Providing Continence Care in Residential Aged Care Facilities: A

Grounded Theory Study

by

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Doctor of Philosophy

Deakin University

February 2013
I am the author of the thesis entitled: Providing Continence Care in Residential Aged Care Facilities: A Grounded Theory Study

submitted for the degree of Doctor of Philosophy

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I also certify that any material in the thesis which has been accepted for a degree or diploma by any university or institution is identified in the text.

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Date: 9th February, 2013
Abstract

In Australia, 54% of individuals living in residential aged care facilities experience more than three episodes of urinary incontinence per day and 34% experience more than four episodes of faecal incontinence per week. In addition, 68% are dependent on staff for assistance to use the toilet. Incontinence is associated with a reduced quality of life, social isolation, depression, falls, urinary tract infections, and pressure ulcers. It is also costly to manage. Thirty-two per cent of the total Australian Government basic residential aged care subsidy is used to address residents’ continence care needs. However, little evidence exists about how continence care is provided in Australian residential aged care facilities. Therefore, the overall aim of the current study was to describe and explain how residents’ continence care needs were determined, delivered and communicated in Australian residential aged care facilities.

Using grounded theory methodology, the researcher conducted 88 hours of field observations in two residential aged care facilities, analysed 87 accreditation reports, and interviewed 18 residential aged care staff members. Through a process of theoretical sampling, constant comparative data analysis, theoretical sensitivity, and memo writing, the findings revealed broader contextual conditions that influenced the overall context of care, and not just continence care. Specifically, the findings revealed a basic social problem that
was characterised by multiple constraints to residents’ day-to-day care, and which caused residential aged care staff to be in a situation in which they were ‘caring against the odds’. ‘Caring against the odds’ was characterised by four major sub-categories: (1) working in a highly regulated work environment; (2) encountering ethically challenging situations; (3) highly dependent residents; and (4) a devalued role.

The basic social process residential aged care staff used to deal with ‘caring against the odds’ was termed ‘weathering constraints’, which was characterised by accommodating strategies such as acquiescing, concealing, protecting, adapting, prioritising, normalising, compromising, and ritualising, as well as self-protective distancing strategies such as blanking out, using distancing language, and reframing care. ‘Weathering constraints’ was a response to real or perceived constraints that caused staff to feel disempowered, but also enabled them to perform their roles in ways that were consistent with their own personal and professional values and beliefs.

The findings indicate the need for a comprehensive multifaceted research-based strategy that addresses the social, regulatory, organisational, and personal constraints to evidence-based, ethical, resident-centred care in Australian residential aged care facilities. The strategy should also counter the dominance of education about continence care from continence product manufacturers, and the pervasive belief that providing continence care is limited to cleaning and containing incontinence.
Acknowledgements

This thesis would not have been possible without the support and encouragement of many people. In particular, I wish to acknowledge:

- My principal supervisor Professor Bev O’Connell, who patiently guided me from beginning to end, generously shared her knowledge about grounded theory, read endless numbers of drafts, challenged my thinking, and taught me all I know about being a researcher.

- My associate supervisor, Professor Patricia Dunning, whose encouragement and guidance helped me stay the course. Also, thank you for turning rambling, long and incoherent sentences into readable form.

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- My good friends who lifted my spirits and made me take time out. Special thanks to Patrick Finlayson for helpful comments on the thesis.

- Michael, Luke and Patrick who survived to become strong, independent young men despite, or perhaps because of a distracted and vague mother.
My husband Darek, who gave me the space to do this study and patiently waited for me. Thank you for believing in me.

My parents, and brother and sisters. I dedicate this thesis to all of my family, but particularly to my mother who set the standard for all of us.

Lastly, thank you to the many individuals who participated in this study and generously shared their experiences. I hope this thesis does justice to them and the important work they do.
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**Definition of terms**

The following definition of terms was used in the thesis.

**Aged Care**

Aged Care Quality Assessors are employed by the Aged Care Quality Standards and Accreditation Agency Ltd to visit all residential aged care homes to assess their performance against the Accreditation Standards, promoting continuous improvement and provide education.

**Continence care**

This term has been coined by the researcher to refer to the range of activities carers perform to assist care-dependent individuals to void or defeacate, including maintaining continence and managing incontinence.

**Enrolled Nurse (EN)**

Enrolled nurses are licenced under an Australian State or Territory Nurses Act or Health Professionals Act to provide nursing care under the supervision of a Registered Nurse. Referred to as a Registered Nurse Division II in Victoria (Australian Nursing and Midwifery Council, August 2002). Throughout this thesis, the term enrolled nurse is used to encompass Registered Nurse Division II in Victoria.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care assistant</td>
<td>The term ‘Personal care assistant’ describes a group of workers who provide direct personal care to assist residents perform basic activities of daily living such as feeding, showering, dressing, toileting. There are a number of other terms used to describe the role including, but not limited to: ‘aged care worker’, ‘assistant in nursing’, ‘carer’, ‘care worker’, ‘extended care worker’, and ‘nursing aide’. Throughout this thesis the term Personal Care Assistant is used to encompass all such terms, with the exception of research from other countries. In such cases, the original term is used.</td>
</tr>
<tr>
<td>Resident</td>
<td>A person who has been assessed by an Aged Care Assessment Team (ACAT) as requiring residential aged care and who resides in an Australian Government–funded aged care service.</td>
</tr>
<tr>
<td>Registered Nurse (RN)</td>
<td>People ‘licensed to practice nursing under an Australian State or Territory Nurses Act or Health Professionals Act. Referred to as a Registered Nurse Division 1 in Victoria’. Registered nurses undertake tertiary level education. ‘The role of the registered nurses includes promotion and maintenance of health and prevention of illness for individual/s with physical or mental illness, disabilities, and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stages of life’ (Australian Nursing and Midwifery Council, January 2006)</td>
</tr>
</tbody>
</table>
Residential aged care workforce Direct care employees who provide or manage the care of older people in residential aged care facilities, including registered nurses, enrolled nurses, nurse practitioners, nurse managers, nurse educators, personal care assistants, allied health workers, catering, cleaning, and maintenance services. Other individuals who provide services to the residential aged care sector including medical practitioners, pharmacists are not generally considered direct employees of a residential aged care facility.
### Key to abbreviations and symbols

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACFI</td>
<td>Aged Care Funding Instrument</td>
</tr>
<tr>
<td>ACN</td>
<td>The Australian College of Nursing</td>
</tr>
<tr>
<td>ACAP</td>
<td>National Aged Care Assessment Program</td>
</tr>
<tr>
<td>ACSAA</td>
<td>Aged Care Standards and Accreditation Agency</td>
</tr>
<tr>
<td>AD</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>ADLs</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>AHQR</td>
<td>Agency for Healthcare Quality and Research</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Healthcare Practitioner Regulation Agency</td>
</tr>
<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
</tr>
<tr>
<td>ARIA</td>
<td>Accessibility/Remoteness Index of Australia</td>
</tr>
<tr>
<td>CNA</td>
<td>Certified Nursing Assistant</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebrovascular accident</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td><em>(Field notes site 1: Night shift 10-11/09)</em></td>
<td>Depicts the date and site and shift during which the field note was recorded</td>
</tr>
<tr>
<td>IAD</td>
<td>Incontinence associated dermatitis</td>
</tr>
<tr>
<td>ICI</td>
<td>International Consultation on Incontinence</td>
</tr>
<tr>
<td>Int-14</td>
<td>Int denotes the term ‘interview’. The number after the abbreviation refers to the number of the interview. Therefore Int-14 refers to the fourteenth interview</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set (MDS)</td>
</tr>
<tr>
<td>NA</td>
<td>Nursing Assistant</td>
</tr>
<tr>
<td>NILS</td>
<td>National Institute for Labour Studies</td>
</tr>
<tr>
<td>NPUAP</td>
<td>National Pressure Ulcer Advisory Panel</td>
</tr>
<tr>
<td>NRA</td>
<td>Notices Requiring Action</td>
</tr>
<tr>
<td>OACQC</td>
<td>Office of Aged Care Quality and Compliance</td>
</tr>
<tr>
<td>PCA</td>
<td>Personal Care Attendant</td>
</tr>
<tr>
<td>PURT</td>
<td>Patterned urge-response toileting</td>
</tr>
<tr>
<td>PV</td>
<td>Prompted voiding</td>
</tr>
<tr>
<td>RAI</td>
<td>Resident Assessment Instrument</td>
</tr>
<tr>
<td>RCS</td>
<td>National Residential Classification Scale</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education Facility</td>
</tr>
<tr>
<td>VET</td>
<td>Vocational Education and Training</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td>UI</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>US</td>
<td>United States of America</td>
</tr>
</tbody>
</table>

[…………….] Square brackets are used in text to clarify meaning. The information within the brackets represents the researcher’s own words
Thesis outline

The thesis is organised in five chapters. Chapter one provides a brief overview of research literature about incontinence and its management in residential aged care facilities. The intent of this brief review of literature is to provide the reader with the necessary background information to demonstrate the gap in research that warranted the current study.

Chapter two describes the methodology that underpinned the research methods and the rationale for choosing the research design. It also describes the grounded theory method used to address the research objectives. It details the setting, sample, data sources, recruitment methods, data collection and analysis methods, and ethical issues.

The findings about the basic social problem are described in chapter three and the findings about the basic social process are described in chapter four. These findings include transcripts from in-depth interviews, notes taken during field observations, as well as information from reports and websites.

Chapter five discusses the findings with reference to extant literature and other theories. It concludes with information about the strengths and limitations of the research and recommendations for education, practice, policy, and research.
Chapter one

Introduction

Introduction

The current introductory chapter presents an overview of research literature about incontinence and its management in residential aged care facilities. The review of literature presents research about the prevalence of bladder and bowel symptoms in the residential aged care sector, and its psychosocial, physical and financial impact. The regulatory framework that underpins the Australian residential aged care sector is described, as is the composition and educational base of the residential aged care workforce. The researcher provides a brief overview of research and theories about the causes of incontinence, and describes international recommendations about managing incontinence in frail older adults. Research about current methods to manage incontinence in residential aged care facilities is described, foecussing on two main approaches: continence products and toileting assistance programs. The chapter includes findings from research literature about residential aged care staff knowledge about incontinence and its management. It also details research about the barriers and facilitators to continence care in residential aged care facilities. The next section describes the search strategy used to locate and critique the research literature.
Search strategy

In order to identify research based information about incontinence and its management among frail older adults and in residential aged care facilities, the researcher developed a broad search strategy. The search was inclusive of qualitative and quantitative research listed in large academic databases, reports, and government and peak body websites. Examples of the latter include: the Cochrane Collaboration, The Joanna Briggs Institute for Evidence-Based Practice, the Agency for Healthcare Research Quality and the National Institute for Labour Studies, and the International Consultation on Incontinence. Journals that focussed on incontinence and/or ageing and aged care were targeted for specific searches on key topics.

Keywords used in the search included: ‘incontinence’, ‘urinary incontinence’, ‘dementia’, ‘carer’, ‘staff’ ‘cognitive impairment’, ‘skilled nursing care facility’, ‘nursing home’, ‘residential care’, ‘toileting’, ‘continence pads’, ‘impact’, ‘quality of life’, ‘prevalence’, ‘risk factors’, ‘recommendations’, ‘education’, and ‘knowledge’. The Boolean operators ‘and’ and ‘or’ were added to the keywords and used to refine and expand the search. The reference lists of all publications were checked for additional relevant sources of information. Terms used were truncated and the various ways of spelling the terms, plurals and synonyms were accommodated.

To ensure seminal works were identified, no arbitrary limitation was placed on the age of the data; however, all publications were required to describe
primary research about incontinence or other bladder and bowel symptoms in elderly individuals with and without cognitive impairment and living in a residential aged care facility, and/or staff working in a residential aged care facility. Although the study addressed incontinence in Australian residential aged care facilities, the search for studies was inclusive of studies undertaken in other countries, but in a similar aged care context. As the term ‘residential aged care facility’ is specific to the Australian context, other terms that described an institution providing accommodation and formal care for older people were used.

Studies were selected that addressed any or all of the following conditions: urinary incontinence, faecal incontinence, dual urinary and faecal incontinence, as well as the condition of being dependent on carers or staff for assistance with toileting or bowel or bladder function. The search was mainly limited to primary research, systematic reviews, and reports written in the English language.

Studies were not specifically excluded on the basis of their methodological design. At the same time, the researcher sought to include studies that were topic relevant, well conducted and provided a comprehensive description of the purpose, procedures and findings. Moreover, as the purpose of the review of literature was to provide a brief overview of research on the topic and not a pooled summary of evidence of interventions, quality appraisal tools were not used and the researcher did not grade the level of evidence.
Each publication was grouped according to whether it addressed the topic of the prevalence of symptoms, the psychosocial impact, the physical impact, the financial impact, current management methods, continence care recommendations, workforce issues, regulation, staff attitudes and knowledge, or barriers and facilitators. Studies addressing barriers and facilitators were displayed in tabular format, summarised and described according to: the study reference, the sample/design, the analysis methods, and the findings.

As the study was conducted over an extended period of time and involved multiple searches, the total number of publications retrieved was 4,620. They were entered into an Endnote library and grouped by topic.

**Review of literature**

**The prevalence of bladder and bowel symptoms in residential aged care facilities**

Australia has 2,760 residential aged care facilities providing permanent care to 165,032 residents (98%) and respite care to 3,969 residents (2%) (Australian Institute of Health and Welfare, 2012). Seventy-one per cent of residents (n=128,473) are incontinent of urine or feaces or both symptoms (Deloitte Access Economics and the Continence Foundation of Australia, 2011). Fifty-four per cent experience more than three episodes of urinary incontinence a day, and 34% experience more than four episodes of faecal incontinence per week (Deloitte Access Economics and the Continence Foundation of Australia, 2011). Likewise, 68% of residents are dependent on staff for assistance to use
the toilet (Pearson, Finucane, et al., 2002) and it is likely they would be incontinent if staff did not provide such assistance. It is also probable that many residents experience other bladder and bowel symptoms and conditions, such as constipation, faecal impaction, urinary urgency and frequency, urinary tract infections (UTIs), and nocturia (e.g. “the complaint that the individual has to wake at night one or more times to void”) (Abrams et al., 2002, p. 168). Up to 93% of men aged 70 years of age and older and 77.1% of older women get up at least once a night to void (Bosch & Weiss, 2010).

Australia is not alone in having high rates of urinary incontinence in residential aged care facilities. A systematic review of 15 studies, most of which were conducted in the United States (US) found 60-78% of female residents and 23-72% of male residents experienced urinary incontinence (Shamliyan, Wyman, Bliss, Kane, & Wilt, 2007). Another systematic review of 12 studies from the US, Italy, Germany, the Netherlands, Switzerland, France, Japan and Sweden found an overall prevalence of urinary incontinence ranging from 43% to 77%; median of 58% (Offermans, Du Moulin, Hamers, Dassen, & Halfens, 2009).

Faecal incontinence among individuals living in residential aged care facilities ranges from 33 to 65% (Brocklehurst, Dickinson, & Windsor, 1999; Markland, Goode, Burgio, & al, 2010; Nelson & Furner, 2005; Nelson, Furner, & Jesudason, 1998; Nelson, Furner, & Jesudason, 2001). Although residents may develop faecal incontinence for the same reasons as individuals
living in the general community, one study found diarrhoea, dementia, restricted mobility, and male gender were independently associated with faecal incontinence among a sample of 388 residents of five US nursing homes. Another factor that increases residents’ risk of developing faecal incontinence is the inappropriate use of laxatives (Brocklehurst et al., 1999). An additional factor that should be considered is that up to 54% of residents experience both urinary and faecal incontinence. Risk factors for such dual incontinence include impaired mobility, impaired cognition, and stroke (Chiang, Ouslander, Schnelle, & Reuben, 2000).

Researchers caution that data about the prevalence of urinary and faecal incontinence should be interpreted mindful of the fact that it is often defined and measured differently (Milson et al., 2009; Offermans et al., 2009; Shamliyan et al., 2007). In addition, differences in care processes in residential aged care facilities may account for differences in prevalence rates (Offermans et al., 2009). However, there is a lack of research about such care processes and how they affect the prevalence of incontinence. Moreover, despite the high prevalence of incontinence and other bladder and bowel symptoms in Australian residential aged care facilities, there is little contemporary research about how staff manages these issues.
Prior research about incontinence in Australian residential aged care facilities

Between 1998 and 2010, the Australian Government Department of Health and Ageing (DoHA) through the National Continence Management Strategy (NCMS) supported over 120 national research and service development projects, and activities aimed at improving community awareness in order to prevent and treat incontinence (McCallum, Millar, Dong, & Burston, 2006) (McCallum, Millar, Burston, Butorac, & Calzoni, 31st August 2010). Of the $49.6 million AUD spent under the NCMS, $805000 AUD or 1.6% of the total funding was spent on projects related to incontinence in Australian residential aged care facilities. The four projects are listed in Appendix A.

Only one such project resulted in information about managing incontinence in Australian residential aged care facilities. The aim of the project funded by the NCMS was to evaluate the resources staff used to manage incontinence in Australian residential aged care facilities. O’Connell et al. (2005) surveyed 149 individuals working in 89 different facilities as well as 21 continence specialists, resource developers or product company representatives. Respondents were asked about: (a) the methods staff used to manage residents’ incontinence, (b) external sources of support about continence care, (c) barriers to continence care, and (d) the continence assessment and management tools staff used. Ninety-three per cent of respondents reported they ‘often’ used disposable pads to manage incontinence, and product company advisors were cited as the most frequent source of external support.
about continence care. Respondents also indicated the cost of continence products, a lack of staff, a lack of staff education, staff attitudes, limited time, and residents’ challenging behaviours were major barriers to continence care.

In addition, one quarter of respondents reported there were no gaps in the resources they used to assess and manage incontinence. However, when 76 resources were rated against international standards for continence care in frail older adults, less than half of the resources contained cues to assist staff to diagnose, manage and evaluate residents’ continence care. For example, only 27 resources prompted staff to obtain information about the degree of bother or impact of incontinence on daily living and only 41 contained a management plan (O'Connell et al., 2005). Whilst information from the survey was helpful in terms of providing self-reported data about how staff in Australian residential aged care facilities managed incontinence, the study did not result in the depth of information required for a comprehensive and explanatory theory about providing continence care. The limited research indicates a gap in knowledge.

The impact of incontinence on residents

Another reason why it is important to further understand the context of care in Australian residential aged care facilities is because of the negative personal, social and physical impact of incontinence on residents’ lives. In older adults, incontinence is associated with a reduced quality of life (DuBeau, Simon, & Morris, 2006), depression (Dugan et al., 2000; Engberg et al., 2001), falls
(Chiarelli, Mackenzie, & Osmotherly, 2009), urinary tract infections (UTIs) (Hedin, Petersson, Wideback, Kahlmeter, & Molstad, 2002; Nicolle, 1997), and incontinence-associated dermatitis (IAD) which can lead to pressure ulcers (Bliss, Zeher et al. 2006). A review of literature conducted by the current researcher about the impact of urinary incontinence on residents’ quality of life and their preferences for continence care identified six qualitative studies and four quantitative studies that evaluated residents’ quality of life related to urinary incontinence, their perspectives about being incontinent, and their continence care preferences (Ostaszkiewicz, O'Connell, & Dunning, 2011). None of the studies included in the review were based on research conducted in Australian residential aged care facilities.

Collectively, the findings from the review of literature revealed residents value having independent bowel and bladder function, and engage in a process in which they attempt to manage their condition in order to protect their physical, psychological and social integrity even though they often experience considerable barriers to maintaining continence (Ostaszkiewicz et al., 2011). One such barrier is residents’ low expectations for improvements in their symptoms, which may relate to the belief that incontinence is inevitable and intractable. The researchers found very little research about cognitively impaired residents’ experiences of being incontinent and/or dependent on another person for assistance with incontinence or bladder and bowel care. Similarly, there is limited research about how staff responds to cognitively impaired residents need for such assistance.
The cost of incontinence in Australian residential aged care facilities

The cost associated with managing incontinence and promoting continence also warrants further research about continence care in Australian residential aged care facilities. The direct costs associated with managing incontinence include: (a) the costs associated with diagnosing and treating incontinence, (b) the costs of routine care such as staff time, (c) laundering and purchasing continence products, and (d) the consequential costs such as the costs associated with falls, UTIs, IAD and pressure ulcers (Moore, Wei Hu, Sybak, Wagner, & Deutekom, 2009). Most of the direct care cost associated with continence care in an inpatient or residential aged care setting is related to staff time (Frantz, Xakellis, Harvey, & Lewis, 2003; Morris et al., 2005). Using what they termed, a ‘bottom-up’ approach, Morris et al. (2005) calculated the costs associated with 3,621 occasions of continence care for 29 patients in an Australian geriatric and sub-acute neurological care unit facility for up to three weeks. They reported the median per capita incremental cost was $49 AUD per 24 hours (in 2003) and $41 AUD of this amount was spent on the labour costs associated with providing continence care. Continence care consumed an average of two hours per 24 hours of staff time.

One third of the total Australian Government basic residential aged care subsidy is spent on meeting residents’ continence care needs (Australian Institute of Health and Welfare, 2006). Specifically, in 2003-2004, the cost associated with providing assistance to Australian residents who required bladder and bowel support, including assistance to use the toilet was estimated at $1.27 billion AUD, or 32% of the total Australian Government basic
residential aged care subsidy of $4 billion AUD (Australian Institute of Health and Welfare, 2006). Deloitte Access Economics and the Continence Foundation of Australia (2011) inflated this figure to 2010 dollars and claimed the cost of managing incontinence in 2010 in the Australian residential aged care sector was $1.54 billion AUD. It remains unclear how the residential aged care subsidy is actually used.

The Australian regulatory framework for the residential aged care sector

In 2009-10 the Australian Government spent $7.1 billion AUD on the residential aged care sector (Australian Institute of Health and Welfare, 2011). In order to receive any funding, facility providers must comply with regulations under *The Aged Care Act, 1997*, which is operationalised through a regulatory framework. The regulatory framework for the Australian residential aged care sector consists of:

- The Funding Model and Aged Care Funding Instrument (ACFI)
- The Accreditation framework.
- The Aged Care Complaints Scheme which is authorised to respond to complaints to ensure residents’ safety, health and wellbeing and to support approved providers to understand their responsibilities.

Managers or service providers of residential aged care facilities apply to the DoHA for a subsidy to meet the cost of each resident’s care needs using the ACFI. However, to be eligible to obtain funding, facilities must first be
accredited by the Aged Care Standards and Accreditation Agency (ACSAA) against four standards and 44 expected outcomes. The four standards are:

1. Management systems, staffing and organisational development.
2. Health and personal care.
3. Residents’ lifestyle.

There are substantial consequences for failing to meet the expected outcomes of the standards. The facility may be reaudited and have their accreditation revoked. Information about the outcomes of each facility’s accreditation, including a list of facilities that are sanctioned, is placed on a DoHA website and is publicly available.

The expected outcome of Accreditation Standard 2.12 is that ‘Residents’ continence should be managed effectively.’ To date, there has been no in-depth and independent analysis of how residential aged care staff understand and/or operationalise the standard. Correspondingly, there has been no in-depth and independent analysis of how Aged Care Quality Assessors (hereafter termed ‘Assessors’) from the ACSAA appraise staff adherence to Accreditation Standard 2.12. There is a need to explore staff and Assessors’ understandings about the accreditation standards; as such understandings are likely to influence how continence care is provided in residential aged care facilities.
Complaints about continence management in Australian residential aged care facilities are common. The Aged Care Complaints Scheme received 8130 complaints between 2010 and 2011 relating to Australian Government subsidised residential aged care facilities. Of these, 3167 (39%) related to health and personal care, including continence management (Australian Government Department of Health and Ageing, 2011b). As the ACSAA is responsible for promoting high quality care in the Australian Government subsidised residential aged care sector, Assessors may follow-up any concerns about the quality of continence care, and indeed, any aspect of residents’ care. Assessors may conduct announced and unannounced visits to monitor how staff determine, deliver and communicate residents’ care, and thereby determine if a facility and staff meet the Accreditation Standards.

The Australian residential aged care workforce

The Australian residential aged care workforce consists of 133000 direct care employees and most of these workers are Personal Care Attendants (PCAs). In 2007, a national survey of 7566 of these workers was undertaken by the National Institute of Labour Studies (NILS) (2008). The survey revealed 63.6% (n = 84,746) of direct care employees were PCAs. PCAs provide direct personal care to assist residents perform basic activities of daily living such as feeding, showering, dressing, and toileting. They are required to work under the direction and supervision of Registered Nurses (RNs) and Enrolled Nurses (ENs), however unlike RNs and ENs, they are not registered with the Australian Healthcare Practitioner Regulation Agency (AHPRA). PCAs are
generally educationally prepared to a Certificate Level III level in Aged Care from a Technical and Further Education Facility (TAFE) or the Vocational Education and Training system (VET). In 2007, and 65% of PCAs had a Certificate III in Aged Care and 24% had no post-school qualification (The National Institute of Labour Studies, 2008). According to the Community Services and Health Industry Skills Council, the Certificate Level III in Aged Care (CHC30212) qualification provides workers with the knowledge and skill to: (a) carry out activities to maintain personal care and/or other activities of living for people in an aged care setting; (b) carry out activities related to an individualised plan; (c) report directly to a supervisor and are not responsible for other workers” (Australian Government Department of Education Employment and Workplace Relations, 2012).

The EN is an associate to the RN and demonstrates competence in the provision of patient-centred care as specified by the registering authority’s licence to practise (Australian Nursing and Midwifery Council). In 2007, 12.2% (n=16,293) of the residential aged care workforce were ENs. Enrolled nurses are educated to practice at a Certificate IV, which leads to a diploma which articulates to advanced diploma level. The Diploma of Nursing consists of 26 units of competence (21 compulsory and 5 electives). It is an 18 month program or the equivalent part-time, and involves three clinical placements. Many ENs working in the residential aged care sector hold leadership roles and are authorised to administer certain medications (Commonwealth of Australia, 2011).
In 2007, RNs comprised 17% of the residential aged care workforce. They mainly held managerial and/or education roles (The National Institute of Labour Studies, 2008). Registered nurses are educationally prepared through a three year undergraduate degree. The degree prepares RNs to be advanced beginning level practitioners (Johnstone, Kanitsaki, & Currie, 2008; Newton & McKenna, 2009) to critically think, and have the capability to make independent clinical decisions to ensure patient safety (Newton & McKenna, 2009) (Etheridge, 2007). Registered Nurses in Australia are educationally prepared to:

- Assess, plan, implement and evaluate nursing care in collaboration with individual/s and the multidisciplinary health care team so as to achieve goals and health outcomes.
- Practice within an evidence-based framework.
- Promote and maintain health and prevent illness (Australian Nursing and Midwifery Council).

As RNs, ENs and PCAs are responsible for addressing residents’ complex care needs, including their need to manage incontinence and maintain continence, further research should be conducted to shed light on how they provide such care.
Research about current methods to manage incontinence in residential aged care facilities

Researchers have expressed longstanding concerns about the quality of continence care provided to elderly people living in residential aged care facilities. As early as 1985, Starer and Libow (1985) published a seminal paper in the US titled *Obscuring urinary incontinence: Diapering the elderly*, which drew attention to a reliance on using continence products such as absorbent pads to manage incontinence in older people living in a ‘nursing home’, rather than actively assessing, preventing and treating their incontinence.

According to the Australian Institute for Health and Welfare 58% of people aged 85 years and older and 55% of persons aged 70–84 years and living in ‘cared accommodation’ in Australia use a continence product (Australian Institute of Health and Welfare, 2006). These statistics include people living in sheltered accommodation settings as well as those living in a residential aged care facility. However, not only are continence products widely used, they may also be used inappropriately (Ostaszewicz, O’Connell, & Millar, 2008; Palese et al., 2007; Starer & Libow, 1985; Zisberg, Gary, Gur-Yaish, Admi, & Shadmi, 2011). A recent Australian survey of inpatients in acute and subacute care settings found 41% of patients wearing absorbent pads reported they had no urinary incontinence or faecal incontinence in the preceding 24 hours and 18% of patients who reported having had urinary and/or faecal incontinence, had no pad (Ostaszewicz et al., 2008).
There is no contemporary research to indicate how staff working in Australian residential aged care facilities makes decisions about using pads to manage residents’ incontinence, and whether such decisions are appropriate. Specifically, it is not known how they select a product and determine when it needs changing before it leaks. If findings from US nursing homes can be generalised to Australian residential aged care facilities, residents’ wear pads for long periods of time before they are changed. Dated research from the US indicated the number of times residents’ pads were changed ranged from 0-2 episodes per resident in a 24-hour period (Schnelle et al., 1996; Schnelle, Newman, Fogarty, Wallston, & Ory, 1991; Schnelle, Sowell, Hu, & Traughber, 1988; Schnelle, Sowell, Traughber, & Hu, 1988). Furthermore, the frequency of pad changes remained stable both between and within facilities.

More recently, Omli et al. (2010) evaluated the daily pad usage of 153 elderly residents from six ‘nursing homes’ in Norway and found female residents’ pads were changed an average of 2.3 times a day (range 0.5-8.0) and 3.1 times a day for male residents (range 1.0-9.0). Consistent with findings from the study conducted by Ostaszkiewicz, O’Connell and Millar (2008), Omli et al. (2010) found residents pad usage did not correlate well with the volume of their incontinence, which suggests staff decisions about when to change residents’ pads may be arbitrary. The issue of how often a resident’s pad requires changing is important as the risk of UTI is greater among residents whose pads are changed less frequently (Omli et al., 2010),
and as previously indicated, urinary incontinence can result in IAD which can lead to pressure ulcers (Bliss, Zeher et al. 2006).

Research literature reveals over twenty years of research from other countries indicating that active approaches such as toileting assistance programs can reduce rates of incontinence in residential aged care facilities (Bates-Jensen, Alessi, Al-Samarrai, & Schnelle, 2003; Colling, Ouslander, Hadley, Eisch, & Campbell, 1992; Colling, Owen, McCreedy, & Newman, 2003; Engberg, Sereika, McDowell, Weber, & Brodak, 2002; Hu et al., 1989; Ouslander, Griffiths, McConnell, Riolo, & Schnelle, 2005; Ouslander, Griffiths, McConnell, Riolo, & Schnelle, 2005; Palmer, Bennett, Marks, McCormick, & Engel, 1994; Schnelle, Cadogan, Grbic, et al., 2003; Schnelle, Cadogan, Yoshii, et al., 2003; Schnelle et al., 1983; Schnelle et al., 1989; Smith, Newman, McDowell, & Burgio, 1992; Surdy, 1992). However, staffs’ uptake and sustained use of these approaches are low. Residents’ rates of incontinence return to their baseline levels once the research team leave (Schnelle, Cadogan, Yoshii, et al., 2003; Schnelle, Ouslander, & Cruise, 1997). Therefore, some researchers hypothesise that urinary incontinence in ‘nursing homes’ may relate more to residents’ lack of opportunity to use the toilet rather than their underlying pathophysiological bladder dysfunction (Schnelle, Newman et al. 1993).
Research and theories about the causes of incontinence

Within the biomedical literature, researchers describe incontinence as a permanent or reversible symptom/condition caused by physical organic factors such as urological or neurological disorders (Abrams et al., 2002; Aggazzotti et al., 2000; Borrie & Davidson, 1992; Brandeis, Baumann, Hossain, Morris, & Resnick, 1997; Hellström, Ekelund, Milsom, & Skoog, 1994; Østbye, Hunskaar, & Sykes, 2002; Ouslander, Morishita, et al., 1987; Ouslander, Uman, Urman, & Rubenstein, 1987; Rait et al., 2005; Wetle et al., 1995). By contrast, within the sociological literature, researchers emphasise an underlying psycho-social aetiology, particularly in organisational settings, and among individuals with challenging behaviours/attitudes. Sociologists posit that in some circumstances incontinence may represent an unmet need or a dysfunctional relationship between a person and their environment (Muller-Hergl, 2004; Upton & Reed, 2005; van Dongen, 2000).

