. Semi-structured taped interviews were transcribed, read and re-read and analyzed in relation to general themes. Credibility and trustworthiness were enhanced by member check and expert review of transcripts and findings.

Overall, interactions in public spaces were resident-to-resident, social in nature, and initiated primarily by residents. On skilled units interactions were primarily initiated by staff to resident but controlled by the resident. Residents interviewed had at least one positive relationship with a direct caregiver, but differentiated as, specific, non-

specific, or distant. The presence, or lack, of close familial relationships did not influence the forming of close personal relationships between residents and nursing assistants. Most of the residents were unable to describe how these relationships developed and were maintained over time due to memory lapses surrounding the initial period of transition. A number of public spaces and social and work opportunities existed that facilitated social interaction. The sisters and staff members supported positive relationships by allowing the residents to be themselves. Knowledge of individual resident preferences was communicated effectively among the staff, enabling residents to decide with whom and how they wished to establish a relationship. Implications from this study include expanding Kim's (2000) conception of the nurse-client domain to encompass interactions that are prolonged and sustained over time, increasing research on transition periods into long term care and the importance of acknowledged individuality.

Acknowledgments

This research would not have been possible without the help, guidance, love and support of many people. First, to the residents, staff and Sisters of Peace House I am deeply indebted to you for the cooperation and openness in which you embraced this study. Your cooperation assisted me greatly in contributing to research in the area of positive relationships within nursing homes.

My intention throughout this study was to focus on the positive relationships that existed within one nursing home, particularly between the resident and nursing assistant. Peace House was selected because of its reputation for providing a high quality of life as well as high quality of care for its residents. It was also known, by some of the residents, as being better than home and did not disappoint. I believe this study provides a positive example that quality of care and life can and do co-exist in long-term care.

I wish to acknowledge Professor Donna Schwartz Barcott, College of Nursing, University of Rhode Island, major professor, for her constant support and expert guidance; Professor Ginette Ferzst, College of Nursing, University of Rhode Island; Professor Alicia Curtin, College of Nursing, University of Rhode Island; Professor Phillip Clark, Gerontology Program, University of Rhode Island and Professor George Willis, School of Education, University of Rhode Island for their guidance and support as committee members.

To my husband Paul, our children Cathleen, Michael (Jessica), Kevin, Rory and Dennis words cannot express the gratitude and love I have for you. Thank you for being there for me during the journey. To my beautiful granddaughter, Aislinn, your

presence and unconditional love always helped put everything in its right place. To my parents the late Thomas and Agnes Cute for instilling in me a strong work ethic.

Dedication

This dissertation is dedicated to my Aunt Lolly who inspired me by her courage, appreciation and optimism during our complicated and sometimes frustrating journey through long-term care.

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Chapter I

Introduction

Currently there are more than 1.4 million people residing in nursing homes in the United States (Centers for Medicare & Medicaid Services, 2011). This number is expected to increase as the baby boomer population reaches retirement age and beyond. Adding to the projected need of nursing home care into the future is the shrinking ability of families to provide at home care for their elderly relatives. Nursing homes are frequently referred to as places of last resort and it is not uncommon to hear phrases like I would rather die than have to live in one (Mattimore, et al., 1997). Numerous analogies have been made that compare them to prisons, poor houses and zoos, where the lack of respect and basic human dignity is thought to be the norm (Eskildsen & Price, 2009). Yet despite these negative connotations, they continue to be a necessary and highly utilized segment of society, which is only expected to intensify over the next several decades.

Concerns with Quality of Care

Concerns regarding the quality of care in nursing homes can be traced back to the 1930's and through three major legislative acts: The 1935 Social Security Act, the 1946 Hill-Burton Act and the 1987 Omnibus Budget Reconciliation Act (Farmer, 1994; Ogden & Adams, 2008). Each led to increasing government oversight and met with some limited success in increasing the quality of care. Ultimately, they led to a newer and broader concern with the quality of life for residents in nursing homes. By 2003, Thomas and Johansson, two gerontological researchers, were arguing that the strict regulations regarding quality of care were actually stripping much of the quality

of life and spontaneity away for the residents and that under such circumstances the human spirit would wither.

In 1997 Congress commissioned a group of researchers, headed by Drs. Rosalie and Robert Kane from the University of Minnesota, to investigate the development of standards related to the quality of life of nursing home residents. The research was ground breaking and resulted in the identification of 11 domains that were deemed quantitatively significant in moving towards measuring quality of life. Additionally, this research established a clear correlation between positive social relationships and quality of life. Whitworth, Perkins and Lesser (1999) warned that interaction is essential to the development of social relationships and if residents are not supported in their ability to interact they could withdraw and cease trying (Cook & Brown-Wilson, 2010).

Significance of Relationships in Long-Term Care

Simultaneously during this period, a number of researchers were examining the culture of daily life within nursing homes (Diamond, 1992; Farmer, 1994; Gass, 2004; Gubrium, 1975; Restinas, 1986). The majority of this research focused on the negative aspects and outcomes of the long-term care environment. There were some anecdotal examples however that showed that positive relationships can and do exist in these settings (Restinas, 1986) and that the relationship between caregiver and resident was foundational and important (Bergland & Kirkevold, 2005; Flesner, 2009; Hauge & Heggen, 2007; Heliker, 2009; Weydt, 2010). What was lacking was research that focused on the nature of the interactions and relationships between

caregivers and residents, how these develop, and are maintained over time, as well as aspects of the environment supporting them.

In this study, a focused ethnography, including participant observation and interviews with ten residents, was used to examine the nature of positive relationships between resident and nursing assistants in a nursing home known for the quality of life experienced by its residents. The study was guided by the following questions:

1. What kind of interactions and relationships exist in the setting?
2. What is the nature of the relationships that residents identify as positive?
3. How did these develop and how were they maintained over time?
4. What environmental factors supported these relationships?

Significance of the Study

Kim (2000) has provided an organizational framework for nursing knowledge and its development. It is organized into four separate domains: client, client-nurse, practice and environment. The framework assists in conceptualizing phenomena from a nursing perspective and identifying those phenomena most important to nursing (p. 42).

“Client-nurse phenomena exist when two human beings, a client and a nurse, with all of the realities of being human, are together in the context of nursing care” (Kim, 2000, p. 105). Additionally, Kim saw the client and the nurse as social agents grounded in human-human interaction that occurred within their respective roles. This domain has been further delineated into three types of phenomena: contact, communication and interaction. The phenomena have been further considered in

relation to their meaning (as nursing therapeutics; a medium for nursing actions and as an expression of a philosophy of care).

Consistent with Kim's (2000) description of this domain clients and nurses assume respective roles that involve social relations that are unique to the situation (p. 105). Kim's primary point of reference was the professional nurse in a hospital setting who had face-to-face interaction and direct contact with clients. In contrast, in the nursing home environment, the client is referred to as the resident and care is carried out primarily by the nursing assistant, who supports the professional nurse. Although not the professional nurse, the nature of positive interaction between resident and nursing assistant adds to our understanding of positive relationships in long-term care.

“The philosophy of care focus is actualized in nursing through various forms, such as in nurses' interactions with clients, through upholding the ethical values of human dignity and autonomy in every nursing action, and in defending patients' rights. It is the nurses' interactions with clients in which the philosophy of care is played out in nursing most importantly” (Kim, 2000, p. 109). An essential component that surfaced in this study was preservation of human dignity and autonomy for the resident. Several of the participants identified being “left alone” as a positive factor that respected their individual needs and desires. An example of this was the gentleman who did not want to go to the dining room for his meals. While in general all residents take their meals in the dining room he was allowed to eat in his room. Another example was the woman who wanted her door closed following dinner, as privacy was important to her. The Administrator asked her to support her reason for

having the door closed and a positive outcome was reached that satisfied both the nurse and the resident. Despite being a Catholic nursing home all of the residents identified the freedom of attending or not attending religious services.

The finding that positive relationships between resident and nursing assistant encompassed different levels of attachment goes relatively unacknowledged by Kim. This study brought out the importance of intensity of interactions that ranged from very low to very high and how that impacted client outcomes. Additionally, as the baby boomer generation ages and the need increases for long term care this study shifts the focus from acute care interactions, as identified by Kim, to the sustained long term interaction experienced by residents and nurses in nursing home settings. Peace House is an example of a nursing home that considers everyday living an important component of a therapeutic environment. This was accomplished by knowing the resident and respecting their individuality.

Following this first introductory chapter, an historical overview of nursing homes, legislative acts toward improving the care within long term care homes and the evolution of quality of life to the importance of positive relationships between caregivers and residents are presented in Chapter II. The use of focused ethnography to study positive interactions in one nursing home is described in Chapter III. The facility beginning with selection of the site and first encounters with individuals within the organization are mapped out in Chapter IV. The findings in relation to each research question are presented in Chapter V. The final Chapter includes a summary, implications and conclusions.

Chapter II

Literature Review

Nursing homes are still thought of as places of last resort and many would “rather die” than live in one (Mattimore et al., 1997) but they remain a significant component of the healthcare system in the United States. It has been suggested that as many as one in twenty older adults reside in nursing homes at any given time (Farmer, 1994; Vladeck, 1980). Additionally the need for nursing home care is not expected to wane as the oldest old, defined as those 85 years of age or older, is the largest growing segment of the population and will require the most health care moving forward (Ironside, Tagliareni, McLaughlin, King, & Mengel, 2010). Furthermore by 2050 those 65 years of age and older are projected to increase from 12% of the population to 24% (Kuhn & Nuscheler, 2011; Miller, Mor, Clark, 2010; Spillman & Lubitz, 2002) which also is expected to lead to an increase demand for nursing home care (Quadagno & Stahl, 2003). The number of persons relying on nursing home care increased dramatically between 1987 to 1997 rising from 0.3 million to 1.5 million (Murtagh & Litke, 2002).

In addition to the age factor other influential societal and scientific developments continue to support the significance of nursing homes within society. As the ageing population increases so do the symptoms associated with it. Medicare Payment Advisory Commission in 2006 identified as many as 82% of elderly having at least one chronic illness that led to long-term medical and nursing management. Additionally, it is anticipated that advances in technology and medicine will increase the life expectancy for older persons and result in an increased need for LTC (Ironside

et al., 2010). Shortened acute care lengths of stay associated with the introduction of a prospective payment reimbursement method has had a significant impact on the need for nursing home beds (Hing, 1987; Shaughnessy, Kramer & Hittle, 1990; Shaughnessy, Schlenker, & Kramer, 1987; USGAO, 1983). Finally, more women working outside the home and smaller families have resulted in an increased need for long-term care (Quadagno & Stahl, 2003). The graying of Americans is expected to ensure the further growth of this segment of healthcare (Eskildsen & Price, 2009; Murtaugh & Litke, 2002; Ogden & Adams, 2008).

Historical Overview of Nursing Homes and Quality of Care Issues

Along with the expected and continued demand for nursing home care is the enduring concern related to quality of care and life issues within them. The nursing home industry has evolved over time as a result of societal responsibilities and governmental financing of care for the elderly within our society. Vladeck (1980) referred to nursing homes as “an inadvertent byproduct of public policy” (p. 42). Due to the requirements associated with payment from the government nursing home quality and development have historically overlapped (Castle & Ferguson, 2010). Organized care of the elderly dates back to early colonial times and from charity organizations to government run “poorhouses” or “poor farms” (Eskildsen & Price, 2009). Over the course of time, nursing homes have undergone several significant changes and continue to evolve today.

In 1935 the United States Congress enacted the Social Security Act that provided funds for elderly care, which served to quicken the demise of poorly run government homes (Farmer, 1994; Ogden & Adams, 2008). Prior to this period

government funding of any type for the provision of healthcare was minimal (Moroney & Kurtz, 1975). The Social Security Act provided payment for homes that initially offered residential care in the form of a roof and meals. Many of these organizations were “mom and pop” type providers (Ogden & Adams, 2008, p. 145) and did little to repeal the overall dissatisfaction with nursing home care (Moss & Halamandaris, 1977; Vladeck, 1980). Over time these homes began to add nursing care and eventually evolved into convalescent or nursing homes (Moroney & Kurtz, 1975; Moss & Halamandaris, 1977). “Facilities were often dilapidated and frequently unsafe; medical and nursing care was minimal; reports of exploitation and abuse of residents quickly circulated” (Vladeck, 1980, p. 38). These reports initiated the second major twentieth century intervention by the U.S. Congress with the passage of the Hill-Burton Act of 1946. This act was intended to provide monies for hospital and nursing home bed expansion with the idea that more competition would facilitate a higher quality commodity (Ogden & Adams, 2008).

By 1953 long-term care was judged seriously inadequate by the U.S. Public Health Service and the Commission on Chronic Illness (Ogden & Adams, 2008, p. 145). The actions that followed this report set up the transition of elderly care from residential to medical managed homes. Government funding of expansion of non-profit nursing homes continued to be supported as long as they were operated in conjunction with a hospital. Vladeck (1980) referred to this period as one in which long-term care of the elderly transitioned from social policy to national healthcare policy. In 1965 the Medicare and Medicaid Act increased the funding to nursing homes and charged the department of Health, Education & Welfare with setting

standards. Almost immediately difficulties were encountered with identifying and regulating the standards. It was identified that few nursing homes would be able to meet the standards and it was unclear who would be responsible for effectively monitoring them. In 1967, an amendment to the 1965 Medicare & Medicaid Act entitled the Moss Amendment authorized the Department of Health, Education and Welfare (HEW) to set and enforce standards uniformly for all states (Committee on Nursing Home Regulation, IOM, 1986).

The 1970's proved to be no kinder than the previous decades for nursing home residents. Reports of numerous deaths related to fires and poor food preparation abounded (Ogden & Adams, 2008). Congressman David Pryor, at the behest of his mother's complaint about the care a relative was receiving in a nursing home, went undercover to see firsthand what was occurring in long-term care and was instrumental in establishing congressional hearings related to nursing home regulation and financing (Ebersole & Touhy, 2006). A White House Conference on Aging was convened and President Nixon identified an eight-point nursing home improvement plan (Ogden & Adams, 2008, p. 151). Vladek (1980) identified this effort as having little impact and reflecting more of a symbolic gesture than a transformative one. In 1982 under the Reagan Administration there was an effort to deregulate the nursing home industry after complaints of stringent standards by nursing home owners however this was not acted upon after public outcry (Castle & Ferguson, 2010; Ogden & Adams, 2008).

The Institute of Medicine Report

Nursing home care was found to be “shockingly deficient” by the Institute of Medicine (Committee on Nursing Home Regulation, IOM, 1986, p. 2) and the General Accounting Office (GAO, 1987) during the mid 1980’s. As a result recommendations by both the Institute of Medicine and the General Accounting Office were incorporated into the House of Representatives Bill 3545 (1987) Omnibus Budget Reconciliation Act (OBRA) (Castle & Ferguson, 2010; Kane, 2001; Ogden & Adams, 2008). Conclusions of the study were as follows:

1. Quality of care was not satisfactory in many homes,
2. More regulation could improve the quality within nursing homes,
3. Stronger federal role was necessary,
4. Improvements were needed in the regulatory system,
5. There were opportunities to improve quality of care in nursing homes that were independent of changes in Medicaid payment policies or bed supply.

(Farmer, 1994, p. 13; IOM, 1986, pp. 21-22)

The changes included a heavier emphasis on resident outcomes versus structures, unannounced visits and increased penalties for violations. Specifically, emphasis was placed on outcomes associated with elimination, infection, nutrition, cognitive functioning, activities of daily living, and use of physical and chemical restraints (Center for Medicare/Medicaid Services, 2004; Rantz, 2003; Zimmerman, 2002). Some have argued that there has been little improvement in the quality of care post 1987 OBRA enactment but most agree that some degree of improvement has been realized (Kane, 2001; Walshe, 2001). This concluded the first wave of nursing

home reform that spanned over fifty years and resulted in uniform standards that addressed the physical care and types of environments provided for nursing homes.

Quality of Life

Following enactment of OBRA 87 it was recognized that while improvements in some areas related to care were present little had changed surrounding the attitude of having to enter into one. The reforms did not lead to a more humanistic culture in nursing homes (Flesner, 2009, p. 273). Thomas and Johansson (2003) identified that while improvements in nursing home care had gotten better, 40% of America still found living in one to be unacceptable. As a result of this continued negative view of long-term care the Centers for Medicare and Medicaid awarded a contract to the University of Minnesota to develop and test measures and indicators of quality of life for nursing home residents. Rosalie and Robert Kane, along with other researchers at the University of Minnesota's School of Public Health, undertook the challenge to develop individual outcomes that collectively reflected quality of life. The attempt was not to define quality of life, per se, but rather identify as many outcomes that represent the best possible quality of life.

The first wave of research was conducted in 5 states with 1988 participants in 40 facilities and resulted in 3 to 13 items for each of the original 11 domains. The authors were unclear how they decided upon these domains to test other than referencing literature reviews, expert opinion, focus groups and discussions with stakeholders (Kane et al., 2003). They acknowledged that the list was not exhaustive (Kane et al., 2003) and that it was better to try and fail than to not try at all. The outcomes identified were: security; physical comfort; enjoyment; meaningful activity;

relationships; functional competence; dignity; privacy; individuality; and autonomy (Kane, 2001). At the completion of the first wave individuality was found to have poor internal consistency and difficult to distinguish from the relationships domain and was dropped from the original list. Later on, for no obvious reason, it was subsequently picked up and dropped again.

The second wave, prompted by Centers for Medicare and Medicaid, focused on reducing the items tested to as small a number as possible in order to increase response rates and decrease administration time. The result was a 34-item domain tool that incorporated meaningful activity and spiritual wellbeing. A weakness associated with the study was the lack of test-retest data for quality of life measures.

Major leaps have been made based on the findings of the above 2 waves of studies, despite the weaknesses associated with domain identification and the belief by some (Fernandez-Ballesteros, 2011) that quality of life should not be reduced to subjective and objective parts. Offshoots of this body of work include Kane et al. (2004) attempt to differentiate between nursing homes based on reports related to the outcomes. It was found that resident characteristics explained more of the variance than the facility differences, which did little to advance the understanding and measurement of quality of life. Another effort was aimed at the stakeholder's ability to identify important quality of life factors for various types of patients (Kane et al., 2003) and reflected the disparity and difficulty in objectively assessing subjective aspects.

Other offshoots of the quality of life initiative were related to the environmental design of long-term care houses and included the introduction of a

small house design and restructuring of caregiver roles (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006) with resultant longitudinal evaluation of those homes (Kane et al., 2007) based on the 11 domains originally identified. One small study did show some differences between the Green Houses and the traditional homes but the findings could not be generalized. Additionally, the Eden Alternative developed by Thomas and Johansson (2003) gained popularity for developing an approach to encourage a habitat of flourishing. This approach involved re-defining the management structure; utilizing small houses versus institutional settings; improving choice and shared governance (Kane, 2003, p. 29). Finally, Degenholtz, Kane, R. A., Kane, R. L., Bershadsky, and Kling (2006) attempted to link quality of life outcomes to already existing data sets. Results indicated that no correlation could be made between these data sets and quality of life for residents.

While this body of work contributed significantly to the efforts of addressing quality of life for long-term care residents it presented with some troubling and irreconcilable issues. First the rationale for investigating and studying quality of life was undertaken from a focus on measurement at the request of regulatory bodies and without a clear definition of what it constituted. Such an assumption implies that quality of life can be objectively evaluated which is illogical without a definition to guide the research. Second, a lack of clarity exists on how the initial domains were decided upon. Third, the rapid acceptance and expansion of research based on domains that may or may not contain the most significant factors in quality of life is questionable. Fourth, Kane et al., (2005) acknowledged a lack of consistency between what residents reported and other raters, such as family or staff, when assessing

quality of life domains. Fifth, self-reports were considered the gold standard for measuring quality of life in the above studies and thus reduced quality of life to a subjective appraisal which is difficult to reconcile with the stated desire to measure it objectively and subjectively.

One of the major problems associated with the quality of life literature and research was the tendency to give identified quality of life factors equal weight and importance. Bergland & Kirkevold (2005) cited the lack of studies that explored individual factors for significance, including the ability to thrive in a nursing home and the type of relationships that supported it. The literature has depicted life within nursing homes as regimented and mechanized with an emphasis on the technical aspects of care (Armstrong-Esther, Browne & McAfee, 1994, p.271; Clinton, Edwards, Moyle, Weir & Eyeson-Annan, 1996) and “dormitories for those who are near death” (Fiveash, 1998; Nussbaum, 1993, p. 245). Thomas and Johansson (2003) referred to the environment as set up to run “like clockwork” (p. 283). They cited the unnatural living environment of a cold, sterile and controlled place, which promoted the withering of the human spirit. These findings reinforced the belief that quality of life, approached broadly, is more a philosophical viewpoint than an operational and concrete outcome that can be described and/or measured.

Impact of the Nursing Home Environment on Relationships

Several sentinel fieldwork studies dominate a body of literature aimed at better understanding the environment of long-term care and the resident’s experience of nursing home life. In Gubrium’s (1975) *Living and Dying at Murray Manor* the organizational culture of life and work were examined. The author examined the

environment as a constructor of life within a particular nursing home by identifying the setting, the staff, the social ties of the clientele, bed and body work, the passing of time, and finally death and dying. The study contributed to an understanding of the types of relationships that unfold in the presence of a regimented system, namely the nursing home. He successfully illustrated how all participants could manipulate the environment, in order to get the “work” done and the lack of importance the social nature of life had for the “top brass.” Despite this, relationships did take root and assisted in residents in adjusting and surviving nursing home life.

One of the interesting outcomes of this study was that staff-resident friendship ties were more likely to be present on the “third and fourth floor,” which referred to a higher skill level of care. While not depicting specific individual examples Gubrium did sketch out what he considered to be evidence of friendships between staff (primarily nursing assistants) and residents. They included doing things that would not be considered part of the job such as purchasing cigarettes, writing tablets, taking a resident out to smoke or allowing them special privileges, such as using the staff phone to make phone calls or possibly accompanying a staff member to break.

Following in Gubrium’s footsteps, Gass (2004) studied life within long-term care and discovered that it is remarkable the system worked at all. He was able to articulate effectively the innate hypocrisy embedded in the nursing home industry. It is regulated so heavily to prevent abuse and disaster that it results in an inability to provide a socially responsive environment. Gass did conclude that despite a heavy regulatory presence the direct staff had a significant impact on many of the residents. Examples of positive relationships that he developed during his stint as a nursing

assistant included taking “Marge” out for a ride to her old neighborhood. It was an effort to relieve her monotony with life inside the nursing home. For another resident named “Marty,” who as Gass exclaimed, “lived in a real concrete horror” (p. 101) suffered from Parkinson’s disease. Marty enjoyed music and he purchased him a Walkman and relaxing tapes to listen to. He described how at times he would slap her leg or give her a peck on the cheek for no reason and she would sometimes look warmly and other times just confused. However, when Gass would threaten to quit Marty would threaten to leave as well. The author depicted his own interactions but provided little insight into how others were interacting with residents.

A significant contribution of this work included recognition of the ability of a caregiver to be a key that unlocked a resident’s mood and the fulfillment experienced by both when that occurred. He pointed to the ingenuity of caregivers and residents’ ability to connect as the prime reason for any success. The final conclusion of this book, as stated earlier, was that it was a miracle the system worked at all. This supported a comment made by Senator Frank Church that “there is nothing positive in the nursing home field...but there are some very fine nursing homes” (Moss & Halamandaris, 1977, p. 199).

Joan Restinas (1986) depicted a similar finding in her study, *It’s OK Mom*, with the identification of friendships and relationships that were capable of being formed despite the hospital-like environment. A significant finding of Restinas was that those residents who retained their historical past or had interesting occupations enabled staff to see them more as people. The purpose of her study was to reconcile the dichotomy of the nursing home. Her findings supported the above statement that

good relationships can and do flourish in nursing homes, even those that appear institutional. Restinas provided examples, including one of a young nursing assistant who took an elderly couple home for Thanksgiving when she learned their children would not make it home. Susan Y., another aide, routinely took “Bessie” home for Sunday dinner. Anne Z. took another resident to the movies. Another example included Lucille L. who was a middle-aged alcoholic whose husband stopped visiting over time. Mildred A. took up chats with her to fill the void. The author noted that these anecdotes were not frequent occurrences however they were not rare. Restinas concluded that a need for regulations, which addressed the emotive, social and aesthetics of nursing homes, was necessary.

Diamond’s (1992) controversial *Making Gray Gold* examined the work of long-term care and the impact on those that were recipients of it. He focused on how the individual was depersonalized through the documentation systems. It was his belief that the most important aspects of the care provided received little to no attention in the systems used to record it. Additionally he focused on the relationships between the nursing assistants and the residents and how those relationships bloomed and were nurtured. He coined the term “mother’s wit” to describe the re-direction of caring away from mechanical tasks and toward social, emotional and political skills (p. 239).

A mother’s wit enabled care providers to promote living by working in and around the rules that regulate nursing home care. He described nursing home life as a purgatory living between the longed for past and the unwanted future. The book primarily portrayed the frustrations that residents and nursing assistants feel as a result

of regulations that smother the everyday aspects of living. He did describe moments that were positive, such as “Mary Karney” summoning a couple of aides to give them a handful of gumdrops. The act violated at least three major rules according to his count but resulted in all involved feeling satisfied. Other examples of successful and positive interactions highlighted the usefulness of knowing the patient. “Jack Phillipson”, suffering from Parkinson’s and dementia, would get dressed for work every morning and Mimi would say “no work today Jack,” at which point he could be directed to breakfast peacefully. Mother’s wit allowed for normal everyday living by putting tasks into a social context and allowed life to go on in an environment that worked very hard at suppressing it.