Recommendations about managing incontinence

The International Consultation on Incontinence (ICI) and the Agency for Health Care Research and Quality (AHRQ) provide evidence-based recommendations about managing incontinence (Abrams et al., 2010; Fantl et al., 1996). Specifically, the ICI recommends any individual with incontinence should receive a comprehensive and individualised assessment to identify any potential modifiable or reversible factors that could lead to reduction in the severity or frequency of their incontinence (Abrams et al., 2010). It also promotes a two tiered approach to assessing individuals with incontinence: a
basic assessment followed by a more specialised assessment if the basic assessment does not resolve the patient’s incontinence (Abrams et al., 2010).

A subcommittee of the ICI, which provides recommendations for assessing and managing incontinence in frail older adults, identified 13 broad factors that should be considered when assessing and managing incontinence in frail older adults (see Appendix B). The subcommittee emphasised it is important to consider the multifactorial nature of incontinence in frail older adults which involves adopting a multidisciplinary approach to assessing and managing incontinence (DuBeau, Johnson II, Kuchel, Palmer, & Wagg, 2009). It also recommended that a minimally invasive approach to treating or managing incontinence that has the least potential to cause adverse complications should be adopted (DuBeau et al., 2009).

In addition, the extent of investigation should take account of such factors as the individual’s life expectancy, quality of life, and the realistic outcome possibilities (DuBeau et al., 2009). Depending on the underlying cause of incontinence, incontinent individuals may benefit from surgery, medications, behavioural and lifestyle interventions, and/or continence products. Behavioural or lifestyle interventions include biofeedback, pelvic floor muscle exercises electrical stimulation, vaginal cones, bladder training and toileting assistance programs.
Toileting assistance programs in residential aged care facilities

The use of toileting assistance programs in residential aged care settings varies among countries. Sgadari, Topinkova, Bjornson, and Bernabeit (1997) analysed documented assessments of 279,191 elderly residents in ‘nursing homes’ in seven countries (e.g. Denmark, France, Iceland, Italy, Japan, Sweden and the USA) and reported 12.3% of residents in US ‘nursing homes’ and 22.8% of residents in ‘nursing homes’ in Italy did not have a documented toileting assistance program. By contrast, over 95% of residents in ‘nursing homes’ in Japan, Sweden and Iceland had a documented toileting assistance program.

Based on observations of practice rather than staff reports, Schnelle et al. (1995) reported staff in the US ‘nursing homes’ provided residents with toileting assistance an average of 0.5 (range 0-1) times per 12 hours. Furthermore, the times staff provided residents with such assistance coincided with other forms of assistance such as preparing residents for a bath. Based on research conducted in the US in the 1980s, the time and labour costs associated with providing such assistance are major disincentives to providing residents with toileting assistance. Schnelle, Sowell, Hu, and Traughber (1988; 1988) reported it takes an average of 7.97 minutes to assist a resident to the toilet compared with 5.55 minutes to change an incontinent resident (t = 2.97, p < .004).
More recently, Ouslander et al. (2005) showed it was possible to reduce residents’ rates of incontinence and improve their physical function by combining a toileting assistance intervention (e.g. prompted voiding) with a low-intensity endurance and strength exercise program termed Functional Incidental Training (FIT). However, the time involved in implementing the intervention up to three times a day for each eligible resident was an average of $20.7 \pm 7.2$ minutes. The time required to locate residents was 3.4 minutes per episode of care, incontinence care alone consumed an average of approximately seven minutes and the exercise portion consumed 10.3 minutes. The researchers calculated “based on the time required to provide FIT, and assuming a ratio of ten residents to one NA on the 7.00 a.m. to 3:00 p.m. shift … staff would need 60 minutes of every hour – virtually all their time – to provide care to the two or three residents under their care who would be anticipated to be eligible for the intervention” (Schnelle et al., 2002, p. 1481).

As resident characteristics and models of care in Australian residential aged care facilities could differ from those described in research conducted in the US, and as data about the labour costs associated with managing incontinence are based on research dating back to the 1980s, there is a need for further research to understand the context that gives rise to such costs.

**Residential aged care staff knowledge about incontinence**

Another factor that could account for the limited use of toileting assistance programs in some residential aged care facilities is that staff lack knowledge to assess and actively manage residents’ incontinence. A number of studies
reveal gaps in nurses’ and residential aged care staff knowledge about incontinence and its management (Cheater, 1992; Connor & Kooker, 1996; DuBeau, Ouslander, & Palmer, 2007; Freundl & Dugas, 1992; Lekan-Rutledge, Palmer, & Belyea, 1998; Mansson-Lindström, Dehlin, & Isacsson, 1992; Palmer, 1995; Saxer, de Bie, Dassen, & Halfens, 2008; Swaffield, 1995). Researchers have developed and trialled education and awareness-raising strategies, based on the assumption that education about incontinence and its management will improve staff knowledge and attitudes, that will subsequently translate into improved practice (Campbell, Knight, Bensen, & Colling, 1991; Collette, Bravo, & Tu, 2009; Collette, Leclerc, & Tu, 2003; Henderson & Kashka, 2000; Karlowicz, 2009; Kincade et al., 2003; Lekan-Rutledge, 2000; Palmer, 1995; Stevens et al., 1998; Vinsnes, Harkless, & Nyronning, 2007). However, even when staff receive education about incontinence and demonstrate higher levels of knowledge following education, they do not consistently adhere to research recommendations to implement toileting assistance programs (Campbell et al., 1991; Lekan-Rutledge, 2000; Stevens et al., 1998).

**Need for theoretically informed interventions**

Researchers now accept that improved knowledge will not necessarily translate into improved practice (Canadian Health Service Research Foundation, May 2005). Palmer and Johnson (2003) stated “there is no point in handing nurses, certified nursing assistants (CNAs) and physicians in long-term care, a 154-page Agency for Healthcare Research and Quality guideline
or providing them with complex and extensive criteria” (p, 1811). Nurse researchers suggest there is a need for new theories to guide continence care in residential aged care facilities (Lekan-Rutledge, 2000; Palmer, 2004; Roe et al., 2004; Wyman et al., 2004).

The value of theory is that is provides a “rational descriptive and taxonomy of phenomena and constructs by which their systematic explanation is possible” (May & Finch, 2009, p. 539). Theory is characterised by “a set of knowledge claims that, in turn, offer the potential for hypotheses or propositions that might be open to further investigation” (May & Finch, 2009, p. 539). To be useful, a theory must be both adequately described and fit for purpose. Arguably, theory about providing continence care in residential aged care facilities should be based on an in-depth understanding about what staff do, how they work, and the barriers and facilitators to their work.

**Existing research about barriers and facilitators to continence care in residential aged care facilities**

A search of the literature by the researcher identified a number of studies describing the barriers and facilitators to continence care in residential aged care facilities (Booth, Kumlien, Zang, Gustafsson, & Tolson, 2009; Funderburg Mather & Bakas, 2002; Gibb & Riggs, 1991; Harke & Richgels, 1992; Lekan-Rutledge et al., 1998; MacDonald & Butler, 2007; O'Connell et al., 2005; Remsberg, Palmer, Langford, & Mendelson, 1999; Resnick et al., 2006; Sacco-Peterson & Borell, 2004; Salsbury-Lyons, 2010; Tannenbaum,
Labrecque, & Lepage, 2005; Taunton, Swagerty, & Lasseter, 2005; Wong & Chueng, 1992; Wright, McCormack, Coffey, & McCarthy, 2007). Studies tend to emphasise staff’s lack of knowledge about incontinence and their resistance to alter routines to accommodate active continence care interventions (see Table 1 on pages 48-52).

Much of the existing research about barriers to continence care in residential aged care facilities was conducted some time ago, or in other countries that have a different residential aged care profile and staff-to-resident ratios to the Australian context. Only three studies describe barriers to continence care in Australian residential aged care facilities (Gibb & Riggs, 1991; O'Connell et al., 2005; Wong & Chueng, 1992). The findings from two such studies were based on questionnaires with fixed response alternatives that were developed based on a predefined view of what constitutes quality continence care (O'Connell et al., 2005; Wong & Chueng, 1992), and the third study (Gibb & Riggs, 1991) was based on data from staff focus group, however the methods and results are unclear. Furthermore, they do not offer an explanatory theory that explains and describes continence care in residential aged care facilities. The current research responds to the need to further understand the context of care that affects the frontline delivery of continence care in residential aged care facilities, albeit, in Australian facilities.
### Table 1. Research about barriers to continence care in residential aged care facilities

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<th>Reference</th>
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<th>Sample/design</th>
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<tr>
<td>(Booth et al., 2009)</td>
<td>To explore nurses’ practices and influences in relation to post stroke urinary incontinence (UI)</td>
<td>One-to-one interviews with 30 RNs from 4 different stroke units in UK, Sweden and China</td>
<td>Thematic analysis</td>
<td>“Nurses reactively managed UI” (p. 1049) ‘There was no systematic approach to screening, assessing or managing post stroke UI (p. 1055). ‘The nurses did not feel that specific education was needed to promote continence effectively” (p 1056). “Measures focussed on preventing pressure sores and preserving skin integrity, preventing UTIs and hypostatic pneumonias, falls prevention and maintaining the stroke survivors’ physical safety and comfort” (p. 1056)</td>
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<td>(Funderburg Mather &amp; Bakas, 2002)</td>
<td>To examine Nursing Assistant’s (NAs) experiences providing continence care to nursing home residents</td>
<td>31 NAs (most women), 77% African American attending one of 7 focus groups in two long-term care facilities in the US</td>
<td>Concept analysis</td>
<td>NAs cited the following factors as barriers to continence care: excessive workloads, inconsistent cooperation, inconsistent communication, and a lack of teamwork</td>
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<td>(Gibb &amp; Riggs, 1991)</td>
<td>To gain as wide a perspective as possible on the issues impinging upon management of incontinence</td>
<td>Group interviews with staff responsible for incontinence aids in an institutional care setting for older people in Australia</td>
<td>Interviews were taped, transcribed and examined for emergent themes.</td>
<td>Staff cited the following factors as barriers to continence care: the cost of continence aids, the burden of care, difficulty documenting care, lack of education, limited RN leadership, and poor communication</td>
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<td>(Harke &amp; Richgels, 1992)</td>
<td>To categorise and describe observed factors that seem to inhibit staff implementing a toileting program for nursing home residents</td>
<td>Researcher’s log books from a trial on Patterned-Urge – Response-Toileting (PURT) conducted in 4 nursing homes in US</td>
<td>Line–by-line dimensional analysis of researcher notes about the process of implementing PURT</td>
<td>The researchers noted the following factors acted as barriers to toileting programs: staff shortages, inconsistent assignments and a lack of involvement of licenced staff and staff lack of ownership, conflicting beliefs and goals, and difficulty or unwillingness to alter routines.</td>
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<tr>
<td>(Lekan-Rutledge et al., 1998)</td>
<td>To investigate CNAs’ perceptions of incontinence aetiology, and barriers to prompted voiding (PV)</td>
<td>141 CNAs from 23 nursing homes in US who responded to a multiple choice questionnaire with one open-ended question about factors to enhance use of PV</td>
<td>Descriptive statistics for multiple-choice questions Correlation analysis for responses to open-ended question</td>
<td>CNAs perceived barriers to PV included: increased workload, nursing staff absenteeism, nursing staff resignation, lack of familiarity with the intervention, and a lack of administrative support</td>
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<td>(MacDonald &amp; Butler, 2007)</td>
<td>To explore the experiences of elderly women with UI living in long-term care</td>
<td>Six elderly women living in one of two nursing homes in Canada</td>
<td>Thematic analysis of semi-structured interviews</td>
<td>Three major themes emerged from the data: (1) ‘shattering the silence’ which referred to the meanings women attached to their experiences of UI, (2) the physical implications of UI, (3) encountering the institutional culture of UI in long-term care.</td>
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<td>(O'Connell et al., 2005)</td>
<td>To ascertain stakeholder views on what is required to implement incontinence management in residential aged care facilities</td>
<td>Phone interviews with residential aged care stakeholders (n = 168) of whom 147 were working in 89 residential aged care facilities in Australia Validation of interview results with 114 staff</td>
<td>Descriptive statistics for quantitative data and content analysis for qualitative data</td>
<td>Staff cited the following factors as barriers to incontinence care: inadequate staffing, staff lack of knowledge, poor staff attitudes, insufficient educational resources, programs and resources for residents and their families, lack of appropriate documentation systems, lack of equipment, resident characteristics, limited access to continence services/experts, lack of standardised tools, and a lack of evidence-based practice guidelines and algorithms</td>
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<td>(Resnick et al., 2006)</td>
<td>To consider NAs and Directors of Nursing (DON) beliefs about managing UI in nursing homes</td>
<td>3 focus groups of 38 participants</td>
<td>Content analysis</td>
<td>NAs and DONS cited the following barriers to managing UI: resident characteristics; staff factors such as not responding to residents’ requests for toileting assistance, lack of knowledge about incontinence, attitudes; and system problems such as poor communication about toileting schedules, family members expectations to use continence aids</td>
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<td>(Remsberg et al., 1999)</td>
<td>To assess the effectiveness of PV and staff perception of effectiveness and compliance</td>
<td>A pre and post evaluation of a 12-week program of PV for 17 patients in 4 units and a survey of 88 staff in a 255 bed geriatric centre in the US</td>
<td>Staff perceptions were statistically compared with observational data about residents’ UI frequency and implementation of PV</td>
<td>A major finding was that staff had limited ability to identify improvements in residents’ continence status as a result of an active intervention program</td>
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<td>(Sacco-Peterson &amp; Borell, 2004)</td>
<td>To gain in-depth understanding of how the physical and socio-cultural environments and residents’ beliefs influence participation in their personal-care activities</td>
<td>An ethnographic study conducted in a women’s ward of a nursing home in a Southern European country</td>
<td>200 hours of observations and 9 resident interviews. Data coded and analysed for concepts and categories using a constant comparative method</td>
<td>Residents encounter a socio-cultural and physical environment that is not conducive to them maintaining independence and autonomy related to personal care</td>
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<td>(Salsbury-Lyons, 2010)</td>
<td>To explore the influence of organisational culture on continence care practices</td>
<td>An ethnographic study of residents and interdisciplinary team members perspectives in two US nursing homes</td>
<td>Coded analysis of data from observations, interviews and record reviews</td>
<td>Factors that influenced continence care practices were institutional philosophy, time orientation, admission policies, employee career goals, organisational turbulence, interdisciplinary team interactions and decision-making processes</td>
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<td>(Tannenbaum et al., 2005)</td>
<td>To identify factors that facilitate or diminish continence care</td>
<td>8 focus groups in 4 long term care institutions in Canada - attended by 42 nurses, NAs and orderlies.</td>
<td>Content analysis</td>
<td>Individual/internal factors that influenced continence care were staff beliefs about UI, attitudes towards the elderly, and knowledge about UI. Institutional/external factors included workload demands, type of patient, environmental support, co-worker support, and attributes of UI interventions</td>
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<td>(Taunton et al., 2005)</td>
<td>To describe care provided to nursing home residents with UI</td>
<td>Case study of three US nursing homes—17 residents, 16 family members or friends and 75 staff</td>
<td>Coded data from observations, semi-structure interviews and record reviews</td>
<td>Factors that influenced evidence-based continence care included: variability in staff understandings about incontinence, program priorities, practice standards, and worker knowledge and attitudes</td>
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<td>(Wong &amp; Chueng, 1992)</td>
<td>To identify the factors that affect the effectiveness of incontinence management in geriatric hospitals and explore ways to promote continence</td>
<td>Nurse survey (n=214) Patient survey (n=20) using the Incontinence Stress Questionnaire-Patient (ISQ-P) Semi-structured in-depth interviews with patients (n=9) and nurses (n=10) in Australia</td>
<td>No report on how interview data were analysed.</td>
<td>Nurses’ comments about barriers and facilitators</td>
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<td>• Not enough staff</td>
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<td>• More education for nurses and patients</td>
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<td>• Professionalised caring process</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• More and better continence aids</td>
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<td></td>
<td></td>
<td>• Better ward design’ (p. 24)</td>
</tr>
<tr>
<td>(Wright et al., 2007)</td>
<td>To identify the contextual indicators that enable or hinder person-centred continence care in aged care rehabilitation</td>
<td>Two rehabilitation units in Ireland, an audit of practice, a staff knowledge questionnaire, and six focus groups (n=26) with multidisciplinary team members</td>
<td>Case study methodology Thematic analysis of observations of practice and focus group data</td>
<td>Factors that hindered person-centred continence care included: professional boundaries, resistance to change, weak leadership, and a focus on tasks, routines, inflexibility, limited individualised care, lack of patient choice</td>
</tr>
</tbody>
</table>
Summary of review of literature

The question of what care staff actually give to residents with incontinence and those who require support to maintain continence, and what factors inform staff decisions about care was first posed by in 1992 when Colling, Ouslander, Hadley, Eisch, and Campbell (1992) conducted a research trial in the US in which they gave ‘nursing home’ staff four hours of education about incontinence and instructed them to implement a toileting assistance protocol. Although the protocol reduced the residents’ incontinence and “considerable effort was made to work closely with the administrative and professional nursing home staff to introduce and support the protocol in a way that would minimise disruption to the staff, the researchers noted “a few [nursing] aides expressed resentment about the project being imposed on them by administrators and outsiders” (p. 140) and “many staff preferred to maintain their current routines rather than adjust to individual patient needs” (Colling et al., 1992, p. 139). Such findings prompted Colling et al. (1992) to ask who was actually responsible for making decisions about residents’ day-to-day continence care.

More recently, the question of who makes decisions about continence care in residential aged care facilities and how such care is actually delivered resurfaced following changes to the regulatory framework for ‘nursing homes’ in the US. The regulatory changes, which were introduced in June 2005, require staff to show they have conducted an assessment to determine the causes of residents’ urinary incontinence and that they have selected and
evaluated treatment. A number of state-wide joint training sessions were convened for ‘nursing home’ staff to learn about the changes. During the training sessions in one state, attendees (n=588) were invited to complete an anonymous survey that tested their knowledge and attitudes about incontinence and to comment on the regulatory changes (DuBeau et al., 2007). Survey respondents included State Surveyors [Assessors], 8%; Nursing home administrators, 15.8%; Directors of Nursing, 27.6%; Assistant Directors of Nursing, 3.8%; Staff nurses, 29%; Nursing Assistants (NAs), 1%, Nurse Practitioners, 0.2%; and Nurse Consultants, 2%.

The researchers reported ‘striking deficiencies’ in the respondents’ knowledge and attitudes about urinary incontinence and distinct differences between Assessors and staff knowledge and attitudes. However, what was particularly noteworthy in the context of the current study was that many of the respondents expressed strong feelings that the changes to the regulatory framework were unreasonable, ‘invasive’, and that the new regulations ‘violated residents’ rights’. The researchers expressed concern that the regulatory changes would not be adopted (DuBeau et al., 2007).

Arguably, there is a need to further understand the context of care that gives rise to the consistent finding from international research that residential aged care staff do not consistently adhere to evidence-based protocols or recommendations that, under research conditions, reduce residents’ rates of incontinence.
In this thesis, the researcher used the term ‘continence care’ to refer to the range of activities carers perform to assist care-dependent individuals to pass urine (e.g. void) or use their bowels (e.g. defeacate), to maintain continence, regain continence, and/or prevent incontinence. The term therefore encompasses activities that assist individuals maintain optimal levels of continence as well as activities that focus on managing incontinence.

A recent systematic review of descriptive studies about managing incontinence and promoting continence in older people in ‘care homes’ identified a lack of research about maintaining residents’ continence (Roe et al., 2011). The reviewers also noted that most of the research that had been conducted about managing incontinence in ‘care homes’ was from the U.S. (Roe et al., 2011). None of the ten studies that were included in the systematic review were based on research conducted in Australia. Given potential differences in resident profiles, models of care, staff-to-resident ratios, and staff skill mix, it is questionable the findings from research conducted primarily in the US are applicable to the Australian residential aged care sector. Clearly, there is a need to further understand how staff members who provide, assess or supervise residents’ continence care, determine, deliver and communicate such care in Australian residential aged care facilities.
**Research aim and objectives**

The overall aim of the study was to develop a grounded theory that described and explained how Australian residents’ continence care needs were determined, delivered and communicated. The objectives were to:

1. Explore and describe residential aged care staff members’ perspectives about providing, assessing or supervising residents’ continence care needs.
2. Explore and describe residential aged care staff members’ beliefs about incontinence and continence care.
3. Explore and describe residential aged care staff members’ experiences of the barriers and facilitators to providing continence care.
4. Describe, through field observations, how staff recognised and responded to residents’ continence care needs in public areas of the residential aged care facility.
5. Analyse and describe how the quality of continence care in residential aged care facilities was documented and evaluated by the Aged Care Standards and Accreditation Agency.

**Significance of the research**

Managing incontinence and promoting continence is an important and costly health and social issue, particularly in the context of an ageing population, the projected increase in the diagnosis of dementia, and the need for skilled care. This study is important and timely as it coincides with the challenge to develop national and
international policies and strategies to respond to the increasingly complex care needs and expectations of older citizens who will require residential aged care support. The Intergenerational Report 2010 (Commonwealth of Australia, January 2010) estimated Australian Government spending on aged care will increase from 0.8% of the gross domestic product (GDP) in 2010 to 1.8% of GDP by 2050. As continence care consumes one third of government subsidies to residential aged care, it is important to understand the context that warrants such expenditure.

A key challenge facing the Australian government and the residential aged care sector is the need to build an adequate workforce to meet the increased demand for high quality residential aged care. The residential aged care workforce comprises about 1.4% of working Australians, however, a rapidly ageing population means that by the year 2050, 980000 aged care workers, more than 4.9% or one in twenty working Australians, will be needed (Australian Government Department of Health and Ageing, 2008) (Commonwealth of Australia, 2011). Such projections highlight the need for a large number of appropriately trained and skilled staff with the knowledge and skills to deliver high quality care, including residents’ continence care.

Having a comprehensive picture of the issues that affect continence care will enable policy-makers, service providers, managers, educators and staff to develop contextually appropriate interventions. Such findings are important because the translation of knowledge gained from clinical trials into clinical practice has been
impeded by an insufficient understanding of the real world context of continence care (Lekan-Rutledge, 2000; Palmer, 2004; Roe et al., 2004; Wyman et al., 2004). The development of a comprehensive theory that describes and explains the contextual factors that influence continence care and the uptake or lack of uptake of evidence-based protocol is crucial if research and practice about such care is to progress in the residential aged care sector. In the absence of such information, any intervention that relies on front-line workers for its uptake and sustained use is likely to be resisted. The findings from this thesis are intended to provide a theoretical basis for the development of education, regulation, practice, and research initiatives to enhance continence care in the residential aged care sector.
Chapter two

Methodology

Introduction

The current study describes and explains the management of residents’ incontinence and other bladder and bowel symptoms in residential aged care facilities in Australia from the perspectives of residential aged care staff members’ who provide, assess, or supervise residents’ continence care. Grounded theory methodology was used to systematically examine, describe and explain how continence care was determined, delivered and communicated in Australian residential aged care facilities. In this chapter, the researcher describes the grounded theory method used to achieve the study objectives outlined in chapter one, including the strategies used to collect and analyse the data. The chapter begins with a description of the grounded theory method, including the epistemology, historical, and current developments of grounded theory.

The grounded theory method

Grounded theory is a theory-generating methodology wherein data are analysed, named and used to generate theory (Glaser, 1992; Strauss & Corbin, 1998a). Grounded theory seeks to develop theory and combines both inductive and deductive
deductive research where researchers set out to prove or disprove a hypothesis,
grounded theory does not start with a hypothesis to be tested. The goal is to
understand the behaviour and the meanings people give to their experience in a
natural setting in order to discover the basic psychosocial process (Glaser, 1978).
Glaser (1998) emphasised the focus of grounded theory is the participants’ main
concern rather than the researcher’s concerns. “The theory is designed to have
predictive power within a specific context and the merit of such a theory is ‘to speak
specifically for the populations from which it was derived” (Strauss & Corbin, 1998a,
p. 267).

The historical and contemporary development of grounded theory

The research literature presents two main schools of thought about the grounded
theory method. These differences can be traced to a public schism between Glaser
and Strauss (1967), whose joint work in 1967 led to the seminal publication The
Discovery of Grounded Theory, and then continued independently over time. Two
main variations to the original version of grounded theory emerged from the schism:
the Glaserian, or Classic grounded theory approach, and the Straussian approach.

Although Glaser, and Strauss and Corbin agreed that grounded theory is characterised
by: (1) theoretical sampling, (2) constant comparative data analysis, (3) theoretical
sensitivity, (4) memo writing, (5) identification of a core category, and (6) theoretical
saturation, there are conceptual differences in the analytical, inductive and interpretive approaches to data analysis. The differences are related to an emphasis by Strauss and Corbin (Strauss & Corbin, 1990) on verification, validating data and detailed methods of checking internal reliability compared with Glaser’s ambiguous concepts such as ‘discovery’, ‘trust’, and ‘emergence’ (Glaser, 1992). Strauss and Corbin developed a paradigm model and encouraged researcher to search for relationships denoting causal conditions, phenomena, context, intervening condition, action/interaction strategies and consequences so that a problem can be managed (Strauss & Corbin, 1990).

Because using the paradigm model requires researchers to ask questions and speculate what might be, rather than focussing on what exists in the data, Glaser (1992) argued the ‘Straussian’ version of grounded theory forces the researcher to concentrate too hard on issues of verifying validating and coding data which resemble the methods used in traditional science. Glaser, by contrast, emphasised the need for researchers to be patient, to believe in the data, to wait and see, to let the concepts emerge and not to concentrate on issues of verification, reproducibility and replication. These fundamental differences continue to be at the heart of a debate about grounded theory.

The differences within grounded theory methodology have also produced considerable debate about the epistemology (theory of knowledge) and ontology
(theory of being) of grounded theory. Specifically, grounded theorists wrestle with questions about whether grounded theory is underpinned by positivism, or interpretivism (Åge, 2011). Positivism assumes an external world which can be discovered in an unbiased way by strictly adhering to certain methodological rules. Positivists are interested in the idea of objective and absolute truth which involves correspondence to the facts and leaves no room for values (Popper, 1963).

In contrast to positivism, interpretivism focusses on establishing meaning and interpretation. It has a long intellectual history that began with the German sociologist and economist, Max Weber (1864-1920) and the German historian, psychologist, sociologist and hermeneutic philosopher, Wilhelm Dilthey (1833-1911). Interpretivism assumes that people interpret or give meaning to their environment and themselves and that the ways they do this are shaped by the particular cultures in which they live, and that this generates the actions and institutions in which they participate. To understand why people do what they do, or why particular cultural norms exist and operate in certain ways, we need to understand the distinctive nature of individuals’ values, perceptions, beliefs, attitudes, etc. Another assumption is that interpretation is always based upon presuppositions and is therefore always shaped by the particular socio-historical location of the interpreter (Willis, 2007). Interpretivism aligns with a relativist perspective which rejects the idea that claims can be assessed from a universally applicable, objective standpoint. Hermeneutics, phenomenology and constructivism are closely based on
interpretivism and relativism. Moreover, post-positivist orientations such as deconstructionism and post-structuralism are more or less closely linked to the orientations of constructivism and hermeneutics, as is social constructionism.

Social constructionism which focuses on the social, collaborative process of bringing about meaning and knowledge emerged in the mid-twentieth century (Willis, 2007). Kathy Charmaz, an American sociologist is largely credited with giving grounded theory a social constructivist bent. Charmaz (1990, 2000, 2005, 2006) described constructivist grounded theory as a contemporary revision of Glaser and Strauss’ classic grounded theory. She argued researchers need to acknowledge the interplay between researcher and respondents, and show how this interplay contributes to the theory. In the current study, the researcher acknowledged that the way in which the data were created was inevitably affected by the subjectivity of the researcher vis-à-vis to the participants. The reflexive and relational procedures adopted in the current study, are discussed in the context of rigour and theoretical sensitivity further on in this chapter.

The grounded theory method has been shaped by the contradictory orientations of both positivism and interpretivism. According to a commentary by Åge (2011) about the influence of different philosophical paradigms on grounded theory, grounded theory contains both positivist and interpretivist elements. Glaser and Strauss brought together their two contrasting philosophical and methodological traditions to bear on
grounded theory. Glaser whose strength was the systematic analysis inherent in quantitative research brought his knowledge of positivism. Strauss who worked at the University of Chicago brought his knowledge of pragmatism (Charmaz, 2009).

Pragmatism is an orientation that is not strictly aligned with either positivism or interpretivism. It is underpinned by four main assumptions: Ritzer (2008) summarised pragmatism as espoused by George Herbert Mead as follows:

1. “True reality does not exist out there in the real world. Rather it is actively created as we act in and toward the world.

2. People remember and base their knowledge of the world on what has been useful to them and are likely to alter what no longer works.

3. People define the social and physical objects they encounter in the world according to their use for them.

4. If we want to understand actors, we must base that understanding on what people actually do (Ritzer, 2008, p. 347).

Three such assumptions underpin the philosophy of symbolic interactionism. Symbolic interactionism was developed by Herbert Blumer (1900-1987) (Blumer, 1969) who was, in turn influenced by one of the ‘fathers’ of pragmatism, George Herbert Mead (1863–1931) during his time at the University of Chicago. Another major influence to Blumer’s work was the American philosopher, psychologist and educational reformer, John Dewey (1859-1952). The first idea or assumption
underpinning symbolic interactionism is that human beings act toward things on the basis of the meanings that the things have for them (Blumer, 1969). This means that people do not respond directly to things, but attach meaning to them and act on the basis of that meaning (Chenitz & Swanson, 1986). For example, staff in the current study attached very specific meanings to the condition or symptom of incontinence which they equated with a state of uncleanliness and indignity. Staff acted on the basis of the meaning incontinence had to them.

Secondly, the meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows (Blumer, 1969). In other words, individuals create meaning in a social context and individuals are active participants in creating meaning in a situation (Morse & Field, 1995). Thus, the meaning staff attached to the residents’ incontinence was based on how other people in their social interaction interpreted and responded to it.

Following on from the second assumption is the belief that that meanings are assigned and modified through an interpretive ever changing process, subject to redefinition, relocation, and realignment (Blumer, 1969). In other words, an individual’s behaviour is not predetermined or fixed and individuals engage in the process of interpreting meaning (Blumer, 1969; Chenitz & Swanson, 1986; Schwandt, 1994).
Although many argue the epistemological assumption that underpins the grounded theory method is symbolic interactionism (Aldiabat & Le Navenec, 2011; Denzin & Lincoln, 2000; Schwandt, 1994), Glaser (1998) asserted grounded theory occupies a position that goes beyond philosophical schools of thought and can be used independently of research tradition or philosophical standpoint. Indeed, although, grounded theory was historically paired with the social theory of symbolic interactionism, Glaser (2005) refuted the need to be informed by symbolic interactionism because to do so may ‘force’ data into a preconceived framework. The theory should be allowed to emerge without adherence to a particular theoretical lens, including the lens of symbolic interactionism.

Whilst the current researcher was cognisant of the debate about the strengths and limitations of ‘Straussian’ and ‘Glaserian’ versions of grounded theory, as the research was concerned with how staff cognitively and behaviourally provided continence care, and in representing their reality, the goal of the study was compatible with that of both grounded theory and symbolic interactionism. The following section describes the rationale for choosing grounded theory and the particular grounded theory approach as the research method to address the study objectives.
Rationale for choosing grounded theory

Because social interaction is at the heart of caring processes in nursing, grounded theory is a useful methodology for the study of interpersonal activities such as activities between residents and residential aged care staff (McCann & Clark, 2003). Grounded theory was chosen to address the research objectives because it offered a method to understand behaviour as participants understand it, to learn about their world and their interpretation of self in their social interactions.

Another reason for using grounded theory is it is a particularly useful method for researching issues where little is known about the topic and when researchers require the freedom to explore an issue without being encumbered by the constraints of a priori knowledge (Glaser, 1978; Glaser & Strauss, 1967). As indicated in chapter one, there is little contemporary research about how staff respond to residents’ continence care needs in Australian residential aged care facilities, and the factors that inform how they determine, deliver and communicate residents’ continence care.

Furthermore, although there is already a large body of research about incontinence and its management in residential aged care facilities, much of the existing research describes organisational interventions such as toileting assistance programs and/or education programs. Such research is underpinned by the following three assumptions:
1. Usual care is inadequate.

2. Toileting programs can and should be implemented to reduce residents’ rates of incontinence.

3. Staff needs further knowledge and skills to implement and sustain toileting assistance programs.

It is therefore based on a predefined view of what constitutes effective, evidence-based, or quality continence care and uses a reductionist approach that does not capture the whole context of care.

There is a need for in-depth information about providing continence care in residential aged care facilities without reference to prior assumptions about what constitutes effective, evidence-based, or quality continence care. With its focus on developing theory inductively and deductively, grounded theory offered a method to generate a theory about the meanings, understandings and phenomenon of providing continence care in residential aged care facilities from the vantage point of staff themselves.

The grounded theory approach for the current research was informed by the combined works of Glaser and Strauss (1967), Strauss and Corbin (1990, 1998a), and Charmaz (1990, 2000, 2005, 2006), however, it follows as closely as possible the descriptions of the methods in the original textbook *Discovery of Grounded Theory* by Glaser and Strauss (1967) and Glaser (1978, 1992). The reason for mainly
following the foundational methods described by Glaser and Strauss (1967) was that as a novice to the grounded theory method, the researcher was anxious to avoid questioning participants and interpreting the data in a way that could simply confirm her existing professional assumptions about continence care in residential aged care facilities.

Although Glaser’s approach is difficult for novice grounded theorist in that it requires researchers to have high levels of abstract conceptual thinking, and to tolerate ambiguity regarding the nature of the data (Glaser, 1992), it held appeal because of the lack of formula and because the researcher anticipated it would offer greater academic freedom to conceptualise. The analytic approach used in the current study is described in detail in the section of this chapter titled ‘coding procedures’.

**Application of the grounded theory method**

**Setting**

The study was conducted in the states of Victoria and South Australia in Australia from April 2007 to December 2012. It involved four data sources. The first of these comprised residential aged care staff who volunteered to participate in semi-structured, open-ended one-to-one interviews about their experiences of providing assessing, supervising, or appraising continence care in a residential aged care facility. To be eligible to participate in interviews, participants had to speak English
and have experience of providing assessing, supervising, or appraising continence care in a residential aged care facility. Each individual volunteered to participate following dissemination of information about the research at professional network forums, such as the Emerging Researchers in Ageing Conference, the Australian Nursing Federation, and the Nurses for Continence and Aged Care Nurses’ Special Interest Groups, as well as to undergraduate nursing students at a tertiary education facility, and after hearing about the study from their colleagues who had participated. Hence, a snowballing recruitment strategy was used.

The second source of information was based on non-participant field observations conducted in two residential aged care facilities. One of the facilities was a private 50-bed residential aged care facility located in a low socio-economic area of the metropolitan city of Adelaide in the state of South Australia, and the other was a not-for-profit 75-bed facility in a higher socioeconomic area of metropolitan Melbourne in the state of Victoria. The facilities were purposively selected on the basis of a diverse staff skill mix, a large number of highly dependent residents, including residents with dementia, and staff willingness to allow the researcher to conduct field observations. The third source of data for the study was 87 publicly available accreditation reports which the researcher analysed using content analysis procedures. The fourth data-source consisted of government reports, and websites.
Formal semi-structure, open-ended interview sample

Eighteen individuals who had experience of providing, assessing, supervising or appraising continence care in residential aged care facilities were formally interviewed. Six of these individuals were RNs, six were ENs and six were PCAs. Four worked as Directors of Nursing (DON) and two worked as Clinical Nurse Educators (CNE). Five of the six RNs had a post-graduate qualification. Of those participants who provided direct resident care, three were enrolled in an undergraduate nursing course and were working in a residential aged care facility. Two were working as PCAs and one was working as an EN. Other interviewees described role titles such as lifestyle coordinator, a ‘continence link person’, a ‘continence coordinator,’ ‘support nurse’. Table 2 on page 72 provides further information about the participants’ characteristics. See Appendix C for a copy of the demographics data collection form used to collect such information.
<table>
<thead>
<tr>
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<th>Age range</th>
<th>First language</th>
<th>Role</th>
<th>Current role</th>
<th>Highest Ed</th>
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<th>Time in RACF</th>
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<td>Full time</td>
<td>1-3 yrs</td>
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</tbody>
</table>
The theoretical sampling procedure for interviews

Theoretical sampling procedures were used in the study. During theoretical sampling the researcher simultaneously collects, codes and analyses the data and makes decisions about who and what to sample based on the emergent findings (Glaser, 1978). The researcher goes back to the field and data to fill conceptual holes. Glaser (1998) stated theoretical sampling provides a means of ensuring that new data add value and that they work with the concepts already compiled through a measure of fit and relevance. Theoretical sampling contradicts traditional sampling procedures because the type and number of participants cannot be stated in advance (Stern, 1980).

The data collection process is influenced by outcomes of the emerging analysis and determined by changes in the criteria for selecting participants according to what has been learned from previous data sources (Morse & Field, 1995). In line with the concept of theoretical sampling, the choice of participant in the current study was guided by the emergent findings. Hence, the emergent concepts and categories rather than number and type of people were the basis for decisions about who to sample. The sample size was therefore guided by the generation of the data and its analysis. The researcher sought diversity of perspectives of staff working in different roles such as direct care, managerial and education roles. These data were coded and then used to guide subsequent interviews and field observations. Hence, the interview guide was modified to explore emergent data and further sampling was conducted.
with individuals who the researcher felt would be best placed to have knowledge about the emerging issues. In practice, the researcher increasingly focused the questions on the emerging categories and questions changed in order to: a) clarify the emerging theory, b) refine categories, c) and search for negative cases. Appendix D includes a sample of the interview schedules.

**Data collection**

The following section describes the data collection procedures for the four different sources of data in the study.

**Source 1: Formal semi-structure, open-ended interviews**

The individuals who consented to a one-to-one, in-depth tape-recorded interview included six RN, six ENs, and six PCAs. The interviews were conducted at a time and venue of the interviewees’ choosing, and each interview lasted between 40 and 60 minutes. Two interviewees were interviewed twice which allowed the researcher to further pursue emergent findings. These two interviewees also reviewed selective parts of the thesis and provided critical feedback about the emerging theory.

Because research literature highlights the importance of the researcher’s awareness of the impact of interpersonal interactions on data during the interviews (Malterud, 2001; Mays & Pope, 1995; Sandalowski & Barroso, 2002), the researcher attempted to conduct interviews in a manner that encouraged participants to openly share their
experiences without feeling judged. Hence, the researcher adopted a neutral, but empathetic stance. As such, although the interview was guided by an interview schedule, discussion was free flowing to enable individuals to share their concerns and opinions. All interviews were tape recorded and transcribed by the researcher.

**Source 2: Non-participant field observations**

In addition to conducting participant interviews, a total of 88 hours of field observational data was collected from two residential aged care facilities. Field observational data were conducted between September and November 2010. They included:

- 32 hours of data from an AM shift (0700-1530 hours).
- 32 hours of data from a PM shift (1400–2230 hours).
- 24 hours of data from night shift (2200–0730 hours).

The value of conducting field observations was that it offered a way to explicate practice realities in context and revealed differences between what people said they did and what they actually did. In grounded theory, the relationship between collecting and analysing data and generating theory is reciprocal (Strauss & Corbin, 1998a). Therefore, researchers should be immersed in the natural field of the participants in order to understand the meaning of the phenomenon from their perspectives (Aldiabat & Le Navence, 2011).
In preparation for field observation the researcher sent a letter, fliers with information about the research, and Participant Information and Consent Forms to the managers who expressed interest in participating. Managers were invited to display the fliers on notice boards in staff rooms and public areas throughout the facilities and to convey information through their usual channels of communication. Entrée to the sites required careful consideration to ensure the researcher respected residents’ right to privacy and did not interfere with staff work. It was also important to build a sense of trust with staff because participants are much more likely to be forthcoming with information if they respect and trust the inquirer (Lincoln, 1995). The researcher anticipated the approach she adopted could have a considerable influence on the depth and quality of the data (Malterud, 2001; Mays & Pope, 1995; Sandalowski & Barroso, 2002). However gaining staff trust is also important in terms of the need to conduct the research as openly and transparently as possible. Whilst staff were initially cautious and guarded in their interactions with the researcher, which was related to a fear that the researcher was ‘from the government’, staff gradually came to accept and trust the researcher as an ‘insider’.

The researcher observed routines of care and social interactions from shared areas of each facility such as from dining rooms, lounge rooms, corridors, reception areas, and from staff offices or meeting rooms. During observations, the researcher invited staff to describe what care they were providing and why. Information from such informal interaction became part of the data. Occasional notes were written about the work
staff performed and the way they recognised and responded to residents’ care needs. These notes were later typed up. The observations were later followed up in in-depth interviews with staff. Appendix E shows a transcript from the field observations. Data from the field notes was used as theoretical sources of information and woven into the emerging categories.

**Source 3: Content analysis of accreditation reports**

In order to determine how Assessors from the ACSAA appraised the quality of continence care in Australian residential aged care facilities, in 2009 the researcher conducted a content analysis of publicly available accreditation reports. A sample of 10% (n=87) of the 870 accreditation reports from facilities in the state of New South Wales (NSW) was selected and analysed. New South Wales was chosen because it had the largest number of residential aged care facilities at the time of the analysis. The names and postcodes of all facilities in the state were identified using the ‘DPS Guide to Aged Care’ website (http://www.agedcareguide.com.au/). At the time of data collection (2009), the website listed 2,843 high and low care residential aged care facilities by state/territory.

The ARIA + Accessibility/Remoteness Index of Australia (ARIA +) was used to determine the location of each facility. ARIA+ is a continuous varying index with values ranging from 0 (high accessibility) to 15 (high remoteness), and is based on road distance measurements from 11,879 populated localities to the nearest service
centres in five size categories based on population size (Australian Population and Migration Research Centre, 2013). All NSW facilities were then grouped into one of five AIHW geographic locations: namely, major cities, inner regional areas, outer regional areas, remote areas, and very remote areas. Next, AIHW statistics about NSW residential aged care facilities were used to identify the number of facilities in each ARIA location, which indicated that 540 were in major cities, 237 were in inner regional areas, 88 were in outer regional, seven in remote areas, none were in very remote areas. Ten per cent of facilities from each of these groups was then selected by choosing every eighth facility until the required number was obtained. See Table 3 below for information on the final number and percentage of accreditation reports in each ARIA location.

Table 3. Number and percentage of residential aged care facility accreditation reports sampled by area

<table>
<thead>
<tr>
<th>State / territory</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote remote</th>
<th>Very remote</th>
<th>All regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>54</td>
<td>23</td>
<td>9</td>
<td>1</td>
<td>0*</td>
<td>87</td>
</tr>
</tbody>
</table>

*There were no facilities listed in very remote areas of NSW
The accreditation report for each selected facility was accessed and downloaded from the ACSAA website, and identifying information was removed. The documentation in each report about performance against Accreditation Standard 2.12 was entered into QSR International’s NVivo 9 software program for data management (QSR International Pty Ltd, 2010). NVivo9 is a qualitative data analysis computer software package that is used to analyse non-numerical or text data. It helps users classify, sort and arrange information, and examine relationships in the data. A typical example of documentation in accreditation reports about a facility’s adherence to Accreditation Standard 2.12 is provided below:

*There are systems in place to ensure residents’ continence is managed effectively. Clinical documentation and discussions with staff show continence management strategies are developed for each resident following initial assessment. Care staff report they assist residents with individualised toileting and monitoring of residents’ skin integrity to determine the effectiveness of continence aids and toileting schedules. Staff record relevant information and chart residents’ continence. Staff ensure residents have access to regular fluids, appropriate diet and medications as ordered to assist continence. There are appropriate supplies of continence aids to meet the individual needs of residents. Residents and representatives are satisfied with the continence care provided.*
The date of each facility’s last accreditation audit was also extracted. The findings showed the majority of facilities were last accredited in 2009. Specifically,

- 54 facilities had their last accreditation audit conducted in 2009.
- 22 facilities had their last accreditation audit conducted in 2008.
- 10 facilities had their last accreditation audit conducted in 2007.
- One facility had its last accreditation audit conducted in 2006.

Data from each report about each facility’s adherence to Accreditation Standard 2.12 were analysed using two different content analysis techniques. The first of these techniques involved inductive coding that resulted in a set of themes or descriptors. Inductive coding involves identifying patterns in qualitative data without reference to a prior framework. The researcher read the text in each report in detail and identified short segments within the text that held a certain meaning. Each segment was labeled or coded. This process continued for all reports. The researcher went back over each report a number of times to check for consistency of codes, resulting in an expansion and reduction in the number of codes. Once the final descriptors [codes] were identified, they were listed and rated from most to the least frequently documented.

The second analysis technique involved deductive coding. While inductive coding involves using the data to generate ideas, deductive coding starts with an idea or theoretical framework and uses the data to verify or disprove the idea (Holloway, 1997). This second method involved comparing factors identified from stage one.
against a list of assessment/management factors recommended by the ICI (DuBeau et al., 2009) (see Appendix B), and subsequently coding the presence or absence of documentation in each accreditation report about each ICI recommendation.

The information from accreditation reports was used as a theoretical source of data and was woven into the emerging categories. During the course of the research, the researcher published the results of the content analysis of accreditation reports in a peer review journal (Ostaszkiewicz, O’Connell, & Dunning, 2012) and presented findings at the 45th National Conference of the Australasian Association of Gerontology.

Source 4: Government reports and websites

Government reports and websites also comprised part of the dataset. These sources of information were used in the same way the information from field observations and accreditation reports was used. An example of this was the review conducted by the researcher of web-based information from the Vocational Education and Training in Australia database about the educational content about incontinence in the Aged Care Certificate courses. The researcher conducted this review in response to the emergent data from interviews about the lack of educational content about incontinence in such courses.
Similarly, the researcher included information from:


- The Productivity Commission report titled *Caring for Older Australians* (Commonwealth of Australia, 2011) in response to interview data about the lack of RN presence in the residential aged care sector. The Productivity Commission is the Australian Government’s independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role is to help governments make better policies, in the long term interest of the Australian community. The Productivity Commission’s independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole. The Productivity Commission was convened to undertake a broad-ranging inquiry to develop detailed options for redesigning Australia’s aged care system to ensure that it can meet the challenges facing it in coming decades. It received over 900 public submissions, convened 13 public hearings and produced multiple and wide-ranging recommendations. It released its final report titled *Caring for Older Australians* in August 2011.
Coding procedures

The coding procedures used in the study involved open coding, theoretical coding and selective coding techniques. These occurred at the same time as data generation and analysis. It is an iterative process requiring both deductive and inductive analytical skills. Figure one on page 84 illustrates the grounded theory method. The analysis process began with open coding procedures. The researcher read short segments of the transcribed interview data to closely examine, interpret and categorise the information. When reading each transcript the researcher asked the following questions: (1) what is this data a study of, (2) what category does this incident indicate, and (3) what is actually happening in the data (Glaser, 1978, p. 54)

One or more coded or labels were assigned to the text to describe what the data indicated. Most cases were developed based on the researcher’s own interpretation of the data. For example, the researcher assigned two codes to the following excerpt.

These were 1) trialling and 2) normalising.

*We try to get them [residents] into the [toileting] regime [regimen] and get them into regular toileting so that we will know one way or another whether that is going to work. Now some of our residents with dementia, that will work sometimes and not others. Usually with our non-dementia residents, if there is such a thing, it tends to be relatively successful. And our aim is to normalise their being here as much as is possible* (Int-07).
Figure 1. A schematic representation of the grounded theory method
In other cases, the researcher assigned codes that represented the staff member’s actual words such as ‘having tack [sensitivity] about you’ or ‘keeping their [residents’] dignity’. Glaser states “open coding allows the analyst to see the direction in which to take his [the] study by theoretical sampling, before becoming selective and focused on a particular problem” (Glaser, 1978, p. 56). Appendix F provides an example of open coding procedures. Specifically, some staff talked about residents having to adjust to and accept their incontinence and dependent status. The researcher coded the transcript with the terms; ‘expecting’, ‘accepting’, ‘adjusting’, and ‘difficulty accepting’.

The researcher simultaneously constructed memos that were her ideas about the coded data. Glaser (1998) defined memos as “the theorising write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analysing data” (p. 177). Appendix G provides an example of a memo the researcher wrote after conducting an interview and openly coding the interview transcript with the aforementioned terms, e.g. ‘expecting’, ‘accepting’, ‘adjusting’, and ‘difficulty accepting’. Through this iterative process, the researcher subsequently theoretically sampled other staff to further investigate the concepts of ‘self-efficacy’ and ‘hope’, which prompted her to ask staff about the extent to which they felt they made a difference to residents’ lives, and what factors kept them in the job.
The open coding stage, and indeed, all stages of the coding procedure also involved performing constant comparative analysis. Constant comparative analysis is one of the most critical aspects of grounded theory. It enables “the generation of theory through systematic and explicit coding and analytic procedures” (Glaser, 2004, p. 15). In practice, constant comparative analysis involved comparing code-to-code, incident-to-incident, category-to-category to establish underlying uniformity and to ensure the data fitted. It is only through the process of constant comparative analysis that researchers can develop higher order concepts (Glaser, 1978, 1998).

Using constant comparative techniques, the researcher noted commonalities among codes. These were grouped together, which resulted in what Glaser termed ‘substantive codes’. Substantive coding delimited the overall number of codes. In other words, the number of codes generated in open coding was reduced during substantive coding. Whilst the initial open coding process yielded 269 codes, the number of codes was reduced to 42 when these codes were grouped. These substantive codes were then coded theoretically. Glaser (1978) states “theoretical codes conceptualise how the substantive codes may relate to each other as hypotheses to be integrated into a theory. They, like substantive codes, are emergent; they weave the fractured story back together again” (p. 72). Substantive coding and theoretical coding are not two isolated or distinct processes. Instead, they occur simultaneously (Hernandez, 2009).
During the fluid and iterative process, the researcher continued to write memos about the emerging data, and theoretically sampled. Hence, the number of codes expanded to accommodate new issues, and decreased as codes were subsumed under other codes/categories. In other words, analytic inferences were substantiated, refined or eliminated when compared [tested] with other coded data.

To facilitate the theoretical coding process, the researcher also schematised the substantive codes pictorially, which helped conceptualise how the substantive and theoretical codes related to each other. At the theoretical coding stage of analyses, the researcher referred to Glaser’s list of theoretical codes and read other grounded theory studies in order to learn about and identify as many theoretical codes as possible to determine whether and how they fit the theory. The researcher found the findings of the current study aligned with the ‘causal-consequence model’. Thus, through the iterative process of constant comparative analysis and selectively and theoretically coding, the researcher ultimately identified a core basic social problem and a basic social problem.

The core category

The core category recurs in the data and is related to many other identified categories (Glaser, 1978; Strauss & Corbin, 1998a). A core category accounts for most of the variation in the data (Glaser, 1978). In other words, it is the central phenomenon or issue around which all the other categories are integrated (Strauss & Corbin, 1990).
Moreover, it has explanatory power (Glaser, 1978; Strauss & Corbin, 1998a). Glaser (2004) stated the core category can be any kind of theoretical code. In other words, it can be a process, a condition, dimensions, a consequence, a range, however, it must: (1) be central; (2) relate to as many other categories and their properties as possible; and (3) able to account for a large proportion of the variation in a pattern of behaviour.

In current study, the core category was the main problem experienced by staff and was identified as caring against the odds. The core category was identified as the basic social problem because it accounted for the greatest variation in the data and related to all the other categories in the data. Caring against the odds accurately described the problem staff experienced and was the basic social problem that fulfilled the criteria set out by Glaser (1978).

**Theoretical sensitivity**

Another feature of grounded theory is theoretical sensitivity, which Glaser and Strauss (Glaser & Strauss, 1967) define as the “researchers ability to have theoretical insight into his [or her] area of research, combined with an ability to make something of his [or her] insights” (Glaser & Strauss, 1967, p. 46). Theoretical sensitivity is something the researcher brings to the study and throughout the research process (Glaser, 1978).
Consistent with Glaser’s (2007) now infamous words, ‘all is data’, the researcher considered anything that came her way was a possible source of information that could be used to develop the theory. Consequently, interview and observational data were analysed, as well as surveys or statistical data the researcher accessed were considered to be information that could enhance the emerging theory. Thus, a visit to a now disbanded ‘mental asylum’ prompted the researcher theorise about tactics used to socially control patients. Similarly, when a close family member felt ‘dirty’ following an interaction with her doctor who repeatedly washed his hands after touching her, the researcher used the family member’s experiences as a source of theoretical sensitivity to compare with the emerging data, and subsequently developed a category titled self-protective distancing strategies.

The researcher’s personal and professional experience plays a large role in the development of data categories (Glaser, 1992). No analysis is without some form of bias, including analyses of quantitative data (Charmaz, 2005). Charmaz (2005) argued researchers inevitably approach their research topic with certain assumptions that are based on their own professional and personal knowledge. Similarly, Morse (1994) refuted the possibility of entering the field completely free from bias and pointed out the absence of prior knowledge or assumptions (a state of ignorance), does not offer any greater guarantee of insider understanding of the issue. At the same time, failure to consider the potential for the researcher’s personal and professional biases to affect the interpretation could in fact, yield a theory that is little
more than an affirmation of the researchers’ own bias’ (Grbich, 1999) rather than an original and grounded interpretation (Wilson & Hutchinson, 1996). By incorporating reflexivity into theoretical sensitivity, the problem of participants’ taken-for-granted assumptions influencing the data is minimised (Charmaz, 1995, 2000; Hall & Callery, 2001)

Guba and Lincoln (1981) defined reflexivity as the process of reflecting critically on the self as researcher and the human as ‘instrument’. The researcher is an RN with clinical and academic expertise in managing incontinence in frail older adults, thus, the data interpretation was inevitably filtered through her professional lens. The researcher attempted to uncover her personal and professional biases that could influence the data. This process required that the researcher to reflect how her age, gender, experience as a researcher and nurse, personal and professional beliefs, values, preconceptions, and behaviour could influence all aspects of the study. In the current study, the researcher’s preconceived beliefs and values were a concern. The process of engaging in reflexivity revealed a number of biases. For example, the researcher commenced the research with a previously unrecognised desire to discover tacit expertise embedded in how staff determined, delivered and communicated residents’ continence care. However, the data did not support the researcher’s bias or perspective.
Glaser (1992, 1998) argues if the grounded theory procedures are followed, it is difficult to impose one’s beliefs on data analysis because the categories develop and emerge from the data. The data analysis procedure ensures that if the hypothesis or concept is not confirmed by the data, it should be dismissed. The researcher found the data did not support her early assumptions. By adhering to the grounded theory methods, what emerged from the data were findings about broader contextual conditions that influenced the overall context of care, and not just continence care. The emergent approach emphasised by Glaser (1978, 1992) ultimately led to a theory that transcended the initial focus.

**Rigour and credibility**

The grounded theory method of research uses methodological procedures that promote rigour and credibility (Silverman, 2001) and the reliability and credibility of a grounded theory study is determined on the basis of ‘fit’, ‘parsimony’, ‘scope’, ‘relevance’, and ‘work modifiability’ (Glaser, 1978, 1992, 1998). In order to ensure reliability and credibility, the researcher followed the grounded theory methods outlined in this chapter, including (1) theoretical sampling, (2) constant comparative data analysis, (3) theoretical sensitivity, (4) memo writing, (5) identification of a core category, and (6) theoretical saturation.

The findings must ‘fit’ the empirical world they purport to analyse. Morse (2001) described ‘fit’ as “the process of identifying characteristics of one entity and
comparing them with the characteristics of another entity to see if similar characteristics are present” (p. 841). The constant comparative analysis process employed in the current study ensured the conceptual fittedness of the theory.

The theory should also be parsimonious. In other words it should have “just enough concepts…to show how a process processes a problem” (Glaser, 1992, p. 119).

Hence, it should not rely on, or be characterised by extensive description, but rather, have immediate ‘grab’. It should also have scope and be relevant, which refers to the explanatory ability of the theory to address problems and processes and provide a workable understanding of, and explanation for the world under study (Glaser, 1992). If a theory has scope and relevance, it should also be easy to use outside of the substantive area from where it was generated descriptive data. Specifically, the theory should be immediately recognisable to people familiar with the instance and will be modifiable to similar situations. In other words, it should have applicability beyond the area of continence care and beyond the immediate sample.

The question of the applicability of qualitative research findings beyond the substantive or indeed, the immediate sample is a contentious issue that tends to polarise researchers who have different beliefs about the nature of truth and how it can best be determined. Within a positivist tradition, “a claim is considered objective and true to the extent that it is free from any biasing influence of context and background beliefs and accurately mirrors the way the world really is” (Schwandt,
However, as Schwandt (2007) asserted, no interpretation is free of context and the very act of generating evidence, or identifying something as evidence is, itself, an interpretation. Hence, interpretivism requires

“an abandonment of the assumption that enduring, context-free truth statements – generalisations – can and should be sought. Rather it asserts that all human behaviour is time- and context bound, this boundedness suggests that inquiry is incapable of producing nomothetic knowledge, but instead only idiographic ‘working hypotheses’ that relate to a given and specific context” (Lincoln & Guba, 2007, p. 17)

Therefore, interpretivists reject generalisation as a goal and the aim is not to obtain exactitude in interpretation or make either axiomatic or statistical generalisations (Lincoln & Guba, 2007). Similarly, Glaser (2006) claimed researchers’ preoccupation with representing the data as a set of verifiable facts blocks researcher’s abilities to conceptualise and reflects a concern with objectivity that derives from hypothetico-deductive and positivist assumptions. Therefore, the intent in the current study was not to reproduce a set of verifiable accurate descriptions of participants’ experiences, but rather, to produce an abstract representation that explained the underlying situation and addressed the research objectives. Given this aim, the key question that should be asked is not how accurately the finding describes the individual’s situation, but how accurately the theory explains the situation (Stern, 1985). Morse (2001) phrased this another way when she said it is the transferrable or applicability of the
theory that is the focus, not the similarity of setting or sample. Hence, instead of making empirical generalisations, the researcher makes theoretical inferences about the relationships that exist between the various categories, their properties and dimensions.

Another criterion for evaluating the reliability and credibility of the findings in grounded theory is the extent to which the data are saturated (theoretical saturation), which is defined as data adequacy and operationalised as collecting data until no new information is obtained (Flick, 2002; Morse & Field, 1995; Silverman, 2000). However, there is considerable debate about the concept of theoretical saturation and how one knows the point at which one has sufficient data to demonstrate saturation. This debate is partly related to the fact that the grounded theory method produces an ongoing conceptual theory and allows for variation and change that make the core theory useful over time and more precise and enduring (Glaser, 1978, 1992, 1998).

Notwithstanding the fact that a grounded theory is always amenable to change and modifications in response to new data (Glaser, 1992), the researcher remained engaged in the ongoing and iterative process of data collection and analysis until no new conceptual information was available within the data to indicate that new codes or categories were needed or that existing ones needed expanding. The researcher continued to theoretically sample, write memos and compare incident-to-incident,
code-to-code, category-to-category and to sort the data until the data moved to a conceptual level whereby the categories and their properties ‘fitted’.

Another criterion used to judge the rigour of a qualitative study involves using different data sources and methods to obtain in-depth understanding of the phenomenon in question (Denzin & Lincoln, 2008). As stated by Flick (2002), “the combination of multiple methodological practices, empirical materials, perspectives, and observers in a single study is best understood, then, as a strategy that adds rigour, breadth, complexity, richness, and depth to any inquiry” (p. 229). Some researchers use the term ‘triangulation’ (Flick, 2002) or ‘crystallisation’ (Richardson, 2000) to describe the multi-modal strategy. Denzin and Lincoln (2008) claimed since “objective reality can never be captured” … “and we can only know a thing through its representation”…. triangulation/crystallisation is “not a tool or a strategy of validation, but an alternative to validation” (p. 7). The researcher applied these principles to the current study by conducting field observations, in-depth interviews and by analysing reports to obtain different points of views or perspectives about the issue of providing continence care in residential aged care facilities. Each point of view or perspective added to the overall picture to create a display of multiple, refracted realities, or an abstract representation.

Further methods to enhance the rigour of the current study involved sharing findings with informants whose feedback added to, or shaped the emerging theory and
concepts. This strategy is either referred to as ‘member checking’ or ‘credibility testing’. As previously indicated, a grounded theory study should be recognisable to participants. It should make sense and speak for itself (Corbin & Strauss, 2008; Stern, 2007; Strauss & Corbin, 1998a, 1998b). The informants included individuals with wide experience of working in the residential aged care sector. The researcher also shared findings with her supervisors, and friends and family members, and invited their critical feedback. Preliminary findings were also presented at Deakin University’s research schools and research colloquium, as well as at a national conference. Other strategies included memoing, journaling and keeping an audit of decisions, and audiotaping thoughts.

Another strategy to enhance the rigor of the study was to remain embedded in the data, and avoid using literature as a source of data until the latter stages of the interpretive process. Glaser (1998) recommends “the first step in grounded theory is to enter the substantive field for research without knowing the problem” (p. 123). Thus, the review of literature was only completed at the end of the study. Once the categories and subcategories emerged the researcher read nursing texts about nursing theories and sociological literature to search for concepts and theories that explicated these data further and to ensure a fit between the emergent data and existing theory.
As previously discussed, engaging in the reflexive process at all stages of the research process, from design, data collection and analysis through to completion the research was another strategy the researcher employed to enhance the rigour of the study.

**Ethical considerations**

The research was designed in accordance with ethical considerations outlined in the National Statement on Ethical Conduct in Human Research (The Australian Government, 2007) and the Deakin University Human Research and Ethics Committee. See Appendix H for a copy of the ethics approval letter.

**Confidentiality and data storage**

All information concerning individuals and sites was deidentified before being analysed. Information was stored as paper copies, tape recordings and electronic computer files. Raw data from interviews was collected using a tape-recorder. The information was transcribed, coded and stored in an electronic format in a password protected computer that was accessible only to the researcher. The raw data including tape recordings was stored in a locked cabinet at Deakin University during the research project and was accessible only to the researcher. Reidentifiable data such as participants’ names, contact details and consent forms were stored separately from the raw data in a locked cabinet at Deakin University. A set of codes replaced individually identifiable data. The list of codes was also kept in a secure locked
cabinet, separate from the individually identifiable data. The list was also stored as an
electronic copy in a password protected computer that was accessible only to the
researchers.

**Ethical considerations during formal semi-structure, open-ended interviews**

Individuals who consented to participate in the one-to-one tape-recorded interview
indicated their interest in participating in the study by contacting the researcher by
phone or email. The researcher sent then a Participant Information and Consent
Forms which described the procedures involved in participating in an interview (see
Appendix I). Participants were invited to select a time and venue of their choice. In
most cases, this venue was a coffee shop or a private room in a residential aged care
facility. They were assured that their names and/or any identifying information would
not be used, and in the thesis this anonymity was demonstrated by using pseudonyms
and coding instead of their names.

The researcher did not anticipate any immediate threats or danger to the participants’
personal safety, however in the event that participants could feel distressed or
concerned about any aspect of the study they were advised the interview could be
stopped or suspended, and they were free to withdraw from the study without
consequences. In addition they were informed they could contact the researcher or the
research office at Deakin University and could seek the opportunity to debrief or
further psychological support. One staff member became tearful and emotional
during an interview because the discussion elicited memories of her mother’s experience of being in a residential aged care facility. No staff member sought the opportunity to debrief or seek psychological support during the course of the study.