Farmer’s (1994) *The Meadows of Madison* proposed a new model of thinking related to nursing home life. She approached the ethnography utilizing the organizational climate to evaluate the major determinants that influence it. She found that the Meadows of Madison was a “nice place” to live for the residents and this vision of the organization heavily influenced that outcome. Farmer proposed a model of care entitled a *Cooperative Model of Long-term Care* that involved residents sharing in the responsibility of daily living. The resident would not be viewed as a product or an outcome but as an important member of the organization. Farmer was successful in identifying the elements of the organization yet the depiction of what constituted individual positive relationships was limited. This is understandable as the purpose and focus was on the organization, as a whole, and not the individual.

It is evident, throughout all of these studies, that positive relationships do occur and are sustained in environments that are unintentionally designed to suppress them.

It was the familiar ordinariness of everyday life that was most identified as a missing element inside a nursing home. The depiction of the positive relationships that developed appeared to illustrate the importance of experiencing a familiar everyday life with all its nuances. Nursing home regulatory systems have attempted to eliminate the unstructured ordinariness of daily life. Thomas and Johansson (2003) referred to life as a basket with large stones, depicting major components of life, and the grains of sand between the stones as the everyday events that make up our humanness and spirit.

Relationships

As noted earlier, in spite of the general belief that nursing homes are not conducive to the development and sustainment of positive relationships, several researchers have provided anecdotal evidence that such relationships do exist between nursing staff and residents (Gass, 2004; Restinas, 1986; Tellis-Nayak, 2010). The impact of the caregiver role on the development of positive relationships between residents and staff has been explored and found to be a critical and essential ingredient (Asmuth, 2004; Bergland & Kirkevold, 2005; Bowers, Fibich, & Jacobson, 2001; Brown-Wilson & Davies, 2009; Cook, 2007; Moos & Igra, 1980; Timko & Moos, 1990). Additionally, there is evidence that positive relationships between care givers and residents contributes to overall quality of life for the resident (Asmuth, 2004; Bergland & Kirkevold, 2005; Cook & Brown-Wilson, 2010; Cook & Clarke, 2010; Crandall, White, Schuldeheis, & Talerico, 2007; Heliker, 2009; Kane, 2004, 2005, 2007). Other researchers have explored and correlated the connection between positive relationships and need fulfillment (Custers, Westerhof, Kuin, & Riksen-

Walraven, 2010), well-being (Bitzan & Kruzich, 1990; Park, 2009; Street, Burge, Quadagno & Barrett, 2007) as well as thriving (Bergland & Kirkevold, 2005).

Development of Relationships in Long Term Care

Lofland, Snow, Anderson and Lofland (2005) defined social relationships as two parties who interact with some interdependence and who view themselves as “connected” to one another, however briefly (p. 126). Authors in the literature have used this definition as a basis for identifying examples of what contributes and what detracts from the development of positive relationships in long term care, specifically between care giver and resident.

Brown-Wilson and Davies (2009), Brown-Wilson, Davies, and Nolan (2009) and Asmuth (2004) have contributed a significant amount of information related to how positive relationships develop between residents and those who provide care for them in long term care facilities and have identified main contributors facilitating the development and maintenance of positive relationships in long term care. They found that physical characteristics and/or contact between the resident and caregiver had a strong influence on the development of positive relationships particularly the presence of a smile and eye contact (Asmuth, 2004; Cook & Brown-Wilson, 2010; Hauge & Heggen, 2007). Eye contact was found to create connections between the stakeholders that facilitated on-going development of the relationship (Asmuth, 2004; Jackson, 1997; Nakrem, Vinsnes & Seim, 2011). Additionally, the giving of a hug was also identified as a physical contributor to positive relationship development between caregivers and residents (Nakrem et al., 2011).

Another area that influenced the development of positive relationships was the ability to “know” the resident. This knowledge included such things as offering a glass of wine in the evening to one resident because “I know she likes a glass in the evening” (Bergland & Kirkevold, 2005). It involved the caregiver taking an active role in getting to “know” the resident through the family and/or direct questioning of the resident, using pictures and artifacts as triggers (Brown-Wilson & Davies, 2009). This led to incorporating that knowledge into care routines, which included the example of the resident who was afraid of the hoist because of his experience in World War II; the caregivers also knew that the gentleman enjoyed singing Irish songs and so engaged him in singing to reduce his fear (Brown-Wilson, Davies, & Nolan, 2009). Another example that illustrates how “knowing” the resident contributed to positive relationships was knowledge of their previous occupations. Such knowledge allowed for the resident to contribute in a meaningful way to the community as a whole. Brown-Wilson et al. (2009) illustrated this with the example of the nursing assistant who took a resident and former cook, to the coffee shop for her break and solicited the woman’s input on desserts that didn’t require baking. The resident confirmed that she felt helpful and part of the community. A key feature of positive relationships between caregivers and residents was knowing what mattered to the resident and why (Brown-Wilson & Davies, 2009)

Sharing of personal information by the caregiver to the resident was an overarching characteristic of facilitating positive relationships (Asmuth, 2004; Bergland & Kirkevold, 2005; Brown-Wilson & Davies, 2009; Brown-Wilson, et al., 2009; Cook & Brown-Wilson, 2010; Hauge & Heggen, 2007; Nakrem et al., 2011).

Asmuth identified particular activities such as exchanging phone numbers between staff and residents as fortifying the relationship. Nakrem et al. suggested that good conversation facilitates a good relationship. This included the nurse and the resident sharing personal interests, which in turn helped to form a mutual platform for the relationship to develop. The majority of personal information shared by caregivers with residents revolved around their families and assisted in facilitating reciprocal relationships that lead to development of a confidante (Bergland & Kirkevold), and a source of advice for the staff member (Bowers et al., 2001; Brown-Wilson et al.; Grasser, 1996). Additionally, reciprocal relationships have been identified as promoting positive feelings, in general, for the older adult (Bocksnick & Hall, 1994; Farmer, 1994; Schulz, 1976). One resident stated that the mere fact they confided and shared information with him made him feel better about himself (Asmuth).

Humor was another area that was identified as important to facilitating positive relationships in long term care (Brown-Wilson & Davies, 2009; Brown-Wilson et al., 2009; Custers et al., 2010; McCabe, 2004; Nakrem et al., 2011). Humor was found to facilitate approachableness in the nurse, which in turn strengthened the relationship (McCabe, 2004). Others identified that humor was only shared with friends and therefore when it was used between resident and caregivers it became an indicator of a positive relationship (Asmuth, 2004).

The other important question, surrounding the development of positive relationships, concerned where these interactions took place and how. Cook and Brown-Wilson (2010) discussed how residents actively seek out opportunities to interact with staff and the importance of staff in recognizing these efforts. For

example, they described how some residents would sit by the entrance and open the door for incoming staff and those leaving. Others (Park, 2009; Street et al., 2007) identified mealtime as providing a key opportunity for residents and staff to develop positive relationships. Bergland et al. (2005) witnessed bathroom trips as another key time that facilitated good conversation and fostered positive relationships. Also, it appeared one of the most opportune times for these relationships to develop was during the provision of care (Brown-Wilson et al., 2009; Cook & Brown-Wilson, 2010).

Identified Limiters of Positive Relationship Development

“Even though the research is quite clear that more...psychosocial talk of a close relationship between nursing home residents and the nursing staff is positive for both interactants, the medical atmosphere and the structured limitations imposed within nursings home creates an environment that may impede competent ...communication”
(Williams & Nussbaum, 2001, p. 208)

Several defining characteristics having negative impact on relationships between residents and caregivers were found in the literature. Limitation of time contributed the most significantly to suppressing opportunities for positive relationships (Asmuth, 2004; Brown-Wilson & Davies, 2009; Cook & Brown-Wilson, 2010; Nakrem et al., 2011), which lead to social and emotional isolation (Cook, 2008; Cook, Brown-Wilson, & Forte, 2006; Kovach & Robinson, 1996).

Other factors related to negatively impacting positive relationships included; a focus on tasks (Asmuth, 2004; Brown-Wilson & Davies, 2009; Gubrium & Holstein, 1999), failure to empathize (McCabe, 2004), lack of privacy (Hauge & Heggen, 2007), infantilization of the resident through baby-talk (Custers et al., 2010), continuity of

staff (Cook & Brown-Wilson, 2010), non-responsivity to individual resident needs (Brown-Wilson & Davies; Cook & Brown-Wilson; Grau, Chandler, & Saunders, 1995; McCabe, 2004), and risk for emotional drain (Asmuth).

Physical limitations, such as low vision and difficulty hearing, were also identified as major inhibitors to the development of positive relationships with staff. Finally, the overall structured and controlled environment were seen as impeding the potential development of positive relationships (Asmuth, 2004; Kaakinen, 1992; Thomas & Johansson, 2003; Yates, Fentunan, & Dewar, 1995).

Sustaining Positive Relationships

Asmuth (2004) has gone the furthest in identifying ways positive relationships between caregivers and residents can be sustained. She identified the key aspect as being frequent interaction. Additionally she cited the need for in-depth conversation that demonstrated a genuine concern for each other that conveyed a feeling of “you really matter.” Some of the characteristics, identified by Asmuth, of the caregiver were: staying with the resident during lunch and coffee breaks, coming in on days off and going the “extra mile.” One nursing assistant in the study, described how it was important to get down to the level of the resident when communicating. She gave an example of how she knelt when she was communicating with a resident confined to a wheelchair and tried to always follow the golden rule of “doing unto others...”

Cook and Brown-Wilson (2009) identified that relationships were sustained by continuous interaction throughout the day and that very often residents sought out opportunities to interact with staff. Several have suggested that the care provider is responsible for cultivating opportunities for relationship development (Bergland &

Kirkevold, 2005; McCabe, 2004; Nakrem et al., 2011) and therefore understanding the behaviors of residents wishing to form positive relationships needs to be explored further.

Summary

Relationships are an integral part of human life and those that are deprived of them can quickly withdraw and wither away. While the literature on what positive relationships look like, how they are formed and sustained is limited there is sufficient research to support a structured examination of the topic.

As stated earlier, there is no disagreement that positive interpersonal relationships are important to the well-being of the older adult. Additionally, it is well documented that positive relationships do exist in long term care. Some of the key characteristics of positive relationships include knowing the resident, feeling connected to the other, sharing information, reciprocity, humor and mutuality. Behaviors that residents exhibit as outward signs of friendship are seeking out opportunities to interact with a staff member, inquiring into their well-being, feeling connected, humor and sharing personal information, communicating concern for the other.

There is limited research as to what specifically sustains positive relationships in these environments but some important factors are frequent and prolonged interaction, going the “extra” mile, following the “golden rule”, interacting on their level (ie., kneeling down for those wheel-chair bound) and taking advantage of every opportunity to interact with residents. This may include visiting on days off, inviting resident to accompany caregiver to coffee or meal breaks or just taking time to visit. It

was identified that relationships develop and are sustained through the significant act of providing care. Even though some view the routines of long term care environments as oppressive they do provide structure and opportunity for the development of long-term positive relationships.

Quality of life is enhanced, as the literature has demonstrated, by the presence of positive relationships. Additionally, many have identified the caregiver in control of whether such relationships develop (Cook & Brown-Wilson, 2010; Hauge & Heggen, 2007; McCabe, 2004). Little things such as smiling, sharing personal information/stories, facilitating introductions can go a long way in improving the depersonalized environment of long term care (Cook & Brown-Wilson). It would seem reasonable therefore for nursing research to focus on what is within the control of nursing, related to the phenomenon of quality of life, and focus attention on integrating newly acquired knowledge in this area into the education of all direct caregivers in long term care.

Despite the usefulness and contribution of the researchers' identified in this section on positive relationships there is a significant component, which is lacking. Specifically, in most cases, the information gathered was anecdotal and lacked a systematic look at relationships between caregivers and residents. As an example, Asmuth (2004) identified the use of observation as a data collection method yet relied primarily on responses to interview questions pertaining to the individual's perception of friendship including what facilitated them, assisted in sustaining them and those activities that detracted from forming positive relationships with little attention to what these relationships actually looked like or how they unfolded and developed over time.

Unfortunately, there was little data to support the respondents' impressions and/or opinions from a participant-observation perspective.

Some researchers have focused their efforts on the content of the communication between caregiver and resident (Asmuth, 2004; Caris-Verhallen, Kerkstra, van der Heijden, & Bensing, 1998; Gubrium & Holstein, 1999; Williams & Nussbaum, 2001;), while others have focused primarily on outcomes such as well-being and/or thriving (Custers et al., 2010). What is needed now is a fuller view of these relationships including a description of the process by which positive relationships are developed in long-term care.

There is evidence that long-term care residents prefer to form relationships with staff members rather than peers (Bitzan & Kruzich, 1990; Custers et al., 2010; Hauge & Heggen, 2006) and heavily rely on staff for feelings of well-being (Nakrem et al., 2011). It is therefore appropriate, related to the significance of these interactions and the number of people potentially facing long-term care in the future, that efforts be focused on learning more about caregiver-resident positive relationships particularly related to what they look like, how they form and develop, how they are maintained and sustained over time, and what aspects of the environment support them.

Chapter III

Methodology Design and Research Questions

“Rather than wandering onto fieldsites as disinterested observers, attempting the impossible task of trying to catalog everything in setting, we can use the visible orientation of the participants as a spotlight to show us just those features of context that we have come to terms with if we are to adequately describe the organization of their action”

(Goodwin, 2002, p. 1508f)

A qualitative inductive approach using focused ethnography was selected to explore and describe positive relationships between residents and nursing assistants in one particular nursing home. Focused ethnography was selected due to its focus on understanding a specific aspect of the culture of a nursing home, that being the tacit knowledge about positive relationships between residents and nursing assistants. The following questions guided this study:

1. What kind of interaction and relationships exist in the setting?
2. What is the nature of the relationships that residents identify as positive?
3. How did these develop and how were they maintained over time?
4. What environmental factors supported these relationships?

Alfred Einstein once stated “*not everything that can be counted matters, and not everything that counts can be counted.*” In deciding on a qualitative design for the study two major questions needed to be addressed. The first was what type of research, quantitative or qualitative, would be most useful on this topic? In Chapter II evidence was presented that emphasized the lack of systematic research related to resident-nursing assistant relationships that were positive in nature. The lack of description related to these relationships and how they were sustained and maintained

over time was further highlighted. Given those challenges, a quantitative study was considered premature. A qualitative approach was selected since the phenomenon could be explored in depth and a fuller understanding of what occurs between residents and nursing assistants in a positive relationship could be obtained.

A second question was concerned with where the research would take place. In order to study the phenomenon in depth it was essential that the research take place in an environment where there were a number of residents and nursing home assistants, such as in a nursing home. It also needed to be a place where one could expect to encounter positive relationships, a rather difficult task given the overwhelming literature on the negative aspects of nursing homes. The home selected offered the opportunity of viewing numerous contextual dimensions of relationships and had a reputation that aligned with the belief that positive relationships between resident and nursing assistant would be observable.

Focused Ethnography

Focused ethnography is a recent modified form of ethnography. It was developed to accommodate the increasing use of ethnography in one's own culture and the decreased need for spending long periods of uninterrupted time in the field.

Since its origins in anthropology, ethnography has undergone several stages of development and spread across a wide range of disciplines, over the last century. In its early beginnings, fieldwork was focused on studying "others" such as primitive natives of distant lands. Boasian fieldwork introduced the importance of understanding the language of those being studied. In the early twentieth century Malinowski (1922) had a major impact on this method of inquiry by putting himself

into the field, in lieu of local data collectors. He recognized the need for first hand accounts, which resulted in the landmark publication *Argonauts of the Western Pacific* (1922). Despite spending long periods of time with the natives, Malinowski remained detached by living in different parts of the town and not actively participating in all facets of daily life with the Trobriands. Both of these methods of inquiry, Boasian and Malinowski's, relied on a realist ontology in which scientists assumed that a "true" depiction of others way of life was possible.

Emerson (2001) identified participant observation as the *sine qua non* (p. 239) of ethnography. It allows for a holistic view, reduction in pre-conceived ideas and more open discovery, ability to extract the nuances of everyday life that may go unnoticed for those not fully immersed in the setting or routines (Patton, 2002). Participant observation allowed a relationship to build between participant and researcher and confirmed, through observation and/or further discussion meaning or discrepancies.

The Chicago School of Sociology in the 1930's was influential in developing the role of the researcher in the field in the United States. Building on the belief in the value of the researcher being present in the field, there was an effort to move the researcher into a more participant role. It also included the explication of participant observation as a method, including techniques of gaining entry, developing rapport and establishing outsiders into the field. Participant observation allowed for a holistic view, reduction in pre-conceived ideas and more open discovery, ability to extract the nuances of everyday life that may go unnoticed for those not fully immersed in the setting or routines (Patton, 2002). It also allowed a relationship to build between

participant and researcher and confirmed, through observation and/or further discussion meaning or discrepancies. Participant observation was carried out in three phases that included a mapping out of the facility during the initial phase, transition to focused observations and interviews during the second phase and finally disengagement from the field during the third and final phase.

Recently, there has been a questioning of realism as a viable assumption undergirding fieldwork. This has led to a realist/relativist divide as described by Emerson (2001). The discipline began with ethnographic realism where the researcher was writing about the reality of a culture or ethnic group where there was a belief that the researcher was an authority and therefore accounts were “real” to another’s way of life. Early ethnography rested on an experiential authority that communicated to the reader an authenticity gained through text and location of the researcher.

Contemporary ethnography has moved from one of experiential authority to one of interpretive authority (Emerson, 2001). The researcher, in interpretive authority, decides what is important or meaningful. Both experiential and interpretive forms speak in one voice, that of the researcher. In reaction to this dilemma polyphonic authority emerged, which made use of multiple voices. Authenticity was based on the writing style (identified above) and how the data were presented.

Focused ethnography is a contemporary form of ethnography, which has been identified as both a process and product of research by Powers & Knapp (1995). The first use of the term in nursing research appeared in an article by Schwartz-Barcott, Patterson, Lusardi, and Farmer (2002). They developed a two-step fieldwork approach that involved three strategies to assist in linking and/or developing theory

from nursing practice settings. It differs from traditional ethnography in that the researcher enters the field with an identified concept and familiarity with the culture or the environment. In the current study, the researcher had a particular concept in mind, positive relationships between residents and nursing assistants, and had extensive familiarity with the environment selected. In focused ethnography the researcher draws on this familiarity to aid in identifying concepts and linking them to already existing theories or inductively developing new theory (p. 283). The steps include:

1. Step I: Hybrid Model of Concept Development
2. Step II: Focused, Full-Scale Fieldwork. This further involves:
 - a. Theoretical selection,
 - b. Theoretical integration,
 - c. Theory creation.

An advantage cited by Schwartz-Barcott et al. (2002) included expediting theory development by utilizing the clinical expertise of the researcher to assist in identification of significant topics. Additionally they cited its value in clarifying concepts and assisting with challenging definitional issues related to clinically relevant topics.

Muecke (1994) identified a number of significant methodological differences between focused ethnography and classical ethnography, including the identification of specific research questions prior to rather than emerging through study.

Additionally, focused ethnography is accomplished in a shorter period of time, participants are located in one place and participant observation is limited to specific times and events. Beebe (2001) considered this method appropriate for a topic of

interest that begins with a need for detailed information and with “how or what” questions. This was particularly pertinent in this study given the time constraints of the dissertation and the desire to have these types of questions addressed. As stated previously, evidence supports the impact of positive relationships on quality of life for nursing home residents (Asmuth, 2004; Bergland & Kirkevold, 2005; Cook & Brown-Wilson, 2010; Cook & Clarke, 2010; Crandall et al., 2007; Heliker, 2009; Kane, 2004, 2005, 2007) yet there is a substantial gap in the literature related to what and how these relationships develop and look over time.

Knoblauch (2005) discussed focused ethnography as a complementary element to conventional ethnography. He further defined it by its limited field visits and use of multiple and intensive data collection strategies, which included but was not limited to tape recordings and audiovisual techniques. Additionally the method presupposed a familiarity with the field being studied, which allowed focused examination (Knoblauch, 2005, p. 2; Yakong, Rush, Basset-Smith, Bottorff, & Robinson, 2010). Focused ethnography has gained increasing popularity for researcher’s interested in studying particular elements within one’s own society.

This research method was appropriate for the research questions put forth in this dissertation for a number of reasons. First the researcher had extensive familiarity with the organization having spent more than ten years (on limited basis) with first semester nursing students. Second, because the researcher entered the field with a desire to target a specific aspect of the culture this method offered a more efficient and appropriate route than the traditional open-ended method. There was no need to enter the field unfocused based on the author’s professional experiences and the intensive

literature base to guide the inquiry. Third the research took place in a nursing home selected for its reputation of providing excellent care to residents. Fourth it facilitated the understanding of positive relationships in a natural setting (Lyons, 2007). Last, it is well suited for health research that can be characterized by:

1. Conceptual orientation of one researcher,
2. Focus on a discrete community or social phenomena,
3. Being problem focused and context-specific,
4. Involvement of a limited number of participants,
5. Episodic participant observation.

(Higginbottom, 2011, p.3; Morse & Field, 1995; Muecke, 1994; Roper & Shapira, 2000)

Use of Focused Ethnography in Nursing Research

Borbasi, Jackson and Wilkes (2003) referred to the easier time nurse researchers have compared to their counterparts in other disciplines. They believed that because the nurse researcher was immersed in a culture that was familiar it helped them avoid mistakes that non-nurses might make (de Laine, 2000). The ability to ask questions and communicate with people was seen as an inherent advantage to the role (Borbasi, Jackson, & Wilkes, 2003). Altheide and Johnson (1994) stressed the importance of locating one's self in the field and the importance of justifying everything from the questions posed to the people selected (and not selected).

Focused ethnography has gained increasing popularity as a research method within the community of nursing but has been erroneously identified by some nurse researchers due to the lack of a constituent element- participant observation (Heaman & Gupton, 1998; Manns & Chad, 1998). A search of the literature utilizing the terms

focused ethnography and nursing yielded several studies that addressed topics ranging from expectant mother's experience of being confined to bed rest (Heaman & Gupton, 1998) to younger sisters of teenage mothers perception of parenting, and sexuality, and the impact of these on their view of teenage pregnancy, either positively or negatively (Simmons, 2006). Other topics included a study on the quality of life for adults with spinal cord injuries (Manns & Chad, 1998), continence care for residents living in long term care facilities (Lyons, 2007), implementation of a shared-governance model on two separate antepartum units (Angus, Hodnett, & O'Brien-Pallas, 2003) and religious and spiritual coping mechanisms for children with Cystic Fibrosis (Pendleton, Cavalli, Pargament, & Nasr, 2002).

Despite the reference to focused ethnography, only three of the studies actually conducted observation and of them only one conducted participant observation. Angus, Hodnett, and O'Brien-Pallas (2003) examined the effort of two separate intrapartum units' in implementing evidenced-based nursing practice. The units were located within different hospital systems and faced different issues, such as the potential closure of Hospital 1 versus the successful and collaborative practice methods at Hospital 2, which ultimately impacted the ability to adopt practice changes. The nurse researcher spent five days at each hospital and visited at all times of the day. Activities were observed in the labor and delivery unit including interactions between laboring mothers (with consent) and the nursing staff. Additionally observations were noted in the hallways and at the nursing stations. The study assisted this researcher in identifying where to observe (public spaces in this study) and to focus on the individuals who possess the knowledge desired by the

researcher (residents), at times that are believed to offer the best opportunity to observe the intended phenomenon. However, despite the reference to participant observation this study provided no evidence to substantiate its claim.

In another study, Simmons (2006) spoke of using of focused ethnography including participant-observation, but there was very little description of participant-observation. This author focused on understanding teen pregnancy through the eyes of the younger sister. Simmons identified the relationships that were observed as; mother/daughter; younger sister/parenting adolescent; younger sister/niece/nephew. An effort was made to prolong the opportunity to observe by offering to help with the baby, which would facilitate prolonged contact with the participants. Field notes included running descriptions of events, people, conversation (with and among people), interpretation, research analysis, thoughts for future questions and personal feelings. A second journal was referred to as a Reflective Journal and was utilized to vent reactions.

Lyons (2007) detailed and substantiated her use of participant observation in a study of continence care at two different nursing homes. She framed her description of participant observation in terms of person, time and place. Key informants were identified as having inside knowledge of the culture and possessing an ability to communicate that knowledge to the researcher. The participants included nursing staff, residents, rehabilitation aides and physical therapy aides. Space was divided into public and private, where continence care could be identified and situated within the context of daily routines. Identified public spaces were hallways, lounges, the nurses' station, offices, conference rooms, staff meetings, educational offerings and social

gatherings. Researchers with the permission of residents entered and described semi-private areas as bedrooms and bathrooms.

Lyons' (2007) rationale for selecting participant observation was the ability to observe participants in natural settings, enable on-going relationships with individuals and obtain information from multiple sources. Lyons, like Wolcott (2010) identified the ultimate advantage of participant observation as the ability to exploit serendipity.