**Ethical considerations during field observations**

Facilities where field observations were conducted were purposively sampled as previously indicated to ensure that had a skill mix that included RNs, ENs and PCAs and a resident population of residents with and without dementia. Following an expression of interest by the manager of each facility, the researcher sent an introductory letter (see Appendix J), a Participant Information Sheet and Consent Form (Appendix K) and a flier about the research. Prior to visiting the sites to conduct field observations, the researcher contacted the manager or visited them personally to: (1) ensure organisational consent, (2) check the suitability of conducting observations, (3) develop a schedule for dates and times to conduct observations, (4) develop a communication strategy for staff, residents and their family members, and (5) seek advice about the most appropriate places from which to conduct field observations. Information sessions were convened for staff. Most of these sessions occurred at the beginning or end of staff handovers. During the observation period, the researcher responded to enquiries and engaged in short informal discussions with staff about what care they provided and why.
Field observations were mainly conducted from staff rooms and public areas of the two facilities, such as from the lounge rooms, dining rooms, and corridors. The researcher regularly checked with staff whether they were at ease about her presence in the facility and whether staff felt residents were at ease during field observations. The researcher positioned herself in areas of the facility to be out of the way of staff and residents such as at the back of lounge rooms. At night, the researcher shadowed staff as they performed continence care rounds, but stayed outside residents’ rooms.

Throughout the period of field observations, the researcher provided information about the study to residents, staff and visitors who enquired, and ensured ongoing verbal assent. If any individual (staff or resident) appeared uncomfortable about the presence of the researcher, data collection was discontinued, and advice was sought from the manager (or their nominee) about the appropriateness of resuming field observations. On one occasion the researcher moved to another area of a facility when a resident appeared distressed. On this and other occasions such as when residents appeared to need help, the researcher also sought assistance for residents from staff members and checked with staff to ensure her ongoing presence was appropriate. Whilst such intervention could have affected the researcher’s neutrality and influenced staff members’ responses, the research was predicated on the need to put residents’ needs over those of the researcher. The researcher sought to be reflexive about her presence in the facilities, which involved being aware of what was
happening in the environment and how other people were interpreting the researcher’s presence.

**Summary**

The current research aimed to generate reliable, rigorous, valid and valuable findings about how continence care in Australian residential aged care facilities was determined, delivered and communicated. In this chapter, the researcher described the grounded theory research methods used to achieve the study objectives. As such the researcher presented the historical and contemporary development of grounded theory and provided a rationale for choosing grounded theory as the research method.

The chapter also detailed how the researcher used the grounded theory method, and how the data were collected and coded. Issues related to theoretical sensitivity and methods to enhance the rigour and creditability of the findings were described. The chapter concluded with information about how the research was conducted in a manner to ensure it complied with the National Statement on Ethical Conduct in Human Research (The Australian Government, 2007) and the Deakin University Human Research and Ethics Committee.
Chapter three

The Basic Social Problem: Caring against the odds

Introduction

In the current study, the researcher sought to answer the overall question of how residents’ continence care needs were determined, delivered and communicated in Australian residential aged care facilities. Through a process of theoretical sampling, constant comparative data analysis, theoretical sensitivity, and memo writing, and with data derived from in-depth interviews, field observations and accreditation reports, the findings revealed RNs, ENs and PCAs involved in residents’ day-to-day care in residential aged care facilities experience a basic social problem that affects not only how they provide continence care, but how they deliver all aspects of resident care. The problem, which emerged as the core category, was labelled ‘caring against the odds’. Therefore, whilst the researcher started out exploring continence care in residential aged care, the study broadened to include overall care.

The basic social problem, caring against the odds, emerged from the understandings and meanings RNs and other key staff (hereafter collectively termed staff) gave to their day-to-day experiences of being constrained in their roles. The researcher chose the metaphor ‘caring against the odds’ to describe the basic social problem because it conveys a sense of the constraints staff encountered while attempting to provide holistic, individualised, and resident-centred care. Although staff aspired to provide
such care, the odds were not in their favour. Four sub-categories emerged from the data analysis as having most impact on staffs’ ability to perform their roles and deliver care. The four sub-categories were:

1. Working in a highly regulated work environment.
2. Encountering ethically challenging situations.
3. Highly dependent residents.
4. A devalued role.

The basic social problem with its sub-categories, properties and sub-properties is illustrated in Figure 2 on the following page. Starting with a highly regulated work environment, the remainder of this chapter presents the findings about the four main sub-categories that comprised the basic social problem of ‘caring against the odds’.
Figure 2. A schematic representation of the basic social problem ‘caring against the odds’

- Difficulty completing the Aged Care Funding Instrument
- Difficulty complying with the Aged Care Accreditation Standards
- Fear of being found non-compliant with regulations
- Inadequate information about residents’ care needs
- An unpredictable work environment
- Highly dependent residents
- Stigmatised work
- Heavy workloads
- Lack of appreciation of role complexity
- Low wages

- Ambiguous Accreditation Standards
- Variability in Aged Care Assessors’ expectations
- Adverse events and complaints
- Aged Care Assessors’ visits
- Expectations to prioritise residents’ cleanliness
- A competing duty of care
- Low staffing levels
- A low of Registered Nurses employed in the residential aged care sector
- Staff with minimal educational preparation and English proficiency

- Working in a highly regulated work environment
- Encountering ethically challenging situations
- Caring against the odds
- A devalued role

- Multiple competing and conflicting expectations about residents’ care needs
- Workforce constraints
Working in a highly regulated work environment

Regulation had a major impact on the way staff determined, delivered and communicated residents’ overall care as well as their continence care. Staff experienced a high degree of regulatory control in their day-to-day work. Staff felt they were caring against the odds in terms of trying to comply with regulatory requirements and fulfil their duty of care to actually deliver care. The conditions that characterised working in a highly regulated work environment included:

- Difficulty completing the Aged Care Funding Instrument.
- Difficulty complying with the Aged Care Accreditation Standards.
- Fear of being found non-compliant with regulation (see Figure 3 below).

Figure 3. Conditions that characterised the category ‘working a highly regulated work environment’
Staff felt they had no choice but to comply with the regulation. One manager stated:

*You must do it* [comply with the regulatory framework]. *There is no option with that. You have to do it. There are no grey areas there* [about the need to comply]. *You have to comply with it* (Int-15).

**Difficulty completing the Aged Care Funding Instrument**

As described in chapter one, the Government allocates subsidies to residential aged care facilities to help them meet the financial cost of providing resident care. The amount of government funding facilities receive is based on information staff provide on the ACFI about each resident’s care needs. The need to comply with regulatory requirements associated with completing the ACFI had a major effect on the way staff determined, delivered and communicated resident’s overall care. The current study revealed the following issues:

- Staff spent considerable time collecting and documenting information to complete the ACFI.

- The funding incentive associated with residents with high care needs resulted in organisational rules and peer norms that caused staff to conduct onerous, extensive, and potentially unethical resident checks, and in some cases provide minimal resident support during the assessment period.

- Staff were not always able to collect and document the information needed to complete the ACFI.
- Staff prioritised collecting information to complete the ACFI over collecting information to guide clinical care.

- Staff commonly believed the information they collected to complete questions four and five of the ACFI was sufficient to guide continence care.

These issues resulted in staff spending considerable time complying with documentation requirements. A manager stated described the time associated with completing the ACFI as follows:

[Completing the ACFI] takes hours...hours because they [the forms] have to be put out to the staff. They are collated after that period. Then they [staff] go through the checklist and complete all of that and then we submit it. And you’ve got to have evidence for everything...absolute evidence for everything...progress notes. They [the Assessors] go through progress notes...even with things like behaviour and you have to document everything (Int-15).

In order to obtain information to claim the highest possible level of funding, staff attempted to observe residents as closely as possible over a number of days. For example, in order to claim for the cost of caring for residents with incontinence and residents who needed toileting assistance, staff had to collect extensive information about when residents’ voided, whether they were incontinent or not and how much staff support they needed to use the toilet.
A staff member described the data collection procedures as follows:

We have them on what we call a three day flowchart, which is bladder and bowel and that is a 24-hour scale and we work it [their incontinence frequency] out each time. We have symbols also if you put done say seven o’clock that person may be dry, eight o’clock you check them again - it might be what you call a U1 - which is only small, [a small amount of urinary incontinence], U2 is medium and U3 is large - plus we have another symbol which is ‘SIT – ‘self-initiated toileting’. So we have all different ones [flowchart] - the continence one, the urine one and one for the bowel. They are on separate sheets and it [the ACFI assessment] goes on for a month. This is what we call ACFI - all the paperwork (Int-02).

More frequent observations optimised the chances that managers or service providers could claim the highest level of funding. Staff attempted to identify as many episodes as possible about residents’ urinary and faecal incontinence as well as information indicating their highest care need related to using the toilet. One manager expressed concern about the funding model was a disincentive for staff to actively manage residents’ incontinence by assisting them use the toilet, in order to claim the highest level of funding for incontinence. He stated:

I would hope that ethically our people wouldn’t do it [make residents’ continence appear worse that it is] but there is a tendency for the...how can I say this nicely...probably a tendency for people to not manage the continence properly (Int-07).
The manager also expressed concern that the funding model acted as a disincentive for staff to seek treatment for residents’ conditions because the time and resource costs involved were not considered in the funding model. As a consequence, staff intervention depended on individual staff members’ or their sense of moral obligation.

_It’s [the funding model and the ACFI] a real burden and it really gets up my nostrils I have to say because you’ve got someone whose depressed and if you’ve had them assessed and you’ve got them on medication and they no longer display any symptoms of depression you get nothing. So it doesn’t recognise all the work up that you do and you get nothing for that so you think ‘why do you bother?’ I mean you bother because you care and have a moral obligation_ (Int-07).

In some cases, staff believed their managers or the government expected them to check residents’ continence status every one to two hours in order to obtain information to complete the ACFI. Continence checks even occurred at night and in some cases, even when residents reacted negatively to being woken. As one staff member stated:

_The new resident is sleeping and we will avoid waking her. She will be on an ACFI soon and then we will have to check her every hour. Some of them [residents] don’t like it [being woken to have their continence status checked] and some get aggressive_’ (Field notes site 2: Night shift 15-16/11).
In order to complete question five of the ACFI, some staff indicated they explained to residents that they had to check their continence status every hour. For example, one staff member stated:

*We’ve got a seven day urine continence trial and a three day bowel trial and in that time we ascertain if the resident has any continence issues. The residents are checked every hour. We always explain to the residents that this is what we have to do to check for incontinence levels* (Int-08).

However, some staff objected to the practice of checking residents’ continence status every one or two hours. For example, a night staff member cited residents’ right to privacy and sleep as her reason for disagreeing with such regular continence checks, and hence, for not doing them. The following comment from a staff member suggests some staff felt frequently checking residents’ continence status was ‘degrading’ to residents, and therefore they did not do it.

*It’s an hourly chart...and it’s pretty degrading to go to someone and say ‘I have to check’. So that [frequent continence checks] goes out the window really* (Int-16).

Staff found it particularly difficult to obtain information to complete question five of the ACFI when the information had to be sought from residents who were cognitively impaired. Collecting information about cognitively impaired residents’ frequency of urinary or faecal incontinence was largely a hit and miss affair because such residents did not always recall using the toilet. Hence, when staff completed the DoHA 7-day
Bowel Continence Record, the information they documented was not necessarily representative of residents’ actual bowel elimination pattern. A staff member stated:

*We do the bowel charting every day for the dementia ones and it works pretty well* [identifying when residents use their bowels] *because we are the ones pretty much who are doing the toileting so we can keep it under control. But like we do it [bowel charting] for the low care and it’s a bit of a joke really because let’s face it… it [bowel charting] is mostly done for the funding. Because you can go round and ask the residents and most of them can’t remember if they’ve been that morning or not. You go in and ask them and they say ‘oh yes’* (Int-16).

Therefore, staff could not always rely on the information residents’ gave them about their bladder and bowel function and hence, forms may or may not have been accurate.

Another problem for staff in terms of complying with the requirements associated with completing the ACFI was that it was not always possible for them to perform regular continence checks because of other competing care priorities such as the need to attend to residents who were acutely unwell or to family members’ needs. A staff member who worked as an RN stated staff did not actually check residents’ continence status every hour although they were required to do so. Instead, they checked when they could and completed forms retrospectively.
The staff member described the difficulty of obtaining accurate information about residents’ bladder elimination habit from residents themselves as follows.

They [staff] have to do it [fill in the continence form indicating they have checked the resident’s continence status]. They have to fill in the form to account for every hour but they don’t really do this. What they do is they fill it in for the preceding hours when they check the residents’ pads so if the pad is wet when they check it, they fill in the form to indicate that the resident was dry between the last pad check and that pad check. But of course, the resident might have been wet for hours (Int-17).

Field observational data confirmed staff sometimes completed forms about residents’ continence status retrospectively. The following field observation data describes the contextual conditions that led to staff completing such forms retrospectively.

Night duty staff have forms to complete every 15-30 minutes about residents with; altered health, dementia, challenging behaviours; and those at risk of ‘absconding’ and every 60 minutes about newly admitted residents’ continence status. Staff also file histories, insert new blank forms into files, review and update care plans, ACFI documentation, drug charts, food and fluid charts, palliative care plans, behaviour charts, pain charts, catheter output charts, and weekly restraint checklists. They develop lists of residents requiring aperients, medical or pharmacy reviews, and health or care reviews. They dress wounds, administer medication, and
conduct continence care rounds 2-3 times a night to reposition and/or clean residents, and change their pads. A newly admitted resident has fallen and hit her head. One of the two staff members checks her vital signs regularly. The other staff member contacts the family, organises medical care and arranges transport to a hospital. During this time, staff are not available to perform the other checks or care. At the end of the shift, a staff member ticked the form indicating that resident checks were conducted (Field notes site 2: 15-16/11 Night shift).

The field observations revealed that, during the night when staff were busy responding to the needs of a resident whose health had deteriorated following a fall, they were not able to perform regular resident checks. Nevertheless, staff had to find a way to comply with regulatory requirements to provide documentation to support ACFI claims. Staff completed the form, albeit retrospectively, which resulted in a discrepancy between documented practice and actual practice.

Not only did staff feel obligated to conduct frequent checks of residents’ continence status, some also believed they had to provide residents with minimal support during the assessment phase in order to identify the full extent of residents’ dependence and incontinence. Therefore, some facilities had policies requiring staff to withhold giving residents’ pads during the ACFI assessment phase. In other cases, staff were allowed to give residents pads as long as the pads were the smallest size pad possible. The practice of withholding pads or limiting them to the smallest size enabled staff to
more easily identify when residents’ were incontinent because their incontinence was no longer contained and concealed. Some staff were uncomfortable about withholding pads and did not always comply. One staff member stated:

*They [residents] are not supposed to have any pads [when staff do the assessment]. They are supposed to be left on a drawsheet [linen material]. Now that’s a bit hard. You can’t really do that!* (Int-03).

However, other staff did not question the practice of withholding pads when residents’ continence status was being assessed. One staff member described a practice of avoiding using pads so that staff could determine how much residents’ voided. She said:

*At night we don’t put them [residents] on a pad so that we can establish how much...during the assessment period...how much they urinate during the night* (Int-04).

Therefore, not only did the requirement to complete questions four and five of the ACFI cause staff to perform onerous and extensive resident checks, in some cases organisational policies or cultural norms caused staff to limit the support they gave to residents so that staff could identify residents’ maximum levels of dependence and incontinence.

Because completing the ACFI was linked to funding, staff felt strongly obliged to prioritise collecting information to complete the ACFI and to prioritise the ACFI
assessment over clinical assessments. Another inadvertent effect of the ACFI was that it undermined clinical assessments that ostensibly guided clinical care because staff commonly equated completing the ACFI with conducting a clinical assessment. For example, most staff equated completing questions four and five of the ACFI with conducting a continence assessment. A consequence of the lack of distinction between conducting an assessment to complete ACFI questions about residents’ continence and conducting an assessment to guide continence care, was that continence assessments were reduced to ticking forms to comply with government requirements.

Even though staff complied with the requirements associated with applying for funding, they also felt, resentfully that funding was insufficient to enable them to meet residents’ care needs. A manager blamed the funding model for what he perceived as staff inability to meet residents’ psychosocial care needs, or cover the cost of supporting residents’ family members. He stated:

*I hate it [the funding model]. I don’t believe it captures all of the residents’ care needs appropriately or accurately. It is the greatest fraudulent act the government has ever done. You can’t capture any of the time that you actually spend with the relatives, with residents...all of the social activities, the lifestyle and leisure. You get nothing for that! I wasn’t in love with the RCS [Resident Classification System] at all, but at least you had an avenue to claim for interaction with the families and some families can take half an hour of your time, just like that. It leaves a sour taste in my mouth (Int-07).*
Having to provide care in a highly regulated work environment caused staff to shift the focus from resident care to filling in forms and developing a documentation trail because of the need to give priority to attaining and retaining funding, meeting accreditation standards, and avoiding complaints, adverse events, and sanctions.

**Difficulty complying with the Aged Care Accreditation Standards**

The difficulties associated with completing the ACFI were compounded by the fact that staff had to demonstrate they adhered to the Aged Care Accreditation Standards. Staff were very mindful of the need to meet or *be seen to meet* the standards. The need to comply with the standards had a major effect on the overall delivery of care and caused staff to deliver care in a way they thought would comply with regulations. The following section describes the properties of the subcategory titled ‘difficulty complying with accreditation standards:’

- Ambiguous Accreditation Standards.
- Variability in Assessors’ expectations about meeting the standards.

**Ambiguous Accreditation Standards**

The ambiguity of the Accreditation Standards was one of many factors that caused staff to experience difficulties meeting the standards themselves. For example, as indicated in the review of literature, Accreditation Standard 2.12 requires staff to ensure that ‘residents’ continence should be managed effectively’ (Commonwealth of Australia, 2008) but the Quality of Care Principles (Commonwealth of Australia,
2008), and the Residential Aged Care Manual (Australian Government Department of Health and Ageing, 2009b) do not provide advice about the processes of care that ensure residents’ continence care is effective.

Staff in the current study shared a specific set of beliefs about what effective continence care was. Staff believed they could adhere to Accreditation Standard 2.12 if:

1. Each resident had a continence assessment and care plan detailing their individual continence care needs, including toileting times.
2. Each resident’s continence care needs were reviewed.
3. Residents received toileting assistance at times that matched their individual voiding and defecation times.
4. The facility had a stock of continence aids of different types and sizes
5. The facility had documented processes in place to demonstrate how they selected purchased, distributed, checked and change residents’ continence aids (mainly pads).
6. Staff engaged in care that kept residents’ urine contained and ensure the facility was clean.
7. Residents and/or their representatives were satisfied with continence care.

The researcher asked a manager to indicate what Assessors appraised when they conducted site visits and checked a facility’s adherence to Accreditation Standard 2.12.
The manager stated:

*Number one, the charting is in place. That you do have sufficient supplies [of pads]. You are not just running the place on the skeleton supply and that you are using the appropriate aid [pad]… they look at all of that… that you are using the appropriate aid [pad] and that residents are actually being toileted (Int-08).*

Similarly, another manager believed ‘effective continence care’ involved doing an assessment, using the right pad, ensuring there was a supply of different pad types, having documentation in order, and having no complaints about pads. He stated:

*Effectively [effective continence care] is when there is an assessment done, there are continence aids [pads] provided and no-one complains (Int-07).*

The researcher compared staff beliefs about factors that would constitute adherence to Accreditation Standard 2.12 to the findings of a content analysis of accreditation reports also conducted by the researcher. The findings of the content analysis revealed a total of 18 factors Assessors’ documented about each facility’s performance against Accreditation Standard 2.12. These factors are listed in Table 4 on page 119 and are presented as the most frequently documented factor to the least frequently documented factor.
Table 4. The frequency and percentage of descriptors documented by Assessors in accreditation reports

<table>
<thead>
<tr>
<th>Factors Assessed documented</th>
<th>Number of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Residents are assessed to identify their continence care needs</td>
<td>79 (91)</td>
</tr>
<tr>
<td>2. Residents and representatives are satisfied with continence care</td>
<td>73 (84)</td>
</tr>
<tr>
<td>3. The facility has a system or process in place to meet residents’ continence care needs</td>
<td>57 (66)</td>
</tr>
<tr>
<td>4. The facility has a stock/supply of continence aids</td>
<td>56 (64)</td>
</tr>
<tr>
<td>5. Staff have access to training / education on incontinence</td>
<td>38 (44)</td>
</tr>
<tr>
<td>6. Staff use external sources of support and information</td>
<td>34 (39)</td>
</tr>
<tr>
<td>7. Residents have individualised bowel management programs</td>
<td>33 (38)</td>
</tr>
<tr>
<td>8. Residents have individualised toileting assistance programs</td>
<td>26 (30)</td>
</tr>
<tr>
<td>9. Continence care is communicated</td>
<td>18 (21)</td>
</tr>
<tr>
<td>10. Equipment to promote continence is available</td>
<td>18 (21)</td>
</tr>
<tr>
<td>11. Staff know residents’ individual needs</td>
<td>16 (18)</td>
</tr>
<tr>
<td>12. Staff provide assistance with continence aids</td>
<td>7 (8)</td>
</tr>
<tr>
<td>13. The facility is odour free</td>
<td>7 (8)</td>
</tr>
<tr>
<td>14. Staff supervise continence care</td>
<td>6 (7)</td>
</tr>
<tr>
<td>15. Toilets are accessible</td>
<td>6 (7)</td>
</tr>
<tr>
<td>16. Information is provided to residents and representatives</td>
<td>2 (2)</td>
</tr>
<tr>
<td>17. Pelvic floor muscle exercises and physiotherapy are available</td>
<td>2 (2)</td>
</tr>
<tr>
<td>18. Staff promote residents’ independence</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>
The four most frequently documented factors were:

1. Residents were assessed to determine their continence care needs.
2. Residents and representatives were satisfied with continence care.
3. System/process were in place to meet residents’ continence care needs.
4. The facility had a stock/supply of continence aids.

Thus, staff and Assessors beliefs about how to demonstrate adherence to Accreditation Standard 2.12 appear to be consistent. However, a closer analysis of staffs’ comments revealed potential for variable understandings about what was involved in ensuring ‘effective continence care’. As indicated, staff also believed they could demonstrate adherence to Accreditation Standard 2.12 if they conducted an assessment to identify what they referred to as ‘residents’ individual continence care needs’. Specifically, 79 (91%) of the 87 accreditation reports reviewed by the researcher indicated each resident was assessed ‘to identify their individual continence care needs’ and 57 (66%) reports indicated the facility had ‘a system or process in place to meet residents’ individual continence care needs. However, most staff believed the clinical reason they did a continence assessment was to identify residents’ pad needs, as illustrated in the following comment.

There is an assessment that will tell you if they [residents] have urinated. It’s a 3-day one for the urine and 7 days for the bowels. And that is how we make the decision about what size pad they need. If they need a yellow one [pad] in the day or a green one (Int-03).
Another staff member described continence assessments as a process they performed once a month to determine if each resident’s pad allocation was appropriate.

*We have continence care assessments on them [residents]. So once a month the care plan is reviewed and we see if they [residents] need a change in their continence aid. [It] depends if they [residents] are becoming less dependent. [We] see how they go. But most of them [residents] are size seven. It’s [the pad] about this big [shows me the size] and last about 4-5 hours* (Int-06).

Therefore, in practice when staff conducted a continence assessment, most focussed on residents’ pad requirements. Similarly, as indicated in the following manager’s comment, many staff believed they could demonstrate adherence to Accreditation Standard 2.12 by reviewing residents’ pad requirements.

*We go along and each week it [the pad] gets reviewed. Then if the pad is not working …it gets documented on their care plan. If its identified that that pad is not doing what it is doing [not containing the resident’s incontinence], they [staff] notify…We have a communication book that goes with the pads and they notate that in there and our quality manager looks at it and then we assign a different pad to trial. And again the same process goes on* (Int-07).
Paradoxically, although most staff understood the term ‘individual continence care needs’ to mean individually selected pads, residents received a set allocation of pads each day (mostly three pads) and the only variation or individuality was in the pad size, which varied depending on whether it was required to day or night. Staff described policies and practices of rationing pads and controlling their distribution so that residents received a pad in the morning, afternoon, and evening, or three pads a day, as suggested by the following comment.

*Residents are allocated three [pads]. One for the morning, one for the afternoon and one for the night and they’re different sizes* (Int-10).

Accreditation reports lacked information about what staff actually assessed when they conducted a continence assessment. Therefore, it is not known whether residents received a comprehensive continence assessment to identify and address reversible causes of incontinence and to institute active management programs, or to determine residents’ pad requirements.

*Table 5* on the following page lists the range of factors Assessors documented about what staff assessed when they conducted a continence assessment. It shows the most frequently documented assessment factor was whether staff monitored resident bladder and bowel function, which was documented in one third of reports. The least frequently documented assessment factors were whether staff used: a validated assessment tool, identified reversible causes of
incontinence, or assessed hydration status; each of which was documented in one report only. The findings suggest there was considerable potential for subjectivity and variability in what staff actually assessed when they conducted a continence assessment and what staff and Assessors understood by the term residents’ individual continence care needs.

Table 5. The frequency and percentage of assessment factors documented by Assessors in Accreditation reports

<table>
<thead>
<tr>
<th>Assessment factors Assessed documented</th>
<th>Number of statements (% of 87)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff monitor residents’ bladder and bowel function</td>
<td>38 (44)</td>
</tr>
<tr>
<td>Staff consult with residents and identify their preferences</td>
<td>22 (25)</td>
</tr>
<tr>
<td>Staff monitor residents for UTI</td>
<td>19 (22)</td>
</tr>
<tr>
<td>Staff identify residents' toileting needs</td>
<td>13 (15)</td>
</tr>
<tr>
<td>Medical staff are consulted</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Staff assess/monitor residents’ skin health</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Staff assess residents’ prior history</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Staff assess residents’ continence aid needs</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Staff use a validated assessment tool</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Staff identify reversible causes of incontinence</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Staff assess residents’ hydration status</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>
Another way staff felt they could demonstrate adherence to Accreditation Standard 2.12 was if all residents had care plans indicating the times staff needed to assist them to use the toilet. Twenty-six (30%) reports documented that residents had individualised toileting assistance programs. Staff used the term ‘individualised toileting assistance program’ to refer to a program they stated was developed based on the assessment information about residents’ individual voiding and defeacation patterns. Most staff believed each resident had an individual predictable voiding and defeacation pattern that staff could identify if they monitored residents closely enough over an extended period of time. A manager described the procedure of collecting information to develop an individualised toileting assistance program as follows:

*When they [residents] are admitted, after the first week they have their assessment for urine and bowels. Then they [staff] look at that and the RNs put in the times they are toileted and what time their pads are checked. Every resident has that there. And the staff are aware because it is in the care plan, so they would know what time to toilet them* (Int-15).

The consequence of the belief that each resident had their own unique individual and predictable voiding patterns was that staff invested considerable time and effort trying to identify when residents were wet or soiled. However, in practice, the information had limited clinical use because information about residents’ bladder and bowel elimination was often incomplete and staff usually developed toileting assistance times based on what they thought was
feasible. In practice, residents’ toileting assistance program were often constructed on the basis of more pragmatic considerations such as the number of staff available, staff and residents’ routines, manual handling policies, and staff reliance on using lifting machines to mobilise residents.

Although staff believed providing residents with toileting assistance at their individual times would comply with regulatory expectations, as shall be described later section in the current chapter, staff were not always able to provide residents with such assistance. Nevertheless, some staff asserted that all residents received toileting assistance whenever they requested it and at the times documented in their care plans.

**Variability in Aged Care Assessors’ expectations about meeting the standards**

Although at face value staff and Assessors seem to share beliefs about what staff had to do to meet Accreditation Standard 2.12, staff also experienced considerable variability in Assessors’ expectations about the care they had to provide in order to meet the standards. What constituted adherence to the standards could differ from visit-to-visit, and different Assessors often had different expectations. Even the same Assessors’ expectations could alter from visit-to-visit. Such variability made it difficult for staff to comply with the Accreditation Standards, which staff viewed as a moving target.
Data from field observations confirmed staffs’ experience of variability in Assessors’ expectations.

The Assessors are on-site. Staff in the dining area are wearing theatre style disposable caps. A PCA is distressed. She states ‘last time we got into trouble for not having hats’ (Field notes site 1: PM shift 13/09).

A manager with extensive experience in the residential aged care sector suggested that the issues Assessors appraised largely depended on the assessor undertaking the appraisal: in some cases it was a positive experience for staff and in others it was negative. He stated:

Of course it’s not supposed to be subjective, but it is subjective. We had an auditor [assessor] who came in who had just finished the course with the accreditation agency and I mean I was gobsmacked. She came out here as an unannounced visit as they’re allowed to do…and she walked up and down and said ‘I will find something here’. And all she could actually pick on was that one of our curtains in one of our rooms had two hooks. And that’s what gives them all a bad name. We had an unannounced visit two weeks ago and that was a joy. It was professional. He kept us up to date...he was here the whole day...kept telling us where he was at, who he had spoken to, and he gave us feedback. It was excellent. It was one of those visits that ends up being a pleasure (Int-07).
Because Assessors’ expectations could vary from visit-to-visit and among Assessors, staff could not rely on the knowledge they gained from prior assessor visits. Some staff blamed Assessors’ different expectations for the difficulty they experienced adhering to the standards. Others blamed their own and their colleagues’ knowledge deficits and lack of training.

Another factor that contributed to staffs’ difficulty complying with the standards was the lack of clarity about care practices staff had to prioritise. Specifically, as previously indicated, the analysis of accreditation reports identified 18 descriptors or factors Assessors documented in their reports about staff adherence to Accreditation Standard 2.12 (Table 4 on page 119). Although the list indicates Assessors appraised and documented some factors more than others, staff had no way of knowing which factors were more salient, or carried more weight with Assessors. When asked how she knew what she had to do to meet the standards, a manager stated:

*They [the government] don’t tell you how you have to do it [adhere to the Accreditation Standards], but you have to make sure that their guidelines are followed* (Int-15).

When staff encountered variability in Assessors’ expectations, they were likely to mistrust the accreditation process and feel uncertain or confused about what they had to do to meet the standards. Given this situation, and the severe consequences for facilities that did not meet standards, staff were not only mindful about the standards; they were also highly fearful of them and of Assessors’ visits.
Fear of being found non-compliant with regulation

The highly regulated nature of the residential aged care environment also caused staff to be afraid they would be found non-compliant with regulations. Staff were constantly concerned about ‘getting into trouble’ and perceived that any anomaly such as an omission or an inconsistency in the documentation could be regarded by Assessors as the facility’s lack of evidence of adherence to standards or as evidence of a false ACFI claim.

Adverse events and complaints

In addition to concerns about anomalies in documentation, all staff were highly mindful about the need to meet standards and avoid complaints and adverse events that could reach the attention of the DoHA. Therefore, staff gave more attention to issues that could incur a regulatory response such as the death of a resident following a fall or with concurrent skin breakdown, the onset of an acute illness including outbreaks of gastroenteritis, resident falls or other injury, a breakdown in residents’ skin integrity, residents’ weight loss, and visible or malodorous incontinence. According to a manager, staff were more attentive to issues that were more visible such as weight loss. She said:

Weight loss is a big thing everyone worries about. RNs know that weight loss and dehydration are two big important issues but weight loss is far more tangible: dehydration is less so. So staff are far more conscious of enough food and less conscious of enough fluid. They know it in theory, but they’d work on the one that is more out there. More visible (Int-13).
Between 2010 and 2011, the Complaints Investigation Scheme received a total of 8130 complaints relating to Australian Government subsidised residential aged care facilities, which equates to 3.8 cases per facility per 12 months (Australian Government Department of Health and Ageing, 2011b). Hence, the fear of a complaint against a facility is not unexpected. Of the 8130 complaints, 3167 (20%) related to residents’ health and personal care including infections, infection control, infectious diseases, clinical care, continence management, behaviour management and personal hygiene.

Officers from the Complaints Investigation Scheme also conducted 1419 unannounced and 925 announced site visits. They reported a total of 1148 breaches and issued 393 ‘Notices Requiring Action (NRA) (4.4% of complaints). Three hundred and fifty-three facilities responded successfully to the notices and hence, no further action was taken. However six cases were referred for further compliance action. In addition, “during 2009-10, Validation Officers conducted 23,394 ACFI reviews. Of those, 3,712 or 16%, resulted in reductions in funding and 6% resulted in increased funding” (Australian Government Department of Health and Ageing, 2011b).