The purpose of utilizing multiple sites for participant observation was to gather information on the location of continence care during the course of a normal day within the facility. This study was extremely helpful in identifying the need for multiple observations in order to reduce risk of misinterpretation of actions and how to organize the note-taking process when conducting participant observation. The researcher utilized three journals; one for field notes, another entitled Researcher's Journal and a third referred to as a standard diary. The field note journal was structured to include date, time, place, actors, context, and activity. The researcher's journal allowed for reflection on ambiguous situations, drawings and/or personal notes related to experiences of participant observation. Finally, the diary provided a place to document expense and purchases related to the study as well as to catalog human subject procedures. The last document facilitated explanation of how the participants were protected throughout the study.

Study Design

“Good field work...depends crucially upon discovering the meaning of social relations and not just those characterizing the “natives” relations with each other. It depends equally upon discovering the meanings of anthropologists' relations with the people they study”

(Karp & Kendall, 1982, p. 250).

The aim of the research was to gain an initial description and understanding of the nature of positive relationships in one particular nursing home, how these relationships developed, how they were sustained over time and what if any environmental features supported them. It involved three phases, which included; gaining entry, focused observation, and exiting the field. The final phase also included data analysis and writing up of the findings.

Selection of the Setting

The facility selected for the study was well known and one where the researcher had witnessed, on occasion, interactions that might be referred to as positive. It was through this process, spanning more than eight years that decisions on topic and place were made. The setting was a Catholic nursing home located in an urban setting in the northeastern United States. It was operated by an order of religious sisters who had dedicated themselves to caring for the elderly poor. Levels of care offered at the site included independent living, assisted living as well as skilled nursing care.

The nursing home was selected based on its excellent reputation and the likelihood of the presence of positive resident-nursing assistant relationships. Gaining entry into the home was considered a coveted achievement within the local community. Recent quality ratings by Medicare and Medicaid Services gave the nursing home a five star rating as well as an average of five stars for user opinion. Additionally the home enjoyed a stellar reputation with the community for achieving a “a better than home” image.

Phase I

This phase began with the need to gain entry to the nursing home to conduct the study and define the role of the nurse researcher. The challenges as noted by Reinharz (1992) included via gaining entry not as a single transaction but as a continual negotiation and re-negotiation process with the administrators, staff and residents. It resulted in what Reinharz identified as an inherent tension that fluctuated between involvement and detachment. Hosts of the researcher could facilitate or obstruct the process and the researcher needed to consider such situations when planning for fieldwork.

Phase I was conducted over a four-week period during late July to mid August 2012. As noted, it included entering the setting, defining the role of the nurse researcher and mapping out the home and public spaces where interaction was taking place, and identifying and recruiting the first participant. Research question one, what kind of interactions and resident relationships exist in the setting, provided the guidance for observation during this time period.

Gaining entry and defining the role of the nurse researcher was critical to the success of the research project. It went relatively smoothly. The first strategy utilized to gain entry was the use of snowballing as described by Taylor and Bogdan (1998), which included having contact with insiders and involvement with the desired site. As stated previously, this researcher had an extensive professional relationship with the facility that episodically spanned more than a decade. Once permission was obtained to use the site for the study several gatekeepers assisted in identifying locations and times of activities that might be of interest and making suggestions related to potential

participants, much like described by Taylor and Bogdan, (1998); Creswell and Maietta, (2002); Wolcott, (2010), DeWalt and DeWalt (2011).

It was anticipated that the familiarity with key individuals would facilitate entry into the organization, but it was also recognized that familiarity posed potential problems. One particular issue related to a sense of understanding pertaining to the language and environment. It was important to not take things for granted and it required diligent examination of notes and clarification from others, even when this researcher felt she understood the context and language. Intimate knowledge of the setting was a double-edged sword and had to be considered continuously as to avoid inaccurate conclusion, which could have negatively impacted findings. One of the safeguards to this potential was the hiatus I had had from the setting for a couple a years. This allowed me to re-enter the facility with a more defined role, that of a researcher, and not have to concern myself with concurrently managing two roles.

Little difficulty was expected or subsequently encountered with reference to gaining entry and or support for the study. Initial contact was made by physically visiting the facility in order to speak with the administrator, a Catholic nun who will be referred to by the pseudonym of Sister Kay. It was thought that by visiting in person time could be saved and an immediate meeting arranged, potentially a preliminary approval obtained. Unfortunately Sister Kay was out of town for the day. The receptionist offered a voicemail number to reach her and leave a message. Not wanting to divulge too much via voicemail, a short message was left introducing the study; including length of time anticipated and the overall focus of the project.

A week went by with no return phone call from Sister Kay. This posed an interesting juxtaposition since as a student of Catholic nuns during grammar and middle schools I was not inclined to be overly aggressive in quest for attention. Finally, I made a follow-up phone call and discovered a very relieved sounding receptionist. Apparently the earlier voicemail message with my phone number had been inadvertently deleted. Sister Kay was distraught as to what to do and had conveyed concern to the receptionist. Upon hearing that communication had been re-established with the researcher, Sister Kay proclaimed, "I was praying in the Chapel that you would call back and you did!"

A meeting was arranged and the study was described. Sister Kay seemed eager to facilitate the process, feeling badly about the delay. I explained that during the study I would be in and out of the facility over a six month period; initially observing interactions in public spaces of the home and then moving into individual interviews with the residents identified as meeting the criteria and willing to participate. Sister Kay provided written permission for the research study (Appendix A) as did the Institutional Review Board for Human Subjects at the University of Rhode Island (Appendix B). Since the nursing home did not have a separate Institutional Review Board, Sister Kay, as the administrator, had sole responsibility and provided formal permission to enter and begin the study. Sister Kay introduced me to the Director of Nurses and a decision was reached that day-to-day contact would be at the Director's level.

As a nursing instructor in prior years, I had acquaintance with the Director of Nurses and this helped solidify the relationship. We established a schedule as to when

and where the observations would be conducted in the initial phase. The Director did not desire a projected calendar and it was agreed that the researcher would “check in and out” with her whenever present in the setting. The Director had intimate knowledge of the facility where most interactions could be observed, (upcoming events included a summer barbecue and International Day) and residents who, down the road, might be potential participants for interviewing in Phase II. Not having been at the facility in a while and attempting to take an outsider’s view, a tour was arranged with the Director for the next day. The tour gave me an opportunity to re-connect with staff, meet new staff, and observe the type of interactions taking place. The Director was very supportive and enthusiastic about the study and conveyed that sentiment when introducing me to residents and staff. Last, it was agreed I would be introduced as a doctoral student from The University of Rhode Island, as well as a nurse.

Unfortunately a few weeks into the study the Director resigned to take an inspector position with the state. This provided for some anxious moments. The former Director was an engaging younger woman who supported the research and lent authority to the study by her embracement of it. It was most concerning who would succeed her and the need to start over with a new Director who might feel threatened and/or unsupportive of the work. Interestingly the researcher was faced with the potential problem Emerson (2000) identified as related to immersion and reciprocity due to the Director of Nursing’s sudden departure.

During this same time, I was notified that Sister Kay wished to speak with me. Feeling a bit apprehensive as to what could be wrong, I began wondering if Sister Kay was unhappy with the study or had received complaints by staff and/or residents to the

presence of the researcher. All fears were put to rest when Sister Kay asked me, “Want a job?” “We are looking for a new director of nurses and I thought of you.” The statement caught me by surprise and my predominant thought was to not insult or belittle the offer. A moment of reflection was gestured and consideration to the “pitfalls” related to responding inappropriately as by Robbins, Dick and Curtis (1973), Myerhoff (1989) and Emerson (2001) was taken. After a moment a follow up response of “thank you so much for thinking of me but I have my hands full right now” was offered. Sister seemed consigned to the answer before it was provided but it was felt that the response hit the right chord, for both parties. A request was that if I knew of anyone to let her know. I assured her I would. A sense of relief overcame me and the study proceeded without further mention of the position.

A few weeks later a new director was hired who had extensive long term care management experience. A semi-retired former director resumed the responsibility of the position during the transition period and introduced me to the new director. A brief description of the study was provided as well as an offer to check in periodically with her. The new Director was supportive but focused on the enormity of the job she was undertaking. A sense of “you stay out of my way and I will stay out of yours” was present. Ongoing interactions with the new Director of Nursing proved to be professional and somewhat distant, as she had limited in-depth knowledge of the residents at that time.

Role of nurse researcher. My role appeared clear initially but it was not long before a re-clarification of my purpose was needed. Staff and nursing assistants, were familiar with my role as a nursing faculty member. They had witnessed my work

ethic and experienced my assessment skills. While that overall was a positive element, there was an uncomfortable situation that arose later during one of the first interviews. I was interviewing a resident when I heard a “body alarm” go off in another room. It was very difficult for me to not respond to the sound yet I concluded that had I been a total stranger to the organization I most likely would not have recognized the sound. Nevertheless I was very uncomfortable not responding and glad when I soon heard footsteps running. Unfortunately, the Aide yelled for help and declared, “Oh my God she is bleeding!” Deciding it would be unethical for me not to respond, I excused myself from the interview and hurried next door.

Arriving in the room I found an elderly woman lying on the linoleum floor, head bleeding with a nursing assistant helping her. I assessed her level of consciousness and attempted to obtain vital signs. Suddenly the Registered Nurse bound into the room. I had only recently met her and we had had a pleasant exchange at that initial introduction. She demanded to know who I was and what I was doing. As I attempted to explain, the Nursing Assistant jumped to my defense saying, “That’s Rosemary she is a nurse and she came running when I called for help.” Soon after the Director of Nursing arrived and 911 was activated, the woman was transported to the hospital and returned the next day after a night of observation. The nursing assistants were extremely grateful for the assistance I rendered and were disappointed with the registered nurse’s response. While it was an uncomfortable moment, between the nurse and I, overall the outcome was positive.

That experience accomplished two things for me: it reinforced my reputation among the nursing assistants who were very important in recruiting and facilitating

participants for the study and second, it demonstrated how unpredictable fieldwork could be. Despite familiarity with the literature related to the nurse's role in the research setting, it was obvious that not all situations could be anticipated. This was one of those situations that caused much angst as to what the "right" action should be. It did somewhat disrupt my interview but I was able to collect myself and continue on with it. However, the experience shook me because of my hesitation in responding and the subsequent response by the registered nurse who suddenly didn't remember who I was or what I was doing there. In the end I was comfortable that I had done the best thing for the study and myself.

Another issue that presented itself early on was my dual role of researcher and educator. One of the nursing assistants had a daughter in another nursing program and asked me if I was familiar with a particular nursing instructor her daughter had had. The conversation commenced as she entered a room to make the bed and I was conducting an interview. There was a brief but courteous exchange at which point I told her that I would look for her on my way out to discuss her daughter's progress. The nursing assistant was satisfied with my response and did not appear to interpret it as a roadblock to discussion. I made it a point to follow-up with her on my way out and we discussed career paths that her daughter was considering post-graduation. I offered her reassurance that her daughter was headed in the right direction and that I would be happy to speak with her or her daughter at any point.

Finally, a fourth situation presented itself to me, which required careful consideration. One of the Sisters asked me to assist her in learning medical terminology. She was a delightful young nun who spoke English as a second language

and desired to be more competent in her medical speech. She relayed that many times that she needed to communicate with physicians and other healthcare specialists. Her role required her knowing medical jargon such as “DNR, B.I.D etc. I arranged to meet her after my observation and interview period and we discussed her needs. I was able to arrange for her to receive a medical terminology book for review and we made a list of common terms and words that she had not understood. The opportunity, while outside my role as a researcher, provided another relationship with a gatekeeper not previously established. To this day that particular Sister hugs me when she sees me and there was a sense of deep commitment to my study by all the Sisters following that exchange.

There were several different groups with whom I negotiated my role: The Sisters who administered the home, the Director of Nursing; nursing staff members and the residents. The following section describes these different groups and strategies employed to facilitate acceptance and support.

As previously identified, the home is administered by a Catholic order of nuns founded in 1851. The Sisters take vows of obedience, chastity, poverty and hospitality. They wear religious habits that include a black dress, which falls below the knee, and gray veils that cover the entire head, and on their feet, simple black oxfords or open-toed sandals. During the warmer months or when providing direct care the Sisters wear all white habits, including veil. A crucifix is worn under their dress to remind them that they belong to God. There are approximately 16 Sisters residing in the home currently. Many were familiar with me, related to my faculty role and others introduced themselves to me along the way. They were very

hospitable and made you feel welcome, even as a visitor. There is a mystery to them and I wondered how much they knew about my study and whether or not Sister Kay had informed them about it. Not getting a sense that my role had been discussed, I incorporated a description of the study when meeting each one individually. Overall they were extremely supportive and greeted me each day with a warm smile and welcome.

The nursing staff, including the first Director of Nursing, wore scrubs and visible nametags with photo identification. Scrubs were colorful, neat and professional. The new Director chose to wear professional attire with a white lab coat. I decided to not wear a uniform or lab coat, which will be explained later in this section. In compliance with the facility's rules on identification a University of Rhode Island identification badge was worn at all time. The nursing assistants were aware that I was pursuing a Doctorate in Nursing and understood the need for me to conduct research as a requirement of the degree. On one occasion a nursing assistant told a study participant, "We love her, she is so smart...this is her home too." This was a considerable boost because it legitimized my presence and facilitated development of participant-researcher relationship.

An initial thought upon entering the facility was how nicely all the residents were dressed and the attention they paid to their personal appearance. Many of the women wore make up and jewelry and the men, for the most part, were dressed neatly with coordinating slacks and sweaters. There was an intense curiosity about who I was during the first few days of the study. Unfortunately many of the residents were unable to read my identification badge and assumed I was a state nursing home

inspector. Once residents were enrolled they quickly became familiar with me and no longer thought of me as “the inspector.” Some of the residents talked to each other about the study and asked to be enrolled. One woman was approached, at the suggestion of staff, and her friend asked if she could participate as well. This helped considerably in the recruitment of participants for the study. There was limited interaction with family members but an offer was made to all participants to share information and meet with their loved ones if they desired.

It did not take long, following the appearance of the researcher in the lobby with a notebook, to be referred to as an “Inspector.” Fortunately the receptionist was aware of the study and was able to provide accurate information. Time assisted with the comfort level of the researcher’s presence as well as the comfort of the researcher conducting observations.

The season was summer and it was very warm outside. Additionally, institutional policy required that all staff wear an identification badge. The researcher decided to use her student identification tag. It was also decided that no laboratory coat would be worn as it might draw attention to the power differential between researcher and participant, which could inhibit responses and willingness to share personal insights. Office casual attire was selected that included linen slacks, light jackets and/or sweaters along with sandals and subtle summer jewelry such as necklaces and bracelets. The attire was intended to reflect what a middle-aged daughter might wear to visit a parent. It was evident, from the outset, that personal attire was important, as everyone encountered, including residents, were dressed fashionably.

Following discussion with the nursing staff the first participant was identified. She was an eighty-four year old woman described as pleasant, talkative and capable of answering the research questions. As luck would have it I had met the woman on a previous day and had an informal conversation with her, which facilitated her willingness to participate in the study. The next day the nurse on the unit agreed to formally introduce me to the woman and briefly explain why I was present on the unit. I proceeded to give an overview of the study and asked her if she would be willing to participate. She asked that her daughter be present when consent was to be obtained and I welcomed the reassurance of having her daughter present. The daughter was very supportive and asked that she be notified of interview times, in order, to ensure her mother did not have a conflict of appointments. Consent was obtained and the interview took place during Phase II of the study.

Types of interactions in public spaces (first floor). Observation was the primary method of data collection during this phase. It began with entry into the facility with two, three hour-long periods of observation weekly in the field. The observation times were primarily during the hours between 9:00 a.m. and noon, as it was discovered early on that this was when the most activity was observed in the public spaces between individuals. This did not preclude attendance at special events that ran in the afternoon or evening. In addition to observation, informal conversation was undertaken with some of the residents in response to the presence of an unknown individual, which also helped later in recruiting participants.

During the first three weeks, visits were made at variable times to observe the nature of interactions taking place in the main lobby, coffee shop, dining rooms,

auditorium and workshop. All observations were recorded utilizing a smart pen marketed as Livescribe. The device allowed for all drawings and notes to be downloaded to a personal computer and included the ability to record conversations, which was utilized in Phase II with consent. Notes were taken during the observations and it was quickly identified that a smaller notebook would be preferable to the larger one initially carried into the setting.

Field notes. Field notes transcribed during Phase I were primarily descriptive in nature. They focused on the physical environment and the types of interactions and communication observed. Field notes were transcribed immediately after an observation period to reduce error of interpretation. They were then typed and organized according to date and time.

The method for recording field notes suggested by Schatzman and Strauss (1973) included observational, theoretical and methodological notes. Consistent with this method observational notes were as devoid as possible of interpretation and limited to recording of events observed; for example,

...the receptionist sits behind a desk answering the phone. A male resident waits for her to finish her phone call and she smiles and wishes him a “happy birthday” to which he responds “77 Sunset Strip.” They laugh and the man moves on.

Theoretical notes allowed for capturing the overall impressions of the researcher and beginning analysis of the data. It incorporated the emotional feelings of the researcher and the opportunity to re-examine the observation notes with fresh eyes and look for congruencies or discrepancies between what was witnessed and what was interpreted. The theoretical notes during Phase I allowed the researcher to identify the importance of the reception area and the receptionist. It was through

observation and subsequent consideration of the interaction in the space that supported the importance of the area.

The methodological notes provided an opportunity to reflect on the research process and plan for the next period of observation. One area highlighted early on in Phase I was how to project the role of the researcher within the environment. It was through the observation of residents and staff questioning one another about the presence of the stranger and the inaccurate conclusion that the researcher was a state inspector that led to refining the process of recording. Decisions were made regarding what to include in conversation and how far to inject oneself into conversation. Initially this researcher was reluctant to engage curious staff and residents in conversation for fear of missing something significant. It was felt that it would be impossible to navigate informal conversation while observing the happenings going around the researcher. This proved to be a false concern that was recognized when one resident refused to take “no for an answer.”

“Avid walks into main lobby with two other women. They greet the receptionist and Avid looks in my direction. She recognizes me and yells out my name and proceeds to tell her friends- I have known her since before she was born. She asks me what I am doing and I reluctantly tell her not sure it is a wise thing to do. Avid is most impressed telling her friends and invites me to the craft shop that she leads. This was a location that was desired to be observed and by engaging in the conversation I was able to garnish an invitation.”

Data management included setting up an electronic folder in Microsoft Word that included interviews, field notes, methodological and theoretical notes, and coding files. Data analysis continued with reading and rereading of the field notes, observing for repetitive words or phrases. Initially codes included the characteristics of the physical setting and types of interactions, roles and rituals. The codes assisted in

providing focus during Phase II of the study as well as assisting with organizing the data for analysis.

In an effort to decrease misinterpretation of findings two PhD nurse-researchers reviewed written field notes. One of the nurse-researchers was a geriatric advanced practice nurse who had extensive knowledge of the research site as well as knowledge of many of the participants. The other reviewer was expert in the research method utilized. Ongoing recommendations, both internal and external, were incorporated into the research process. Notes were reviewed concurrently and late in the research process to compare interpretations, with only minor differences noted.

The reflexive journal, maintained by the researcher, provided an opportunity to record thoughts, ideas, explore prejudices on the experience of the fieldwork and how personal emotions factored into how questions were asked and what to focus on. It also included examination of personal values and beliefs related to what it would be like to live in a nursing home. The reflexive journal allowed a way to audit feelings and reduce bias and was employed during the entire fieldwork phase. An example of the usefulness of the journal related to one of the first interviews conducted with a woman who was hyped as a “great one to participate.” Early on in the interviewing process I realized she might not view relationships in the manner anticipated. This caused some anxiety but by exploring my feelings in the reflexive journal I was able to visualize the importance of letting the research follow the road shared by the participant. It was not my ideas or ideals that were in question and the journal allowed me an opportunity to re-connect with the purpose of the study and the method being utilized.

There were moments of unease when I would imagine, a bit too closely, what I would do if faced with living in a nursing home. Nothing puts life into perspective like chatting with a couple of centenarians. It was not unusual to feel the pangs of guilt over my freedom to come and go yet this was not the same despair I felt when leaving my loved one in other homes. Despite the fear of not being able to come and go I was struck with a sense of hope for these residents. They verbalized their contentment with the home on a daily basis. This was backed up by relaxed facial expressions, rooms that reflected their individual personalities and the opportunities for fun such as a trip on the “fun trolley”. Additionally, at least three participants emphasized that this place was their “home” and they were all “family.”

There were times I found it challenging to write objectively. Given my previous familiarity with the environment it was important that I reflected on my observations and vented any biases, be they positive or negative, in an open and honest manner. The preceding sentiments reflected the range of thoughts feelings, values and judgments experienced over the course of this research and helped to facilitate disengagement from the individual participants and eventually the facility.

Other strategies employed to decrease personal observer effects included extensive familiarity with the organization. Additionally, purposefully removing self from the setting for an extended time prior to instituting the research. This absence allowed the researcher to disengage from the role of a nurse-educator and facilitated the transition into student-researcher. It also provided the opportunity for this researcher to enter the facility with a more objective lens having not been present in the recent past. Nevertheless it was a challenge to ensure objectivity due to the

identification of the home as a positive environment for the development and maintenance of positive relationships between nursing assistants and residents. It was helpful to have been disengaged for a period time in order to observe interactions firsthand and without background information. Ongoing consultation with the nursing staff as well as the administrative staff provided insight into whether observer error was occurring. During Phase II this type of member-check was provided to all participants.

Phase II

Phase II, extended over a four-month period (August-November 2012). During this phase of the study observation was continued but the focus shifted to informal and semi-structured interviewing. Interviews during this time focused on research questions 2 through 4. Question 2: What is the nature of the relationships that residents identify as positive? Question 3: How did these develop and how were they maintained over time? Question 4: What environmental factors supported these relationships?

During this phase participants 2 through 10 were identified and recruited for participation in the study. Eligibility for inclusion in the study encompassed the following criteria: older adult, ability to understand English, decision-making capacity and ability to answer questions related to the study. Additionally the study was restricted to those residents who lived on skilled nursing units. Participants were identified through collaboration with the nursing and religious staff. Both groups were acutely aware of who was capable of participating as well as those who might be willing to do so. Based on sample sizes in the literature a decision to have a total of

10 participants was identified. A total of eleven residents were approached to partake in the study with one declining. It was not clear why the resident chose not participate but she appeared very uneasy when learning about the topic.

The process of recruitment involved the researcher and a staff member approaching the resident. The staff member's role was simply to make the introduction and reassure the resident that I had permission to be on the premises and speak with them. Once the initial introductions were made the staff member left the room and I proceeded to explain, briefly, the purpose of the study. I then made an appointment with the resident to obtain formal consent. At times, if the resident desired, I would leave the consent form so the resident could read it and/or share it with a family member. Other times the resident expressed a desire to sign immediately and the consent was reviewed from beginning to end and signature obtained. Throughout the process of obtaining consent residents were continually asked if they had questions or concerns that needed to be addressed. The process went smoothly with no issues encountered.

The interviews. An interview guide (Appendix D) was utilized to provide structure to the focus of the research questions. The guide focused on research questions 2-4 and related to how resident came to live at the facility, what it was like to live there and explored any "good" relationships the individual had with caregivers. The guide also included exploratory questions related to the environment and those aspects that supported positive relationships between the resident and caregiver.

Recording during this phase was significantly more focused than during Phase I. While observational notes continued to be made they became more succinct

and concise. Instead of attempting to take in all that was happening, there was focused attention on the replies to the questions as well as the body language of the resident during the interview. All but one interview took place in the resident's private room. One took place in a solarium, located away from pedestrian traffic with only the resident and myself present. Each interview last approximately one to one and a half hours, depending on the resident's desire to keep going or not. Initially, it was decided a series of three separate interviews, per participant, would be necessary. That strategy was carried out with the first three residents and it then became evident that the resident did not enjoy the repetitiveness of the questions and no new information was being uncovered. A decision was made to let the interview follow a natural flow and as my own ability to phrase and probe for detail improved, the time required to conduct the interviews was reduced.

The majority of interviews occurred during the hours of 9:00 a.m. and 11:00 a.m. The afternoons were busy times filled with entertainment programs, outings, exercise classes and recreational activities such as bingo and card playing. Schedules were very structured in the environment, primarily revolving around meals and religious activities (breakfast at 8:00 a.m., Mass at 11:00 a.m., lunch at noon). All interviews were audio-recorded and a separate audiotaping consent (Appendix C) was obtained from the participant. All participants agreed to have their responses recorded and the researcher provided verbal reinforcement of anonymity with each participant throughout the interviewing process. A Livescribe pen was utilized during this phase and facilitated concurrent audio recording and note taking. The pen

facilitated verbatim transcription following the interviews and allowed for easy replay by touching a word in the special notebook that accompanied the pen.

The grand tour questions were designed to elicit dialogue pertinent to the investigation. The first question, as identified above, related to how the resident came to live at the home. This question gave the resident an opportunity to provide a historical context surrounding the move and situated the individual in the location. A follow up question was related to what it felt like to be in this nursing home? This also provided the resident an opportunity to free associate their feelings with words to describe what it was like to live in this particular environment. Gradually the questions began to focus on specific relationships within the home, particularly those related to direct caregivers. For those able to identify a positive relationship or “good” relationship between themselves and a caregiver further exploration was conducted as to how the relationship developed, was maintained and sustained over time.

For those unable to identify such a relationship with a direct caregiver they were asked if there were others within the facility with whom they would describe as having a positive relationship. This extension was decided upon when the first interviewee denied having a personal relationship with direct caregivers but demonstrated an emotional and friendly relationship with the Activities Director. Finally, each participant was asked what characteristics they valued in a caregiver and in what ways did the staff respect them.

All participants offered a unique perspective on what led them to this nursing home. Embedded within the answer to this question was also information pertaining to the follow-up questions relating to how it was to live there, whether or not they had

experienced a “good” relationship with one or more caregiver, and how they felt respected by the staff. Due to the narrative nature of the response and the ease of “getting off the track,” strategies to re-focus were routinely employed by the researcher, which included; rephrasing of a question, repeating a question and/or probing when necessary.

At the completion of each interview I would offer thanks and ask if I might return, should I need additional information. I was met with a positive reaction one per cent of the time. We disengaged effortlessly, as if we both had accomplished what we had set out to do. There was great concern among all the participants that they give me “worthwhile information.” Many would preface their responses by saying, “I don’t know if this is the right answer...” or “I hope I am helping you?” I would consistently remind them that there were no “right” or “wrong” answers and that their participation was a tremendous asset to the study.

As themes emerged subsequent interviews became more and more focused and explanatory. For example early on a theme emerged from the first three interviews that referred to “they are always there.” Having heard it from several residents, a more in-depth exploration of the meaning of that term was conducted, which led to a consensus of anticipation of needs and a sense of security. Another theme that emerged fairly early on was the term “they leave you alone.” It was determined, through follow-up questioning, that this was a positive action by staff to not interrupt letter writing, telephone calls or insist on participation in activities that did not interest the resident. The interviews in all cases continued as long as the resident had something to share on the question.

Further explanation of methodological issues will be discussed in the following section- Methodological Issues. Presentation of the data will be provided in Chapter IV.

Methodological issues in interviewing the older adult. Several issues arose during the process of interviewing residents for this study. The problems and solutions employed in the field will be discussed in this section.

Three problems related to interviewing the older adult arose during the interviewing process. They included a few physical problems. The physical characteristics that proved challenging were related to limitations in eyesight and hearing and the effects of debilitating chronic illnesses. Several of the participants had difficulty hearing and hearing aids needed to be secured and functioning before the interview. At times, despite the assistance of hearing devices, I had to speak in a loud tone of voice in order to be heard, which in turn raised a concern for privacy.

One participant had very limited vision and difficulty seeing objects and/or people even close up. In addition, she had difficulty hearing and as a result had a loud booming voice. Again this was a concern as she responded to questions including those about her happiness living at the facility and the type of relationships she had experienced with caregivers.

Several strategies were employed to address the identified issues above. First, prior to all interviews, confirmation of the presence of all hearing devices was carried out. If the hearing aide were not in it would be located and placed in the participant's ear. The same strategy was employed for those with limited vision and who utilized eyeglasses. Additionally, for those with sensory impairment a staff member

accompanied the researcher and remained present during the explanation and consenting process. Finally, I would position myself on the side closest to the better ear. This reduced the need to speak loudly and thus threatening confidentiality of the participant.

A third significant challenge was that of chronic respiratory illnesses that caused shortness of breath and/or difficulty in speaking loudly enough to be heard. Four of the residents interviewed had chronic respiratory conditions that required simultaneous monitoring during the interviews and the taking of breaks when necessary. Throughout the process these participants were encouraged to notify the researcher if and when they were fatigued and if so a follow-up session would have been scheduled.

Those participants suffering from respiratory ailments were most challenging as it was felt they would continue on even to the point of exhaustion. It was the responsibility of the researcher to determine when they appeared fatigued and encourage rest periods. Early on it became evident that the quality of the voice may pose an issue and that was realized when an audio recording failed to pick up responses by the resident. To safeguard against this in the future a back up recorder was used at all times as well placing the device in close proximity to the resident during the interview.

Interviews were scheduled at times that were identified as “best times” for the resident. This usually meant following breakfast or lunch as residents returned to their rooms, a time when there usually were limited interruptions by staff for personal care and/or family or other residents. Allowances for the resident to reminisce or share

“stories” were incorporated into the interviewing process. It was important to learn early on when to divert the conversation and when to let it proceed. In the storytelling residents often gave insights into what they valued in terms of their relationships with others.

Another factor was that some residents had difficulty remembering specific events. For example one of the participants identified the uncomfortable feeling she had while having her picture taken during her admission process to the home. Unfortunately she could not describe this in any more detail. Additionally the need to “tell their story” often resulted in data unrelated to the inquiry. It was also through this recognition of the type of data collected that a decision was made to cut the interview sessions down and proceed uninterrupted with all guiding questions.

In addition to the above issues related to memory many had difficulty expounding on questions about caregiver relationships with them. Response such as “they are all nice” or “I ain’t gonna say nothing in that regard because I would say 100%.” Still others were unable to identify a good relationship with a caregiver at all as evidenced by the response of one participant: “That doesn’t enter my mind. They are doing their job and as long as they keep doing their job I am happy.” Participant observation was helpful during this phase as it allowed the researcher to confirm, by observation, what was being said by the participant.

Trustworthiness of the interview data. The use of participant observation in this study enhanced the credibility of the data collected by corroborating what was observed and how the resident responded. In addition to participant observation several other strategies were utilized to increase the trustworthiness of the data.

Detailed and extensive field notes on the time spent in the setting observing, speaking with different residents and developing rapport with the participants and gatekeepers were kept to further enhance the credibility of the study. Additionally the use of two different techniques of data collection (participant observation and semi-structured interviews) and member checking were employed. The confirmability of the study was facilitated by including all raw data in the field notes and reflexive journal, which provided a detailed description of decision making during data collection facilitated confirmability. Further, notes were checked and re-checked with a faculty member expert in the method.

Transferability was enhanced through detailed accounts of field experiences that highlighted cultural and social relationships in the context of the setting. Finally, dependability was increased by the use of external audits by two doctorally prepared researchers, not located in the field, for the purpose of evaluating the whether or not the interpretations, findings and conclusions were supported by the data.

Phase III

Phase III of the investigation was conducted over a two month period, December 2012-January 2013. Exiting the field was gradual and transitioned into time focused on data analysis and write up of the findings.

Chapter IV presents a mapping out of the setting and description of the participants. Chapter V presents the findings of the study, along with illustrative examples of positive relationships between residents and nursing assistants as well as the type of interactions observed in public spaces, previously identified and will

conclude with discussion of findings. Chapter VII provides the summary, conclusions and implications for future research.

Chapter IV

The Setting and Participants

Three characteristics were used in seeking a suitable long term care environment in which to conduct this research. The nursing home needed to be known as special home with a high quality of care and known for high quality satisfaction of its residents, as well as be conveniently located. Given the intended purpose of the research, it was a non-negotiable factor that the environment exceeded the common threshold of “nice, if you have to be here” or a “good place.” The need to have sustained communication required that the setting be within easy travel distance to the researcher. Accessibility allowed for variable visitation and attendance at special functions throughout the research phase.

The selection of the nursing home that I came to refer to as Peace House was somewhat of a revelation that occurred through earlier professional contacts. As a critical nurse in a local hospital in the early 1980’s, I had observed the physical care residents of Peace House had received before entering the hospital. Overall their physical condition was excellent. It was not uncommon to care for a centenarian whose skin was supple and intact and without contractures, which was in contrast to residents from many of the other nursing homes. Colleagues would remark frequently “I want to go there if and when I need a nursing home.”

Later as an instructor of nursing students, I gained more intimate knowledge of Peace House, which further supported the belief that something special was happening there. One of the main differences was the vitality, engagement and overall perceived

contentment of the residents. Particularly, notable was the genuine attention to the personhood of the individual.

Confirmation of the uniqueness of the Peace House grew when I was faced with the task of placing a loved one into long-term care. The experience was traumatizing and eye-opening, compounded by knowledge of a better place that was out of reach. The comparisons of what would become three facilities for my loved one to Peace House became increasingly obvious. These observations and experiences undergirded the assumption that the Peace House was a “good” one.

The Setting

Peace House is a non-profit continuing care facility located in a largely populated inner city in the area of the Northeast United States. It is a Catholic organization that is run by a religious order of nuns dedicated to caring for the elderly poor. It has been located on the present site for over 125 years. The current building was built in the late 1970's following code enforcement needs.

Peace House is part of a group of continuing care homes operated by the order located throughout the United States and world. Each individual home has a board of directors, which oversees capital improvement campaigns and outreach to the community at large and a management staff. According to the administrator of Peace House the aim is to provide “humanistic and dignified care” to the residents who reside with them. Peace House offers several levels of living beginning with independent apartment living, assisted living and skilled nursing care all located within one connected network of buildings. Peace House has established itself as a

leader in long term care in this area of the country and has received a five star rating from its local department of health.

The Path to Peace House

Peace House is located on a corner of a main street, encircled by an interstate highway, in a rundown urban neighborhood of a former mill city. The area is predominantly populated with immigrants of Hispanic and African heritage, which is reflected in the businesses surrounding the property and the signage. Peace House also borders a more affluent section of the city not uncommon in older urban cities. The street leading to the home at one end is dotted with single-family homes classic in design (Georgian, Tudor and Capes). Entryways are decorated with wreaths and baskets and the yards are neatly manicured. As one travels further down the street and towards Peace House the houses take on a different image and the dwellings transition into multi-family structures; lacking the manicured lawns and decorative doorways of the houses a block away. Older model cars are parked on curbs and in driveways also in contrast to the vehicles located up the street.

The road ends at a busy intersection which has a large parcel of land located on the left side of the street. A large red brick building, surrounded by a six-foot wrought iron decorative fence and beautiful shrubbery, sits in juxtaposition to the dilapidated structures on the outer perimeter. A piece of serenity located in the middle of strife and poverty would be an apt description. There are 2 large buildings located on the campus, which are connected to each other through a common corridor and accessed through a circular drive with parking lot. The building in the back (Figure 1) is the apartment complex where elderly independent residents live. The main building

(Figure 2), located in the front of the property, houses the offices, chapel, and resident units. There are four floors visible to the visitor.

Exterior View of Peace House

Approaching the complex one notices a large brick structure with a driveway leading to sliding glass doors. This view is visible from the street and is a multi-storied apartment complex attached to the main building (first building encountered and behind main building). The area surrounding the entrance to this building is adorned with colonial black wrought iron lanterns and two benches on either side of the door. There are large trees and shrubs encircling the perimeter of the property. Through the windows wall sconces can be seen lining the hallways.

Progressing down the driveway, past the front entrance of the apartment house, leads to the back of the main building. Ahead is a large parking lot filled with older model sedans belonging to those residents who can still drive. A sign at the entrance to the lot identifies it as “Resident Parking all others will be towed.” To the right the backside of the apartment building can be seen. This view enables the visitor to view the apartment windows of the Independent Living building. The windows have brightly colored curtains, shades and lamps highlighting the individuality of each occupant.

Straight ahead is the back of the dining room. Large sliding glass doors are noted as well as a patio area containing gas grills, tables, chairs and umbrellas. A walled garden area surrounds the space and is home to several religious statues. Immediately preceding the picnic area is a driveway that has a small (28 passenger)

bus with the inscription “Fun Run Trolley” on its side. On the back of the bus is another inscription that reads “Making the elderly happy is all that counts.”

To gain access to the main building one must exit the back parking lot and proceed further down the street to the next driveway. An approximate six-foot tall black iron fence surrounds the entire campus. Once in the drive way the parking lot flows in a circle. Ahead a tall spire outlining the chapel greets the visitor. To the left is a large four-story building home to the assisted living and skilled nursing residents. Each floor has a balcony and is adorned with window boxes full of summer flowers.

To the right of the four-story structure is a sitting area, dotted with lawn chairs and umbrellas, a tomato garden (maintained by one of the residents and built by the Boy Scouts), and a walking path. The walking path is designed in a deep U-shape and is lined with foliage, including tall evergreens and annuals. At the base of the walking path is a shrine to the Blessed Mother. Benches are located every few feet for rest if needed. The area is entirely fenced in and belies the urban landscape that lies beyond the fence. The day is cool and showery and there are no walkers or residents visible in the area.

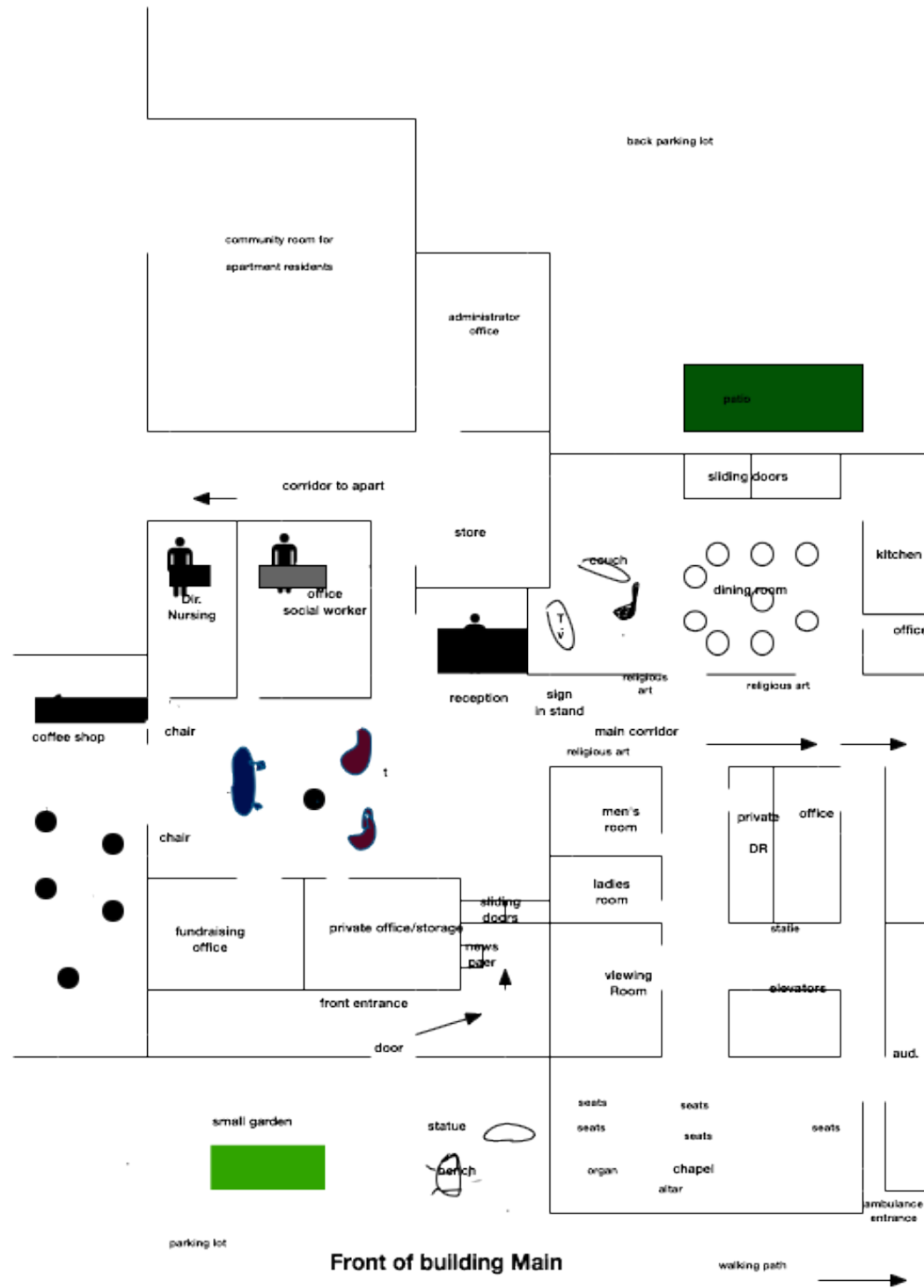
Back out on the main walk heading north one come upon the main entrance. The front entrance has various religious statues adorning it including one dedicated to the patron Saint of the home. Immediately adjacent to the front entrance a staple of Catholic architecture greets the visitor, beautiful stained glass windows and a large spire. The overall design is modernistic and consistent with Catholic architecture of the time. Flowerbeds, benches and small garden figurines including one that states, “where there is love there is life” surround the main entrance.

First Floor Public Spaces

Once inside the main doors a receptionist desk faces the visitor as one enters the main lobby. The receptionist is seated behind an elevated wooden counter that contains a basket with candy and a newspaper. To the left of the counter is a sign-in book for visitors. To the right of the main desk is a sitting area. It is neatly decorated in soft beige walls with floral borders. The space contains traditional furnishings including a floral sofa, two high-backed crimson wing chairs and two light colored club chairs in the corners. Accent tables, including a coffee table with a picture album and teapot set, and lamps finish the setting. Offices of the director of nurses, fundraising and social worker are directly located off this area.

Figure 1

Main Floor Public Spaces



Coffee shop. Located at the back of the lobby is a coffee shop area referred to as “Our Place” and is noted as such on the sign. It is a popular gathering point for all residents (nursing home, assisted and independent living), visitors and volunteers. The room is decorated in bright orange, green and yellow. A tiled floor, matching the color scheme along with art deco style tables and chairs complete the space. A piano sits at the far end of the room and a computer stations sits along the inside wall. There is a counter that contains baskets with packaged snacks and a pastry caddy that contains fresh baked cookies and muffins. Coffee, juice and cold drinks are available and a mirror behind the counter gives the impression that one is sitting at an old fashioned soda fountain. The room was usually occupied with people during the study and also used for games of bingo on Mondays and Saturdays.

Country store. Behind the receptionist’s desk is a store that is operated by residents. It offers personal items such as toiletries, snacks and items made by the “sewing group.” Items also include nurse’s scrub tops, aprons, dolls; doll clothing and knitted baby sets. A white haired elderly woman sits waiting to assist the next customer.

Proceeding past the receptionist area down the long corridor leading towards one of the dining rooms several paintings hang on the walls on both sides of the hall. The paintings depict the patron saint and contain several inscriptions including “family spirit without fuss, with much kindness, charity and unity through collaboration.” The pictures reflect a late nineteenth century time period and show elderly women caring for each other while another is of a sewing circle of elderly women. Throughout the

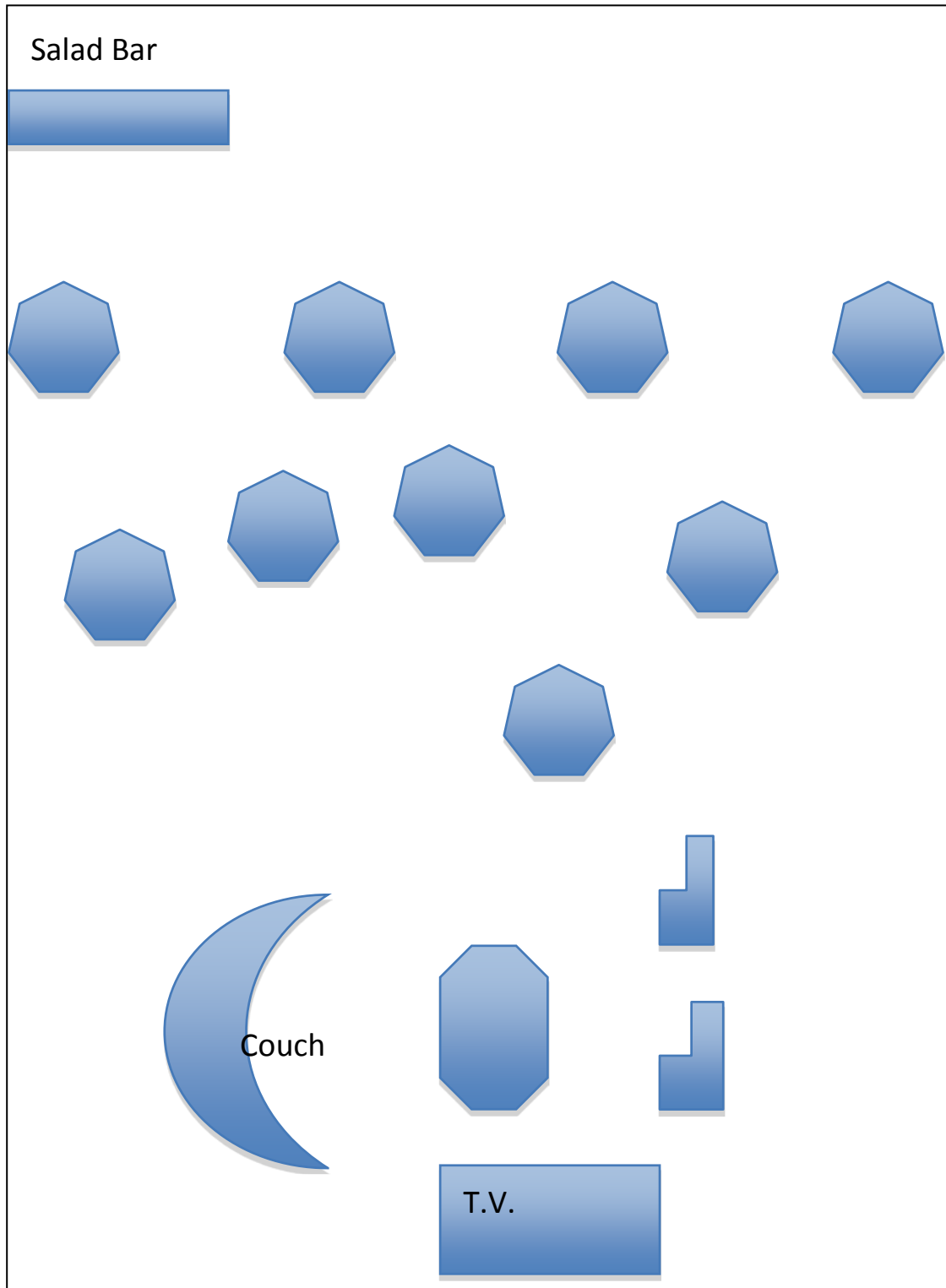
facility visual reminders of the founding philosophy are plentiful and give support to the on-going work happening within the home.

Main dining room. The main dining room is a large room, located off the main corridor, with approximately 10 round tables capable of seating 6-8 residents (Figure 2). The tables are covered with white cloths and square red plaid table toppers. A hutch containing knick-knacks and place cards is located near the entrance. At the opposite end of the room is a seating area that has several recliners, a couch in earth tones, a jigsaw puzzle in progress, and a large screen T.V. Several large sliding glass doors are located along the opposite side of the room and lead to a patio area that has a couple of gas grills and several tables and umbrellas along with white resin chairs. The scent of cooked food greets one upon entering the room.

During meal times the corridor outside the dining room is lined with walkers and assistive devices all adorned with identifiable personal touches. The residents are neatly dressed. Seating is assigned and each table has a framed menu identifying the selections for the day. A salad bar is set up in the front of the dining room and the residents help themselves. Kitchen staff, clothed in neat green uniforms, serve those that are unable to assist themselves. A bell rings and a clergy member leads the before meal prayer.

Figure 2

Main Dining Room



Chapel. The chapel is located to the across from the dining room and is accessible from two entrances, one the first floor and a balcony entrance on the second. Inside the chapel the design and décor reflect the time period in which it was built and is modern and sparsely decorated. The altar is a large wooden structure and white marble lines the floor. Two distinct wings comprise the space with one directly facing the altar and the other to the side. Each area contains several rows of plain light wooden benches. A large Crucifix adorns the altar and the windows let in multi-colored sunlight through stained glass. An organ is to the right of the main altar area and songbooks are located in each row. Daily mass is offered at 7:00 a.m. and 11:00 a.m. with prayers at 4:45 p.m. Several of the residents are retired priests and are responsible for the liturgical schedule. They are assisted by several of the residents who act as readers, altar preparers and choir members.

Auditorium. Further down the main corridor, beyond the chapel and dining room, sits a long corridor running perpendicular to the main. To the right a large auditorium is located that contains a stage and piano. The space is used for weekly musical entertainment, special gatherings such as “International day” when residents and staff provide food from their native cultures and on the sad occasion of a residents passing it serves as a viewing room. The left side of the corridor contains several workspaces including the kitchen, hair salon, and physical therapy room and ladies workshop. Upon embarking down this corridor one is greeted with the scent of hairspray, the hum of hair dryers and conversation consistent with that location. Further down the corridor on the left side is the kitchen, which is a large space filled

with stainless steel stoves and refrigerators and emanating scents that make one check the time for lunch.

The coffee shop, located off the main corridor as described earlier and called “Our Place”, is a popular gathering point for all residents (nursing home, assisted and independent living), visitors and volunteers. It is a bright room with orange and yellow tiled floor and art deco style furniture. Several tables and chairs provide comfortable seating and facilitate friends meeting. A piano sits at the far end of the room and a computer stations sits along the inside wall.

The coffee shop is a welcoming room that offers snacks placed invitingly on the counter and includes muffins, crackers and cookies. Coffee and cold drinks are available as well and a mirror behind the counter gives the impression that one is sitting at an old fashioned soda fountain. The room is usually occupied with people coming and going and is also used for games of bingo on Mondays and Saturdays.