*Aged Care Assessors’ visits*

Onsite visits from Assessors from the ACSAA were another source of fear for most staff. As indicated, Assessors can conduct announced and unannounced visits to determine whether a facility meets the standards and to monitor their ongoing performance. According to the most recent Aged Care Standards and
Accreditation Agency Annual Report, in the 12 months from June 2010-2011, the ACSAA conducted 3,488 unannounced visits and performed 5,121 assessments (Aged Care Standards and Accreditation Agency Ltd, 2010-2011). Thus, equates to an average of two visits per facility in the 12 month period, hence, most staff have personal experience of the accreditation process. The following field observation data illustrates the fear some staff felt during Assessors’ onsite visits. The observational data were collected at different times over a seven hour period.

‘The government people are here today and they [the Assessors] keep us on our toes’. ... A PCA is distressed. She says ‘it’s not fair – this is the third visit in as many months. I wish they’d just go away and pick on somebody else. Staff here do a fabulous job and they really care, but they [the Assessors] don’t see that. It’s not fair. We’re not nurses. We can’t be expected to know everything. We provide great care, but they are only interested in how we document. The accreditation system is not fair’. ... An EN states ‘the Assessors are out to get them’. ... A PCA states ‘they [the Assessors] should be reported for bullying’. ... The manager says ‘they [the Assessors] will find something’ (Field notes site 1: PM 13/09).

A PCA indicated that prior to a visit by an assessor, staff had excessive work to do as because they had to ensure all residents’ notes and care plans were accurate. Despite all the time and effort staff expended, staff expected only a small proportion of the documentation would in fact, be audited by Assessors.
Some staff were resentful at what they perceived was a disproportionate amount of time they had to spend on documentation that may or may not be audited and which they felt was undertaken at the expense of resident care. A PCA described a state of panic in the facility in the weeks leading up to a visit by Assessors and on the day of the audit; staff hid from Assessors in order to avoid being interviewed. She said, by keeping busy delivering personal care and taking residents to the toilet, staff were able to avoid being interviewed.

*For management, they freak out months before because they know it's [accreditation] coming up. The whole place is in a panic for weeks before when they know they are going to get audited...even if it's a pretty good place. They [the Assessors] go through... You spend so much time going through the notes and the care plans trying to get everything perfect and the auditors will come in and they just pick on one or two and they go through it with a fine tooth comb. We hide, we all just hide. We just toilet people all the time* [laughter] (Int-16).

Fear of being found non-compliant with regulations caused staff to act in ways they thought would protect them from punitive regulatory action. For example, staff spent considerable time developing a paper trail of documentation that would comply with regulatory standards. However, having developed such documentation, staff had to ensure the paper trail remained up-to-date and accurate. RNs in particular were so preoccupied with the relentless need to document to ensure funding and meet accreditation requirements, that they
were distanced from staff who performed personal care work and hence, from residents.

Therefore, one of the unintended consequences of the highly regulated nature of the work environment was that staff shifted focus from resident care to funding and the ostensive aspects of regulatory compliance. Another staff response to the highly regulated nature of the work environment was an overly-protective approach to resident care. Being overly-protective was also related to the fact that staff worked in an ethically challenging environment, as described in the following section.

**Encountering ethically challenging situations**

The second sub-category that comprised the basic social problem was that staff encountered frequent ethical challenges in the context or performing their roles and providing care. In recent years there has been increased recognition of the need for resident-centred approaches to care, which includes involving residents in decisions about their care and promoting their autonomy. For example, the quality of care in residential aged care facilities is partially evaluated on the basis of residents’ involvement and satisfaction with care. Residents have the right to independence, choice, decision-making, participation and control over their lifestyle that does not infringe on the rights of others (Commonwealth of Australia, 2008). Residents feel their autonomy and self-respect are violated when staff make decisions that do not involve them (Flesner & Rantz, 2004; Malmedal, 1998). The ability and opportunity to
exercise autonomy is important for physical health (Moutsopoulus, 1984), psychological health (Hummert & Morgan, 2001) and the loss of control over one’s own life leads to potentially negative health consequences (Pecchioni & Nussbaum, 2000). More recently, Tuckett (2003) explored care providers’ (PCAs and RNs) and residents’ understandings about truth-telling in the care provider-resident dyad in an Australian high level residential aged care facility. Informed by the epistemology of social constructionism and the theoretical stance of symbolic interactionism, Tuckett (2003) claimed residents’ health was directly linked to care provision that allowed the resident to be self-determining about their care and thus allowed them to make reasonable choices and decisions.

The Australian Human Rights Commission also emphasised the need to promote residents’ choice (Australian Human Rights Commission, 2012) and stated the aim is to promote people-centred decision-making and real change in organisational culture. Patients’ [residents’] choice is also upheld in codes of ethics, professional conduct and competency standards for RNs and ENs. For example, The Code of Ethics for Nurses in Australia requires nurses to abide by the following value statement: “nurses respect the rights of persons to make informed choices in relation to their care” (Nursing and Midwifery Board of Australia, 2005, p. 3).

Although staff in the current study did not cite documents such as nursing codes or standards, they were nevertheless, very aware of the need to respect
residents’ autonomy which they equated with residents’ individual right to participate in, and determine what care they wanted and when and how they wanted care provided. Staff also claimed residents had the right be treated as if they were in their own home. Indeed, aged care policy in Australia advocates care in a homelike environment and advertisements for residential aged care promise a ‘home away from home’, ‘choice’, ‘autonomy’ and ‘care’.

However, data from the current study suggests that knowing residents’ rights to choice and autonomy and being in a position to fulfil their obligations to operationalise residents’ rights were two different issues. The conditions that characterised encountering ethically challenging care situations included: (a) multiple, competing, and conflicting expectations about residents’ care needs, (b) workforce constraints, (c) inadequate information about residents’ care needs, and (d) an unpredictable work environment (see Figure 4 below).

Figure 4. Conditions that characterised the category ‘encountering ethically challenging situations’
Multiple, competing, and conflicting expectations about residents’ care needs

Two main factors contributed to staffs’ experience of multiple, competing expectations about residents’ care needs. These factors included: (1) the tacit expectation that staff prioritise residents’ cleanliness over other aspects of care, and (2) a competing duty of care. Collectively, these factors contributed to an ethically challenging care environment.

Expectations to prioritise residents’ cleanliness

The findings revealed a set of taken-for-granted values and expectations about the need for staff to prioritise resident cleanliness over other aspects of residents’ care needs. Staff felt pressured to achieve the goal of cleanliness for all residents. As one staff member stated:

*On a daily basis a lot of staff feel they just need to get the job [assisting residents to shower, bathe, wash] done*(Int-12).

Additionally, residents’ personal care had to be completed before an arbitrary predetermined time: mostly before lunchtime and, in some cases, before breakfast. One staff member stated:

*S sometimes the staff where I work still have residents to do [assist to shower or bathe] after lunch and I know that that is like...that is terrible!* (Int-03).
If staff did not keep residents clean from incontinence, they could receive complaints from other staff, family members and managers about resident neglect and allegations that the environment was dirty. They also felt they violated their own and other staff members norms about care if residents were unclean. Staff were highly critical of other staff members who did not check and change residents’ pads when residents were significantly wet or soiled. One staff member expressed disapproval of other staff members who left residents in a wet or soiled pad and left the task of cleaning them to her.

*What do I see as most [upsetting]? It happens sometimes when I come in at three o’clock and we do the handover and you start your shift and there is one lady in a fallout chair [a chair used for people who are immobile], and they have a blanket over their legs and ‘phew phew’. Why do they have a blanket? And then you take the blanket away and it’s smelly and wet. I had one shift where I find three residents like that. I was so mad. The first hour you have to already give them a shower and I thought...’why did you put a blanket and not change them? Clean them [residents] up first.’ I don’t care if they leave dishes for me or some dirty bin...’but clean up the residents’ [laughter] ‘you are here for them’...And that really upsets me. That is really hard (Int-01).*

Staffs’ taken-for-granted values and expectations about residents’ cleanliness were related to taken-for-granted values and expectations that other staff, managers, residents, family members and regulators held about cleanliness,
and about the uncleanliness and social stigma of incontinence. Staff equated cleanliness with a state of dignity. When asked why staff felt compelled to spend most of their time washing residents, a staff member stated *we have to keep their dignity* (Int-04).

The work involved in keeping residents clean was labour intense work that consumed most of staffs’ working time, particularly on a morning shift. Furthermore, the unrelenting demands associated with meeting residents’ need to be clean meant staff who were employed in direct care roles, had little time to address residents’ other care needs, such as their toileting needs. Therefore, these staff felt constrained in their role because most of their time was dedicated to achieving the goal of resident cleanliness. These factors contributed to them feeling devalued in their role which is described in a later section of the chapter.

Because residents’ voided a number of times a day and many were incontinent, residents’ cleanliness was a short-lived state of affairs. However, staff were not in a position to shower or bath every resident each and every time they were incontinent. Staff needed remain vigilant to identify when residents were no longer ‘clean’. As most residents were incontinent, most residents’ went from being clean to unclean a number of times a day.

In this study, staff had very specific interpretations of what constituted a state of cleanliness among residents. Staff considered residents’ to be unclean [dirty
or undignified] when their incontinence was uncontained, visible, malodorous, or excessive, but not if they had a small volume of urinary incontinence that was concealed and contained. Therefore, staff did not necessarily equate cleanliness with the absence of urinary incontinence. By contrast, staff equated any level of faecal incontinence with a state of uncleanliness, regardless whether it was contained in a pad or not.

Such subtle difference in staffs’ understandings of the terms ‘clean’ and ‘dirty’ affected their decisions about whether they washed a resident or just changed the resident’s pad after an episode of incontinence. In general, staff showered, bathed or washed residents following the resident’s episode of faecal incontinence. As a general rule, they also tended to shower, bath or wash residents whose urinary incontinence was excessive, visible, or malodorous. However, residents with minimal urinary that was contained, concealed and not malodourous had their pads changed, but were not always washed.

_A competing duty of care_

Staff espoused residents’ rights to autonomy, independence and self-determination, including their right to make decisions about what care they wanted and when they wanted it. At the same time, staff felt limited in how much they could actually operationalise residents’ rights, particularly the right to decline assistance with personal care such as assistance to shower or use the toilet. Staff knowledge about residents’ rights did not always assist staff to model ethical care. In other words, knowing a resident’s rights and upholding
them were two different things. For example, during theoretical sampling the researcher asked a staff member to comment on what things made residents feel dignified. She stated:

[Give residents] independence and control over their care. If they don’t want to get out of bed, don’t get them out of bed - it’s their choice still. But, it is constrained. If they don’t want to get up but its 2.30 in the afternoon and you are about to leave and you have to get your residents up and do the care before you leave. And they don’t really have a choice then (Int-06).

One of the main reasons staff found it difficult to operationalise residents’ right to autonomy was because staff were often caught in a situation of having a competing duty of care. For example, whilst assisting a resident to shower, staff were aware that another resident needed assistance to use the toilet, and that without staff assistance, the resident could fall or become incontinent. One staff member described the dilemma as follows:

You might be doing [assisting a resident to shower or bathe] one person and you know that another person is dying to go to the toilet but you can’t leave that person (Int-10).

Although staff had an ethical responsibility and duty of care to respect residents’ right to decline assistance with personal care, they had an equally compelling duty of care to keep residents safe from harm such as from a fall or
Margaret [pseudonym] sits in a crouched over position in a chair in the lounge room. Her legs and arms are contracted. She seems to have her eyes closed, but each time staff approach her, she screams and recoils. She does not walk. She is unable to hold a cup or feed herself. Staff use a lifting machine to move her. Her screams are particularly loud when staff change her pads at night. One of the staff members states ‘Margaret cries out because she has contractures and doesn’t like having her legs pulled apart to have the pad changed. She just doesn’t like it [having her pad changed]. We’re not killing her’. Another staff member says that they try to get the job done as quickly as possible so that they disturb her as little as possible. They tell me later Margaret has a history of sexual abuse (Field notes site 1: Night shift 10-11/09).

Margaret was unable to communicate or perform any activity of daily living. She resisted every attempt staff made to address her physical care needs. Staff had to choose to either ignore Margaret’s screams to clean her incontinence, or leave her in an unclean state. The latter situation would lead to a breakdown in Margaret’s skin integrity leading to pressure ulcers, infection, an earlier death, claims of neglect by family members and/or Assessors, and a subsequent
punitive regulatory response. Staff had to find a way to deal with their competing duty of care to respect Margaret’s desire to decline care and their duty of care to address her physical care needs. In the absence of alternative concrete options for care, staff chose to clean Margaret and change her pads. To do so, they ignored her resistance. Although staff disregarded Margaret’s’ screams, they were conscious of other people’s potential negative reactions and reacted defensively e.g. asserted we’re not killing her – she just doesn’t like it.

Staffs’ competing duty of care to protect residents from the embarrassment of visible incontinence, and the need to respect their right to manage their incontinence as they wished could also result in highly charged emotional encounters for staff and residents. The following comment from a staff member describes an attempt her colleagues made to apply a pad to a resident who resisted the pad, which led to an emotionally charged situation.

You sort of find the men are the most difficult [have the most difficulty adjusting to wearing pads]. We have a new man at the moment and he will just not wear pads at all. I think it is a bit of cultural thing and he has lost a lot of independence and he can use the urinal...which is fair enough, but I think the staff were worried because he’s in a wheelchair – if he is incontinent of faeces – so that is why they wanted to put the pad on him. Like I said...its independence. He obviously thinks he can still make the decision to go and I haven’t heard that he is incontinent with the
A competing duty of care also generated tension for both resident and staff when residents whom staff believed were at risk of falling, attempted to walk to the toilet unaided. This situation was problematic for staff because they wanted to respect residents’ rights to independence and thereby promote residents’ functional abilities, but they also had to ensure residents did not fall. However, another reason staff were concerned about residents falling was that falls rates are monitored by the ACSAA, and a high falls rate could result in a visit by an assessor. A staff member stated:

*Every month we have to put in falls criteria, pressure ulcer care, infection rates. So if you have a client who was exerting their independence or you want them to exert their independence with walking and they fall so many times, well the government will investigate. The aged care accreditation will more than likely do a spot check right there and then – from two consecutive falls in a month!* (Int-12).

In some cases, staffs’ duty of care or ethical responsibility to protect residents from harm such as a fall caused staff to restrict residents’ rights to independently use the toilet. For example, staff felt residents often needed help to use the toilet. Without staff help, residents might fall and/or wet or soil their clothing. A staff member caring for a resident who had a CVA described her
attempts to protect the resident from being embarrassed by his incontinence.

The transcript starts with the staff member’s description of her response to the resident who had a wet patch on his trousers after attempting to use the toilet alone.

_The first afternoon he comes out [from the toilet]. And I said ‘you didn’t ask anyone to help you darling’. And he goes ‘no’. I and said ‘no and now your trousers are wet’. You need to ask someone to adjust your clothing and readjust when you’ve finished and so he goes...’and its awful to say but I know what will happen...you know... and then I said ‘darling you’ve got to ask because these are the things you have and you don’t want to be walking out there with all these people knowing you’ve got this wet patch’. It’s their independence. It’s their total independence. He was, ‘I was doing it at home’. But the difference was that if he was doing it at home, if he did have some wet spots, there was no-one looking at him. He was home by himself. I have to let him know ‘there are 49 other people here looking at you mate. How embarrassed are you going to be when you realise you are wet. This is what we are here for – we are here to help you’. And I said to him ‘I’ve gone through this with another lady and she signed a contract to say she wanted to do it all on her own and when I came back from holiday she had a broken hip. Because you have only one hand, you need to balance and someone needs to adjust your clothing so please do that. I do not want to see’... (Int-09).
In their everyday attempt to protect residents from harm, staff had to continuously judge the degree of risk associated with each resident’s choice and then weigh the risk against the benefit. However, staff and residents often had different opinions about the risk associated with residents’ choices. Caring for residents who did not believe they needed protection created an ethical dilemma for staff, which is illustrated in the following staff members’ description of an interaction with a resident whom she believed was unsafe walking unaided to the toilet. The staff member stated ‘she [the resident] wanted to do things when she [the resident] wanted to do them’ (Int-09). The resident did not heed the staff member’s advice to ask for assistance to use the toilet, fell and sustained a fractured hip. The staff member felt vindicated in her judgement about the resident’s risk. The staff member stated:

*We have trouble with the CVAs. We have one that...she used to get up and walk and try to do everything by herself. And I said ‘I didn’t like the idea of her walking ‘because you still needed someone to adjust your clothes when you go to the toilet, to adjust your clothes when you get off the toilet, you only have one hand’. But she insisted. She wanted to do things when she wanted to do them. My fear was she going to be off balance, fall down and break her hip. She did this. She can’t get up now* (Int-09).

In addition, staff felt bound by rules and regulations that restricted them from using restraints, even when they felt it was the best possible course of action. On the one hand, staff accepted that residents had the right to walk and not be
restrained. On the other hand, staff felt residents had a right to be protected. These equally compelling rights placed staff in a difficult position as depicted in the following staff member’s description:

_We had a resident and he was falling over every day because he still wanted to get up and walk with his walker. It was pretty much every day he was falling. Every time you’d come on and he’d have bruises. And we couldn’t keep in in the chair – in the fall-out chair. You could see him sort of stagger around and you couldn’t just put him anywhere safe because you couldn’t restrain him. It’s horrible because you know just every day it was fall after fall. Certain people you really do need that bit of restraint for their own good. It’s really hard. Everyone has the right to walk around. It’s a hard one (Int-16)._ 

The ethical challenges staff encountered in the context of performing their roles were compounded by workforce issues as described below.

**Workforce constraints**

Staff identified three main workforce factors that contributed to the ethically challenging situations they encountered. These factors included:

1. Low staffing levels.
2. A low number of Registered Nurses employed in the residential aged care sector.
3. Staff with minimal educational preparation and English proficiency.
Collectively, workforce constraints contributed to the ethical challenges because the data showed:

- Holistic care was not possible.
- Staff felt they had to rush care and adopt efficiencies that meant they could not spend time with residents.
- Staff felt they were unable to consistently provide toileting assistance.
- Staff felt they were unable to change residents’ pads as often as they would like.
- A limited number of staff available, a limited number of RNs, and staff with inadequate knowledge and skill led to situations in which residents and staff were at risk experiencing an adverse event.
- RNs were not always physically present at facilities.

**Low staffing levels**

Staff described having insufficient time to address residents’ care needs, which was seen as a direct consequence of an inadequate number of staff, as illustrated in the following comment:

*I think oftentimes, all things in those places and the issues that you see [quality of care] come down to inadequate staffing levels. You get people who are so overworked, underpaid, have to work far too many shifts, have to work overtime because there are not enough staff. You have to increase nurse-to-resident ratios because you have a lack of staff* (Int-05).
One staff member stated holistic care was not possible because there was simply insufficient time to perform the work.

*It’s very constrained and there is not enough time or enough people to do the work you want to do. They say its holistic care in aged care but you really don’t have the time* (Int-06).

An inadequate number of staff to address residents’ care needs meant existing staff had to work harder and faster to complete their work. One staff member described being ‘run off her feet’. She stated:

*I’ve got to say that the biggest problem I’ve faced when I worked in those facilities is purely the lack of time. There is not enough staff and not enough time and the care you are giving...whether it be the continence care or whatever. It isn’t as good as it should be because you are just run off your feet. You are running late. You’ve got to have them all showered by 10am and morning tea is coming and you are still showering* (Int-05).

According to some staff, the consequence of low staffing levels was staff who were rostered on did not have enough time to meet residents’ care needs and were unable to change residents’ wet or soiled pads as often as needed, respond in a timely manner to residents’ need for toileting assistance; manage residents’ behaviours at night, provide the level of supervision residents needed, sit with residents and listen to them, and provide holistic care.
Low staffing levels also placed residents and staff at risk of an adverse event as was evident in the field notes the researcher complied. The field notes describe a staff member’s efforts to assist a resident to use the toilet, and her inability to obtain help from other staff.

The facility has recently employed an additional staff member to work from 4-7pm to help with ‘the wanderers who take up a lot of time’ and are allegedly at risk of absconding. Vivian [pseudonym] is employed for the four hour shift to help with ‘the five wanderers who are in a lounge room. She says she is there ‘to help out during the busy and crazy time’. She emerges from a room with Bill [pseudonym], who walks with a frame and who needs to be accompanied to the toilet. Vivian calls out and looks for a staff member to stay with the remaining residents while she does this. No-one responds. Bill is anxious to use the toilet. Vivian has to choose between staying with him or the other residents. She chooses to go with Bill. In the meantime, one of the more mobile of the now unsupervised residents exits the lounge room. Vivian returns and attempts to return both residents to the lounge room. In the midst of this effort, Bill’s walking frame collides with Vivian who sustains a bruise. She is distressed. Another staff member appears and together they direct both residents back into the lounge room. Vivian finishes her shift at 7 pm. Before leaving she says ‘I feel like a dog trainer. All I am doing is telling them to sit down. It is hell for the three hours. I hate this shift!’ (Field notes site 1: PM shift 09/09).
Vivian was expected to care for six cognitively impaired and distressed residents in a room with no stimulation other than a television and with no staff support. A low number of staff available to provide care caused her to leave a group of high risk residents unsupervised, to sustain an injury and to avoid being rostered for the shift in the future. Her decision to assist a resident to the toilet left other residents at risk because they were unsupervised. Vivien left the shift feeling inadequate, demoralised, depressed and unwilling to be rostered for the ‘hellish’ shift again as she did not want to feel like ‘a dog trainer’.

A staff member expressed incredulity that facilities could pass Accreditation Standards within the context of existing staff-to-resident ratios, particularly the night-time ratios. She stated:

_They [Assessors] look at staffing levels but I don’t how places get away with it because for the whole facility, there is only four staff for 100 people for the whole night! And that’s 30 or so in high care that need turning and changing! That includes a 13-bed dementia wing where they’ve [residents] been wandering half the night. How they [facilities] can pass accreditation with that I don’t know! It’s crazy! You need someone [staff] in the dementia wing alone_ (Int-16).

Most staff blamed the government for the lack of funding that caused low staffing levels that in turn, caused them to have insufficient time to address all
residents’ care needs in ways that were consistent with their beliefs and values. Staff indicated they had considered resigning because of inadequate government funding that created the conditions that caused staff to be unable to perform their roles as they wished. Indeed, some had already resigned, citing work constraints as the main factor.

A low number of Registered Nurses employed in the residential aged care sector

Another workforce issue that contributed to ethically challenging situations was a low number of RNs employed in the residential aged care sector to provide care and/or nursing leadership. Some staff described working in facilities that employed no RNs or ENs, as illustrated in the following comment:

Places now, I’ve heard of places where they’re only employing PCAs. Where I was before there were no RNs or ENs, That’s because they all left. PCAs were just running the place (Int-16).

As indicated in the review of literature, the NILS (2008) reported significant restructuring of roles and skill mix in the residential aged care sector in recent years, where more care is now provided by PCAs and less by RNs. Specifically, between 2003 and 2007 the number of RNs working in the residential aged care sector decreased by approximately 1600, whilst the number of PCAs rose by 17500. “This trend towards increased use of PCAs
will continue” so much so that by the year 2020, the PCA workforce will increase to 71.7%, while RNs will decline to 12.2% and ENs to 10.5%” (The National Institute of Labour Studies, 2008, p. 10). The effect of the lack of RNs was that existing staff felt alone and unsupported. A staff member said:

The management [RNs] are never on the floor in aged care. The organisation I work for has about seven different facilities and the managers go around to all the facilities and manage them all on different days. They are only in our place one day a week. We have no-one to report to really. We’re on our own (Int-06).

The perceived lack of RNs employed in the residential aged care sector had a direct impact on the roles and responsibilities of the remaining workforce and resulted in a situation whereby resident care was largely overseen and delivered by ENs and PCAs. In the current study, ENs and PCAs described making decisions about residents’ health, wellbeing and day-to-day care with little RN support. PCAs proudly claimed to perform the following activities.

- Manage the facility and/or ward/unit.
- Conduct resident assessments.
- Make decisions about residents’ continence care.
- Identify when residents had urinary tract infections
- Orient new staff and update existing staff about continence care.
- Advise staff about responding to residents’ with behaviours of concern.
- Convene lifestyle activities.
- Administer residents’ medication.
Some staff, particularly RNs expressed concern about PCAs working beyond their educational abilities. An RN stated:

*Facilities now, especially the private ones largely rely on staff with very low education and who need to work. They have no choice. They [PCAs] are very important. We need them in aged care but their education level is very low. The problem is they think they know what to do so they are doing things they shouldn’t be doing like checking the residents’ blood glucose levels, doing observations, and they don’t know what things mean or what to report. They do know they shouldn’t be doing these things. And of course there are some situations where RNs know they are doing it and letting them. There could be a number of reasons for this – one is the RNs are just too busy themselves and they are grateful for any help they can get. The other is they might just not be available (Int-17).*

Another consequence of the low number of RNs was that those RNs who were still employed in the residential aged care sector mainly worked in administrative and managerial roles where they were responsible for addressing funding and compliance issues, managing human resource issues, and budget issues. These staff described major changes to their roles over the period of time they had been employed that resulted in increased professional jurisdiction over residents’ care, limited opportunity to provide clinical care and/or mentor other staff, and reduced knowledge about individual resident care needs.
RNs indicated that changes in their roles meant they were in the uncomfortable position of being ethically and legally responsible for the care provided with an inadequately trained workforce. One RN described ‘being sick with worry’ that her changed role meant she would no longer know residents’ care needs or be able to identify changes in residents’ wellbeing. Another RN felt the lack of RNs would put residents at greater risk because other staff lacked knowledge and skills to detect and interpret symptoms of residents’ poor health. She stated:

*You are not going to have the EN’s picking up issues – cardiac issues, respiratory issues, dehydration. From a nursing perspective PCAs are not going to pick up the nuances of nursing* (Int 13).

The following notes from field observations illustrate how changes in staff skill mix actually affected staffs’ roles and resident care.

*There is an RN and an EN on night duty in the unit. A newly admitted resident fell shortly before they commenced their shift. The EN checks the resident’s vital signs regularly, documents it, and informs the RN. The residents’ blood pressure rises over the next few hours. The RN checks the resident and thereafter spends her time contacting the family, organising medical care and transport for the resident to a hospital. She checks drugs, liaises with a pharmacist who arrived to remove unwanted scheduled 8 drugs, and completes multiple charts. The ambulance arrives*
and the resident goes to hospital. The resident was in atrial fibrillation at the time of her departure. The RN states ‘it is a bit hard when you don’t know the residents’. She expresses concern that RNs now have responsibility for greater numbers of residents and have to rely on staff with less educational qualifications. She states that tonight she is lucky because they are all ENs, besides herself and that sometimes, when there are no ENs, she ‘feels sick with worry’. She comments on the value of having ENs as skilled as X who identified that the resident’s blood pressure was dangerously high and states they would not have been able to rely on non-nursing staff to pick that up. She comments that sometimes there is only herself and all non-nursing staff and that she goes home feeling sick with worry (Field notes site 2: Night shift 15-16/11).

**Staff with minimal educational preparation and English proficiency**

Staff generally felt their own personal knowledge and skills were adequate for them to perform their roles. However, they expressed considerable concern about other staff members’ minimal educational preparation and English proficiency.

As part of the theoretical sampling procedures, the researcher asked staff how they learnt to provide continence care. Staff responded by describing how they learnt to use pads. Hence, a lack of education about continence care was
generally regarded as a lack of education about pads, as the following comment shows:

Some staff get frustrated about their lack of understanding about why a certain continence aid is more preferable to another one – so they want to gain that knowledge of which one [continence aid] is the best one. They want to be able to understand it. You know, why a flex wrap around one is more successful that a pull-up pad for this particular resident (Int-08).

RNs and ENs expressed concern about PCAs limited educational preparation for work in the residential aged care sector, which they felt placed residents at risk and added to the constrained nature of the work environment. One staff member indicated that PCAs were inadequately educated for the workplace after a three week course and often did not know how to perform basic tasks.

Another staff member commented on what she perceived was other staff members’ inadequate education about managing incontinence. She stated:

I think as far as continence, I think it takes a bit more than a four or six week course to really understand it [incontinence]. There needs to be more education in the certificate courses. The PCAs are really lacking in continence knowledge...really understanding it. They don’t have that knowledge and they don’t get that knowledge in their course. I think it is really lacking (Int-08).
A PCA also expressed concern that her training did not adequately prepare her for the complexity of issues she encountered in providing care. As part of theoretical sampling, the researcher asked her how she learnt to perform the role. She stated:

Oh well, we have the training. It was the TAFE training. [We learnt] how to shower the client. And then on the change-over you know who is your client and you read up in the care plan what the client has and you go from there. Yes best of luck [laughter]! (Int-14).

In order to identify PCAs and ENs educational preparation to manage incontinence, the current researcher reviewed the National Register of Information on Training Packages, Qualifications, Courses, Units of Competency and Registered Training Organisations (RTO) database. Using the terms ‘aged care’, the researcher located information about the course requirements for the qualification of Certificate III in Aged care (Course code CHC30212), and the qualification of Certificate IV in Aged Care (Course code CHC40108). The researcher then used the terms ‘incontinence’ or ‘continence’ to search for information about incontinence in the core units that comprised both courses The findings revealed one reference to the term ‘incontinence’ and one reference to the term ‘continence’ in the core information workers require for a Certificate III in Aged Care qualification.
These terms occurred in the following units:

- CHCAC318B - Work effectively with older people.
- CHCAC412A - Provide services to older people with complex needs.

The findings revealed three references to the term ‘continence’ and one to the term ‘incontinence in the core information workers require for a Certificate IV in Aged Care qualification. They occurred in the following units:

- CHCAC318B - Work effectively with older people.
- CHCAC412A - Provide services to older people with complex needs.
- CHCICS401B - Facilitate support for personal care needs.
- CHCAC417A - Implement interventions with older people at risk of falls.

Appendix L lists the core units that comprise Certificates III and IV in Aged Care, shows the unit descriptor and indicates whether or not the course outline provides any references to the terms incontinence or continence.

Unit CHCAC318B prepares workers to develop the knowledge and skills to work effectively with older people. The only reference to the term incontinence occurred in the context of the requirement for RTOs to educate workers about chronic and age-related conditions including incontinence.

Unit CHCICS301B prepares workers to develop the knowledge and skill to support or assist a client with their personal care needs within the framework
of an individualised care support plan. The only reference to ‘continence’
occurred in the context of the requirement for RTOs to educate workers about
using continence aids.

Unit CHCICS401B prepares workers to develop the knowledge and skill to
develop, implement and monitor support of client personal care needs through
the framework of a personal care support plan. The only reference to the term
‘continence’ occurs in the context of requiring RTOs to educate workers to
assist client with toileting and using continence aids.

Unit CHCAC417A prepares workers to develop the knowledge and skill to
work in partnership with older people and their carers to implement
interventions in the context of an individualised plan to reduce the risk of falls.
The term ‘incontinence’ occurs in the context of requiring RTOs to educate
workers that incontinence is a risk factor for falls.

Based on review of the core units that comprise the course material that
prepares workers for work in the residential aged care sector, it is highly
unlikely that the educational content about incontinence in Certificates III and
IV in Aged Care equips PCAs and ENs to proactively assess, prevent or
manage incontinence.

According to a manager who had previously worked as a teacher in the TAFE
sector, another factor that contributed to their minimal educational preparation
was the quality of assessments PCAs received in order to determine their readiness for clinical practice. She stated some clinical Assessors who were employed to assess PCAs did not check their skills and readiness for practice, but passed them nevertheless. Another problem she identified was the lack of nursing qualifications of the staff who were employed to teach PCAs how to provide nursing care. Furthermore, there was no requirement for TAFE Assessors to check PCAs competence in the workplace, and no quality checks on the quality of the assessments performed in the workplace, thus, PCAs could find staff to rate them as competent without actually assessing them. The manager stated:

*I was teaching it [a Certificate III course] prior to coming here. A lot of the people that teach it aren’t nurses that have had experience of working in aged care or even a nursing background. They just do it from the course that’s in front of them. A classic example is the girl that I took over from. I said, ‘oh there’s a lot of work that you have to do at home – marking their papers and checking’. And she said ‘oh don’t read it – just tick it off’. So if you’ve got people like that then you can see how people slip through the net. Plus I did the training, but I didn’t have to go and assess them in the workplace. The workplace does that. So if they find a workplace that doesn’t care, they’ll just sign it off anyway. And that person gets through and they haven’t really been assessed as clinically capable in certain areas. So that’s the gap that needs to be filled* (Int-11).
Staff stated that the consequence of having to work with inadequately educated staff was the responsibility for developing their knowledge and skill fell to existing staff who had to adopt a mentoring role. In addition, their own workloads were increased because they had to help newly employed staff get through the workload. Working with a staff member who was unfamiliar with the resident and how to deliver care impeded the overall delivery of care, slowed care down and made it difficult for staff to complete their work.