Ladies workshop. Located at the end of the corridor is a busy place known as the “Ladies Workshop.” The craft room is a neat large area with several worktables taking up a wide proportion of the space. Green and pink draperies adorn two large windows, which provide light and compliment the green and pink floral wallpaper. Sewing machines are located around the room as well as a wall of cabinets and shelves. The shelves contain remnant pieces of cloth, baskets, buttons and lace. Every fall the home sponsors a Christmas Craft Fair, which is well attended by people from far and wide with many of the products put up for sale.

A wooden barn made out of what appeared to be Popsicle sticks sits on a table. A worker proudly points out it was made by one of the men who resides in the home

and that “the doors open and everything”; it will be raffled off at the fair. In addition to the Christmas Fair the ladies sew things to sell in the shop, located behind the reception area.

The clicking of scissors cutting and the sound of pencils outlining patterns could be heard throughout the room. Most of the women were residents of the facility; although most are from the apartments there were a couple that lived in the assisted unit. It was later learned that residents on the skilled nursing unit also contributed to the merchandise by working on knitted and crocheted blankets and other items in their room. “Avid” the shop supervisor identified that they work Monday-Friday 9:30 a.m.- 4:00 p.m. and that their efforts earned \$800.00 last month in the store (Figure 3).

Figure 3

Ladies Workshop

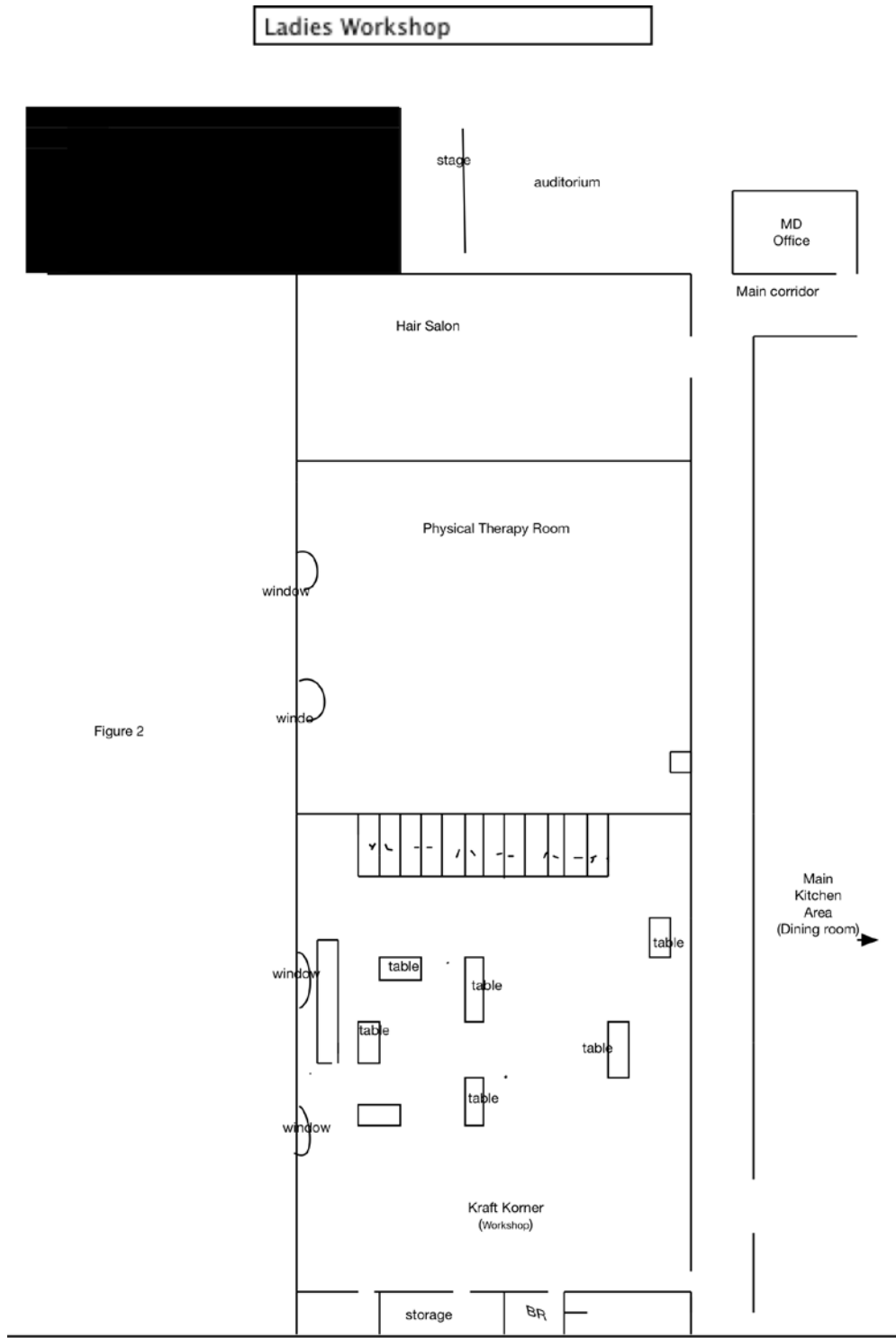


Figure 2

Description of Residence Units

An elevator lobby is located between the Chapel and the auditorium that contains two elevators. The elevators connect the main floor to the upper resident units. The main residence houses an assisted living unit and two skilled nursing units. The floor plan for all three units is essentially the same with a long corridor connected with another corridor, which runs perpendicular to the first (J-shape). Resident rooms are scattered throughout with most of the community rooms being located off corridor 1. Beginning on the fourth floor where assisted living residents are located one is met with a quiet peacefulness upon stepping out of the elevator. The color scheme is a soothing mauve color and the walls and some resident rooms are adorned with silk wreaths as well as religious artifacts such as statues including statues of the patron saint.

Each unit has a solarium, which is one of the first rooms encountered upon entering the floor. The solariums have a theme on each of the three floors such as billiards on the fourth, music and exercise on the third and plants and flowers on the second. Additionally the fourth floor houses a modest size library that includes current novels, DVD's and games. The library is open to all residents of the facility including those living in the apartments. All three floors also have a "living room" where a large TV is located and according to the unit different activities take place. For example, on the assisted living unit each night a movie is shown at 7:00 p.m. preceded by a cocktail hour for those inclined to join. The cocktail hour had recently caused concern for some of the staff but the administrator felt "it's their home they can

do as they please.” A sign adorns the door to the living room that reads “SHOWING TONIGHT_____”.

Assisted living unit. The fourth floor Assisted Living unit is home to 26 residents. In addition to the universal spaces it also offers a laundry room for residents to do their own laundry and a small breakfast nook with an adjoining sitting area for those that desire a light breakfast and/or snack. Two “Kissing Birds” occupy a corner of the sitting room and are cared for by several of the residents. The private resident rooms vary from small to quite large and all have their own bathroom. Most of the rooms have their doors closed for privacy but those that were opened appeared neat and contained furnishings from home. A nurse’s room is located outside of the breakfast nook area where patient records and medications are kept.

Third floor. The third floor is a skilled nursing unit and houses residents with more intense nursing needs. The color scheme is light green and yellow with spotless linoleum floors. A woman ambulates with a small-wheeled device and greets us with explaining, “I turned 100 a few months ago and everything has fallen apart.” The rooms are all neat with most of the doors open and furnishings that have been brought from home. A solarium is located off the main corridor near the elevator and has an exercise bike and an organ along with a round table and chairs. The room is encased in windows that let the warmth of the sun in. The unit has a dining room with approximately six tables with three to four chairs at each. A small kitchen is located off the dining area for meal preparation and clean up.

Second floor. The second floor (Figure 4), where the majority of the study was conducted, is organized in the same way. The color décor on this unit is soft blue and

a statue of the Blessed Mother greets the visitor when the elevator doors open. Upon entering this unit more assistive personnel are noticed. An elderly woman walks ahead dressed smartly in blue slacks and red flat shoes. She is leaving the sunroom where she takes responsibility for the plants and flowers. This room is furnished with white wicker chairs and a table making it seem like a summer room.

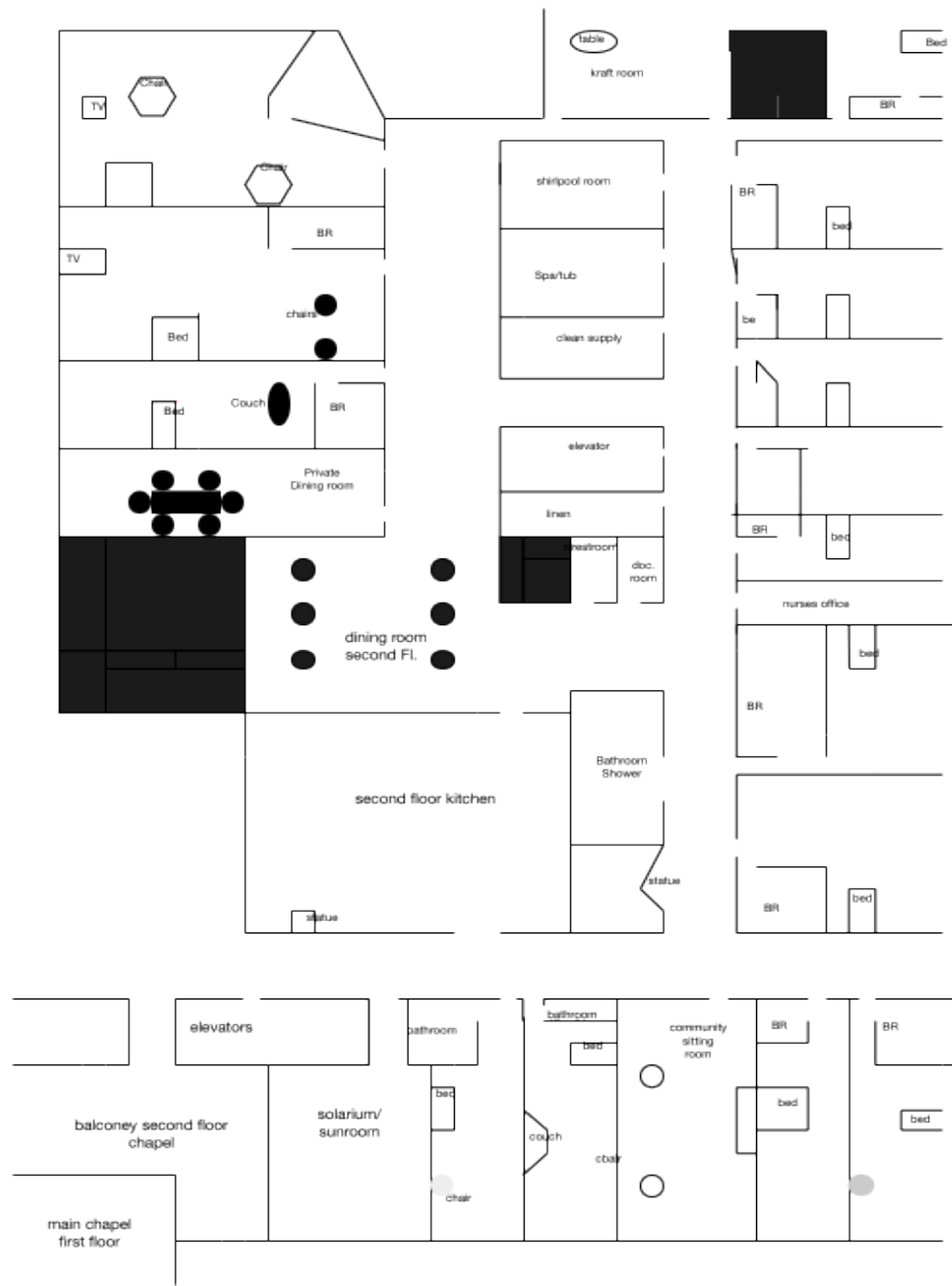
Further into the unit the resident rooms are located along a long corridor that curves and comes up the other side of the unit. There are 22 residents on this unit who require intense nursing care with many unable to ambulate on their own and/or feed themselves. Most rooms are private except for two semi-private rooms used for new admissions or until a private becomes available. All rooms have private bathrooms with a tub room at one end of the hall and a shower room at the other. The tub room on both units has calming colors of blue and sand and contains a whirlpool tub with a lift. Privacy is afforded to each resident during the bath and is scheduled at consistent times two to three times per week. For those not desiring a bath, a shower room, which is tiled in white and green, is available. Once again residents are transported to the shower or bath covered in robes and assisted discretely by staff. All residents are completely dressed in the shower/tub room before exiting.

A mainstay of the unit is the large sitting room located off the main corridor, down the hall from the elevators. It contains a couch and several recliner chairs a large screen TV and a parakeet that is chirping away. A few of the residents are reclining and acknowledge everyone that enters the room. One of the Sister's is sitting very close to an elderly woman, who is seated in a wheelchair. The Sister is encouraging the woman to drink some juice as she places an arm around the woman's

shoulders to encourage her. Another woman, possibly a resident from the fourth floor or a resident in the apartments sits with a couple of other ladies chatting about the day's events and news.

Figure 4

Second Floor



A Typical Day on the Unit

The day begins on the second floor with morning care and dressing for breakfast. There is a sense of business in the air as aides move swiftly from room to room with minimal conversation between the staff during this time period. Some of the nursing assistants work 6:00 a.m.-2:00 p.m., which allows for early wake-ups. Many of the residents prefer waking up early and “getting going”. Some have baths scheduled before breakfast. The assigned nursing assistant will run the bath water, ensure safe temperature with a bath thermometer, and add scented oils if so desired by the resident. While the tub is filling the nursing assistant goes back to the resident’s room and assists him or her out of bed. The resident is greeted with a “good morning! Are you ready to get up?” Once out of bed they enter the bathroom for mouth care and elimination and then onto the bath. As previously stated, all residents are assisted to the bath fully clothed. There is attention to the dignity of the resident at all times including ensuring they are properly dressed and not exposed.

As the morning sun increasingly overtakes the unit all make their way to the dining room for breakfast. Breakfast is served at approximately 8:15 a.m. with the expectation that residents begin arriving by 7:45 a.m. Those capable of ambulating on their own do so and the nursing staff transports those requiring assistance. There are 3-4 nursing assistants on duty for 22 residents and are consistently assigned to a geographical area. Once in the dining room the aides don aprons and hairnets along with the Sister in charge of the unit. The professional nurse is preparing medications to administer and does not participate in the meal. Each resident is assigned to one of five tables and joins two to three other residents. All the tables have crisp tablecloths

and napkins and/or terry cloths with attached chains for use as a napkin holder. The center of the table contains a “lazy Susan”, which holds a small container of milk, sugar, syrup and other condiments.

The routine is the same for all meals. The residents enter and take their seats, greetings are exchanged with tablemates and those requiring assistance sit together. Tables that house “assists” have extra chairs for the staff and/or volunteers. The chairs allow the feeder to get close to the resident and coax them to take nourishment. Residents are fed with care and touch; usually with the nursing assistant embracing the resident much like a mother would a child. Once all seated Sister begins with prayers (noticeably shorter than main dining room) and announcements of the day. Next, cereal and fruit are served followed by hot selections brought to the unit in steam tables. The steam tables are placed in the middle of the room and each resident is asked what they would like, including eggs to order that are cooked in the large stainless kitchen off the dining room. Residents may have 1 pancake or slice of French toast, which appears to give them choice related to their diet.

At the conclusion of meals it is back to the room for toileting, rest and/or activities. Scheduled hair appointments, doctors’ appointments and any outside visits begin once breakfast has ended. Volunteers, from within and outside the facility, begin to show up and assist with transportation of the residents to their respective destinations. The nursing assistants begin to see a slow down in their work while the residents are resting or off the unit. It is not unusual to see them delivering freshly laundered clothing to resident rooms and putting them away or dancing into a room that has a radio on. A conversation will ensue when the resident is present and is

usually related to how they are doing and what is new? The aide may tell the resident how nice they look or that they need to comb their hair.

The respite is short-lived as residents begin to return to the unit and those attending mass are readied. Not all residents desire to attend daily mass but the opportunity exists to do so and the nursing assistants are very knowledgeable as to who goes and who does not. The certified nursing assistants (CNA) are responsible for taking the resident down the main corridor of the unit to the left of the elevators where double fire doors lead to a large balcony overlooking the chapel. Once inside the upper balcony the resident is positioned in a particular spot in which to partake of the mass below. Eucharistic ministers (mostly volunteers) bring Holy Communion to those able to receive on the second floor balcony.

The day is marked by meals, religious activities and other events such as the music program or outings. All of the resident participants were fully informed of the happenings through the weekly bulletin and Sister announcing daily events at morning meal. Most participated in some or all of the activities while a couple chose not to but were pleased others found enjoyment in them.

At the end of the day, following the evening meal residents return to the rooms and watch TV or talk on the phone with loved ones. Others receive visitors from other units or family members. As bedtime approaches some have scheduled baths others are assisted with mouth care and final trips to the bathroom. Call lights are placed within reach and lights are turned down. One resident complained that she didn't want her door open at night and spoke with the administrator who informed her the "rules were here before you but you are welcome to change them," which the resident did.

She negotiated that her door be closed following her return from the evening meal while she watched TV and spoke with her daughter. Once she was in bed the door was opened far enough that the nurse could check in on her.

The Participants

Identification of potential participants was made through a collaborative effort with the nursing staff on the skilled nursing units of this facility. As stated previously, eligibility required that the resident be a member of the skilled nursing unit, be able to understand English and be capable of answering the interview questions. Based on that criterion recruitment commenced with one resident being interviewed and another being simultaneously identified for the next interview. This strategy worked well and provided a seamless and efficient progression of interviews.

The residents included nine females and one male. Their ages ranged from 74-102 (with one in her 70's, 4 in their 80's and 4 in their 90's). A total of eleven residents were approached, with ten agreeing to participate in the study. The length of time in the facility ranged from one year to twelve and included time spent in apartments and/or assisted living. Four of the ten had lived in Independent living and accounted for the longest residing residents interviewed. Three came from the Assisted Living (AL) unit, including one who had also been in the independent living prior to AL. Three residents were admitted from home and one was a transfer from another nursing home.

A majority of those interviewed (8/10) had actively sought admission with an expressed desire to live in this facility. Six of ten participants had previous knowledge of the home through volunteer activity and/or family connections. Family connections

included one resident whose sister-in-law was a member of the order, another whose father had been a resident and two who had siblings that had resided there, which provided a basis for their desire to move in. Three of the ten participants had children who had selected the home for them and one woman found it on a walk one day. The latter woman described taking a walk from her high-rise elderly apartment a few miles away and came upon the home, entered and inquired as to how she could obtain an apartment.

Nine of the ten residents interviewed had actively sought, either personally or through children, to live at the home. One resident “cried like a baby” when she was told by her daughter that she was going to transfer her from the nursing home she previously occupied to this one. When asked why she cried she responded, “my husband ran a pharmacy and used to fill the prescriptions for the old home. I would deliver them and the place looked like a haunted house.” She had been unfamiliar with the new building and since moving in said “I love the place.” Examples of other comments related to coming to live at Peace House are as follows:

“I thank God everyday I am here”

“I was impressed with the way the sisters ran it and wanted to be here.”

“I always wanted to come here”

“We knew they had apartments available so we put our name on the list”

“Well everyone was telling me it was a beautiful place and I was living in my own apartment and I didn’t like it. I was scarred. I was scarred to be alone. In fact I used to put a laundry cart up against the door in case...it was bad. So I put my name in but the Nun died and I waited. I tried again...it’s a good catholic place and I am a catholic and I heard it was very, very good and I came in and tried it for 3 days and I liked it. I like the way they operate. I said this is the place for me”.

“I wouldn’t go anywhere else I mean homes to live... I came here because I am Catholic and I have a spiritual you know connection?”

“It was a wonderful find, to me anyway. I am so thankful I did. We found each other –it’s was love at first site. The people and the Tabernacle it was love at first site”.

Seven of the ten participants had children or a significant family member such as a niece/nephew or sibling that played an important role in day to day to life within the home. They visited frequently, sometimes several times per week but at least once a week. Additionally five residents identified strong friendships among their fellow residents that involved daily card dates, visits after dinner, and outings to a local senior center for cribbage games (102 year old resident).

All of the participants suffered from mild to severe impaired activities of daily living. Notwithstanding those limitations all those interviewed participated at least partially, in their own personal care. Additionally five of the ten had sustained a fall, either in their apartment or on the assisted living floor, which required transfer to the skilled nursing unit.

Chapter V

Findings

“...my father told me of a careful observer, who certainly had heart disease and died from it, and who positively stated that his pulse was habitually irregular to an extreme degree; yet to his great disappointment it invariably became regular as soon as my father entered the room.”

(Charles Darwin, 1872/1965)

This chapter focuses on presentation of the data related to the research questions in this investigation and discussion of the findings. Pseudonyms are used to protect the identity of the participants. Quoted excerpts from transcribed taped interviews provide illustrative examples of social interactions between residents and caregivers in one particular nursing home.

The study took place in three phases, as previously described. During Phase I observations were carried out in public spaces within the home and categorized by the type of interactions occurring and location. Detailed field notes were written up during this phase that provided description and context of the interactions observed.

Phase II of the study involved interviewing ten residents who resided on the skilled nursing unit and met the specified eligibility criteria. All interviews were face to face and all participants gave full responses to the research questions. Some residents were more descriptive and expansive in their responses, which at times included information not entirely relevant to the questions. Data will be presented in the order of the research questions.

Research Question 1

What kind of interactions and relationships exist in the setting? During this phase of the research, interactions were observed that included staff and resident,

resident and resident, resident and visitors. Observations during different times of the day revealed that primary locations for interaction, on the first floor, were the front desk area, coffee shop, main dining room, auditorium and workshop (Figures 1, 2, & 3). On the second floor the primary areas for interaction were the dining room and the resident's own room (Figure 4).

The major portion of interaction was informal and actively initiated by both staff and residents. Certain locations within the facility afforded greater opportunity for interactions to occur. One of the main locations for interactions was noted to be the front desk, located in the main lobby. Residents were observed approaching the desk at multiple times during the observation period. As described previously residents sought out information pertaining to where they could obtain stamps or how to find a certain member of the staff. Other topics discussed at the front desk included: the weather; what was watched on television the previous evening; and general informal inquiries into one's health or special events such as a birthday.

The following section will address the location and type of interactions that occurred in those public spaces.

First Floor Public Spaces

Reception area/main lobby. The receptionist's desk served as hub for news, information/guidance, hugs and words of encouragement. If anyone wanted to know what was going on or who was in the building this was the place. The receptionist was a pleasant middle-aged woman who knew all the residents by name. She had an easy smile, bright eyes and exuded a willingness to help who ever approached her

desk. No one passed the desk without acknowledging her or without being acknowledged.

The interactions observed between the residents and the receptionist ranged from informal bantering to assistance, information sharing and encouragement.

Following are examples of the range of interactions observed in this space:

It is getting close to 11:00 a.m. and Mass will be starting. A resident is walking quickly and Rosary beads jingling in her hands. The receptionist greets the resident by name who responds by saying “I am late” and hurries off towards the chapel. Within seconds Hymns and voices fill the air.

Two residents (1 male and 1 female) approach desk. Receptionist states to the male resident; “I wanted to get you a segway but instead we will have to get you a red wagon. They laugh and move on.

Another group of residents approach desk and discuss the weather and the recent Miss USA pageant.

An elderly male, short and slim wearing black pants, a plaid sweater and white sneakers walks brusquely by the receptionist’s desk and says, “it’s raining I’ll have to take my walk inside today”.

At other times the Receptionist was a conveyor of support as evidenced by the following exchange between a resident and the Receptionist:

Residents continue to stream towards reception desk. One looking for stamps one inquiring on someone they are expecting. Another resident approaches receptionist and shares something indecipherable to me. The Receptionist instructs the resident “not worry, everything will be alright.” Phone rings and the conversation ends.

Still other times she was a source of information and assistance:

An elderly gentleman wearing black sweater, orange shirt and grey slacks enters the reception area and is recognized by the receptionist. He informs her he wants to speak with a Sister. She instructs him to take a seat on the couch and offers him the paper.

Receptionist greets elderly female resident and asks, “Did you get your stamps?” The woman replied “no.” The receptionist identifies two people, by name, who may have stamps.

At other times the interaction had to do with a specific event or topic. The following are examples of specific interactions related to events, (past or present) which were observed in the main lobby/reception area.

The birthday party. The first resident interaction observed was immediate upon entering the facility. It involved an elderly gray-haired gentleman neatly dressed in gray slacks and a cardigan sweater and the middle-aged receptionist seated behind the desk. The man had a skip to his step and a wide smile on his face when he approached the receptionist desk. The following is an excerpt of that exchange:

I enter the building and follow the corridor to the main sliding doors. Once inside I approach the receptionist desk. There is a perfumed scent to the air and a resident is conversing with a middle-aged receptionist who has ready smile for all who come upon her. She sits behind the desk answering the phone and questions from residents, staff and visitors. An elderly gentleman approaches the desk and the receptionist is wishing him a happy birthday. She inquires as to his age and he responds “77 Sunset Strip”. Both laugh. The receptionist asks about the “party” and the man states “it was the best birthday of my life; everyone was in on it”. Laughter erupts between the gentleman and the receptionist.

This exchange demonstrated the familiarity the Receptionist had with the resident. It also reflected the pride that the resident had regarding the number of people, within the home, that knew about the party and/or participated in it.

Welcome home. Another type of interaction that was observed in this space was that of a new resident arriving at the front door:

Further commotion is heard behind me coming from the sliding doors. I observe a middle-aged man guiding an elderly woman who is using a walker. She is white-haired and dressed in a raincoat and has a ready smile. I also notice a small crowd has gathered including one of the

Sister's standing in what looks like a welcoming committee formation. The male refers to the bad weather but Sister states to the woman "It is a beautiful day because you have come to live with us...It is a blessing you are here." The elderly woman responds: "I have been praying for this for a long time." Someone asks the woman if she is familiar with home and she states that she is and asks about a male resident who is a friend. Sister reassures her that he has been checking on the progress of preparation for the new resident and has requested that he be seated at his table for meals.

This was an impressive observation as it allowed an outsider the opportunity to witness what it was like to enter the home as a new resident. It was in stark contrast to personal experiences with the same process. The greeting lacked the coldness of entering a facility unnoticed, perhaps by wheelchair or stretcher and being delivered to an assigned room. The welcoming committee included the Sister in charge of the unit, nursing staff and social worker.

Welcome back. The lobby was an area that many of the residents visited several times a day. As previously stated it was central to the main dining room and the coffee shop, where residents gathered regularly to talk, play cards or bingo. It was also noticed that many former staff members continued to volunteer and/or visit in their retirement. They were greeted like a visiting friend or long lost relative when they arrived. Below is an excerpt of such a visit.

The lobby is busy this am with residents and visitors coming and going. This vantage point allows full view of the desk. The lobby doors open and a short, stout middle-aged woman enters in a blue jogging suit and sneakers. She is accompanied by a man of similar age wearing a Red Sox jersey, jeans and sneakers. Once inside there are several residents gathering to greet this woman. I recognize her as being an employee. She spots me and gives me a warm greeting. I ask her if she is still working and she states that she has retired recently. Her presence has caused quite a commotion.

The crowd spills over into the coffee shop and the retiree enters to cries "We miss you!" The woman is clearly happy to have such a reception.

After a while she and her husband bid everyone good-bye with the promise to return soon.

This researcher was also not immune to a warm welcome back by many of the staff and residents who remembered her from previous roles within the organization.

The following is an example of one particular interaction between the researcher and a resident:

An elderly woman wearing stylish jeans and a matching blue print sweater and heavy makeup enters the lobby with two other ladies. I recognize her as a former neighbor of mine while growing up and go over to say hello. She is thrilled to see me and introduces me to her friends and explains to the receptionist she has known me since before I was born. She told them how wonderful my mother and dad was and what a good neighborhood we lived in. She tells me she is 92 and is running the sewing room and invites me to come and spend some time there.

Coffee shop. The coffee shop was a popular place for residents to gather and visit with each other, volunteers, visitors and staff. The room had a bright orange and yellow floor with complimentary yellow wall paint. It smelled of freshly brewed coffee and there were baked goods on the counter, a self-serve industrial coffee station and a hot chocolate maker. Several tables and chairs outlined the space and as well as art décor in style with red vinyl seats and stainless tables. Along one wall sat a piano and a computer station occupied another corner of the room. Windows lined the opposite wall of the counter and were decorated with café style curtains.

A resident entered the room. She was a stately looking woman approximately 5'7"-5'8" in height and slim. Her hair was white and cut stylishly. Her facial features were angular and attractive. She was wearing a white skirt, white sneakers and a grey/black sweater with a small black shoulder bag. She asked what I was up to and I explained that I was a nurse finishing a doctorate degree in the nursing. She identified

that her niece is a nurse and is “very good” at what she does. She acknowledged what a difficult profession it is and that her niece has had to leave some long term care environments because her “standards are high.” She ended our conversation with the comment: “My niece is experienced in nursing home care and she says this one is one of the best.”

A volunteer entered the room and took a seat at the table with the resident. Another woman entered wearing a navy, red and brown fleece with a nature scene on it. It was coordinated with brown pants and light colored knitted hat. She also wore stylish earrings. The woman was greeted by the other 2 ladies and informed them her son was picking her up. She was excited that another son was visiting from out of town and all the women present agreed she had great children. One of the ladies decided to take a cookie and invited the other two women to also take one. Suddenly one woman stopped and cautioned another:

“You better be careful with your diabetes!”

It was obvious that the two women were personally familiar with each other by acknowledgment of great children and concern of indulging in sweets due to diabetes. The majority of conversations taking place in this space were casual and time passing in nature.

Another interaction was observed in the coffee shop and it related to the birthday party that was being discussed at the front desk earlier. It involved two women sitting at a table in the coffee and one describing to the other the birthday party:

One elderly bespectacled white-haired lady dressed nicely in a mint green blouse and beige slacks was sitting facing the door. She was

chatting with another resident about the birthday party of the older gentleman. She described the food and particularly like the “chicken pot pie.” The second woman mostly listened and occasionally asked clarifying questions but otherwise had little to say.

The exchange demonstrated the widespread awareness of a joyous event within the facility that involved one of the residents. The woman providing the description did so with an authoritative tone, which emphasized her pride in being part of the guest list. The other resident listened attentively, occasionally asking a clarifying question such as who was present and how the gentleman reacted when he entered the room.

Dining room. The main dining room (Figure 2) was another active space for interaction. During mealtime several conversations could be heard simultaneously. It was similar to being in a busy restaurant at the height of breakfast, lunch or dinner. The tables were arranged with five to six residents at each. Permanent table assignments were observed, as were personal place cards for each resident. It was noted that the males tended to sit together and many of them were retired priests. The aroma of freshly cooked foods filled the room. Large sliding glass doors provided light and views of the garden. At the back of the dining room another sitting area was available that contained a large television and jigsaw puzzle in the process of being built.

The mealtime served as a framework for activities and decision-making as the residents openly considered visits, appointments and outings related to the timing and serving of meals. Each of the resident units (2nd, 3rd and 4th floors) had their own dining areas and in addition there was a main dining room located on the first floor off the main corridor. The main dining room was available to residents that lived in the

attached apartments and those residing on the fourth floor assisted living unit. Meals were served at 8:00 a.m., 12:00 p.m., and 5:00 p.m.

Lunch was observed in the main dining room and breakfast observed on the second floor. An example of what lunch was like in the main dining room follows:

The room was very large with 10-11 tables, seating 6-8, all with white tablecloths and square plaid table toppers. To the right stands a hutch that had knick-knacks and the day's menu as well as different cards for "reserved", "birthday" and "won't be dining." In the event that a resident, who usually dines in the room, goes out they are expected to place a placard at their table spot to identify their absence. At the opposite end of the room there was a seating area that had several recliners, a couch, a long table with a jigsaw puzzle in progress and a large TV. There was a loud humming of voices that mostly involved greetings of "how are you" and "lousy weather."

The room was loud with conversation and the smell of delicious food permeated the air. A salad bar located at the front of the room offered fresh vegetables and salad dressings. Residents milled around the salad bar self-serve and kitchen staff dressed in crisp green scrubs with hairnets assisted those unable to leave their seats. A tall slender white haired gentleman sat at the first table. He was dressed in navy blue slacks, a wine colored shirt and a navy sweater vest. The man was identified as the "Bishop". Suddenly a bell rung and everyone took their seat and quietness filled the room. The tall gentleman (Bishop) stood and began to pray and residents joined in response to his offerings. Once the prayers concluded the conversation commenced with indecipherable topics interjected with laughter. In addition to the sounds of casual conversation, there was the clanging of dishes and pots as well as interactions between the wait staff and the residents that related to requests for more food or drink.

On this particular day a young girl popped into the room wearing a lavender ballerina tulle skirt and holding a stuffed White kitten. She was accompanied by her

mother and was introduced as a great niece of one of the diners/resident. “My daughter is her Great-grandniece and she loves to come to see her aunt.” The residents were happy to see the little girl and offered Oohs and ahhs as she made her way from table to table. It was apparent that the young child was familiar with the setting and the residents as she laughed and talked easily with all of them.

The workshop. Peace House is known for its skill at generating revenue.

Upon entering the main lobby one is met with a table lined with dolls, all beautifully dressed in clothing made in the home. Next to the dolls stood a small wire rack that contained additional articles of dolls clothing. Each year in late autumn the home sponsors a bazaar and it is widely successful. People from the community attend and are able to choose from baked goods, both donated and prepared on site, as well as craft items made in the workshop.

A ninety two year old woman, named Avid, a former “floor lady” in a local mill, manages the workshop. That background made her a logical choice to organize and oversee the inventory for each year’s annual bazaar.

The Kraft Room, as the sign on the door stated, was large with several tables lining the space. Walls were covered with soft crème colored wallpaper with a border of light pink roses. Two large windows provided light and neat curtains complimented the color scheme of green leaves and pink flowers. The room was empty of people upon my arrival a woman stops by and stated, “they are probably on break and should be right back.”

Six sewing machines were positioned strategically around the room and were covered with colorful quilted protective covers. There were walls of cabinets and

shelves. The shelves contained remnants of materials, baskets with buttons and lace as well as craft supplies. Voices were heard approaching the room laughing and talking. Four elderly women entered the room and Avid introduced me and explained, “she is going to be a doctor.” She informed the ladies of how long she had known me, which facilitated my acceptance into the workspace.

A volunteer appeared at the door and was welcomed and waved in to the room. There were several conversations going on. Avid organizes the workspace and assigned tasks to other women. “Raine you start working on the clowns.” “Mary continue with the knitting.” “Thelma I need that cloth cut from the place mat pattern.” “Dora you can work on the lining of the pot holders”.

Avid sat down at her machine, which had a sign above that that read “Garden Diva” and began to sew. She was making a doll’s outfit. Avid was dressed in beige slacks, a light blue/Beige sweater and wore beige sandals. She was interrupted time to time by the other women asking for guidance on their assignment. Suddenly she hopped up and stated, “I have some money that Mother gave me to buy supplies and I need to put it in my purse. I am going today with Raine to Ryco and will buy lace for the doll’s clothes” “I love that store”. Asked about the work hours she replied, “9:30 am-4p Monday through Friday” “We are very busy and earned 800.00 dollars last month in the gift shop with our products.”

Another woman joined the group she was wearing red scrub pants and red/white scrub top. Marie was a petite woman with dark hair, middle aged who sat with May and another worker. They began to work on knitting and the conversation picked up surrounding a review of play one of the women was going to attend. The

ladies did not agree with the critic's assessment of "Forever Plaid." Thelma explained she was going to see it the next evening at the Newport Playhouse. She and one of the other ladies were members of the Red Hat Ladies.

The woman working on potholders drew Avid's attention to a pile of work done yesterday by a volunteer who Avid referred to "as not right" (pointing to her head). The worker pointed out that the edges were not even and Avid instructed the woman to redo them. Frustrated Avid exclaimed, "I can't give her any job. I feel bad for her she just lost her mother and all. I understand she lives alone in a big house." The others agreed that they felt sorry for her and they were sure her coming to the home to volunteer filled her day. The discussion continued for several moments on the topic of the volunteer and how they should handle her offer to assist in the workshop. It was interesting to hear the residents express concern for a much younger volunteer and contemplate how to keep her busy without stalling their work.

Marie got up and went to a small refrigerator located in the corner of the room. She explained that her husband had caught some fish over the weekend and that it was available for sale. The price was \$2.00 for the fish and it was cleaned and ready to cook. She went on to tell the women that if they every want any fresh fish to let her know and she would get it for them as her husband was a Commercial Fisherman. Shortly after that Marie left the room to follow up on some other work in the home.

Most of the women in the Kraft Room resided in the apartments or on the Assisted Living Unit. One lady, Thelma, was an outside volunteer who came in a couple of days a week and knew Avid from their years in the mill. They worked and chatted throughout the observation.

A staff member appeared at the door of the room pushing an elderly woman in wheelchair. The woman's hair has just been done and one could smell the scent of fresh hairspray. The resident was dressed nicely in mint colored slacks with a coordinated mint, blue, white and pink striped shirt. She wore pearls around her neck and had on large pearl earrings. Her feet were covered with leopard skinned non-skid socks cut to accommodate her swollen red feet.

The aide asked if the ladies could repair a button for the resident and they agreed to do so. Avid informed the woman that the garment would be sent upstairs as soon as it was ready.

Marie returned with a cart full of colored blouses, skirts, slacks and dresses. She asked Raine if she could sew nametags into the garments; "Sister wants to know if you can sew the names into these clothes?" The worker was not pleased with the request but replied, "Sister keeps me busy; of course I will but I have to get to my clowns...I have several back ordered." Each resident had designer nametags stitched into their clothing. The Administrator believed that such attention to personal belongings instilled respect for the individual and was more pleasing to the eye than indelible marker.

Seated on a table along the wall of windows was a miniature barn made out of Popsicle sticks. "Look inside the doors open and everything" said Avid. She pointed out the bales of hay and the small farm animals that were carved out and placed strategically around the barn. "Joe made that and we are going to raffle it off at the bazaar." Joe lived on the 4th floor and had a talent for building dollhouses, barns and other small structures.

The time is almost 11:00 a.m. and Avid announces “time for Mass” at which all the ladies put down their tools and prepared to depart for the Chapel. They would lunch in the main dining room following the Mass and then make their way back to the Kraft Korner for the afternoon shift.

The interactions in the workshop focused primarily on the job at hand interspersed with personal stories and social events upcoming. There was a great deal of pride in the work that was being produced in the room as evidenced by the income obtained through their efforts. Additionally, the environment resembled that of any workspace with a leader directing the flow of work and occasional conversations pertaining to outside interests. This day outside interests discussed included the availability of fish for sale and an upcoming trip to the theater as well as disagreement with the Theatre Critic’s review.

Second floor public spaces.

Dining room. Mealtime on the second floor was considerably different than what was observed in the main dining room. Exiting the elevator at approximately 7:45 am one was met with the sweet aroma of maple syrup and the sizzling of breakfast meats. Several elderly women were observed shuffling towards the dining room assisted by staff members. Immediately outside the dining room two ladies sat in high-backed floral chairs and appeared curious as to the early morning visitor but did not ask any questions. The women sat quietly and did not speak to one another.

Sister Rae, the unit manager, waved me into the room. She was an older woman with a bright smile garbed in a white veil and uniform that dropped below her knees. She wore black open-toed sandals. Once inside the dining room six tables were

noticed each with four chairs positioned around them. The tables all had pink tablecloths with silk floral arrangements located in the center. The chairs were wooden with blue/gray vinyl. Each table had a lazy Susan in the middle, which contained a small pitcher of milk, sugar, salt and pepper. There were no trays or food trucks visible or used. Eggs are made to offer in the moderately sized kitchen located off the dining room. The kitchen is decorated in light green with an abundance of stainless steel cabinets, stove and refrigerator.

Three residents sat at each of the five tables with one table remaining empty for special occasion guests such as birthday luncheons etc. Sister and the Dietary Aide were preparing cereal for distribution. The room was humming with morning greetings between tablemates. Soon another younger Sister arrived to help with the morning meal. Nursing Assistants arrive with their residents and don hairnets and aprons. They also assist the Nuns and the dietary aide in distributing cereal first followed by eggs, meat and toast. Some residents have fresh prunes mashed up before them and others enjoy a glass of orange juice. The room is bustling with conversation, primarily between the staff and the residents, and pertaining to the likes and dislikes of the menu offerings.

Sister announces “good morning” and the room quiets down. She identifies the date and day and a large calendar adorns one of the pink covered walls. In addition to welcoming the residents (all female) to breakfast she leads them in prayer and informs them of any activities of the day including Mass at 11:00 am.

The staff, including an activities aide began serving the main course once the announcements had been made. For those requiring assistance with eating the staff sat

beside them and placed their arm around the resident and encouraged them to eat what was placed on spoon or fork. At another table two women reached for milk to put on their cereal or in their coffee. They talked softly to each other in undecipherable words. The third lady at the same table noticed the visitor and kept peeking around the corner. There were three tables that enjoyed sustained conversation among the inhabitants but at two other tables the interaction was primarily one-side from caregiver to resident. The caregiver/feeder would encourage intake of food by referring to the resident by name and maintaining physical contact via an arm around the shoulders. Additionally the caregivers sat in a chair next to the resident requiring assistance, which put them at eye-level and transmitted a non-rushed demeanor.

Mother Kay entered the dining room. She was the administrator and executive of the home and easily recognized by Residents and staff. Her authoritative position, both administratively and within the religious community was evident as all turned their attention towards her when she entered the room. Once in the room Mother noticed the elderly woman whom appeared distracted by the presence of the unknown visitor. Mother approached the woman and asked, "Why aren't you eating?" With that she attempted to entice the woman to take a drink of juice, which the woman accepted cheerfully. Another woman at the table greeted Mother and Mother Walked over to her and asked how she was doing. The woman spoke softly and asked Mother to keep her in her prayers. Mother leaned in close to the resident and it appeared someone in the woman's family was ill. Mother spoke quietly to her and assured her she would keep the lady and her family member in her prayers.

By 8:45 breakfast was over and many began to leave the dining room. Staff wheeled some out while others shuffled with walkers and/or roller aides. All assistive devices, except those utilizing wheelchairs, were parked outside the room. There is a policy of “walking in to dining room” as it is believed to encourage the residents to remain active and function to their full potential. It was also identified that the absence of assistive devices in the dining room gives it more of a home feel and does not remind the resident of their limitations.

At the conclusion of breakfast one of the resident’s (a future participant) engaged this researcher in a conversation. She was awaiting her morning medications and sat in one of the chairs immediately outside the dining room. The following is an excerpt of that interaction:

An attractive elderly woman with a short stylish haircut approached the empty seat beside me. She was wearing khaki crop pants, black leather shoes, and a white top with red and blue trim. She has a push cart that had her belongings in the basket and a sunflower made of felt wrapped around the handle. She engaged me in a conversation and apologized for not speaking clearly because she had had a stroke and suffered from Parkinson. The Nurse approached her and asked if she needed something for her arm pain and she said “yes.” The nurse returned with the morning medications for the woman and said, “I am going to give the big pills separately, I know you like to down them all at once but you scare me.” The woman laughed. She told me her husband died 27 years ago and that he was a pharmacist. He was only 54 and so was she. She said “I still miss him very much.” “He used to call me his “old lady because I was two weeks older than him”. “When his birthday came around I would say “I am not your old lady anymore.” The woman stated she had 2 daughters and 2 sons. Her oldest daughter visited every day at noon except Mondays because she played bingo. I told her she looked very nice and she said my daughter is taking me to the “foot Doctor” this afternoon. She stated she wanted to keep her own foot doctor when she got admitted last fall. The nurse administered her pills, one at a time, and the woman headed back to her room to await her daughter’s arrival.

Community room. The dining room had emptied and the residents were assisted either back to their room and/ or the community sitting room located on the first main corridor on the second floor, before the elevator. The room was large and bright with a pink and blue floral couch, a large TV and several comfortable looking recliners in neutral colors. Prior to escorting the residents into the sitting room they were toileted at a nearby restroom. Once in the room two women were positioned comfortably in recliners and two in wheelchairs. A morning talk show was tuned in on the T.V. A parakeet “Bubbles” chirped in a cage near the entrance to the room.

The conversation in this public space was minimal, as many of the residents appeared to have significant impaired cognitive functioning. Some dozed and others watched the television. One woman said her prayers aloud. The bird chirped mostly unnoticed. Around mid-morning a volunteer arrived and chatted with one of the women. The volunteer was identified as a resident of the Assisted Living Unit who came down to the second floor for visits with the residents. Soon after her arrival, one of the younger Sister’s, seen earlier at breakfast, arrived with a beverage cart. She offered different flavored juices and/or ginger ale to the ladies. One woman was seated in a wheelchair and Sister poured a juice and went and sat beside her. She encouraged the resident to take a sip of the beverage, which she did. She used phrases such as “c’mon just a little bit more...you can do it.” It took quite a bit of time before the resident finished the cup of juice but the Sister sat beside her the entire time and coaxed her gently calling her by name.

Organized events/entertainment. In addition to location, interactions were also observed as they related to organized activities. The following section describes

the types of organized events and entertainment that involved resident interaction occurring during Phase I of the research process.

There were several opportunities to observe “special events” and they included an International Day Luncheon, a summer barbecue and the weekly musical entertainment program.

Musical program. Entering the auditorium a middle-aged female musician was observed warming up on the guitar. There are a few residents sitting in the front rows and others in wheelchairs line both sides of the room. The musician greets members of the audience and calls many by name. It is obvious that they are all familiar with one another by the exchange of pleasantries and personal inquiries. The room begins to fill up with residents; many assisted by staff members, who provide information on when they will return.

The musician is a friendly middle-aged woman with blonde hair, dressed casually in blue jeans and a navy blue shirt that leaned against the stage tuning her guitar. To her right was a large baby grand piano on wheels and behind her, up on the stage was an elderly gentleman holding a drum. He was dressed in a light blue polo shirt, light blue slacks and white sneakers. He was balding and not very tall.

A tall elderly woman distributed tambourines and cymbals. Two gentlemen sat in the front row to the right of the stage. One man was wearing beige slacks, light beige sweater vest and matching beige patent leather shoes. The other gentleman was dressed in dark blue slacks, a plaid dark shirt and blue sweater vest. A staff member pushed an elderly pleasant looking woman with a short curly gray hair and a smile on her face into the room. She was positioned along the wall and next to the front row.

Following the woman into the room was a tall elderly Man who took a seat to the left of the stage. He was a large man wearing a red Sox Jersey and khaki pants and possessed a full head of white hair. The gentleman positioned himself so he could keep eye on his tomato garden located to his right, beyond the sliding glass doors. He had a concerned look on his face as he watched two pre-teens, a boy and a girl, run around the yard. Eventually he got up and went outside to tell them to stay away from his garden. It was later discovered the children were waiting for someone who had entered the building.

Two white-haired women sit at the end of the row. One is in a wheelchair and the younger of the two, seated in a folding chair has her arm around the older one. They are sisters and live in the home. The music started and at first participation was tepid. Suddenly the Activities Director bounded through the stage right door and grabbed a guitar. She joined in with Bye, Bye, Blackbird and got the group singing. Next Heart of my Heart rings out. The room is coming alive. The singing and clapping got much stronger. The tall older woman moved around the room and danced with several of the residents. She would take their hands and move their arms looking directly into their eyes smiling and singing. It was later learned that the tall slim woman responsible for audience participation was the wife of the “drummer” and both had volunteered at the home for over thirty years. The past few years they have resided in the apartments and volunteer internally.

A woman sat in front row, in a wheelchair; her head was flexed towards her chest. She had a full head of curly brown hair and appeared to be younger in age than the other residents. A muscular and fit appearing older man sat beside the woman

with his arm around her. She was disengaged until the song “only you” was sung. She lifted her head and mouthed the words to the song. Immediately after the song finished she returned to her world and nodded off. The man was her husband and occasionally tried to engage her in different songs to no avail.

The room is raucous with laughter and song as everyone joins in on the Hokey Pokey. There was so much noise a kitchen aide came to the door to see what was happening. She laughed and joined in with the dancing. One of the resident’s daughters was invited up to sing a song and she reluctantly approached the stage to cheers of the audience. This attracted the attention of a Sister who came into the auditorium and sang along. It was like a party. A few of the residents that could get up and move danced in the back of the room. The “gardener” had returned and took a dance partner. He was a smooth dancer choosing to embrace a ballroom style motion.

The afternoon flew by and two middle-aged men entered the room with a small Dog “Lucy.” The residents and staff were obviously very familiar with her and the Musician led everyone in “How much is that doggy in the window”. Lucy’s handler’s encouraged her to sign along and she howled loudly. Approximately 90 minutes have passed and “Lucy” has left the room. The Musician and Activities Director talked about the next sing-a-long being close to July 4. They suggested some patriotic songs be sung in preparation for a musical celebration of the holiday. Songs included God Bless American and My Country tis of Thee”. At the conclusion of the last song the residents began to file out of the auditorium. Staff members returned to accompany their residents back to respective units. There was much revelry as everyone wished one another adieu.

One of the men sitting in the front row, wearing the navy slacks and sweater vest, appeared a bit agitated. He refused to return to his room and stated, “I want to go home, let me go home.” He became verbally and physically aggressive. The man pulled away from one of the staff members and made his way down the corridor toward the main entrance and out the door. The man was a retired priest who suffered from dementia and the staff was most concerned as to how to get him back inside the home. A young Sister exited the building in pursuit of him and managed to catch up with him as he was heading into the parking lot. She tenderly wrapped her arms around him, held him close and explained he was home and escorted him slowly back into the building. There was no commotion, arguing or public attention when they entered the building. It was as if people melted into the walls and cleared the path for this young nun as she walked the priest to his room. Everyone knew what to do.

In summary, the nature of resident interaction going on in selected areas (public spaces on 1st and 2nd floors) within a continuing care facility, were primarily active and included multiple dyads. The area that generated the most interaction was that surrounding the receptionist’s desk in the main lobby. Residents appeared to view this area as a checkpoint for information, updates and support. The receptionist, by her welcoming demeanor and knowledge of the residents, promoted the interactions between herself and the residents. Chatting was observed in all public spaces at different time intervals throughout the day. However, the morning and early afternoon appeared to be the most popular times.