Another factor that staff alleged contributed to the overall difficulty associated with addressing residents’ physical and psychosocial care needs was the requirement to work with staff, mostly PCAs, who could not speak English proficiently. This situation created difficulties caring for residents because staff with limited English did not always know how to verbally encourage, coax, cajole or humour residents to accept staff assistance with personal care, or read care plans, medication chart and other forms of documentation.

A staff member commented that staff with a limited command of English relied on their limited range of English words and used authoritative commanding language, such as ‘come, I shower you’, which caused some residents, particularly those who were cognitively impaired, to react negatively. One staff member stated that, whilst it was unfair for residents to be cared for by staff who did not speak the same language, it was also difficult for staff with limited English.
She stated:

*A lot of them* [staff] *can hardly speak English which is really hard for the elderly residents so I think it’s really unfair for them. It’s also pretty hard for these young girls [staff]. *A lot of them* [staff] *are very nice people but they are put in this situation they can’t understand us and we can’t understand them* (Int-16).

Some staff used language proficiency and educational preparation as social markers to classify or categorise other staff into those they believed were altruistically and professionally committed to resident care and those whose motivation was economically driven. For example, a staff member described her concern that it was easier for people to get a job in aged care than it was to get a job in a factory and that there was a need to exert greater regulation over who could work in the sector. She stated:

*People that they get in aged care now, they can’t even speak English half of them. If they [staff] can’t understand me when I speak to them, how can they understand an old person? I don’t think people should come and work in aged care unless they’ve got some kind of heart, because it’s not a job. They are not a box on a production line. But you see they [PCAs] can’t jobs in factories. My nephew used to work in a factory and I asked him if I could get a job over there and he said ‘Auntie you don’t want to work here it is a production line’. But I’m just staying you don’t have that problem with aged care. You do a two week course and you can get a job in aged care. What do
you understand about continence – what do you understand about anything after two weeks (Int-03)?

Inadequate information about residents’ care needs

Another factor that contributed to the ethically challenging situations in which staff found themselves, was staff did not always know the residents or their care needs. Staffs’ lack of knowledge was exacerbated by an inadequate number of staff to provide care, using agency staff, a lack of RNs, and changes to RNs’ professional jurisdiction over nursing care, which caused RNs to be caught up in an administrative role and physically removed from the clinical interface.

In addition, as the starting times of shifts were often staggered, staff were not always able to obtain up-to-date information about residents and their care needs. A further complicating factor was that information about residents’ care needs, routines and behavioural cues was not always documented or available. According to one RN, inadequate assessments also contributed to a lack of information about residents’ care needs. Although the facility had a computerised set of assessments, she felt they did not adequately address all of the issues that needed to be considered. She stated:

Yes, they [assessment forms] give you a picture as such, but you don’t know how much [residents] they have voided. You don’t know if they’re dribbling. So, if I notice someone is getting up three of four times a night because of his age...let’s have a look at what’s
going on with him. Let’s put him on a continence assessment, [and] a fluid balance chart. I want to know how much he is voiding each time so that gives you a much better picture before he goes to the urologist because they need that information anyway. With nocturia, that affects their daytime moods and everything. Plus their creatinine, urea...that could be out of whack. They could be in early stages renal failure (Int-15).

Not knowing residents needs was particularly difficult for new staff members and students who relied on care plans being available and up-to-date. When I asked staff how they learnt to identify residents’ individual behavioural cues, one staff member said:

_You don’t know - it’s not written down. It’s hands on. You pass it down to the new staff. It’s never official. [If you are a new staff member] that’s where it’s hard. You don’t know. If you have a nice staff on that will spend half an hour with you at the start of the shift, you can tell them. Like I’ve this list at my facility of every resident and their care plan so that if agency comes on, they get this information about the resident and their cues on how to help them and what they are like during the day...so that helps them. But some agency just have to ask and put themselves out there ...it’s hard for them_ (Int-06).
In some cases, staff felt it was a matter of luck if care plans were available and if there were staff available who knew residents’ care needs and were kind enough to share such information. One PCA stated:

>You hope their [residents] care plans are in an accessible position and you hope that the nurse that is on has worked with the residents before and you hope that they are friendly (Int-05).

The PCA, who worked in a facility whilst studying, continued by saying staff sometimes expected her to know what to do even though they did not provide her the information she needed to do the job. She stated:

>I've been in situations where they just said ‘you’ve got rooms 10-13. ‘Go and shower them [residents]’ It's like ‘can they walk, are they walking with a frame or lifting machine?’ My very first shift as a PCA in a facility they just said ‘you’ve got those four rooms...go and do your thing’ (Int-05).

**An unpredictable work environment**

An additional factor that contributed to the ethically challenging situations involved in providing care was that staff lacked control over their day-to-day work. Field observations revealed staff were frequently interrupted throughout the course of their day by unplanned issues.
In the current study, unplanned issues included:

- Resident falls.
- Residents’ acute or deteriorating health status that sometimes led to challenging resident behaviours.
- Resident deaths.
- Outbreaks of gastroenteritis.
- Human resource issues such as staff with inadequate knowledge and skills, staff injuries, staff shortages, new or agency staff; changes to or new policies and procedures.
- Family members needs for support.
- Visits from doctors, Assessors, and consultants, etc.
- Complaints from residents, family members or from the Office of Aged Care Quality and Compliance (OAQC).
- Uncontained incontinence.

One PCA described the difficulty controlling or predicting work in a dementia care unit where anything could happen, including situations in which staff were confronted with shit everywhere causing them to stop what they were doing and clean it up. The staff member described her work as follows:

_Every day something different happens. You can’t say it is 3 o’clock and I’ll do this now. You can’t do it because sometimes they [residents in the dementia unit] are in a good mood and sometimes they are not and sometimes you find shit everywhere. Every day is different_ (Int-01).
As unplanned issues could occur at any time and divert staff from addressing residents’ care needs, staff were worried about whether they would have to reprioritise their work or be unable to perform their role. Therefore, staff operated under the constant expectation of an impending crisis.

**Highly dependent residents**

The basic social problem of caring against the odds was exacerbated by residents’ high levels of cognitive and physical dependence. Staff generally described residents as incontinent, cognitively impaired, unable to make decisions that were in their own best interest, unable to walk, do anything for themselves, and in constant need of staff advocacy and protection. For example, one staff member said:

_They [cognitively impaired residents] don’t do the normal job anymore. They are sitting and sleeping most of the time. They are not active. They are sitting in the room and you try to get them up for activities and exercise and they say, ‘why, why do I have to do this’_ (Int-01).

Staffs’ believed that most, if not all residents were cognitively impaired. This belief had a major impact on how staff provided care. For example, residents’ cognitively impaired status complicated continence care because they were not always unable to verbally or behaviourally communicate their continence status and did not always have predictable bladder and/or bowel elimination.
times. Many staff felt it was futile to provide highly cognitively impaired residents with assistance to use the toilet because they would:

- Not be able to cognitively interpret the purpose and use of the toilet.
- Not use their bowel or bladder because they would lack sensory awareness of the urge to void or defeacate or be unable to interpret the sensation.
- Respond in a distressed manner to being assisted to the toilet and could hurt the staff member.

Therefore, staff had to guess when cognitively impaired residents needed to use their bowel or bladder or had an episode of incontinence. The only way staff could know whether such residents were incontinent was by regularly checking their continence status which involved visually inspecting their pad.

Residents’ high levels of physical dependence also added to the difficulty staff experienced providing residents with toileting assistance because such residents required the assistance of two staff members and a lifting machine. In some cases, residents would be unable to physically sit or stand to use the toilet because they had contractures or were hemiplegic. From staff perspective, the workload associated with assisting highly physically dependent residents each time they needed to void and defeacate was onerous and labour intensive, particularly when residents could only move with the aid of two staff members and a lifting machine. A staff member estimated that it would take staff 15-20 minutes to assist a resident use the toilet if staff needed to use a lifting machine:
She said:

*If they* [residents] *are on a Delta machine* [a lifting machine], *it* [providing toileting assistance] *can take up to 15 minutes...20 minutes by the time you've got that person on the toilet, they've voided and got their clothes back on and sitting in the wheelchair* (Int-10).

Most staff believed the majority, if not all residents had established and intractable incontinence and that their incontinence was caused by their old age, female status, medical condition and dependent status. Consequently, whilst staff felt it was aspirational to assist residents to use the toilet; it was not always appropriate or practicable. Moreover, staff felt residents’ did not always void or defeacate when taken to the toilet and hence, the time and effort staff consumed in providing residents with assistance to use the toilet was often futile. In other words, staff experienced providing toileting assistance as a ‘hit and miss affair’. They found it worked for some residents sometimes but not other times, or that it or worked for some residents and not others. A manager felt better results were obtained among residents who were not cognitively impaired. He stated:

*We try to get them* [residents] *into a regime* [toileting regime] *and get them into regular toileting. So we know one way or another whether that is going to work. Now some of our residents with dementia, that will work sometimes and not others. Usually with our non-dementia residents, if there is such a thing, it tends to be relatively successful* (Int-07).
Because of the difficulties posed by residents’ high levels of dependence, staff viewed toileting assistance programs as an aspirational form of care, and indicated they provided such support if and when they could. Consequently, sometimes staff toileted residents and other times they didn’t. One staff member suggested toileting assistance programs were a good idea, but it was not realistic for staff to provide individualised toileting when things went wrong on the shift. She stated:

On paper it [toileting programs] looks fantastic but in theory it [toileting programs] doesn’t really...It doesn’t really happen. It does happen... there are people who...in my experience it depends who are on [what staff are on] it depends on how busy they are – what else is also going on in the shift – sometimes everything is going wrong and you don’t have time to toilet certain people (Int-03).

Even though staff conducted a continence assessment for every newly admitted resident, staff generally did not necessarily know which resident would respond to a toileting assistance program. In other words they were not able to differentiate between intractable established incontinence and incontinence that could respond to a toileting assistance program or to medical treatment. The difficulty in predicting which residents would benefit from a toileting assistance program added to staff belief that toileting programs were an ideal form of care, but in practice were largely a matter of trial and error.
Residents’ incontinence and dependent continence status also compounded the ethical challenges of providing care because staff needed to find a way to respect residents’ rights to maintain independent bladder and bowel function, even when they were incontinent and did not perceive their need for assistance. Staff also had to respond ethically and sensitively to residents’ attempts to conceal the difficulties they experienced attempting to maintain independence. In other words, the challenges associated with addressing residents’ continence care needs in a way that respected residents’ rights were exacerbated when residents were cognitively impaired, did not acquiesce to staff intervention, and when staff interpreted residents’ responses as resistance.

Some residents also displayed behaviours that challenged staff beliefs and values about what was and was not socially appropriate behaviour. For example, staff described situations whereby residents hid incontinence pads or washed and attempted to dry them. One staff member described finding used pads in ‘strange’ locations. She stated:

_They [residents] throw them [pads] in the toilet or they drop it somewhere in the houses, or you find them in strange places [laughter]. You find them [pads] in garbage. Or some of them take them off when they have faeces in them and they don’t tell us. They try to also hide it [incontinence], but we always know who it is. If you work here on the floor, you know who it is. Because we have a lot of people here with dementia_ (Int-01).
Another behaviour staff found challenging was when residents were incontinent in order to gain attention from staff. A staff member stated:

*We have people who don't want to get up to go to the toilet. They don't care. There are some others who do it [incontinence] because then they can push the button [ring the bell] and they know that someone is coming and have some time for them and change them [their pad] (Int-01).*

In the process of conducting theoretical sampling, the researcher asked a manager whether he believed some residents’ incontinence could represent a behavioural disorder. The manager stated:

*I’ve got two residents actually in mind here in our high care area who I would feel would use it [incontinence] to gain attention, not because they are hostile to staff, just they want the attention. You can nearly predict. There are two particular dementia residents. And it’s when there is a whole lot of other activity going on and they are not getting particular attention and then you can see that behaviour (Int-07).*

In most cases staff attributed residents’ socially inappropriate behaviours, such as incontinence, to their impaired cognitive status. However, impaired cognition was not the only reason residents were incontinent or were socially inappropriate. According to some staff, some residents chose to be incontinent because it was their preference to use a pad to void or defeacate rather than use the toilet.
A staff member stated:

*Some residents are quite happy to sit in a pad and could actually go to the toilet but don’t because it’s too much effort so they void in a pad* (Int-10).

Another staff member described a resident who did not use pads when he left the facility to go on holidays, but on his return, he asked to wear pads. She stated:

*You get some people who like to wear them [pads]. It may be a behaviour that they become lazy too. We have one resident - he is quite capable to get up and go to the toilet or to use a bottle but his choice is that he wishes to have a continence aid during the day and night. Whereas the person did go away for 10 days. I asked him if wanted to take anything and he said no. So for that whole 10 days he walked to the toilet but since he came back, that’s it, I want that back’. His choice, he’d rather urinate in a pad than get up and go to the toilet or use a bottle* (Int-02).

Given residents’ high levels of dependence and accompanying challenging behaviours, staff felt continually challenged to meet residents’ care needs.
A devalued role

The third sub-category that comprised the basic social problem of ‘caring against the odds’ was ‘a devalued role’. Being respected and recognised for their role, competence, and for the care they provided to residents was important to staff. Most staff felt other people did not understand or fully appreciate their roles, and would react negatively to the knowledge they were a nurse or worked in a residential aged care facility. The conditions that contributed to a devalued role included: 1) stigmatised work; 2) heavy workloads; 3) a lack of appreciation of the complexity of the role; and 4) low wages (see Figure 5 below).

![Figure 5. Conditions that characterised the category ‘a devalued role’](image)

Stigmatised work

Heavy workloads

Lack of appreciation of role complexity

Low wages

A devalued role
Stigmatised work

One of the factors that caused staff, particularly PCAs, to feel devalued was their expectation that other people would hold negative opinions about them on the basis that their work involved contact with other people’s urine and faeces – which some staff termed ‘dirty work’. When staff informed other people about their role as a nurse or a staff member in a residential aged care facility, they expected people to respond with the refrain ‘I don’t know how you do what you do’. Whilst this comment could pertain to many issues, staff generally interpreted the refrain as ‘I don’t know how you deal other people’s incontinence and other body care needs’. One staff member believed other people would be disgusted by her role because she had contact with some ‘unspeakable matter’, as the following transcript from field observational data shows:

A PCA described her daughter’s response to her attempt to prepare food. The daughter allegedly did not want her mother to prepare her dinner – ‘after touching what you've been touching’ (Field notes site 1: AM shift 09/09).

Another staff member described her expectation that people would stereotype her as a wiper of people’s bottoms because she worked in a residential aged care facility. She said:

I think that continence and everything that is associated with working in residential aged care is that there is a lot of stigma behind it and everyone says
if you are a PCA and are working in a residential aged care facility, then your job is to wipe bums. I think that is the impression that everyday society has and I think that reflects on the everyday work that you do. Unfortunately societies input does have input into the everyday care (Int-05).

PCAs and ENs who had the most contact with residents on a day-to-day basis also described being limited to cleaning residents, which necessarily involved dealing with their incontinence. Staff described such work as ‘dirty work’. One staff member stated ‘we just do the wees and poos’. Another stated ‘your role as a nurse is to clean up really’ (Int-05). Yet another staff member stated: ‘You are a PCA so you know that it [cleaning up urine and faeces] is what you have to do’ (Int-01).

Having a role that involved managing incontinence and performing personal care generally positioned staff at the bottom of a staff hierarchy. A staff member stated:

*If you are a Div 2 [EN] your job is medication – so you do medication rounds and PCAs report to you if they are concerned about the resident. But you don’t get as much of the role as regards to their everyday care – their toileting, feeding – all of that goes down to the PCA. The PCA is just the one to report to the RN if they have any questions or concerns, but the PCAs do all the dirty work* (Int-05).
In the staff hierarchy, RN’s roles were largely limited to administration and paperwork. The demands of paperwork meant RNs felt removed from resident care and were seldom able to provide hands-on care, supervise or support PCAs. RNs had little occupational exposure to residents’ incontinence. Some PCAs felt resentful that ‘RNs just sat in the office and did paperwork’. In contrast, whilst RNs felt PCAs were an important part of the workforce, they were regarded as having little understanding of the RN’s role.

Staff had very clear opinions about which staff within the hierarchy could and could not help residents use the toilet or clean their incontinence. Field observations indicated RNs, lifestyle staff, and family members’ delegated so-called ‘dirty work’ to ENs or PCAs, mostly PCAs. Allied Health staff usually asked PCAs to remove residents with uncontained incontinence from their activities and to clean them. PCAs often resented such requests.

Organisational policies required PCAs or ENs to accompany residents on outings or activities convened by Allied Health staff if the outing or activity had residents who needed help to use the toilet. A staff member stated:

*PCAs go with them* [go on outings with Allied Health staff]. *It’s hectic because there is only one PCA for 11 or 12 residents. I’m the only one in charge of toileting and everyone else is more about activities. The others [Allied Health staff] will do the psychosocial and interacting and stuff* (Int-06).
When asked why Allied Health staff could not assist residents to use the toilet, one staff member stated that occupational health and safety rules allowed Allied Health staff to assist mobile residents use the toilet; however they were not allowed to assist residents who were not mobile. Some Allied Health staff covertly offered residents toileting assistance. PCAs and Nurses looked favourably on Allied Health staff who were willing to engage in such ‘dirty work’. Ironically, although Allied Health staff had limited involvement assisting residents to use the toilet, Allied Health staff were responsible for assessing residents’ toileting abilities and advising nurses and PCAs about strategies to assist the resident use the toilet. Some staff were aware of the irony of this situation and resented Allied Health staff telling them how to assist residents use the toilet, and leaving the actual day-to-day dirty work to nurses and PCAs. The following transcript offers an insight into one staff member’s feelings about the responsibilities of different groups of staff.

[Providing residents with toileting assistance] - that is just a PCA and nursing role. Some physiotherapists will pop them [residents] on the toilet and then come and tell us they are on the toilet. For the physiotherapists, that is part of getting to know what they [residents] can and can’t do, especially with their walking and to see if they can transfer up and down (Int-10).
**Heavy workloads**

Another factor that contributed to a devalued role was the fact that staff had heavy workloads. They described being continually rushed off their feet, under the pump, and unable to meet their own and other peoples’ expectations to provide care. They attributed their heavy workloads to a lack of government funding that caused service providers to employ a minimal number of staff to minimise as a cost saving measure. As previously indicated staff perceived they wore the brunt of inadequate funding for resident care because cost-cutting had a negative effect on their workloads and resulted in a situation in which they were unable to perform their roles. One staff member described the constraints to care as follows:

*Time is a big issue for them [staff]. Time and staff shortages are a big one. By that I mean there are just not enough staff. I’d say almost all places run on the minimal number of staff and that’s economically driven* (Int-17).

A student nurse who worked as a PCA during her course described the lack of status and workloads as follows:

*You get people who are just so overworked, underpaid, have to work far too many shifts. You have to work overtime because there are not enough people to cover shifts. You have to increase patient ratio, resident to nurse patient ratios because you have a lack of staff. No one wants to work in these facilities, because you get paid crap and it’s not a flattering job necessarily* (Int-05).
Lack of appreciation of the complexity of the role

Another factor that contributed to staff feelings of being devalued was the sense that other people did not appreciate the complexities of their roles. As previously indicated, staff described residents as highly dependent and unable to do anything for themselves. They perceived that the government in particular, did not understand the level of care residents’ actually required. Thus, staff cast themselves as advocates for residents as they alone had a deep appreciation of just how much care residents needed. A PCA described the complexities of her role as follows:

*It is very complex when you are in a nursing home. It is not only that you are a personal care worker or care worker. But what does it really mean? It means more than just washing or feeding. You observe the clients. You see the changes in them from day to day, hour to hour by assessing. Say for example, they are a little bit pale – something is going on. They are shaking...you are monitoring them, helping them* (Int-14).

Low wages

Some staff working in the current study felt they were devalued because they felt they underpaid for the work they performed. PCAs in particular, receive low wages and are very conscious of their subordinate position within the residential aged care staff hierarchy. In 2007, the NILS (2008) reported, two-thirds of PCAs earned between $500 and $1000 AUD per week. And although RNs receive considerably more pay than PCAs, their wages are not
commensurate with RNs working in other health care settings such as acute care. RNs in the residential aged care sector are paid at least 10% less than their peers in the acute care sector for performing similar or equivalent work. The Productivity Commission acknowledged residential aged care staff are highly dissatisfied with their pay and RNs find their pay inequity grossly unfair. Aged care providers commonly cite low wages and wage disparities as the reason for difficulties recruiting and retaining staff (Australian Government Productivity Commission, September 2008). It recommended:

*The Australian Aged Care Commission, when assessing and recommending scheduled care prices, should take into account the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services and the appropriate mix of skills and staffing levels for the delivery of those services* (Commonwealth of Australia, 2011).

**The consequence of the basic social problem**

The factors described in the current chapter collectively contributed to a situation in which staff struggled against multiple odds to deliver care that met residents’ basic care needs, let alone their other care needs. Staff were often frustrated, demoralised and disempowered with this situation. A staff member who had worked as a manager in many different facilities claimed staff felt frustrated when they were unable to reconcile their ideals with the reality of practice
She stated:

*Most of them [nurses and PCAs] the vast majority of them actually care about the residents ... they want to do a good job; they feel better if they know they are doing a good job. So it is a tension if they can’t do the job they want to do. There is always a tension. In that, every person you could spend the whole day with but at some point you’ve got to walk away and say OK, I’ve got to stop now and go to someone else. And that’s an ongoing tension* (Int-13).

As previously indicated, one staff member felt so distressed by the difficulties she encountered providing care that she used the metaphor of a ‘dog trainer’ to describe how she felt about her role. Another staff member was distressed when she reflected on the work conditions that resulted in residents being unable to access staff assistance to use the toilet because staff were too busy doing other things. She stated:

*And I think – oh my God – even to go to the toilet and the staff are busy and I don’t know, it’s just terrible and it’s not getting obviously any better* (Int-03).

The findings revealed that operationalising the requirements of the ACFI caused staff to conduct onerous and potentially intrusive checks of residents’ continence status, and in some cases, provide minimal resident support when they assessed and reviewed residents’ continence care needs in order to collect
information to complete questions four and five of the ACFI. More frequent checks optimised the chances that staff would identify a higher frequency of residents’ incontinence, and therefore, be able to claim a higher level of funding as did the practice of leaving residents without pads during the assessment phase. However because staff felt it was unethical or unrealistic to collect such information, they did not always conduct the checks they documented, and the forms they completed were often completed retrospectively. Hence, the information was potentially inaccurate. Another negative effect was that continence assessments were largely undermined because most staff equated an ACFI assessment with a clinical assessment.

Staff felt powerless to alter the regulatory framework that caused them to prioritise funding and compliance issues, and adopt a risk adverse approach to care. Staff also perceived they were powerless in the face of multiple competing duties or ethical responsibilities that caused some staff to override residents’ choice and autonomy. Staff perceived they lacked concrete options for care. For example, they felt they had no option other than to prioritise care that would keep residents clean. At the same time, performing personal care work consumed most of staffs’ working time, was regarded as ‘dirty’, ‘repetitious’, ‘rushed’, ‘heavy’ and ‘poorly paid work’, and did not give staff time to address residents’ other care needs. Moreover, staff who performed such personal care work were part of a staff hierarchy that was constructed partially on the basis of staffs’ occupational exposure to residents’ urine and faeces. They felt devalued and limited to work that centred on keeping
residents’ clean and dealing with their incontinence and other basic physiological needs.

Compounding the basic social problem of ‘caring against the odds’ was the fact that staff did not have feel they had the autonomy to alter the conditions that caused them to work with an inadequate number of staff to provide care, a lack of RNs, and with staff who were inadequately educated or lacking English language skills. Additionally, staff perceived they could do little to alter residents’ high levels of dependence, address the organisational issues that made it difficult for them to know residents’ care needs, or predict and control their work environment.

Summary

The current chapter presented findings showing staff encountered a basic social problem termed ‘caring against the odds’ that affected staff abilities to provide holistic, individualised, and resident-centred care. It also affected the way staff determined, delivered and communicated continence care. This problem was related to the highly regulated nature of the work environment, the ethical challenging nature of the care environment, residents’ highly dependent status, and having a devalued role. The next chapter describes the basic social processes staff employed to deal with the basic social problem of ‘caring against the odds’.
Chapter four

The Basic Social Process: Weathering constraints

Introduction

The preceding chapter revealed a basic social problem that was characterised by multiple constraints to residents’ day-to-day care and which caused residential aged care staff to be in a situation in which they were ‘caring against the odds’. This basic social problem affected how staff determined, delivered and communicated overall resident care, including residents’ continence care. The current chapter describes and explains the overall basic social process that the staff members used to deal with or respond to the problem.

The basic social process residential aged care staff members’ used to deal with caring against the odds was termed: ‘weathering constraints’. The metaphor ‘weathering constraints’ was chosen because it captures the staff members’ accounts of affectively and behaviourally dealing with the constraints they encountered in the context of performing their roles and accounts for how they continually attempted to resolve their main concern of delivering care in the face of multiple constraints. The data revealed two sub-processes the staff members used to deal with the basic social process. They included: (1) attempting to accommodate the context of care; and (2) adopting self-protective distancing strategies.
The first sub-process of the basic social process, ‘attempting to accommodate the context of care’, was characterised by six main strategies. They were:

1. Acquiescing to regulation.
2. Protecting residents.
3. Prioritising care.
4. Delivering ritualistic care.
5. Drawing on a range of sources of knowledge.
6. Accommodating a devalued role.

The second sub-process, termed ‘adopting self-protective distancing strategies’ involved three main strategies. They were:

1. Blanking out.
2. Using distancing language.
3. Reframing care.

For the purposes of clarity, the sub-processes and strategies are presented separately, however there is overlap between them and they are not mutually exclusive. Staff could adopt any one or all of these strategies. The remainder of this chapter presents the sub-process and related strategies that comprised the basic social problem. It includes excerpts of interview and field observational data to show the sub-processes and strategies the staff members’ adopted when trying to deal with the basic social problem of ‘caring against the odds’. A schema of the basic social process with the characteristics of the two sub-processes and their properties is illustrated in Figure 6 on the following page.
### Developing a paper trail of evidence of regulatory compliance
- Attending to cosmetic issues

### Protecting residents
- Using conditioning techniques
- Using skilled and therapeutic communication techniques
- Using strategies that caused and/or exacerbated residents’ distress

### Prioritising care
- Prioritising residents’ cleanliness
- Compromising care

### Delivering ritualistic care

### Drawing on a range of sources of knowledge
- Problem-solving
- Using written information
- Drawing on medical understandings
- Learning from others
- Following rules
- Using experiential knowledge and values

### Accommodating a devalued role
- Seeking occupational status
- Concealing care

### Blanking out
- Maintaining emotional distance
- Maintaining physical distance

### Using distancing language

### Reframing care
- Striving for the best
- Framing care as a dignity measure
- Espousing the greater good
- Normalising and downplaying
- Externalising

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**Figure 6. The basic social process, sub-processes, and strategies of weathering constraints**
Attempting to accommodate the context of care

Staff in the current study felt they had little control over the highly regulated nature of their work environment; the ethically challenging care situations they encountered; and/or their devalued role. As such, staff attempted to accommodate the overall context of care. In the current study, the researcher chose the term ‘accommodate’ to refer to a process in which staff adapted or conformed to, complied with, and buckled under to deal with the issues they encountered in the context of performing their roles. Accommodating responses contrast with those that involve active or open resistance, challenge, and defiance. The sub-process termed ‘attempting to accommodate the context of care’ is illustrated in Figure 7 on the following page.

Acquiescing to regulation

As indicated in chapter three, staff experienced a high degree of regulatory control in their day-to-day work that generated a climate of fear in which staff were preoccupied with activities that would secure funding for resident care, getting the facility over the line in terms of complying with regulation, and avoiding complaints, adverse events, and sanctions. Staff attempted to accommodate regulatory pressures two main ways. One such response was characterised by protective behaviours toward residents which is discussed in a later section of the current chapter. The second response involved developing a paper trail of evidence of regulatory compliance and attending to cosmetic issues as described in the following section.
Figure 7. Staff responses that characterised attempting to accommodate the context of care
Developing a paper trail of evidence of regulatory compliance

As indicated in chapter three, staff were very mindful of the possibility that Assessors could regard any documentation anomaly as evidence of non-compliance with standards or a false ACFI claim. Therefore, staff had to be particularly careful about what they documented. One staff member spoke about the possibility that their documentation could ‘let them down’ in terms of meeting the standards. The following data from field observations illustrates the importance staff gave to accurate documentation.

Jane is responsible for selecting and allocating residents pads. She advises that night staff give out the pads. They place each resident’s daily allowance of pads in residents’ wardrobes for use the following day. There is a list with information on the number and type of pad each resident receives. This information is also on a card on the inside of residents’ wardrobe doors. It is also documented in residents’ medical files. Jane advises that the information on all source needs to match because it may be audited and any discrepancy can ‘let them down’. As there is considerable work involved in ensuring that the information in each source document is accurate, Jane will request a shift where she can focus solely on the task of ensuring paperwork is accurate (Field notes site 2: PM shift 15-16/11).

However, having developed a paper trail, staff had to ensure it remained up-to-date and that information was consistent and accurate in all the places it was
documented. One of the strategies managers and service providers used to cope with the demands of keeping paperwork up-to-date was to set aside specific times for staff to focus on paperwork, which removed staff from clinical care. For example, the manager of one site designated one day a week for staff to focus on paperwork. All staff referred to the designated day as ‘the paperwork day’. On paperwork day staff checked that residents’ files were up-to-date to ensure there were no inconsistencies among the various forms of documentation. Staff found themselves in a situation whereby they had to spend more and more time and resources documenting care that may or may not have been provided.

Managers and service providers also responded to the documentation burden by delegating some components of documentation to senior staff, contracting it out, or employing specific staff such as ‘Quality Managers’ and staff whose main role was ‘doing the ACFIs’ [completing the ACFI documentation]. The consequence of having to develop and subsequently maintain a trail of paperwork that complied with regulatory requirements was that completing paperwork shifted staff focus from resident care to completing forms and keeping documentation accurate. As one manager stated:

*Accreditation has probably gone a little bit too far to the point that we are all buried under paperwork and that is taking us away from what we should be doing in looking after the resident* (Int-10).
Although staff spent considerable time collecting and documenting information to complete forms they thought might comply with regulation, as indicated in chapter three, staff could not always collect such information. As indicated in chapter three, multiple factors hindered staff from accurately completing forms. One such barrier was staff workloads and staffs’ prioritisation of residents care needs over completing forms. Another was the unrealistic nature of expectations about completing forms. For example, field observations drew attention to an organisational policy that required night staff to check some residents every 15 minutes, other residents every 30 minutes and other residents every hour. However, the time required to perform the number of checks as often as required exceeded the time staff had available, even if they had no other care to perform.