Interactions in public spaces were noted to be resident-resident, resident-staff member, and resident visitor. The resident-staff interactions on the main floor

included office staff and administrative staff. It was further noted that residents did much of the initiating of interactions whether it was resident-resident or resident-staff. The single nursing staff-resident observation in this geographic space was related to a new resident arriving for admission and that interaction was reflective of a warm welcome.

Research Question 2

What is the nature of relationships that residents identify as positive? Ten Residents participated in the study and all ten identified that they had experienced positive relationships with their caregivers. The nature of those relationships however differed significantly. Three participants identified positive relationships with direct caregivers that involved specificity related to name and familial references, four reported positive relationships that did not involved specificity and four had positive relationships that were distant and were considered in terms of ability to deliver care.

Overall the residents were content with their caregivers and thus viewed their relationships in a positive manner. One resident did identify a negative relationship, which admittedly was one-way, as the caregiver did not seem to be aware of the resident's dislike of her. In that case the resident found it easier to discuss the negative relationship than to identify a positive one with specificity. That finding will be discussed later in the chapter. The presence or absence of close family relationships did not appear to affect whether or not a positive-specific relationships developed.

Positive relationship with specificity.

Sally. Sally provided the most illustrative case, of a positive relationship between a resident and nursing assistant. She was a 77-year-old slightly obese cheerful woman whose hair was white and cut in a traditional close-cropped nursing home style. Sally had a long history with the home as she and her late husband had volunteered for many years and eventually moved into the apartments approximately ten years ago. She was a delightful woman with a permanent smile anchored by red chubby cheeks.

In addition to her long relationship with the home her husband had been a resident on the same unit and passed away three years ago. A sister-in-law is a member of the religious order that staffs the home and another family member is the Activities Director. These aspects afforded her a longitudinal attachment with the home but nevertheless her admission to the skilled nursing unit was new for her and one that was not without challenges. Following the death of her husband Sally, still living in the apartments, experienced several falls. The last time she fell the Administrator told her it was time to come into the main house for her own safety.

Once admitted to the second floor skilled nursing unit she was placed in one of only two double rooms. All other residents' rooms on the unit are private. Sally's roommate was a Portuguese-speaking woman with advanced dementia and propensity for abusive language. The woman would yell at her and open the curtain when she was bathing etc. Sally's nursing assistants would communicate with the woman in Portuguese and remove Sally from the room, thus facilitating a more pleasant

environment. She felt the nursing assistant's actions were protective of her and eventually the roommate was transferred to another home due to her psychiatric needs.

Sally eventually got her own room and is where we met for the interviews. The walls were a soft white and mauve colored curtains hung on two large windows that overlooked the garden area in the back of the campus. Large trees draped outside the windows and provided shade in the summer but were losing their foliage fast as autumn took over. She was seated in a wheelchair appearing very neat wearing a grey shirt and lavender slacks. Black soft shoes covered her swollen feet. A smile lit up her face and she informed me she had just returned from the hospital after suffering from congestive heart failure. She agreed to notify me if she became fatigued or had any shortness of breath.

The resident's demeanor was a happy one and her room reflected her disposition. It was neat but not perfectly organized, which reflected her personal presentation. Many family photographs adorned the walls and the tabletops. A large television sat in front of the window. In accordance with her happy go lucky nature several stuffed animals were positioned throughout the room. She spoke quickly and with a chuckle that followed many of her responses. Sally appeared to be a happy person and confirmed that many times verbally during the interview.

The interview began by taking a history of her relationship with the home, described above. She was then asked how it felt to live at Peace House?

“It's fantastic. I couldn't ask for any better place...if you need something they come right in and they might say what do you want and I will reply don't be a pain”

In addition Sally described the impromptu visits by her nursing assistants that included stopping by and telling her a joke. She described the nursing assistants as “always there for you”. This sentiment was backed up the majority of those interviewed.

When asked if she had a particular relationship with one of the nursing assistant’s that she would describe as positive she did not hesitate to identify and describe one. The following is an excerpt of her taped interview where she identified the aide (pseudonym) and described why she felt so close to her.

“Ariel is fantastic! I have her all the time and anything I need or want she gets...she knows what I want before I do that’s how good she is”

The nature of the relationship was treated in a familial way that included the nursing assistant referring to her as a sister. The Assistant’s biological sister was also a nursing assistant on the unit, which is why she was included in the three. Sally stated that Ariel and she talked like “friends” and that the Nursing Assistant was good at keeping the conversation going and that she was simply “indescribable”. Other terms used to describe the individual; “she is one in a million. She doesn’t know how good she is”. “I can tell when she is down...I can read her and I will say alright what is the problem today and she does the same for me”

The nursing assistant talked about her family to Sally and knew many members of her family. For example Ariel would say, “How is my niece or nephew?” when referring to Sally’s children. Additionally Ariel’s son visited with his little boy and that brought much enjoyment to Sally.

Sally also identified a nursing assistant on the second shift that she felt very close to. That relationship lacked the familial references of the first one but

nevertheless significant. The relationship was primarily based on concern for the resident's well being. Sally described her in the following way:

“fantastic, a real sweetheart. She comes in and asks did you sleep alright last night? If I have a problem or question I just talk to her and if she needs to speak to the nurse she will do it and straighten everything out”

Eleanor. Eleanor was a pleasant woman whose physical features belied her age of 88. She had a full head of gray hair, nicely styled and a warm smile. Eleanor had difficulty holding her head up due to the effects of Parkinson's Disease and wore rather large designer eyeglasses. She too had a long association with the home having lived in the apartments for many years with her late husband. Additionally her husband had been the official photographer for the Sisters and taught many of them how to drive. She was especially grateful for how the Sisters kept her husband's memory alive and stated “I prefer to hear them brag about him.”

Eleanor's room is located on the first main corridor, below the elevators. It was decorated with home furnishings including a large brown couch, dark colored wooden dresser, lamps and a recliner. This morning she was seated in the recliner and her nephew, who visits once a week consistently, stayed throughout the interview. In addition to the furnishings Eleanor had several religious statues placed around the room and religious photographs adorned the walls, along with photographs of her late husband and her children, grandchildren and great-grandchildren.

After her husband passed away Eleanor experienced several falls, which resulted in her being moved over to the main building. She had resided in her current room for two years. Eleanor described the environment as “wonderful” and so different from the nursing home her sister was in: “Not even a chair to sit in and the

nurses were fight amongst themselves”. She described her life as full and happy and that “they make you feel right at home” and “it is a family-like atmosphere here”. “They” was a general term that was used at intervals throughout the interview and was clarified to mean the entire staff.

When asked whether there were one or more nursing assistant that she felt especially close with Eleanor did not hesitate to describe a nursing assistant that worked on the second shift (3-11). She described, “looking forward” to this individual coming in and felt they had become “friends”. When asked how she felt they had become friends she described having a “connection” with the woman. They were both widows and enjoyed telling and sharing jokes. She particularly enjoyed hearing about the renovations the nursing assistant was undertaking in her home:

“I looked forward every day to her coming in and updating me on the colors she chose and how the paint looked”.

Additionally, Eleanor felt that the nursing assistant treated her differently than others by claiming, “I am the only one she checks in on every night”. She further stated, “we tell each other their problems” and she enjoyed being a source of support for her as well. She further offered the following actions to describe how this relationship differed from the others:

“I give her two cough drops every night and she puts my shoes outside my door so they can be polished overnight”

She concluded the interview by summarizing her feelings about living at Peace House: “I thank God every day I am here”.

Tina. Tina was a petite woman with an olive complexion and a sparse amount of wiry light brown hair. Her attire was neat and coordinated and she wore leather

beige colored sneakers. Her legs were noticeably swollen and wrapped with ace bandages. Tina is a ninety-year-old female who has lived in the facility for approximately three years and has occupied her current room for two. The room was bright and cheery with a large window located along the far wall. The color scheme was crème walls with soft mint accented bedcovering and drapes.

The bed, bureau and nightstand were white. Additionally she had an attractive white wood television console that matched the rest of the furniture. In the far corner of the room stood a white alabaster column that held a silk floral arrangement. The design was Grecian and consisted with the woman's heritage. Everything was in its place and the space was symmetrically balanced; not overcrowded or cluttered.

Family pictures hung on one wall and were balanced with a seashell wreath across the room. A decorative mirror hung over the night table.

She was very proud of her room and smiled when complimented on the design. This was further evidenced by her pride in the comment offered by the Sister in charge of the unit who said: "it completes the space, I love it!"

Tina pointed out that the bed was from a child's collection and worked perfectly for her size. Resting on the decorative mint green pillow sham was a Barbie doll sized replica of Princess Grace in her wedding gown. It was authentic looking right down to the lace and veil. She stated, "One of the things I like most is that they let you fix your room the way you want to".

Tina sat in a recliner near the window and a chair was located across from her for the researcher. She suffered from severe pulmonary disease and at times was difficult to hear, as her voice was raspy and soft. Unlike the previous two residents

Tina did not have prior knowledge of the home or its reputation. She was residing in Florida, near Orlando, when her children decided she needed to be closer to them. One of her daughters passed the home on her way to work everyday and stopped in to visit. Additionally, the daughter asked colleagues and friends about the home and heard “good things”. She was convinced to come up for a trial visit and was admitted to the Assisted Living Unit. Shortly after arriving on the unit she experienced leg swelling and difficulty ambulating, which necessitated her move to the second floor.

Initially Tina was in a two- bedroom and described it as challenging. Her roommate was confused and would yell out at night. One night the roommate tried to get out of bed and Tina was able to call the nurse before the woman fell. She described being happy to assist the woman but worried that it affected her ability to get rest. She loves her current room and has been in it approximately two and a half years.

When asked how it felt to live at Peace House she responded, “ I would recommend this place to anyone...I am not Catholic but my Pastor came to visit me and he said when it is time for his own mother to need a place he wants her to come here”. Her demeanor was relaxed, pleasant and appeared to support her comment that “I am happy to be here”.

Tina initially described her relationship with the nursing assistants as “super” and that they “Will do anything for you...they know what you need before you even ask”. When pressed further about whether she had experienced a close relationship with one or more the aides she responded, “Yes Edie”. Below is an excerpt of her description of the relationship with Edie:

“She would tell me about her mother...we are about the same age and she has swollen legs like me. Edie has to wrap her mother’s legs like mine so I ask her about her mother” “She pops in and says how are you doing? And “She is always trying to help me with my hair”

In all three examples the residents were able to readily identify a nursing assistant by name and describe what it was that caused them to feel close to the individual. This differed significantly from the next group of residents who spoke in general terms and lack the in-depth knowledge associated with a close personal relationship.

Positive non-specific. The second type of positive relationship identified among residents and caregivers was positive non-specific. Four participants admitted to a more superfluous relationship with their nursing assistant caregivers, however it was considered positive. One refused to identify a single individual because “they are all good...across the board 100%”. These residents also referred to the caregivers as “they”, which put more emotional distance between themselves and the nursing assistant. In these cases the resident enjoyed hearing stories about the caregivers personal life but were unwilling to share their own personal histories. As Dolly put it “I don’t go too deep into their business because I don’t want them going into mine”.

Four women fell into this category and they included; Ava, Allie, Dolly and Rose (pseudonyms). Several examples of responses for residents claiming to have a positive non-specific relationship with a caregiver follow.

Dolly. Dolly is a delightful gal with short white hair, pale skin and an easy smile. One is struck by her booming voice when introduced to her and the perfect elocution of her speech. She appears to be a low maintenance type of girl. Her appearance is a bit disheveled and her poor vision and hearing prevented direct eye

contact. Dolly would focus off to the side when speaking, not making eye contact with the other person. This was primarily due to her poor visions

She had a dry sense of humor and at first one was not sure whether she was annoyed with the interruption or just kidding. The researcher soon learned it was the latter and not the former. She was most gracious and willing to discuss what brought her to Peace House; how it was to live there and the types of relationships she has formed since arriving.

Dolly's ties also went back many years to the organization. She had volunteered years ago and informed "I use to come in every Saturday and Sunday and feed the people right on this floor". She indicated it was always her desire to live there, "I always wanted to come here" because of the "way they treated old people", "everyone seemed contented". She liked the cleanliness of the home and "excellent help". She too initially moved in to the Assisted Living Unit but experienced a fall a year ago that caused her to break her hip and shoulder. Due to her injuries she was moved to the second floor for more intense assistance with activities of everyday living.

When asked how it felt to live at the home she replied without hesitation "Heaven...next to Heaven!" Dolly had an almost theatrical emphasis when she spoke her emphasis and tone of the above response supported her genuine belief that this was as close to Heaven as one could get on earth. Pressing her a bit further as to why she felt that way she offered the following:

"Because it is spotless. It is as clean as you will ever find any place. The help in my opinion are almost excellent...I will say excellent. I

don't want to be too sugary because then you wouldn't believe me, but they are excellent as far as I can see".

She was comical in her responses such as when she was asked what she liked most about living here "Oh God Peace! When I think of it you are not afraid at night and nobody bothers you during the day...as long as you don't do anything stupid like try to get up on your own". Dolly was just as humorous when asked whether or not she had developed a positive relationship with one or more of her caregivers? "I ain't gonna say nothing in that regard because I would say 100% across the board". She further elaborated, "They have been told the patients are in charge...if you ask for something they do it-what more do you want?"

Dolly identified that one might have to wait a couple of minutes but qualified it by stating "Well you know it's because they have a lot of sick people". A follow up question was posed regarding whether she was familiar with the nursing assistant's families? An emphatic, "NO it's not important to me because I don't mix. I have my own people and that's all I need." Pressed a little further about whether or not she cared about the personal life of the caregiver she responded, "Yes and No...I will tell you you like to know if they are married. Ahh...I wouldn't want to go to deep with them because I don't want them going deep into me, do you get it?"

Allie. Allie was a pleasant over ninety female resident. She had an easy smile as well as a soft voice. She was dressed neatly in a coordinated blue pantsuit, jewelry around her neck and wore a hint of make up on her face. Her hair was styled neatly and appeared as if she had just returned from the hair salon. The room was small but neat with a bed occupying a large portion of the space. Light blue walls with a floral

border provided a calming influence to the environment and family pictures dotted the walls. Her expression was calm and

Allie readily welcomed the researcher into her room and was more than happy to share her experience of living in the home. She described her situation as being a widow who had sold her home and moved into elderly housing within the city.

Unfortunately, the apartment house was overrun with robberies and “hanky panky” and left her feeling unsafe. The following is an excerpt from Allie’s story:

“Well everyone was telling me it was a beautiful place and I was living in my own apartment and didn’t like it. I was scared. I was scared to be alone, in fact I would put a laundry cart up against the door in case...it was bad. So I put my name in but the Nun died and I waited. I tried again...it’s a good Catholic place and I am a Catholic and I heard it was very, very good. I came in and tried it for three days and I liked it. I like the way they operate and I said this is the place for me”.

Security was a major issue for Allie and she felt very secure when she visited, so much so that she told her daughters “I said this is for me; this is my dream!”

Additionally the Catholic environment was very important as she referenced it several times stating “I am Catholic and I go to Church and they have Mass right here”.

When asked if she felt particularly close to any of the nursing assistant’s she spoke in general terms about the need for them and replied:

They are so good. They take good care of you. They treat you like a human being, not you’re sick so I am not going to bother with you. I can’t complain about anybody in here”.

Shortly after our interview began the power went out in the home. A strong wind was howling outside and appeared to have knocked out the power. Suddenly the door cracked open and a nursing assistant came in to ask if she needed anything and explained a transformer had been hit down the street and that they hoped to have the

power restored soon. The aide assured her they would check in frequently and also offered her a beverage, which she declined.

Interestingly when Allie was first asked about describing one or more “good” relationships she gave the following response:

“Well you know I will tell ya...they have these people who come into volunteer and there are a couple of ladies that live in the apartments and they will pick me up and take me to Mass and take me back because when I broke my leg I couldn’t walk and they came over to make sure I got to Mass. After Mass they take me to the dining room. I have never met such wonderful people- I was alone I was really all alone”.

She confirmed that these ladies had become her friends and that was backed up by the description she provided and the affectionate tone she used to depict their goodness towards her.

Ava. Ava was a sweet short woman with a full face and happy smile. She was neatly dressed but did not wear jewelry or make up like Allie. Her room was located at the end of the corridor and looked out at the back of the building. She directed my attention to a tree outside the window and said that a little bird shows up most morning and she believed it was the Holy Spirit. Her room is neat and heavily decorated with religious pictures and statues. She additionally had a couple of family pictures including one of niece that had passed away and a close friend who was nun who had also passed away.

Ava’s world clearly revolved around her spiritual life as evidenced by her description of her daily activities in terms of prayers, Mass and religious programming that she tunes into twice a day. She like many of the other resident had a strong connection to the home. Her brother and sister-in-law had lived there for many years (now deceased) and she would dine with them every Sunday in the main dining room.

In 2011 her husband passed away and she described the following sequence: “I put my name in and got letter telling me they had room”. “I wouldn’t go anywhere else because I am a Catholic and I have a spiritual connection”. She described herself fortunate for being there and stated, “Everyone is nice”. She resisted singling one nursing assistant out when asked if there was one or more that she knew well and considered to have a good relationship with? “No, they all take good care of you and I am not too friendly with them.”

Rose. Rose, a self-described Nomad, was a unique woman who was confident in her speech and her demeanor. Her quick wit initially caused some concern but rather shortly discovered that she was sweet and considerate. The interview took place in the solarium, surrounded by plants, where she spent her mornings reading the local newspaper. This day she was dressed in a red and black wool skirt and a black sweater. Her hair was curly, white and full and did not appear to have recently been “done”.

Her story was somewhat unique in that she discovered the home on a walk one day. She lived a few miles down the street in an elderly apartment complex and communicated very eloquently how she loved to walk. “I love to feel the leaves crunching beneath my feet and the feel of fresh air”. One day she walked a bit further and came upon the home. Curious she stepped inside and asked about the apartments. She applied that day and shortly thereafter got a call telling her they had an apartment for her if she still wanted it.

After spending a couple of years in the apartments she required heart surgery and was transferred to the assisted living unit. She found the transition easy and

described it “same building, same people, same auditorium”. Eventually her health deteriorated further and she was moved to the skilled nursing unit, where she now resides. When asked how it felt to live in the environment she replied “Euphoric”. She described the residents reaching out to the “New kid on the block”. She used the word home several times to depict how it felt to live in the environment.

On the topic of nursing assistants she identified that she had a “good” relationship with a couple of them. “As usual there is going to be one situation or part of situation that needs a little tweak now and then and we can work on that...that is part of living too you know?” Unable to name the individuals she described their ability to know their job and ability to “know when you have this or that” Rose indicated that she discussed family with some of them; “You like to know about them and they are interested in you and its genuine, you know? “When you need things they are right there”. Probed a bit further as to what “right there” meant to her she described it as “Like a parent anticipating one of your needs you know? Something you were going to ask about and they beat you to the punch”

Overall the respondents in this category preferred a more superficial relationship with their direct caregivers. Two primary reasons appeared to trigger this type of relationship; an aversion to share personal information with caregiver and a desire to not single one individual out.

Positive-distant. The last group had a neutral view of the direct caregiver (nursing assistant) and only considered their clinical competence in determining their role. Susan, LeRoy and Josephine fit into this grouping and openly expressed little desire to engage in a relationship with the caregiver. Susan, however, over the course

of observation, did exhibit a close relationship with the Activities Director. It was a powerful demonstration of ties that connected them and exposed how they helped one another through difficult times. At the conclusion of this section Susan's profile will include a description of that relationship.

LeRoy will be discussed first as he was the most challenging of all the interviewees. He had a clinical perspective of his direct caregivers and even took some time to get warmed up to the questioning but eventually he did and a great deal was learned by his interpretation of the caregiver role.

LeRoy. LeRoy is an elderly man tall in stature and slim. His attire was a plain, cream-colored sweater and brown trousers and neat. The room was distinctly masculine decorated in yellow and brown earth tones and lacking the knick-knacks and family photos noted in the female resident rooms. Overall the room had a feel of a hospital room with the bed up against the wall, an oxygen tank by his recliner and a window fan blowing softly towards him.

He had a long history with the home, as his father had been a resident there in the 1960's. Additionally he worked for a dry cleaning company that used to provide dry cleaning services to the residents and nuns and became friendly with some of them. That dated back to the 1950's. LeRoy was extremely quiet and explained that he came to live in the apartments several years ago at the suggestion of his brother. He had been living in elderly housing in a nearby urban city. He was divorced and had one adult daughter who was not able to take him in.

After several years residing in the apartments he found himself "getting tired of doing all the work" and entered the assisted living unit on the fourth floor.

Following a couple of falls it was determined he would be safer on the skilled nursing unit and was transferred. He described his current room as comfortable and stated “I am not fussy.”

When asked about his arrival on the unit and the nursing assistant’s role in helping him to adjust he responded, “well they didn’t have a welcoming party”. He flatly denied that he had a caregiver that he felt a close relationship to: “No the only person I would describe like that would be my sister-in-law...she got me here and she watches out for me”. “I am happy with them”. Asked another way about forming friendships with the nursing assistants: “that doesn’t enter my mind-they are doing their job and as long as they keep doing it I am happy”.

LeRoy’s demeanor was relaxed and he appeared content as he stated he was. He communicated his fear of entering a nursing home with the following statement:

“I dreaded going into a nursing home. I had been in one with my sister-in-law, she had serious problems and the smell of the place, the noise and the staff not paying attention...I prayed I wouldn’t end up in one”. “I didn’t like two people in a room”. He concluded with “I wanted to be here and I don’t consider this a nursing home.”

Josephine. Josephine is 103 years old. She is a tall woman neatly dressed with a full head of white hair with soft curls. She is very hard of hearing and has a booming voice. Her skin is smooth and contradicts her chronological age. The interview was conducted in her room, which was cozy. A large recliner provided a seat for her and comfortable upholstered chair for the visitor. Family pictures and religious artifacts filled every available wall space and tabletops.

Family connections provided the connection for Josephine to Peace House. Previously to her moving in she had two sisters who resided within doors of each other

on the unit. Following the death of one of her sisters, and at the age of 98 she was encouraged by the Sisters to give up her coastal home and move in. She is widowed and has a son nearby and a deceased daughter. “She smoked!” This woman continues to be active and attends cribbage games at the local Senior Center on occasion.

When asked how it felt to live at the home she replied “Well it feels lucky. Very lucky I am here. I am very glad to be here...they really know how to treat an old woman!” That question was followed up with whether there was a particular person, in terms of the staff, that she looked forward to seeing? Well I love Sister E. but you know one day they are assigned another place...” “I miss her she could move mountains and say don’t worry I will take care of it”. Probing more specifically to the nursing assistant relationship she said, “well you keep your distance you know?” “They move along”. Additionally, she found it difficult to establish a personal relationship because “they are so busy...always on the go...but they are good”. “I really don’t tell them much of anything because they are not her long enough you know what I mean?”

Her primary sources of social support were her network of friends at the Senior Center, her son, grandson and a nephew who is a priest. She was extremely proud of her nephew who is a pastor at a nearby parish and takes her out to lunch each week.

Susan. The last resident in this category is a pleasant, attractive and petite woman who is impeccable in her appearance and has no reservations identifying her likes and dislikes. Her French Canadian accent was measured and slow, a result of two strokes and Parkinson’s. She was the first person interviewed and proved the most challenging for multiple reasons. First of all she experienced some short-term

memory loss and was easily shaken off topic by the phrase “yes ma’am”, which she used frequently. It prompted her to think of her daughter and granddaughter who live in the south. Any short answer might trigger that response and result in repeated stories of how much she missed them.

Susan had been widowed for more than twenty-seven years. Her husband was a pharmacist and died suddenly at the age of 54, leaving her with four young children. She talked about sad events in her life such as the birth of a stillborn baby and the death of her oldest son. Interestingly, her association with the home came about initially delivery medications from her husband’s pharmacy. When asked how she felt when she learned she would be transferring from another nursing home she said, “I cried like a baby”. Through probative questioning it was determined that her memory of the home was the old house, which she described as looking like a haunted house.

Family was extremely important to her, especially her relationship with her eldest daughter. The daughter visited nearly every day and fulfilled the role of an advocate. Susan was grateful for her daughter’s attention and shared what the daughter had said to her “you took care of me for twenty seven years and now it is my time to take care of you”.

In addition to getting off topic easily Susan presented another challenge she adamantly denied the importance of knowing her caregiver on a personal level. This was a bit disconcerting as the initial premise was that those relationships were significant and possibly central to the adjustment and happiness of a nursing home resident. Instead she provided a detailed description of a negative relationship she felt she had with a younger nursing assistant. It was unclear whether or not the aide knew

of the dislike. Susan did not like that she talked about her children. “They are taking care of me I don’t need to know their stories at home. Am I getting the point across?”

She did indicate, other than the aide described above, she was comfortable with all of them (referring to the nursing assistants and nurses). “I like to be friends with everyone but I don’t get into family discussions”. All attempts to focus on positive aspects of her relationship with her nursing assistants went directly back to the young aide. “She has her children’s pictures hanging all around the dining room... I heard she just got them back”. “It’s not her fault she tries to be friendly. It is partly my fault I don’t like her!”

Despite being unable to describe a positive relationship with her nursing assistants there was an opportunity to observe her interact with one of them. During one of the interviews her regular nursing assistant came in to make her bed. The greeted each other warmly and joked back and forth. It was clearly a comfortable relationship and Susan acknowledged she like the woman very much. On another occasion a very powerful exchange took place between Susan and the Activities Director (AD). The AD is in her mid fifties and became a widow last year. Her husband was diagnosed with cancer and died shortly after. This particular day the AD came by to ask Susan if she wanted an absentee ballot for the local primary election. She did not desire a ballot but went on to chat about where the AD was going on vacation etc. Suddenly Susan turned to the researcher and said, “You want to know one of the best ones? Her! I feel close to her.” The following exchange occurred between the two:

AD: “we have a bond huh?”

Susan: “well we don’t say it that much but we do. We don’t want people to talk” “I don’t know what I would do without her”

AD: “I have been here 33 years and want for nothing

Susan: “especially since you lost your husband I know that. I have been 27 years I was older than you but still certain things I do catches me”

AD: “Me too..someone will mention a month and it sounds strange but I can’t even decipher it...am I going backwards or forward?”

Susan: “27 years for me and I have been single all that time. I buried one I won’t bury two. I told my children if I find someone I will live with them (laughter). “Remember the day we cried together?”

AD: “I just leaned into her lap”

Susan: “We cried on each other” “Did I help you that day?”

AD: “You helped me as much as I helped you”

In summary the nature of relationships between residents and nursing assistants in this study was overall positive. It entailed different levels of intimacy that appeared to be decided upon by the resident exclusively. The residents interviewed communicated clearly that they determined how intimate the relationship would be with their care providers and actively decided whether or not to engage in a personal relationship that entailed reciprocity.

Based on analysis of the findings and in conjunction with review of the literature the following types of relationships were identified: positive with specificity, positive non-specific and positive distant.

Research Question 3

How were these relationships developed and maintained over time? This question proved most challenging, as many of the residents were unable to describe

the initial days and weeks surrounding their move into the home. Susan described moving in as a “blur”. She described being aware of coming in to the home but no detail surrounding. Susan did recount how she “cried like a baby” when her daughter and son informed her that she was going to move. Eleanor described the following: I honestly don’t remember it. I came in from the hospital and the nurse told me I had no idea where I was”, while Mille described the time period as a “complete fog”

Sally was the only one who was able to describe how her relationship developed: “Oh yeah she said I just adopted you. In fact she said my sister and me adopted you... I am the oldest of the three of us. I don’t know we just hit it off”. She also identified the shared role of being a mother and grandmother as a starting point for their relationship to develop: “she will talk to me about her grandson or her own two sons and uh and even uh her husband we chit chat and everything. She tells me a lot about them”.

Research Question 4

What environmental factors supported these relationships? A major facilitator who assisted in the development and sustainment of positive relationships was the uniqueness of the environment, which included its Catholicism roots and that “they leave you alone”. Seven of the ten participants identified the importance of the Catholic environment and values as helping them to feel more comfortable and at home. Allie described it in the following way: “Every day I go to mass and I like it...the mass got me. There is a woman here that lives in the apartment and what does she do? She comes down here and picks me up and takes me to mass. Now where you could you get that? Now if she didn’t like me she would not do this”. Ava’s

primary relationship was a spiritual one and described how the environment helped her “I wouldn’t go anywhere else- I mean homes to live. I came here because I am Catholic and I have a spiritual connection you know?” Josephine also provided support that the Catholic environment facilitated feeling at home; “I go to mass every day. Either 10:30 or 11 and then 3:00 is the Chapel of Mercy that’s rosary and then benediction is at 4:45pm”.

In addition to the spiritual environment the other significant finding that appeared to facilitate the development of positive relationships between the resident and caregiver was that they “leave you alone”. This behavior was related to not forcing participation in activities such as bingo, going to mass or eating in the dining room. LeRoy identified himself as having a positive, but distant relationship with his caregivers, his choice. What he liked most was that “I can do what I want to do.” “They know I don’t like to mingle so I eat in my room...I like it that way.” Susan, another resident that described her contentment in the home but did not desire a close personal relationship with her caregiver described the nursing assistants as “not holding a gun to your head- you can do what you want”. Dolly provided a similar response: “They know I am not a mixer”. Allie felt respected by being left to do her own thing: “Not being forced to do anything you don’t want to do” and treated like a “human being”.

The most significant findings regarding this question were related to the environment providing a comfortable atmosphere, specifically the traditions of the Catholic faith and their individuality being respected by being left alone. The environment, as stated previously, was unique in that while it incorporated physical

dimensions of long term care facilities such as long corridors and schedules, they were not viewed as inhibiting the development or ongoing sustainment of relationships.

Findings will be discussed in the following section.

Discussion

This study was conducted to enhance knowledge related to the types of positive relationships that existed in one nursing home and what facilitated and sustained those relationships. Researchers have shown that such relationships can have a profound and positive impact on the quality of life for older adults residing within a long term care facility (Diamond, 1992; Gass, 2004; Gubrium, 1975; Patterson, 1992; Restinas, 1985). Additionally, researchers had anecdotally identified factors that facilitated and inhibited such relationships.

One of the findings in this study was the significance environmental space had on the opportunity for residents to interact. Numerous studies have identified the mechanized, sterile and unnatural living conditions within nursing homes (Clinton et al., 1996; Fiveash, 1998; Nussbaum, 1993; Ryvicker, 2009). Some have equated to them as “dormitories for those near death” (Armstrong-Esther, Browne, & McAfee, 1994, p. 273). Gubrium (1975), Diamond (1992) and Gass (2004) did little to detract from these descriptions.

In contrast to the studies identified above, Peace House was bustling with life. Several spaces, within the home, supported resident-resident, resident-staff and resident-visitor interactions. The Receptionist desk and lobby were popular areas for residents to gather and talk among themselves, staff and visitors. The coffee shop located off the main lobby was another area that provided space for meeting and

socially interacting. There were numerous spaces throughout the home that offered a place to visit, read or play cards. Tina and Eleanor met every afternoon at 2:00 p.m. to play cards in the second floor solarium. Barnes (2002) and Parker et al. (2004) identified the importance of available space as a facilitator of positive social interaction. The dining rooms also facilitated resident-resident and resident-staff interactions. The main dining room was active with conversation and table assignments reflected resident preferences and backgrounds. The dining room on the second floor was quieter but had more physical contact as evidenced by the nursing assistants cradling and talking to residents while feeding them. This was in contrast to Ryvicker's (2009) description of meal time at one nursing home where nursing assistants looked for the most expedient way to feed "feeders." which often involved moving residents around like furniture.

Activities (formal, informal and work-related) were another area that was identified in this study as facilitating positive resident interactions. During Phase I observation of the types of resident interactions occurring in public spaces was conducted. The most common informal activity observed during this time frame was chatting and it involved all levels of interactions (resident-resident; resident-staff; and resident-visitor). Sherer (2001) and Hubbard, Tester, and Downs (2003) supported this finding in the literature. However, unlike Hubbard et al., the focus of the chatting was not on feelings related to living in a nursing home. The major topics of chatting included the weather, current events and special occasions related to individual residents, such as birthday parties.

Additionally, informal chatting was observed during Phase II and was supported by a lower than average resident to nursing assistant ration, which allowed for time to be spent with the resident throughout the day. Nakrem et al. (2011) identified the importance of the caregiver being available to have sustained interaction time with the resident and the subsequent formation of a positive relationship. Conversely, Kovach and Robinson (1996) identified the lack of time, on the part of the caregiver, as contributing to social and emotional isolation.

Music has been identified in the literature as helping to improve cognition and emotional and social skills (Brotons & Koger, 2000; Götell, Brown, & Ekman, 2002). The musical program at Peace House was scheduled every Tuesday afternoon and was well attended by all residents. Most of the participants were familiar with the musician and participated by playing an instrument, singing along or dancing. This was in contrast to Ryvicker's (2009) finding that often a student-teacher relationship was exhibited in similar group activities that involved admonishing residents and suppressed positive interactions.

Kane (2001) found the importance of meaningful activity as a contributor to overall quality of life. The Kraft Korner, located on the main floor of Peace House, was a hub of energy and talent. Several women, under the guidance of a ninety-two year old resident, assembled Monday – Friday to sew and work on craft projects that would be sold in the store and at the annual holiday bazaar. Avid expressed pride when she pointed out that their products had earned over \$800.00 the previous month in the store. Allie described the enjoyment she got from going to her “job” every

Friday afternoon 1:00 p.m.-4:00 p.m. in the store. She assisted customers with purchases of soaps, stockings and snacks.

A third significant finding of this study was that all ten participants considered themselves to have experienced a positive relationship with a direct caregiver. They differed on the degree of intimacy they attributed to the relationship and the finding was consistent with that of Bergland and Kirkevold (2005) study of thriving and positive relationships. They found that thriving existed in the presence of close personal relationships with caregivers, non-personal relationships and distant relationships. Similarly, this study found that the relationships, described as positive fit into three categories: positive with specificity; positive with non-specificity; positive-distant.

Knowing the resident transcended all three levels of relationships and involved the nursing assistant anticipating needs. McGilton and Boscart (2007) supported this finding and reported resident's defined close relationships as being present when the nursing assistant knew what was needed without being told. Tina provided the example of how her nursing assistant would bring Kleenex and fix her hair just the way she liked it. Rose described her caregivers as knowing her like a parent would know their child.

Several researchers have found self-disclosure to be a major factor in solidifying resident-caregiver relationships (Asmuth, 2004; Bergland & Kirkevold, 2005; Brown-Wilson & Davies, 2009; Cook & Brown-Wilson, 2010; Davies & Nolan, 2008; Hauge & Heggen, 2007; Nakrem et al., 2011). This study found all those reporting a positive with specificity relationship identified self-disclosure as a key

characteristic of the relationship. Reciprocity was another dimension cited by residents reporting a positive-specific relationship. This finding has been supported by Shulz (1976), Bocksnick and Hall (1994), Farmer (1994) and Nakrem et al. (2011). Eleanor gave the example of providing cough drops each night to her nursing assistant before she left and Sally described how satisfied she feels when she can lift the spirits of her caregiver.

Those residents who described positive relationship without specificity reported that they did not desire to know personal information of their caregivers, nor divulge their own private information. This was also consistent with Bergland and Kirkevold's (2005) findings. Additionally residents in this category and positive-5distant tended to describe their caregiver in non-personal terms such as "they". Goffman (1961) reported a similar finding in his study, *Asylum*.

In addition to self-disclosure and reciprocity, humor (Hubbard, Tester, & Downs, 2003; McCabe, 2004), knowing their needs (Bergland & Kirkevold, 2005; Brown-Wilson et al., 2009; McGilton & Boscart, 2007), "always there" (Cook & Brown-Wilson, 2010; Grau et al., 1995; McCabe, 2004) and "leave you alone" (Nakrem et al., 2011) contributed significantly to the on-going positive relationship.

Consistency of the caregiver was found to have significantly facilitated the formation of positive resident-nursing assistant relationships. Cook and Brown-Wilson (2009) linked the lack of continuity in caregiver as suppressing positive relationships between the resident and caregiver. The nursing assistants in this particular home are assigned to geographic locations and most work full-time. In addition to consistency of assignment most have been with the home for more than a

decade. Bowers, Esmond, and Jacobson (2000) reported the importance of time and stability of the nursing staff in assisting in developing knowledge of the individual resident.

A unique management style was identified as a major facilitator of positive interactions within the home and supported the ongoing sustainment of them as well. This finding creates a new category of nursing home ethnographies that goes beyond Diamond (1992) and Farmer (1994). Institutional bureaucracy dominated in Making Gray Gold was identified as depersonalizing the individual and depicted acts of human kindness as violations of the rules. The residents were passive recipients of care that took no account of their likes, wishes or desires.

Farmer (1994) on the other hand deliberately sought out The Meadows to conduct her research on nursing home organizational culture because of its good reputation. Residents described it as “a nice place if you have to be here.” Her findings concluded that The Meadows reflected a hotel style management style. She concluded that this organizational model, which focused on service, had its difficulty, namely the fluidity of the membership within a hotel. While the surroundings were elegant there was also a sense of temporariness that one experiences when checking into a hotel, as well as the juxtaposition of sight and sounds. For example, Farmer described the contrast between striving for perfection as a five star hotel and the imperfections of debilitation.

Peace House was also deliberately chosen as a research site based on its excellent reputation for providing care to the elderly. It went beyond Farmer’s (1994) of “a nice place if you have to be here.” Peace House was a sought after place to live

and descriptions provided by residents included “Heaven” and “It’s my home”. The nature of this nursing home could be described as “letting one be,” which has not been previously identified or described in the literature. Unlike The Meadows, which focused on service as a business model Peace House incorporation of service was directed at the whole person; body, mind and spirit. Reciprocity permeated the environment and the hierarchal nature was one that positioned residents very high. This was evidenced by Rose’s claim: “they know that light is on they don’t want the Sisters to see it” and another’s proclamation that “the residents are in charge.”

Chapter VI

Summary

The purpose of this research was to answer the following questions:

1. What kind of interaction and relationships exist in the setting?
2. What is the nature of the relationships that residents identify as positive?
3. How did these develop and how were they maintained over time?
4. What environmental factors supported these relationships?

Chapter I provided an overview of the significance of long term care in our society was provided and the argument was developed for increased attention on the impact of social interactions experienced by residents who reside in long term care facilities. A detailed description was provided that supported the need for more in-depth examination of positive relationships that occur between residents and care givers.

A literature review was conducted in Chapter II that addressed the significance of the problem, historical background of nursing homes since the introduction of the Social Security of 1935 and the evolution from a quality of care focus to that of quality of life. Further support was presented for the link between positive relationships and an improved quality of life for residents who reside within long term care; specifically between the resident and their direct caregiver. The need for descriptive research related to positive relationships was argued.

Focused ethnography was identified in Chapter III as the method employed to investigate the research questions. A brief review of the historical development of ethnography was provided as was a review related to the more contemporary method

of focused ethnography. Support was provided for the focused ethnography based on familiarity with the environment by the researcher and the limited time associated with a doctoral dissertation. Additionally, data collection methods were identified that included participant observation and open-ended interviews with ten participants who spoke and understood English, were capable of answering the research questions and willing to participate. A detailed description of the three phases of the study was provided, which included Phase I, gaining entry; Phase II, interviews and participant observation; Phase III, disengagement and analysis.

Chapter IV provided a detailed description of the setting was described along with its unique focus of caring for the elderly poor. Catholic orders of Nuns administer the home, which is one of thirty in the United States and located in an urban city in the Northeastern United States. The philosophy of the Sisters is to go out into the community to seek assistance from local shop owners, who provide gifts in kind as well as financial support. Inside the home all members of the community, Sisters, staff and residents contribute to the ongoing operation of the facility. This includes residents working in the store as well as utilizing their talents at sewing and crafts, which earns money for the home. Everyone contributes, in different ways, to the day-to-day life within the home itself. A profile of the participants was also provided in this chapter that included nine females and one male, slightly higher than the 3:1 ratio identified by the Centers for Disease Control.

Analysis and discussion was highlighted in Chapter V and included resident responses to research questions 2-4. It was identified that all ten participants considered themselves as having a positive relationship with their caregiver, but the

depth of that relationship differed significantly among the ten. Additionally the majority of residents interviewed were unable to answer research question three, which addressed how these positive relationships developed. Most of the participants were unable to remember the initial phase of their entry into the environment, adding support to Patterson's (1992) finding related to a disorganization phase during the initial days and weeks. The residents were able to provide substantive information related to how these relationships were facilitated and sustained over time.

During the first phase of the study it was found that the majority of interactions were occurring in public spaces with the home and were of a social nature. Additionally it was identified that certain spaces supported those interactions as well as individuals such as the Receptionist. In Phase II, the focus was on resident interviews that described the presence of positive relationships and factors that facilitated them.

Conclusions

The major finding of this study was that positive relationships existed between resident and caregiver but they differed on level of involvement. All ten participants considered themselves as having a positive relationship with one or more of their caregivers but differentiated the relationship by how much information they shared with the provider. Three types of positive relationships were identified that included: Positive with specificity in which the resident identified self-disclosure and considered the caregiver as a friend or part of their family; positive-non-specific, which involved joking and superficial exchanges related to common interests such as sports; and last,

positive-distant that was characterized totally on the caregiver's skill at performing their job.

In relation to research questions three and four, it was additionally concluded that residents had difficulty recalling their first days and weeks in the nursing home and were therefore unable to identify how these relationships developed.

Relationships were facilitated and sustained by primarily four factors: (a) "always there"; (b) "know what I need"; (c) "leaves me alone"; and (d) communal environment.

An important finding not explicitly identified in the literature was the last facilitator "leaves me alone." There appeared to be a balance between "always there" and "leaving me alone." The residents interviewed pointed to the reliability of staff to respond but also allow them to have time to themselves. Further investigation into this phenomenon appeared to support knowledge of the individual's likes and dislikes that is incorporated into day-to-day interactions. Another significant finding of this study was the evolution from the commoditization of nursing home residents as depicted by Diamond (1992) in *Making Gray Gold*, to Farmer's description of the shift to a more consumer-focused environment along the lines of a hotel, which lacked the opportunity for reciprocity and had a transient feeling, to it to this study, which suggests a commune type of approach to structuring the environment. Despite an organizational framework that identifies the Sisters as administering the home three groups existed simultaneously; the Sisters, the staff and the residents. Each had a role that contributed to the overall well-being of the home.

Limitations

There were three major limitations identified in this study. They included: uniqueness of the setting, the dominance of female participants and diversity. The setting is a religious environment that relies on strong community ties to support the organization. Additionally residents must meet a poverty level in order to be qualified to enter the home. While this is a limiting factor it also demonstrates a positive approach to providing care for infirmed older adults. It is a non-profit organization that is administered by Sisters, which reduces the overhead of financial obligations of the home.

The second major limitation was the predominance of females in the sample. There were nine females and one male, which is a higher ratio as compared to national averages. In addition to the imbalanced representation of the sexes the overall ages of the participant fit into the very old age group, with most of the participant being over the age of 85.

Cultural diversity was the third major limitation as all participants were Caucasian and Catholic. The majority of residents interviewed desired to be in the home and in many cases sought entry on their own.

Implications

There are four major categories that must be considered moving forward; research, theory, education and practice.

Research. Further research is needed that examines the organizational culture of this organization. Comparing the consistency of these findings to other homes within the network would help identify whether it is an overall philosophical

perspective or is occurring at the local level. Additionally research that focuses on the phenomenon of “leaves me alone” offers a potential path forward to understanding how the ordinariness of everyday life can be incorporated into long-term care. It would also be useful to conduct research that includes the nursing assistants to explore their understanding of the relationship compared to that of the resident.

Theory. Symbolic Interaction theory would be useful to consider interactions within the setting. It has been used to examine the hospital environment but not a nursing home.

Education. The literature supported the importance of positive relationships and the resident’s quality of life. Additionally the findings of this study supported the literature in that spending time and “checking in” throughout the day contributed significantly to sustaining these relationships. The ability of the nursing assistant to communicate and follow the cues of the resident appeared to contribute to the ability to the formation of a relationship that met the resident’s need.

Practice. The findings also supported the importance of knowing the resident. While the literature perpetuates the notion of the intimate resident- caregiver relationship as being the ideal this study found that not all residents desired a deep personal relationships with their caregivers. Similar to what Bergland and Kirkevold (2005) found there were three different levels of involvement identified in this study and the level was decided upon by the resident. In all cases the residents considered themselves as having a positive relationship. Investigation on how or whether the nursing assistants were empowered to respond to the resident’s willingness to establish a relationship warrants further investigation.

Finally, this environment is not without regimen and structure. The day is organized around mealtimes and religious services, which is a positive attribute according to the residents interviewed. Researchers have been particularly critical of structure environments as sapping the spontaneity out of life for those who reside in long term care but this study appears to suggest that a balance between the need for structure and the ability to “be” can co-exist.

Appendix A

Informed Consent



COLLEGE OF NURSING
White Hall, 2 Heathman Road, Kingston, Rhode Island 02881-2021
Phone: 401-874-2766 • Fax: 401-874-2061

CONSENT FORM FOR RESEARCH

You have been invited to take part in a research project described below. The researcher will explain the project to you in detail. You should feel free to ask questions. If you have more questions later, Rosemary Costigan R.N., the person mainly responsible for this study, (401) 316-9866, will discuss them with you. You must be at least 18 years old to be in this research project.

Description of project:

You have been asked to take part in the study, which is about positive relationships between nursing home residents and their direct care-givers. The purpose of the study is to gain a better understanding of what these relationships are, what they look like and how they develop over time, and what facilitator assisted with their development and continuation.

What will be done:

If you decide to take part in this study here is what will happen: you will be asked to commit to 1 hour one to two times per week with the researcher. These visits will last no longer than one month and will include the researcher talking with me and interviewing me. The researcher may audio tape the interviews and periodically take notes during the visits.

Risks or discomfort:

Sometimes people feel uncomfortable being observed and/or tired answering questions. These potential risks are minimal. However, if you do become tired and/or uncomfortable, you can quit at anytime.

Benefits of this study:

Although there may be no direct benefit to me for taking parting in this study, the researcher may learn more about the existence, development and maintenance of positive relationships between nursing home residents and care givers. Such information could lead to more pleasant living conditions for future nursing home residents

Confidentiality:

Participation in this study is confidential within legal limits. The researcher, Donna Schwartz-Barcott Ph.D, and The University of Rhode Island will protect my privacy unless they are required by law to report information to city, state or federal authorities, or to give information to a court of law. Otherwise, none of the

information will identify me by name. All records will be locked in a file cabinet in the researcher's office. My name will not be used in any reports or publications.

In case there is any injury to the:

If this study causes you any injury, you should write or call Donna Schwartz-Barcott Ph.D. (401) **874-5337** at the University of Rhode Island. You may also call the office of the Vice President for Research, 70 Lower College Road, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

Decision to quit at any time:

The decision whether or not to take part in this study is up to me you do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will not in any way change your relationship with my caregivers or affect my care at The Jeanne Jugan Home. If you wish to quit, you simply inform, Rosemary Costigan, 316-9866, of your decision.

Rights and Complaints:

If you are not satisfied with the way this study is performed, you may discuss your complaints with Donna Schwartz-Barcott Ph.D. (401) (401) **874-5337** or with Rosemary Costigan (401) 316-9866, confidentially, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

You have read the consent form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study.

Signature of Participant

Signature of Researcher

Typed/Printed Name

Typed/Printed Name

Date

Appendix B

Consent to Record



COLLEGE OF NURSING
White Hall, 2 Heathman Road, Kingston, Rhode Island 02881-2021
Phone: 401-874-2766 • Fax: 401-874-2061

CONSENT TO RECORD FORM

You understand that this study involves recording your interviews with the researcher. Neither your name nor any other identifying information will be associated with the recording of the interview.

You understand that the recordings will be transcribed and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or part for use in presentations or written products that result from this study. Neither your name nor any identifying information (such as your voice) will be used in presentations or in written products resulting from the study.

You further understand that immediately following the interview you will be given the opportunity to have the recording erased if you wish to withdraw your consent to participate in this study.

By signing this form, I am consenting to:

_____ having my interview recorded

_____ having the recording transcribed

_____ use of the written transcription in presentations and written products

By checking the line in front of each item above, I am consenting to participate in that procedure.

The above permissions are in effect until the following date: _____. The recordings will be retained for three years after the study is completed.

Participants signature _____

Appendix C

Agency Approval Letter

April 12, 2012
Office of Research Compliance
University of Rhode Island
70 Lower College Rd.
Kingston, RI 02881

Dear Members of the Internal Review Board,

I have been contacted by Doctoral Candidate Rosemary Costigan from the College of Nursing at The University of Rhode Island to obtain permission to conduct a study within our organization related to positive resident-nurse relationships focusing primarily on those between residents and nursing assistants. Ms. Costigan has identified this qualitative study will require up to six months of involvement with the organization and the participation of between 3 and 5 residents who will meet with the student for two one hour visits per week over a maximum of one month per resident. Ms. Costigan has identified to me how residents' anonymity will be protected as well as that of the organization. She has also indicated a willingness to share a summary of findings upon completion of the study as well as an offer to present the findings personally if so requested by the organization. Risks have been identified as minimal to the resident with the right of the resident to withdraw at any time. It is understood that benefits may or may not be direct to the individual participant but may potentially be a significant contribution to understanding these relationships within long-term care.

Based on my communication with Ms. Costigan and my role as Administrator for the [redacted] permission is granted for this study to commence during the time frame identified by the student.

Sincerely yours,

[redacted signature]

Appendix D

Interview Guide

Examples of open-ended questions to address research questions 2-4

Grand Tour Questions

1. What led you to come to live at the Jeanne Jugan Home?

2. How does it feel to be living at Jeanne Jugan?

Probe: What helped you adjust most, when you first moved in?

Since moving in, what have you enjoyed the most?

3. Could you describe a “good” relationship you have with one of your caregivers?

Probe: Are there ways in which this caregiver makes you feel like a friend or family member?

Are you interested in and familiar with your caregiver's personal life and family? If so, how does this caregiver involve you?

Can you describe some ways you help this caregiver?

4. Could you tell me some of the most important qualities you look for in your direct caregiver?

5. Are there particular aspects of the environment that make you feel comfortable and respected?

Probe: Is there anything you do not like about living here?

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