Staff indicated they attempted to accommodate the situation of being unable to fully comply with data collection procedures by completing forms retrospectively, or based on a best guess. Therefore, documentation did not necessarily reflect residents’ actual status or the care provided. Hence, documentation had a limited clinical usefulness. Staff concealed the difficulty they experienced adhering to regulatory expectations to document care. The consequence of concealing such difficulties was that staff were inadvertently complicit in generating a smokescreen of acquiescence to regulatory expectations.
Attending to cosmetic issues

Another accommodating response to regulatory pressures involved attending to cosmetic issues such as the appearance of the facility, the appearance of being well staffed, and as previously indicated, documentation that offered the appearance of adherence to accreditation standards. Some staff, particularly PCAs, were cynical about what they perceived was an attempt by managers and service providers’ to temporarily improve the cosmetic appearance of the facility in order to improve the chances of meeting regulatory standards when Assessors conducted on-site audit. One staff member who had worked as a PCA in three different facilities stated:

*I think it’s [the accreditation process] all rubbish! I’ve had a few different experiences in three different places. The first place they [the service providers] rented all this nice décor stuff and they had like a water feature and drinking fountains and a statue in the garden. And after, it all just went. I’ve had other ones where staff come in like an hour and a half earlier on the day, just to have everything all nice, showers all organised and breakfast right on time. I think its bullshit! I hate it!* (Int-16).

Another response to the basic social problem was to adopt an overly-protective approach to resident care, as indicated in the next section.
Protecting residents

An additional way staff responded to the highly regulated nature of the work environment was to adopt a highly protective approach to residents’ care. A staff member with extensive managerial and education experience used the term ‘overprotection’ to describe staffs’ responses to the highly regulated nature of the work environment and stated the problem was that staff had to decide between promoting residents’ independence or not. She stated staff adopted an overprotective response because they were afraid that adverse events could prompt investigations by the ACSAA. She stated:

_We don’t want them [residents] to hurt themselves. So its overprotection of the clients [we overprotect residents]. Nobody wants anything to happen to their clients [residents]. They [staff] are very protective of them [residents]. We do everything to protect them instead of allowing [encouraging] their [residents’] independence and its [the issue is] independence versus risk. And unfortunately at the moment, risk is winning every time – especially coming up to accreditation. And so this is what they [staff] do. They may not mobilise them as much, they might take their walking frame away from them so they don’t get up and walk. They might have them in bed for longer than they should be. They might have them on pads instead of having them on a toileting regime because they might get anxious when they are trying to go to the toilet. They [residents] might fall with [urinary] urgency. They [residents] might get very anxious which all leads to falls, so they [staff] try to minimise that by putting a pad on them_ (Int-12).
The Productivity Commission (2011) also expressed concern that the Australian government had adopted what it called ‘a zero tolerance approach to risk’ in the residential aged care sector, and stated it could have the inadvertent effect of undermining or ‘distorting’ care. It stated:

In the aged care sector, it seems that successive Australian Governments have tended toward a ‘zero tolerance to risk’ approach... Efforts to reduce risk to residents, often in response to a single unfortunate (but well publicised) incident, have added to monitoring and reporting costs and constrained the nature of the activities services are willing to offer their clients (p. 127).

Field observations revealed the following protective measures that were designed to minimise the risk of residents’ falling:

- Reminding residents of their risk of falling
- Discouraging residents from walking unaided.
- Placing residents’ beds in low positions to reduce the impact of a resident fall.
- Placing mattresses on the floor beside beds to reduce the impact of a resident fall.
- Using sensors to detect resident movement.
- Placing residents in chairs they could not get out of.
- Using lifting machines instead of promoting residents’ mobility
- Applying hip protectors to residents.
Staffs’ concerns about the need to protect residents, particularly cognitively impaired residents also influenced staff decisions about how they managed residents’ incontinence. As indicated in chapter three, staff described extensive procedures for determining what type and number of pads residents should use, when and if to take residents to the toilet, and the levels of assistance staff needed to give residents to use the toilet. They also described policies that required them to check and change residents’ pads at set number of times a day, or according to a fixed schedule.

Staff shared a strong sense of obligation to protect residents from pressure ulcers which they believed would develop if residents’ skin was exposed for long periods of time to urine and/or faeces. Staff also shared the belief they had to protect residents from malodorous, excessive, or visible incontinence which they felt could make residents feel undignified and embarrassed and cause them to socially isolate themselves in their rooms. Therefore, staff placed considerable value on residents’ use of pads and on checking and changing residents’ pads at regular intervals.

Another reason why staff valued residents’ use of pads was because, as indicated in chapter three, regulator, managerial and family expectations about keeping residents’ clean and the need to keep the physical environment clean. Not only would uncontained incontinence cause the physical environment to be ‘contaminated’, it would also generate considerable extra work for staff. Hence, staff were under considerable pressure to contain and conceal
residents’ incontinence, and pads were seen as the answer to these issues.

Data revealed staff adopted a range of communication and behavioural strategies designed to optimise the chances that staff could assist them address their continence care needs, such as their need to wear pads. These strategies were characterised by (a) conditioning techniques, (b) skilled, therapeutic communication techniques, and/or (c) strategies that caused or exacerbated residents’ distress.

Using conditioning techniques

The conditioning techniques staff used to help them deliver continence care included: reminders, repetition, and normalising strategies. Staff often found themselves reminding residents they needed to call for help to use the toilet because were at risk of falling if they attempted to walk to the toilet alone. Another often repeated instruction was that residents needed to wear and use pads because were not able to maintain continence. As part of theoretical sampling, the researcher asked a manager how residents’ ultimately accepted wearing pads. He stated:

*I think they [staff] spend time telling the resident just why it’s [a pad] important. That it’s there and it’s for their comfort. Not for anything else. And other people are using it and it’s not just you... It is quite difficult [when they have cognitive impairment]. So it’s time and repetition and eventually I think they [residents] probably get worn down* (Int-07).
Repetition and reminders were not only used to protect residents who were cognitively alert. As indicated by a comment from a PCA who worked in a Dementia Specific Unit, some staff also used repetition and reminders with cognitively impaired residents, albeit, with varying success.

So you explain why you give it [a pad] to them [residents]. [Staff say] ‘you [the resident] are not going to the toilet by yourself. You are going too late’. You have a chat with them, and five minutes later they have forgotten what you said to them so they have taken it [the pad] off and you notice that they have taken them off and then you tell the whole story again [laughter] (Int-01).

Another conditioning strategy involved gradually introducing pads to residents. Staff encouraged residents to initially trial wearing a small pad, a different combination of pads and pants, or pads/pants that resembled underwear. The comment below from a staff member shows how a staff member introduced the idea of using pads to a resident by describing it as a trial.

We had one resident who might have been continent for quite some time, but slowly all of a sudden she became incontinent and not realised that she's done it. But then I explained that ‘maybe it is time that we start using some continence product and would you feel comfortable about it? Try it for a week and if you are happy about it, we'll stay with it’ (Int-02).
The underlying intent was to assist the resident adjust to wearing a pad. Once the resident accepted wearing a small pad or a pad that felt like a normal pant, staff gradually increased the pad size or type to better accommodate the frequency and volume of the resident’s incontinence. A staff member described giving a small pad to a resident who constantly pulled out her pad. Staff introduced the idea of ‘net pants’ to the resident which were successful in keeping the pad in place.

*So this lady was pulling the pad out. So we put small ones in. Gradually we used our net pants instead of using the ordinary underwear. We use the net pants and the pads so it [the pad] stays there* (Int-04).

The strategies staff used were accompanied by normalising processes whereby staff told residents’ incontinence was a normal condition for their age; that most women who had borne children were incontinent; and that incontinence was associated with their medical condition. One staff member stated:

*I always try to empathise [identify] with them – ‘yes I’ve had kids’, ‘I know what happens when I laugh too much’. ‘It happens to us all’* (Int-03).

Staff also told residents they were used to dealing with incontinence and it was a ‘normal’ part of their job. Normalising incontinence and pad use were strategies designed to protect residents from embarrassment and help staff gain their acceptance to wear and use a pad.
Using skilled, therapeutic communication strategies

Communicating with residents in a skilled, therapeutic manner was another way staff attempted to gain residents’ acceptance. Skilled, therapeutic communication strategies included: using touch in an appropriate manner, making eye contact, speaking in low tones, offering residents choices, and using encouraging language and humour. Staff spoke about ways of interacting with residents they felt would enable them to assist residents with personal care activities such as going to the toilet, showering or bathing, and changing pads. A PCA with many years of experience described how she interacted with a resident to encourage him to accept her help to be clean after an episode of incontinence, and to wear a pad. She said:

_Slowly slowly, by talking to him – not telling him… ‘it’s OK love we going to clean up after you’. But there’s a way to talk to him – ‘Look we all have an accident – what we do is we change this and we keep this on for you – for your own protection – you can still go to the toilet’. And he feel good and he starts going out again and joining in the activities (Int-04)._ 

Some staff described very deliberate efforts to minimise the potential for residents to respond in a distressed manner to staffs’ efforts to assist them. During field observations, a PCA who had attended a one-day course on managing psychological and behavioural symptoms of dementia and who was responsible for advising other staff about said to the researcher she did not see the point in arguing with cognitively impaired residents about situations they
were unaware of, and unlikely to remember.

Mary emerges from her room and sits in her usual spot near the front door. The PCA [an older experienced staff member who had attended a course on ‘behavioural management’ and indicated she provided advice to other staff about ‘behavioural issues,’] tries to coax her back to bed, but Mary refuses. The PCA doesn’t argue with her. She says to me that she has always wondered why people attempt to argue reality with people with dementia (Field notes site 1: Night shift 10-11/09).

Skilled and therapeutic ways of communicating or responding also involved deferring care to a later stage. A PCA with many years’ experience working in a Dementia Specific Unit described the latter strategy. She stated:

Sometimes we just have to go back later, especially in the dementia area because usually they’ve [residents have] forgotten that you’ve tried ten minutes previously. Sometimes you try and it’s just not going to happen and then you keep them happy, keep them calm and keep trying (Int-16).

Another therapeutic and skilled technique that helped a staff member perform their role and address residents’ physical care needs involved breaking down a task, describing the task to a resident, and capitalising on the residents’ ability to be distracted.
A staff member described her approach to ‘winning residents around’. She said:

*Usually you can win them [residents] around a little bit like um. Yes, if they are resistive to showering you just say ‘you just sit here on the toilet and I will help you’. And bit by bit you can get the face-washer and wash little bits without them being too aware that they are actually getting nicely cleaned up. Like, while they’re distracted watching the TV or whatever, I can just slip their teeth in* (Int-15).

**Using strategies that caused and/or exacerbated residents’ distress**

Most staff anticipated that assisting residents with personal care activities such as checking and changing their pads would cause residents to feel embarrassed and distressed. Staff identified two groups of residents who they thought would be particularly distressed by their need to accept staff help to maintain continence or to manage incontinence. One such group were male residents who staff felt valued their independence more than female residents. Moreover, staff felt female residents were more accustomed to the ideal of wearing a pad than male residents. Another group of residents who staff felt would respond negatively to being incontinent or to being helped with their incontinence were residents with mild or moderate cognitive impairment. However, once residents were highly cognitively impaired, staff felt they were unaware of what staff were doing and hence, were less likely to respond in a distressed manner to staff efforts to assist them.
Some staff felt residents were distressed because assisting residents to manage incontinence confronted residents with a problem they wished to conceal. Encouraging residents to wear pads meant residents had to acknowledge in some form or another, the fact they were incontinent and dependent on another person for assistance with a highly personal issue. Staff, who had no choice but to deal with residents’ continence care needs on a daily basis, were acutely aware the care they provided was not always easy for residents to accept. A staff member expressed the situation as follows:

*Some people don’t like wearing the pads. And you are confronting them because they’re incontinent as well* (Int-10).

In addition to confronting residents, some continence care interactions were also characterised by communication and behavioural strategies that caused or exacerbated residents’ embarrassment and distress. The transcript on the following page shows an example of a staff member who chastised a cognitively impaired resident following a resident’s episode of incontinence. The staff member who reported having worked in a Dementia Specific Unit for many years described her attempts to encourage a resident to accept staff help to use the toilet, and her initial negative response to the resident’s incontinence being ‘everywhere’. She then asked the cognitively impaired resident whether she knew what a toilet was and pointed out her incontinence to her. The resident denied, or was unaware of being incontinent. The staff member persisted in her efforts to make the resident aware of, and admit her
incontinence. The resident allegedly became distressed when she ultimately recognised that the incontinence issued from her own body. The staff member reminded the cognitively impaired resident to call for help next time. The staff member said:

_We had a resident she is doing it [incontinence] everywhere and I said ‘oh no, not again…well what did you do?’ But they have dementia and when I ask ‘do you know what a toilet is?’ And she says ‘of course I know what a toilet is’. ‘Ok, but you did it on the floor’. ‘I didn’t do it’. She did it. Because the first thing is…’I didn’t do it, another lady did it’. I said ‘sorry it’s your pants, it’s your underwear…you are wet’. And they say ‘oh, oh yes. I am so sorry. I am so sorry. I am so sorry’. And I say ‘no, no, it’s ok…you don’t know…it’s an accident. Come on I’ll fix you up and now don’t be sorry. It’s my job. I don’t care. But I have to tell you, tell me if you need to go to the toilet, push your buzzer and I push you to the toilet so that we can be on time so that you are not wet’_ (Int-01).

Some staff expressed concern that residents may feel ‘as if they are in trouble’ from other staff following an episode of incontinence. For example, a staff member suggested that busy working conditions meant staff were sometimes unable to respond to residents’ need for toileting assistance and if residents’ didn’t anticipate the amount of time they would need to obtain assistance, they could become incontinent which would cause them to feel as if they were ‘in trouble’ from staff’.
In other cases, staff allegedly used physical force in their attempts to elicit residents’ acceptance to wear pads that would ‘protect’ residents. A staff member described observing other staff using physical force to obtain a resident’s acceptance of wearing a pad, and/or prevent them from walking to the toilet independently.

*I heard the yelling so I went to see what was going on and the staff are trying to put a pad on the man. Now the man is screaming and carrying on. ‘No, get away from me’. Why you would persist for a start after getting yelled at? Why you would want to be stuffing a pad down the man’s pants? I’ve got no concept. But I told them ‘leave him’. And the man is like... ‘get out’. And I said ‘leave him alone, leave him, he doesn’t want to wear it, big deal, he uses the urinal, leave him’ (Int-03).*

The transcript not only illustrates that some staff used force to apply a pad to a resident; it also shows the staff’ members’ alternate response which was to respect the man’s desire to not wear a pad, and to communicate to her colleagues that the resident was capable of using a urinal. The scenario suggests the two staff members’ who allegedly used force did not know the resident was capable of, and perhaps, preferred to use a urinal.

**Prioritising care**

A further way staff attempted to accommodate the overall constraints to care was to prioritise care. As previously indicated, staff were responsible for
meeting the physical and psychosocial care needs of large number of highly dependent individuals who had multiple care needs. Most staff described attempting to perform their role against a background of inadequate information about residents’ care needs, not enough staff to deliver the care, a lack of RNs, and a workforce with minimal educational preparation and English proficiency. These constraints contributed to a situation in which staff were faced with two or more equally compelling responsibilities.

In order to deal with the day-to-day demands of providing resident care within the context of these constraints, staff prioritised some aspects of their work over others. The data showed (a) staff prioritised residents’ cleanliness over their other care needs such as their need to socialise, and (b) made decisions about care that inevitably involved some degree of compromise.

*Prioritising residents’ cleanliness*

The value staff placed on residents’ personal cleanliness had a considerable impact on how staff determined, delivered and communicated resident care. For example, staffs’ sense of obligation to keep residents’ clean affected the time of day staff showered or bathed residents. Showering or bathing was a pragmatic way to clean residents from incontinence. Indeed, one of the reasons staff attempted to shower or bath residents as early as possible in the morning was because many residents were wet or soiled from nocturnal incontinence.
The following comment conveys, the importance to a staff member of keeping residents looking clean.

*We have a resident who is incontinent. At first he didn’t like wearing it [a pad] and he was always pulling the pad out when he is still able to ambulate [when he was mobile, the resident was able to remove the pad]. And when he lost his mobility, he was still restless and still able to pull it out. But we have to keep his dignity...sitting out there...otherwise he has to stay...[in his room]. Because you know the family is very typically of trying to keep him looking decent...keep him dignified [the family expects us to make him look decent and dignified]. So we have no choice, we have to use the incontinence pad. With those people [residents] who don’t ambulate or communicate anymore...[they are] just chairbound [unable to independently get out of a chair] and they are just sleeping, they wake and open their eyes and that’s it...those are the people that we just try to keep them clean so that when the family comes, they nice and clean and dignified. They’re not smell of urine or...*(Int-04).*

Not only does the staff member’s comment illustrate the sense of obligation she felt to keep residents clean: it also shows the staff member’s belief that being clean made residents feel dignified. It also indicates her belief in the dignifying effect of using pads because pads give the appearance that the resident is clean. Finally, it illustrates the underlying and pervasive belief that
staff had no other option but to promote residents’ use of pads.

Staff felt they were under pressure to achieve the goal of cleanliness for all their assigned residents within a certain predefined timeframe. A PCA described the pressure she felt to complete the task of showering her ‘clients’ before breakfast. She stated:

\[\text{At 7am the shift really starts and 7am is nearly dark and you have to get up the patients [residents] for shower. They are fast asleep and you have to shower them. Why do they have to be showered at 7am in the morning? That’s the routine that the nurses set up and if you have seven clients you have to shower them. And they set it up that you have to have all the clients showered before breakfast. Why can’t they be showered after breakfast? Some of them stay in bed after breakfast anyhow. So that was that particular nursing home (Int-14).}\]

When asked if she had ever managed to shower seven people before breakfast, the PCA laughter and stated:

\[\text{Never did! It was impossible. I feel pressured. And actually not by the nursing staff but by the peer co-workers who say ‘oh you haven’t done that. You should have...come on...get on’. You just have to get on with it (Int-14).}\]

Sometimes, as indicated in the preceding comment, pressure from ones’ peer
caused staff to feel they had no choice but to ‘get on with the job’ of prioritising residents’ cleanliness. Another staff member described what she termed a culture of bullying in her workplace, which caused PCAs to feel pressured to buckle under and conform, especially as they had few employment prospects and needed the work. She stated:

> A lot of these people [PCAs], they want the job, they need the job and they just get conditioned into it. Its, if you want a good time here and you want to be looked after at work rather than bullied, then you do it this way, cause this is the way we do it (Int-12).

Another reason staff prioritised residents cleanliness over other care needs, was because they believed other people, including residents, residents’ family members, managers, service providers and Assessors expected them to keep residents clean.

Staffs’ sense of obligation to keep residents’ clean also affected staff decisions about when they changed residents’ pads, which in turn affected the time of day staff assisted residents to get up and/or to return to bed. It was easier for staff to change highly dependent residents’ wet or soiled pads when such residents were in a lying position.

The duration and quality of residents’ sleep was another aspect of residents’ life that was affected by the need to prioritise residents’ cleanliness. Staff
expected most residents would be incontinent and therefore, unclean during the night. Consequently, they conducted a set number of continence care rounds each night during which they checked residents’ pads and changed them if they were wet or soiled. In the current study, observations of practice at night revealed the following:

- Staff conducted two continence care rounds in site one (a 50-bed facility): @ 0100hrs and 0500hrs. At 0100hrs staff checked 17 residents’ pads and at 0500hrs they checked 23 residents’ pads (a total of 40 resident checks for the night). Resident’s pads were dry on 18 (45%) of the 40 checks.

- Staff conducted three continence care rounds in site two (a 75-bed facility): @ 2130hrs, 2300hrs and 0500hrs. At 2130hrs staff checked 32 residents’ pads, at 2300hrs they checked 11 residents’ pads and at 0500hrs they checked 29 residents’ pads (a total of 72 resident checks for the night). Residents’ pads were dry on 56 (78%) of the 72 checks.

Therefore, of the 112 occasions where staff from the two sites checked residents’ pads at night, residents were continent (dry) 74 times (66%) which suggests staff prioritised residents’ cleanliness at night, which may have been misplaced for some residents. It also suggests decisions about care were influenced by other factors, including the need to adhere to ritual.

Staff values about residents’ cleanliness also affected residents’ participation in activities or social interactions such as outings. Staff attempted to ensure
residents were clean before they left their rooms and if a resident was unclean [incontinent] during a social activity, staff felt obligated to intervene to take them back to their rooms to clean them and assist them to regain a socially acceptable appearance. Some staff only encouraged residents who could use the toilet independently or residents who needed minimal nursing staff assistance to use the toilet to participate in outings. In part, this unstated policy was underpinned by the implicit understanding that only nurses or PCAs were allowed to assist residents use the toilet – not lifestyle or allied health staff. Other staff accommodated the dilemma by placing large size pads on residents whom they thought would have difficulty using a toilet whilst on an outing. Hence, outings were typically of short duration. Some staff believed using pads would enable residents to socialise more and would make residents with incontinence feel dignified.

Although staff prioritised work that kept residents clean, they did not cite residents’ incontinence as a reason for the pressure they felt to shower or bathe residents within a certain timeframe, or to wake residents to check and change their pads. Nor, did they recognise the impact of their values about cleanliness on their day-to-day practices.

Compromising care

In the process of prioritising residents care needs in order to accommodate the context of care, staff made decisions about care that inevitably involved some degree of compromise. Staff compromises included taking short cuts, rushing
care, completing forms retrospectively, omitting care, and in some cases, providing inappropriate care. Staff viewed the practice of sedating residents at night to manage any potential behavioural disturbances as a compromised, but nevertheless, necessary response to an inadequate number of staff rostered on at night. A staff member who managed a Dementia Specific Unit said residents who could have challenging behaviours were sedated at night to solve the problem of there being an inadequate number of staff rostered on at night to deal with such behaviours. Sedating such residents reduced the need for staff to deal with potentially disruptive and challenging resident behaviours. She stated:

*Sometimes the staff is reduced* [there are staff shortages]. *Once they* [residents] *wake up it will be difficult for them to go back to sleep and that becomes another problem. Because people with dementia...they tend to...their sleeping pattern is not stable...they are being given a* [sedative] *to aide them to have a good sleep during the night. Without the help of sedation they* [residents] *wouldn’t have any good sleep during the night because they tend to wander and be awake during the night. Some who is fully incontinent, what they* [staff] *do is...if there’re* [the resident is] *asleep they* [staff] *just leave them sleep especially if we have a resident with a behaviour problem...he* [the resident] *prefers that to be being disturbed. He* [the resident] *tends to get saturated with urine and totally become aggressive and miserable if you try to change him* (Int-04).
The staff member’s comment also highlights the tendency by some staff to reframe and thus, legitimise compromised care, which is discussed in a later section of the current chapter. For example, the staff member reframed the practice of administering prophylactic sedation as something the resident preferred and which was more acceptable to the resident than being woken during the night. The staff member’s comment also highlights the fact that staff had to consider a range of factors in order to determine what care to give. Specifically, it showed staff avoided checking and changing a resident’s pad at night if they thought the resident might respond combatively, or if they thought the resident would remain awake and distressed during the night. Field observations confirmed that staff had the unstated policy of delaying or avoiding night-time continence care for aggressive or distressed residents.

Compromised care occurred when staff felt they had to choose to respond to the care needs of one resident over another. For example, staff often encountered situations where they had to compromise a resident’s ability to remain continent because of the equally compelling need to address the care needs of another resident. When staff were not available or able to assist a resident to the toilet, staff felt residents either attempted to ‘go it alone’, or voided or defeacated into a pad.

Cognisant of the difficulties associated with consistently providing residents with toileting assistance, staff sometimes encouraged residents’ to void and/or defeacate into pads. One staff member felt staff would not need to rely on
residents’ using pads if there were more staff members available to enable them to assist residents to use the toilet. She regarded pads as a compromised, but necessary response to the situation of being unable to assist residents use the toilet because there were not enough staff available to provide such support. She stated:

If there was more staff and we had time to toilet them when they asked, we probably wouldn’t need them [pads] so much (Int-06).

Another staff member indicated when staff were unable to assist residents to the toilet they resorted to the practice of regularly changing residents’ pads. She stated:

Sometimes they [staff] really can't do the toileting and they just change the pads...they [staff] try to do it [assist residents to the toilet] but sometimes it is so busy (Int-01).

Another way staff coped with the compromising situation of being unable to respond to all residents’ need for toileting assistance was by being selective about which residents they assisted to go to the toilet. During field observations over an eight-hour period the researcher noted some residents received no assistance to use the toilet. Multiple factors influenced staff decisions about which residents they assisted to use the toilet.
According to one staff member, staff were more likely to assist residents to the toilet if residents were highly vocal and ‘insistent about needing such support. Staff also seemed to make decisions about whether or not to assist a resident to use the toilet on the basis of the resident’s physical dependence. Although it was common practice to assist residents to use the toilet just prior to their shower or bath, staff did not appear to assist residents use the toilet at other times of the day if they were highly physically dependent and/or confined to bed.

Another factor that influenced staff decisions about assisting residents to the toilet was the facility’s occupational health and safety policies. Some staff described rules that restricted them from using lifting machines at night, ostensibly because of the minimal number of staff rostered on at night-time. Hence residents’ whom staff felt needed to be transferred to the toilet using a lifting machine to void or defeacate at night were unlikely to receive toileting assistance. Staff accommodated such compromised conditions by encouraging residents’ to wear and use pads at night.

Another compromise some staff described was to encourage residents to use large, highly absorbent pads that did not need to be changed as often as smaller, less absorbent pads. A staff member indicated that staff would have more work to do if they put a small pad on a resident with a large volume of incontinence. In contrast, if staff applied a more absorbent pad than the resident needed, they did not have to check the pad as often.
She stated:

_If you put a smaller pad on a person who has a large void, well then you have to change the person completely whereas if you’ve allocated the more absorbent than this person needs, then you are only changing the pad and doing hygiene_ (Int-10).

Another staff member stated:

_Inadequate staffing means that those that are working are really run off their feet and the last thing they think about is changing the pad on Mrs Smith_ (Int-05).

Although staff were aware that residents and/or their family members were often distressed when staff were unable to respond to residents’ requests for assistance to use the toilet, staff did not always feel they had to power and authority to alter the situation. Staff accommodated the lack of control over the situation of a lack of staff to address residents’ care needs by explaining to residents and/or family members the constraints they experienced, as the following transcript shows.

_Some family members get quite distressed and we often do an acute plan and that’s so everyone on the floor knows that this family isn’t happy... that the resident has been wet at a certain time and that we need to toilet them more promptly...some of them [resident family members] get upset that the resident has been ringing for some time and nobody has come And I_
mean that does happen quite often. When you explain that there’s only two staff member and we need two staff members for that person...they will need to wait at certain time...but we try not to (Int-10).

In some situations, managers assisted staff to learn to compromise in the delivery of care. The following data from an interview with a manager describes her instruction to a new staff member whom she felt had to learn to modify her expectations about what was achievable for individual residents.

The manager stated:

She’s a lovely person and a good and thorough nurse and she would spend so much time with one resident that the other nurse would spend too much time frantically trying to care for the others. And I pointed this out to her. I said ‘you’ve spent so much time giving personal care to this one and completely neglected the others.’ The other six [residents] had missed out [on personal care]. When I put it to her like that...she said her mother had been in an institution and she really wanted to care for people the way she wanted her mother to be cared for. And that’s a lovely way to approach it. But she’d deprived the other six. So then the tension that we all live with...and you’ve really got to resolve that tension. Every person you could spend the whole day with but at some point you’ve got to walk away and say OK, I’ve got to stop now and go to someone else. When I spoke about the impact of it on the workload of the other nurses, she wasn’t so concerned, but when I spoke about the impact on the other residents, it touched her deeply. It hit a core point (Int-13).
In order to prioritise care to cope with the constraints to care, staff focussed on care they believed was important as well as achievable.

**Delivering ritualistic care**

Another accommodating response to the constraints staff encountered whilst performing their roles was to deliver ritualistic care. Field observations and interview data indicated staff developed set ways of working that was repetitive, rushed, routine, and appeared to be based on implicit and explicit rules about care. The researcher used the term ‘ritualistic care’ to describe such work patterns. Ritualistic care was rushed, predictable, rule-bound and routine.

Researcher observations of practice yielded numerous examples of ritual in the every-day care staff delivered. For example, as previously indicated, staff conducted night-time continence care rounds at set times and followed a highly ritualistic set of behaviours that involved checking residents pads, changing pads and repositioning residents. One staff member started her shift every night with a ritual of placing urinals near the doorways of the male residents she anticipated would call for a urinal during the night. Another staff member commenced her shift by ritualistically checking that all the doors and windows were locked. Staff also had a ritualistic approach to how they distributed residents’ pads at a set time each night.

Staff also delivered personal care in a ritualistic manner. One staff member
compared performing personal care work to working on a production line. She commented: ‘everything is rush, rush, move onto the next one [resident], feed this one, move onto the next one’ (Int-03). Another stated ‘it [performing personal care] is constantly task, task, task, task’ (Int-06). Yet another staff member alluded to what she perceived was a futile and repetitive effort because staff spent all their time assisting residents to get up for the day only to find they had to return them back to bed. She stated:

> It seems like we just get them [residents] up...all that effort...and then they go back to bed again (Field notes site 1: AM shift 09/09).

Rushing work was a response to the need to get through the workload and achieve the goal of cleanliness for all residents within a certain arbitrary timeframe. The pressure staff felt to complete residents’ personal care caused them to adopt a highly efficient approach to care. For example, staff commonly used lifting machines, which meant they could transport highly dependent residents to the toilet and bathroom quickly and safely. They set up trolleys with linen supplies, pads and rubbish bins, which they placed outside the rooms of residents being showered or bathed. Preplanning was efficient and enabled staff to access supplies quickly and efficiently, which in turn, enabled them to complete their work more easily.

Rule setting was part of the ritual. Staff described extensive rules they had to follow on a daily basis. They included rules about what care had to be
performed, by whom, and within what timeframe; about setting up trolleys, using lifting machines, distributing pads, checking medicines, disposing soiled or wet pads, the order and structure of handovers, etc. For example, in relation to continence care, staff were bound by rules about how often they had to check residents’ continence status, fill in forms about residents’ bladder and bowel function, and change residents’ pads. Staff had set times they had to check and change residents’ pads. A staff member stated:

*It* [changing residents pads] *would occur probably four times a night from 10pm until 6am. And they’ve also got times that they are required to change their pads. There is a time to change to change the morning pad, in the afternoon, there is a time to change the afternoon pad and whether or not that is full, for want of a better word, it is still changed* (Int-07).

Staff also described rules about how many pads each resident could have for the day and when staff could change the pads. These rules were largely related to managerial and staff concerns about the cost of pads. Staff had to sign a form if they used an extra pad for a resident.

*We have a pad box in each nurses station and they have extra pads in them so if anyone needs an extra pad there’s a form as well and they have an extra pad allocation and you have to put the residents name, the room number, and why...like incontinent of faeces...and you will have tick it and sign your name that you have given the extra pad* (Int-03).
Staff described having to justify why a resident needed an extra pad or a different size or type of pad. If staff used more pads than were prescribed in residents’ care plans, they could incur managerial disapproval. However if staff did not use enough pads, they could also incur managerial disapproval because equated infrequent pad use implied infrequent pad changes which increased residents’ risks of developing pressure ulcers.

The findings revealed staff also broke the rules in an attempt to accommodate the constraints they encountered performing their roles. For example, in order to determine whether residents’ continence care needed to be reviewed, managers monitored the number of pads staff used on residents. When staff used too many pads on any one resident, managers asked them to review residents’ continence care needs. Reviewing residents’ continence care needs meant staff had to recollect three days of continence information. In order to avoid doing a continence review and because of the need to deal with the situation at hand, some staff took pads that were allocated to other residents and stored them in obscure places in the facility in anticipation of needing them for another resident at another time. Other staff complained about pads that went missing and blamed the staff member who was responsible for the original allocation. Thus, accommodating the context also involved breaking rules when staff felt such rules interfered with their ability to provide care.

Rules were often developed following an adverse event or increased regulation. They were typically developed by managers or other senior staff.
The following data from field observations illustrates the contextual conditions that caused a manager to develop a new set of rules. It also shows the impact on the involved staff of the manager’s attempt to exert greater control over staff practice.

A staff member arrives for night-duty and notices a new form titled ‘Pressure Area Turn Chart’. She is advised that it lists residents that need to be repositioned during the night and that she has to tick and sign that she has performed the task. The staff member responds angrily and expresses concern that its use will result in a greater number of residents being turned unnecessarily at night, and that more residents will be awake. The form requires staff to complete the Norton Scale score for each resident, reposition residents at the listed times, document the date/time residents were repositioned, document if creams or emollients, or aromatherapy oils were used, if residents’ pads were changed and the position in which the resident was turned. As far as I can tell, the routine of care is no different from any other night shift. Staff conduct the same number of continence care rounds and appear to provide the same care to the same group of residents as the preceding night. I later learn that the manager developed the form following a complaint and investigation about a resident who had a wound at the time of her death (Field notes site 1: Night shift 10-11/09).

The manager’s reaction to the adverse event was to attempt to improve resident care at night by giving staff a list of residents who needed to be
repositioned because of the risk to their skin health. However, staff resented the list and regarded it as an attempt to restrict their autonomy. They resisted the rule, and attempted to thwart it by completing the documentation without actually altering their practice.

Another reason managers developed rules and increased the number of documentation-based prescriptive orders for ENs and PCAs to follow was because of changes in RN roles. As indicated in chapter three, RNs had increased managerial responsibilities and subsequent limited opportunity to provide clinical care. Consequently, they had less direct knowledge about individual residents’ care needs. To meet their professional nursing responsibilities to provide effective and safe resident care and to delegate care appropriately, RNs developed rules or documentation-based prescriptive orders requiring ENs and PCAs to check residents on a frequent basis and report to them if there were changes in certain predefined parameters such as changes in residents’ blood pressure or behaviour.

**Drawing on a range of sources of knowledge**

One of the many factors that contributed to the basic social problem was that staff did not always know the residents or their care needs. Staff attempted to cope with this situation by drawing on information from a range of different sources. The processes staff employed to deal with the lack of information about residents’ care needs included: (a) problem-solving, (b) using written and oral information, (c) drawing on their medical understandings, (d) learning
from others, (e) following rules, and (f) using experiential knowledge and personal values.

**Problem-solving**

Decisions about care were often based on problem-solving, which sometimes involved trial and error. Managers in particular, used problem-solving to determine residents’ individualised care needs. However, only one manager described using a problem-solving approach to identify the causes of individual residents’ challenging behaviours or ill health, which subsequently informed the development of residents’ care plans. She stated:

*Each one [resident] is so different. Each personality is so different. Their care levels are totally different. So we will look at Mary. Mary is resistant to everything but she will wear a pad. But Jean doesn’t want a bar of it. So you need to put some behaviour management strategies in place to manage things – to manage their individual situation. It all comes back down to individual choice. It’s all an individual thing. There’s no set rules for everyone. Everyone is so different and individual. You have to look at that person as a whole. You have to know their behaviours – the whole lot. Monitor that and then you put your plans in place. And you look at why this person...why is this happening? Why do you think this is happening? OK lets trial this, trial that. Look at her bloods. Do you think she has renal failure? OK just watch all these things. Put them in a fluid balance chart. Look at why these things might be happening. Let’s find a cause. You really do have to look outside the square (Int-15).*
Some staff used their personal frame of reference to problem-solve and at other times, they used a structured assessment approach. Although staff, particularly managers, emphasised the importance of a structured and individualised assessment to inform their decisions about care, they also used trial and error. In other words, trial and error was part of the problem-solving process. For example, although staff indicated they conducted individualised continence assessments to identify what pads residents’ needed; other staff suggested choosing the right pads for residents’ and determining when to change them was largely a matter of trial and error. One manager stated:

> Under ACFI we are required to do a 3-day bowel assessment...both urine and bowel. You do that. But we don’t start that until a few weeks after they [residents] are here, until we have a much better picture. We then make a [decision]. If they are incontinent we make a decision as to what best continence aid and what type we would actually use with them. And admittedly that is trial and error because some people [won’t keep their pad on]. We have one particular resident who at the moment won’t keep the normal pad on but will use the panties. So [the process of choosing the right pad for the resident] that was trial and error ...the panti pad... not pants with the pad (Int-07).

**Using written and oral information**

Staff also relied on being able to access up-to-date written and oral information about resident care to inform how they delivered resident care.

Staff stated they provided care that was consistent with residents’ documented
care plans. However in practice on a day-to-day basis, staff relied on information derived from verbal handovers and from notes they wrote during these handovers.

Facilities also had multiple lists such as lists of residents requiring; suppositories, wound care, urine tests, continence checks, cognitive evaluations, medical reviews, ACFI assessments, behavioural checks, pads, etc. These lists were typically kept in the staff office and night staff checked them to ensure they were complete. In addition, some staff wrote lists for new staff members such as agency staff so that they would be aware of the residents’ individual care needs. A staff member who worked as an EN in a residential aged care facility during her undergraduate nursing training stated.

*I've developed this list at my facility of every resident and their care plan so that if agency [agency staff] comes on, they get this information about the resident and their cues on how to help them and what they are like during the day...so that helps them* (Int-06).

Researcher observations also revealed staffs’ mainly relied on worksheets to know residents’ care needs. These worksheets which were located in each resident’s room contained information about the daily tasks staff had to perform for each resident. Likewise, each resident had a list in their room indicating the number and type of pads they were allocated, including information about when each resident’s pad needed to be changed. Similarly,
night-staff had a corresponding list of which pads they had to distribute to each resident.

**Drawing on medical understandings**

Staff also relied on their knowledge of residents’ medical illnesses to help them determine what care was needed and how to give care. However, staffs’ medical knowledge caused them to adopt either a passive or active approach to resident care, depending on their beliefs about whether residents’ conditions were treatable or not. For example, some staff believed residents’ incontinence was an intractable symptom of chronic and incurable medical conditions such as dementia and stroke. One staff member stated:

*It [incontinence] is part of their [residents’] complaint [medical illness]. It is part of their illness and the bladder has lost its control, the bowel has lost its control due to strokes whatever their illness will be* (Int-09).

As previously stated, a consequence of the belief that residents’ incontinence was not treatable was that staff did not necessarily adopt a proactive approach to identifying and resolving residents’ incontinence. In contrast, staff regarded UTIs as treatable and adopted a proactive approach to identifying and resolving UTI symptoms. When residents had UTIs they often developed behaviours that had a negative impact on staff and other residents. Staff were very mindful of the possibility that such behaviours could signify a UTI and acted promptly to seek a diagnosis and treatment.
**Learning from others**

Staff also indicated they learnt how to provide care from watching and listening to other people, mostly other staff, and from representatives of the pad manufacturing industry. Staff did not always document care and their personal knowledge was almost never documented. Thus, staff often learned on the job by observing other staff and asking questions. When asked how she learned to do the job, a staff member stated:

> You don’t know…it’s [information about the job] not written down. Its [learning about the job] hands on. You pass it [information about the job] down to the new staff. It’s never official (Int-06).

Staff, particularly new staff, stated they learnt how to provide continence care by following what everyone else did. A staff member stated:

> I think it [knowing how to provide continence care] is one of those things you learn on the job. The way it [incontinence] is actually handled, you learn on the job as opposed to sitting in a classroom. I was a PCA after my first year of University so I just did it based on what I learnt in the first year but there wasn’t very much speak of about continence during that time. My recollection of it is that you just learn on the job (Int-05).

Another source of information about continence care was from staff members who were responsible for supervising how staff used pads. A PCA who said
she was responsible for residents’ continence care oriented new staff and
PCAs to the continence products that were used in the facility and educated
them to avoid using creams or powders that could interfere with the
absorbency of pads. She stated:

*When we have new staff, it’s my job to orientate them to
what pads are all about and no creams, no powders – bare
minimum of cream because you put powder and it clogs –
its stops the absorbency of the pad. I teach the students
across the road as well [students doing a course at a local
TAFE]. They are doing a PCA course. So I go through all
the continence aids, catheters, illeostomy (Int-02).*

Staff also learnt how to provide continence care from representatives of the
pad manufacturing industry who provided staff working across all shifts with
free onsite education, free samples of pads, computer programs that enabled
staff to electronically order pads, stickers, lists, assessment forms, care guides,
and hangers with pockets that staff used to store individual residents’ pads.
Staff recalled learning about the need to protect residents’ skin by selecting the
‘right pad’, changing pads at the ‘right’ time, repositioning residents regularly,
using pads, creams, and pads, and avoiding powders. A manager described the
educational support from pad manufacturers as follows:

*I’ve dealt with quite a few organisations [pad manufacturers] for continence aids [pads]. They’ve
been very good. The education and the person who
provides the education is a Div 1 nurse. Continence is
obviously her area of expertise. I understand that it's a business and she is promoting their products as well. But here education has been really really good. She doesn’t focus so much on this particular brand. It’s about the different sorts of continence aids that are fairly universal to every organisation. And they are available on the phone all the time. They’ve got a really comprehensive website too (Int-08).

In some cases staff members’ beliefs about how to deliver care changed as a consequence of their educational experience. A staff member stated it was only when she became a RN that she questioned the time-honoured practice of getting residents out of bed, dressed and in the lounge room before morning tea. She stated she no longer agreed with the practice of rushing to complete residents’ personal care before morning tea and would not mind coming on a shift in the afternoon and finding some residents were still in bed. However as she believed ‘other staff would feel that they haven’t done their job properly if they don’t get all the showers done in the AM’, she did not challenge the way staff delivered care (Field notes site 1: Night shift 10-11/09).

Following rules

As previously indicated, knowing the rules of care also assisted staff to provide care. Knowing rules about which residents required assistance to use the toilet or have their pad changed, helped staff structure their daily work. Rules also helped staff to know which staff could do certain type of tasks. For example, as indicated in chapter three, staff had very strong views about the
social division of labour in the facility. For example, ‘PCAs felt they did all the dirty work’ (Int-05). An EN stated ‘PCAs were trained to shower you, wash you, change your pad, and feed you and that’s the extent of it’ (Int-06). PCAs described RNs and ENs roles as ‘doing medication rounds, running the ward, ensuring the documentations are done, filling in all the paperwork, getting residents’ personal details and doing the assessments’ (Int-06). One participant stated ‘lifestyle staff do the psychosocial stuff’. Another stated ‘PCAs and nurses do not teach residents’ pelvic floor muscle exercises…that would come under the physiotherapy role’ (Int-09).

Within the division of labour, managers were responsible for residents’ overall care and for delegating tasks and activities to other staff members. Managers commonly delegated residents’ continence care to staff members who had various titles including the ‘Continence Nurse/Person’, the ‘Continence Link Nurse/Person’ and the ‘Continence Advisor’. These staff members stated they were responsible for ‘assessing and managing residents’ incontinence’ and for teaching staff about continence care. In practice, their role was often limited to assisting staff determine which pads residents required and policing how staff actually used such pads. For example, they were responsible for ensuring staff did not change residents’ pads too frequently or too infrequently.

**Using experiential knowledge and values**

Experiential knowledge and values also influenced staff’s deliberations about residents’ care. Such knowledge enabled staff to anticipate residents’ personal
care needs such as their need to use the toilet, even when residents were cognitively impaired and unable to articulate their needs. One staff member indicated that staff developed personal and experiential knowledge about residents over time just by working in the facility. Being familiar with the facility and with residents’ and their care needs enabled staff to structure their work, fulfil their role, and deliver care in a way that met residents’ individual preferences. One staff member stated:

_You do get to know when the person wants to go to the toilet or the best time to get them up and put them on the toilet. Rather than getting someone up at 7am who likes to go to the toilet at 9am or 10am. So you try and wait until that person is up at 10am rather than getting them up early. That’s one of the things that happens with regular staff_ (Int-10.)

When staff were familiar with residents, they felt they could interpret resident individual behaviours that acted as cues to their needs. For example, one staff member spoke about being able to identify when cognitively impaired residents’ needed their pads changed from their facial expressions and behaviours. She stated:

_I’ve had experiences where you go and change the pad and you think that this has been on for hours and hours and no one has changed it and they [residents with dementia] know it. Even if they can’t speak – you can tell by their expression. And you go and change their pad and they are clean and dry and they get washed. They are just happier. They’re whole expression can just change_ (Int-05).
Knowing residents’ individual idiosyncrasies also enabled staff to recognise changes in their behaviour that might indicate underlying medical problems such as a UTI. A staff member working in a Dementia Specific Unit stated:

When you work all the time in the same house, you know them [residents] in and out and you even see when they are quiet or upset. We had one lady who was so mean [whose demeanour changed] and we know ‘ok, we have to do a full ward test - I think she has a UTI again’. I don’t have to do it [a urinalysis] because I know already that she had it. Because normally she is laughing and singing (Int-01).

Having experiential knowledge about residents was particularly helpful when staff cared for residents with cognitive or intellectual impairment because staff were better placed to identify such residents’ behavioural cues that indicated their individual needs, such as their need for assistance to use the toilet. As one staff member noted:

There is one resident whose got Down’s Syndrome and when he arks up [changes in behaviour] and starts being angry and aggressive generally it’s because he’s had an accident in his pants and you take him to the toilet and he’s completely calm again. If you get to know the resident…they have behaviours of when they want to go to the toilet. You get to know the resident and if they need to go to the toilet at different times to the set times (Int-06).
Staff also drew on their personal beliefs and values about the care they or a loved family member would want when determining how to deliver care. The following comment illustrates how a staff member’s personal beliefs and values informed her decisions about care.

> It can be me walking around or my Mum or someone else and they are dependent on a PCA and their mind is so far away and if it was me and I had an accident and need someone to help me too - You feel ashamed that you are wet...I try to go back to if it was me, what do I want from the staff (Int-01).

**Accommodating a devalued role**

As described in chapter three, the findings about the basic social problem revealed staff felt their roles were devalued because of the stigma associated with their work, excessive demands and expectations, a lack of appreciation of the complexity of their roles, and low pay. The data revealed three main accommodating responses to the devalued nature of staff roles. The first response was characterised by an attempt to seek occupational status. The second response comprised concealment strategies and the third response involved the using self-protective distancing strategies.

**Seeking occupational status**

Different roles within the residential aged care sector have different values and status. All staff, including PCAs, regarded PCAs as having the lowest role
status, whilst ENs had a higher status and RNs had the highest status. Some
ENs and PCAs sought to elevate their role status by taking on additional role
responsibilities such as responsibility for advising other staff how to manage
residents’ behaviours, or being responsible for residents’ continence care.
Others proudly described orienting, mentoring and teaching new staff
members, being in charge on shifts, doing wound dressings, and administering
residents’ medication. Being in a role that involved advising and training other
staff was important for one staff member who stated:

<My role], its nursing, physio, rehab and return to work
coordinator, I train the no lift policy. I do all that. In all my
years of experience, I wanted to suggest things, but I’ve
just been the little EN. So it [advising other staff] doesn’t
go down you know. Other places I work, you know, the
RN...OK that’s how it works (Int-09).

Having a leadership role was also important to some staff. An EN who
proudly indicated she was a facility manager suggested providing ENs with
leadership over PCAs was one way to retain ENs in the residential aged care
sector. She stated:

To keep them [ENs] in aged care we give them the team
leader role and give them other little duties on top of that
as well to keep them keen and happy. Give them that
leadership role over the PCAs (Int-08).
Staff members who were responsible for purchasing, distributing and controlling pads described having ambiguous status. Although they had increased status because they had the power to make decisions about how pads were used, and in some cases they were also responsible for educating staff about continence care, conversely they believed their work colleagues did not have a high regard for their role because it was linked to residents’ incontinence, and hence it was ‘not flattering’ (Int-08). Moreover, as previously indicated, because these staff members were responsible for allocating residents’ pads, they anticipated being criticised when pads went missing.

**Concealing care**

Another accommodating response to the negative role status involved concealing care. Even though personal care work consumed most of staff time, staff seldom spoke about such work. Staff described concealing the nature of the work that went on behind closed doors from families. They don’t see much of it [incontinence and care] (Int-06) said one staff member. Another stated:

*On the whole, most of them [family members] are quite satisfied that their resident is dry when they come in. They don’t see the rest of it. So long as they [residents] are clean. Most of them [family members] are quite happy with that* (Int-10).
Staff also tried to conceal and thereby protect families from knowing about some of things some residents’ did. A PCA felt that concealing information about residents voiding or defeacating in inappropriate places showed respect for the resident and/or their family. She said:

_They [residents] could have been quite dignified people and then they poop in the cupboards or in their handbags. You know they [residents] do the most disgusting things. If the family knew they would be just mortified. So I think there has to be that real confidentiality thing...that real respect for the residents and you don’t just talk about some of the things they do...especially to the family...depending on who the family is. But there are just some things you never ever tell them. They’re too horrible_ (Int-16).

Staff dealt with residents’ incontinence in ways that ensured incontinence remained concealed, contained and controlled. They provided personal care and continence care behind closed doors, in private and in residents’ bedrooms, bathrooms and toilets, and in the morning when there were few visitors in the facility. Incontinence was also concealed from view. Staff placed soiled linen in linen skips and pads in rubbish bins, which were removed from the public areas of the facility as quickly as possible to ensure there was no odour of urine or faeces. The invisibility of personal care work contrasted with the visibility of the work Allied Health staff performed, which was often used in marketing material and promoted in photographs strategically located throughout many facilities.
Adopting self-protective distancing strategies

The basic social process of ‘weathering constraints’ was additionally characterised by a range of self-protective distancing strategies. The category titled ‘adopting self-protective distancing strategies’ is illustrated below in Figure 8. It was characterised by three sub-processes: (1) ‘blanking out’, (2) using distancing language, and (3) ‘reframing care’.

![Figure 8. Strategies that characterised adopting self-protective distancing strategies](image)

**Blanking out**
- Maintaining emotional distance
- Maintaining physical distance

**Using distancing language**
- Striving for the best
- Framing care as a dignity measure
- Espousing the greater good
- Normalising and downplaying
- Externalising

**Reframing care**
- Striving for the best
- Framing care as a dignity measure
- Espousing the greater good
- Normalising and downplaying
- Externalising
Blanking out

Blanking out was characterised by: (a) maintaining emotional distance; (b) maintaining physical distance.

Maintaining emotional distance

Staff described a strategy that involved maintaining emotional distance from emotionally difficult or conflicting residents or situations. For example, staff felt it was important to emotionally distance themselves from their feeling of disgust when handling residents’ urine or faeces or other bodily fluids. Some staff described mentally dissociating themselves from their emotions as they attempted to deal with residents’ need for continence care. A staff member stated:

*Take yourself away from it* [resident’s urine and faeces].
*Don’t think that it’s disgusting, and don’t say that it’s gross.*  [Say] *that it’s natural* (Int-06).

Some staff also described distancing themselves from negative feelings about residents whose behaviours would, in any other context, not be tolerated. Thus, staff felt they had to accept, tolerate, excuse and rationalise residents’ verbal and physical abuse. The comment on the following page shows how a staff member rationalised a residents’ incontinence by laughing and reminding herself that the resident was not incontinent on purpose.
She stated:

_You know that they [residents] don’t know that they did it_ [incontinence]. _They didn’t do it on purpose and you think OK you clean it and sometimes and I laugh first_ (Int-01).

Another emotional distancing strategy involved remaining silent. Staff spoke about needing to ‘just get through the work’ or ‘just get on with things’ and ‘just do it’. As one staff member stated you’ just have to get on with it’ (Int-14). Many staff stoically coped with the work constraints because of their own and other people’s expectations about care. It was important to not only cope, but to also be seen to cope with the difficult conditions and expectations.

**Maintaining physical distance**

Staff blanking out responses also included physical distancing strategies. In order to perform their role and meet their own and other people’s expectations about care, staff adopted highly efficient methods of working that included maintaining physical distance from residents as well as from situations staff found distressing or disturbing. For example, getting a job done as quickly as possible with minimal resident contact or interaction was one way some staff attempted to deal with situations where staff interventions distressed residents. Some staff also adopted physically distancing strategies to deal with behaviourally distressed residents who they felt impeded staff from providing care they felt was more important.
Physical distancing strategies were also used to help deal with aesthetically unpleasant and ‘dirty’ body matter such as residents’ incontinence. These distancing strategies were validated by infection control policies that mandated staff adopt such measures in order to minimise cross infection. For example, staff kept residents’ urine and faeces at arm’s length by adopting ritualistic ways of working that involved using gloves, plastic aprons, masks, rubber boots, plastic bags, sprays. As one staff member stated:

*If it may be the bowels [if they have faecal incontinence]…you don’t know where to start. So the easiest way is to pop them [residents] in the shower – it’s easier* (Int-01).

According to one staff member, staff members tolerance of or ability to deliver care that involved managing residents’ bodily excretions differed among individuals. Whilst one staff member could deal with situations that involved having to clean residents’ faeces, others could not. She indicated staff dealt with the situation by taking over the resident’s care if a staff member was unable to emotionally deal with the situation. She stated:

*Sometimes you need a break from different residents. We have all got something that we are really like adverse to. There’s one person I work with…she cannot stand phlegm and snot [nasal secretions] whereas she’s quite happy to do the poop [faeces] and everything and then you have someone who cannot be with somebody when they’re vomiting or whatever. So if we know that about someone, we just take over and say ‘don’t worry, I’ll do it’* (Int-16).
A more far-reaching form of physical distancing was to remove oneself entirely from the situation and to resign. As previously indicated, most staff in the current study indicated they had thought of resigning, had resigned, or were on the verge of resigning because of the working conditions.

**Using distancing language**

An additional self-protective distancing or dissociative practice was to use distancing language. The term ‘distancing language’ is used in this thesis to describe using labels to refer to residents, and codes and abbreviations staff used to describe care. It also includes patronising or infantilising ways of speaking to residents. Examples of distancing language included the following terms or phrases:

- ‘Doing the hygienes’ – to describe assisting residents with personal care.
- ‘Doing the pads’ – to describe checking and/or changing residents’ pads.
- ‘Doing the feeds’ – to describe assisting residents to eat.
- ‘Doing the toileting’ – to describe assisting residents use the toilet.
- ‘Doing the ACFIs’ – to refer to the task of undertaking an assessment.

Similarly, the labels staff used to refer to residents included:

- The ‘dementias’ – to describe residents with dementia.
- The ‘self-initiates’ – to describe residents who attempted to use the toilet independently.
The ‘CVAs’ – to describe residents who had a diagnosis of a cerebrovascular accident.

The ‘furniture walkers’ – to describe residents who held onto furniture as they walked.

‘Full care’ – to describe residents who require the most help to perform their activities of daily.

‘Lifters’ – to describe residents who require the use of a lifting machine to transfer.

Terms of endearment such as ‘darling’, ‘love’, and ‘darl’ were commonly used in one of the two sites where field observations were conducted, and staff often referred to residents by their first names, or used pet names. One staff member approached a resident in a kindly familial manner, tickled her and repeatedly referred to her as ‘my little rabbit’. However, in the other facility, staff addressed residents by their title.

Reframing care

Another category of weathering constraints involved reframing care, which also involved portraying themselves, their colleagues, the facility, and the residential aged care sector in a positive light. Staff accounts yielded many examples of moralising, rationalising, justifying, explaining and reasoning about the care they provided. The properties of reframing care included: (a) striving for the best, (b) framing care as a dignity measure, (c) espousing the greater good, (d) normalising and downplaying, and (e) externalising.
Striving for the best

Some staff made sense of the constraints to care and of difficult or ethically challenging care situations by adopting the view that that the best thing they could do under the circumstances was to strive for the best. One staff member stated she felt satisfied she could make a small difference to a residents’ day. Another indicated that it was enough for her to know that at the end of her shift, she had made one resident day a bit brighter. She said:

*I just love making that person’s day a bit brighter and knowing that they are more comfortable because it is as they say God’s waiting room – but it’s like you’ve done something to make their last days with a smile knowing they are comfy and not in any pain* (Int-02).

Yet another staff member described the satisfaction she derived from making residents feel comfortable and clean. Another staff member spoke about looking for a leeway [a small window of opportunity] to offer residents some degree of choice about their care. She stated:

*Sometimes there’s a bit of leeway depending on the feel of the day on the weekend and we might let them have a sleep in and then we do them [shower or bath them] after breakfast. It depends who else is awake because we’ve got a certain amount of work we’ve got to get done – especially if they’ve got activities to go to. So you can’t sort of drag out the showering time too long. But occasionally they have breakfast in bed* (Int-16).
Striving for the best involved trying to achieve a balance between conflicting, competing expectations. For example, when trying to balance residents’ right to walk independently to the toilet with staff duty of care to protect residents’ from falling, some staff observed residents from a safe and unobtrusive distance. Having ensured a resident was sitting safely on a toilet, a staff member then stood outside the toilet doors to allow the resident to use the toilet in private. In contrast, other staff restricted residents’ attempts to walk to the toilet, as previously discussed.

All staff claimed to strive to do the best they could to meet residents’ care needs. For example, a manager described how she attempted to encourage staff to aim for the best, but also conveyed the fact that it was not always possible to deliver care consistent with one’s aspirations. She stated:

> As a manager I try to encourage people. I say ‘the ideal is up here, the reality is there’ [illustrates with hand movements to show ideal care being higher than reality]. You are not going to get up there but you can move toward it. So I’d probably say ‘the ideal is unachievable, but don’t settle for the baseline reality...move it up toward the ideal (Int-13).

In striving for the best, most staff, particularly managers attempted to project a positive and ideologically acceptable representation of themselves, their colleagues, the facility, and the residential aged care sector more generally. Managers adopted a managerial discourse as they spoke about ‘systems and
processes, policies and procedures, individualised assessments, care plans, review procedures, and audits’.

Other staff also attempted to project a positive and ideologically acceptable portrayal of themselves and the facility. ‘We are all family’ is how one staff member described residents and other staff. Staff described visiting residents in hospital, calling them their friends, attending their funerals, and being fond of the residents’ families. Within the context of these beliefs, some staff saw themselves not only as resident advocates, but also as their last line of defence, particularly when they felt most families had relinquished care.

Some such staff also claimed to deliver holistic, dignified, individualised, resident-centred care even though they felt it was not really possible. Similarly, staff frequently stated the facility was the resident’s home, and residents had the right to be treated in a manner that was consistent with being in their own home, but in reality, some staff felt such lofty ideals were just that – ideals. One staff member stated:

_We’re great at talking about patient-centred care, talking about residents involvement and that, but on a daily basis a lot of staff feel they just need to get the job done and they do it the way they’ve always been doing it because that’s worked for them_ (Int-12).
Therefore, as previously indicated, striving for the best was characterised by aspirations and rhetoric, and involved coming to terms with the reality that it was not possible to provide the type of care they wanted, and settling for less aspirational care.

**Framing care as a dignity measure**

The term “dignity” was part of staffs’ everyday language, particularly when staff spoke about incontinence and continence care. ‘We have to keep them nice and clean and dignified’ one staff member said. As previously state, most staff members believed pads dignified residents, but only if the pads contained and concealed residents’ incontinence. Hence, staff placed particular emphasis on choosing the ‘right’ pad. ‘Pads help residents with their dignity’ according to one staff member. According to some staff, different types of pads conferred different degrees of dignity. Hence, a pull-up pad or a pad that was not too large was considered more dignifying than other types.

**Espousing the greater good**

An additional property of reframing care that assisted staff to reconcile or manage the conflicting and constraining nature of their work was to appeal to, or espouse the notion of ‘the greater good’ associated with the care they provided. Staff beliefs about the greater good helped them provide care, even when residents resisted care. For example, some staff rationalised restricting residents’ mobility to prevent them from falling as a greater good than allowing residents to exercise autonomy to walk to the toilet alone. Believing
in a greater good was generally accompanied by the belief that many residents were incapable of making decisions in their own best interest.

Espousing the principle of the greater good associated with a particular course of action was accompanied by the belief that staff had no other choice but to deliver care as they did. For example, as described in chapter three, staff felt they had no option but to ensure residents wore pads. Some staff attributed the lack of options to a lack of staff and/or other organisational limitations. In such cases, staff portrayed care as necessary because the alternatives would be contrary to their professional duty of care, organisational rules, government regulations, and in some cases, by law. For example, one staff member felt she was required by law to use a lifting machine and another staff member when she wanted to move a resident who was highly dependent. Therefore when staffing levels were low and she was unable to rely on another staff member to assist her use the machine, she felt she had no choice but to encourage highly dependent residents to use pads as a substitute for the toilet.

**Normalising and downplaying**

Normalising and downplaying situations were other ways some staff accounted for situations. Having to clean up faeces from the inside of a resident’s handbag was abnormal in most social situations and settings. However, staff, who had to deal with such situations, reframed them as normal. Staff also normalised residents who displayed abnormal behaviours. The following field observations illustrate that staff normalised the dire
situation of repeatedly finding a resident crawling on the floor in a pool of urine at night.

Amy [pseudonym] appears oriented during the day. She interacts with her son during his visits to the facility. She knows her way around the facility and is able to locate her room. However, towards four o’clock in the afternoon Amy becomes confused and distressed. Her confusion and distress increase as the evening progresses. To minimise the risks of Amy falling at night, staff lower Amy’s bed to a very low position. This makes it difficult, but not impossible for her to get out of her bed. In addition to lowering her bed, staff put a mattress beside the bed to minimise the impact of a fall. As the evening and night progress, Amy’s confusion increases. On four occasions during the night, staff find Amy on her hands and knees at the entrance to her room. On each occasion, her clothes and bed linen and the floor are wet with urine. On each occasion, two staff members enter the room. They assist Amy to her feet, return her to her bed, change her wet pad and clothing and then proceed to clean the floor. There is minimal verbal interaction between the staff members and Amy. Staff express no emotions about Amy’s obvious distress and confused state. They tell me Amy sleeps and other nights she doesn’t. I get the impression that staff consider the situation to be normal (Field notes site 1: PM shift 09/09).
Researcher observations also drew attention to a process of normalising a resident’s distress associated with a traumatic past relationship.

*Mary [pseudonym]. is very restless and has an extremely anxious appearance most of the time. She licks her lips constantly and has unusual movements of her tongue. Her speech is often jumbled and incoherent. She continually paces the facility, albeit very slowly. On one occasion she enters a nearby resident’s room and drinks from a tap. She chokes as she attempts to swallow the water. No staff come to her aide. Occasionally Mary assumes a deep male voice and berates herself. Her voice then changes back into a female voice as she says ‘he is a ‘naughty boy isn’t he’. Mary is less anxious when staff are with her, however there are very few interactions between Mary and staff. However, in one such interaction a staff member notices that Mary’s pad is visible and falling down. The staff member guides Mary back to her room to change her saturated pad. On another occasion a staff member tries to reassure Mary that the person she seems to fear is not present in the facility and that Mary is now safe. The staff member’s response alleviates Mary’s anxiety temporarily. The rest of the time she is alone and anxious. She often calls out ‘nurse, nurse’. Most of the time, staff walk past Mary as they are busy. One of the staff members says ‘Mary’s just like that’ (Field notes site 1: AM shift 08/09).*

As previously indicated, staff framed residents’ incontinence as a ‘normal’ condition and regarded wearing pads as a ‘normal’ practice. Staff believed if residents were not incontinent at the time of admission to a residential aged
care facility, they very soon would be, especially if they required a high level of care. Moreover, the development of incontinence was considered a ‘normal’ state of affairs.

Another phenomenon that staff accepted as normal was the situation of being on the receiving end of violence from residents. For example, when asked about residents’ resistance to continence care, a staff member stated ‘I’ve been hit in the face. It just goes with the territory’ (Field notes site 2: 15-16/11 Night shift).

Normalising processes were characterised by attempts to downplay situations. For example, when describing difficulties providing toileting assistance a staff member felt other staff downplayed residents emotional responses to using pads to void or defeacate. She stated:

Someone [residents] who requires a hoist lift …the staff say that’s too much effort [to assist them to the toilet]. We’ll put a pad on them; they’re too much out of it to notice ….with bad dementia (Int-05).

Similarly, some staff downplayed residents’ emotional responses to being in a facility and being dependent on staff for care. Indeed, most staff felt residents’ got used to their situation over time. For example, when asked how residents reacted to being dependent on staff for assistance with continence care and wearing pads, a staff member stated:
I think they [residents] become used to it [receiving continence care] [they] become...you know...how they say prisoners become institutionalised...I guess in aged care they sort of become that as well don’t they because there is no more freedom to get up when they want, have their breakfast when they want, it’s 8am is breakfast, 10am is morning tea, this is this – you know what I mean. They are sort of used to it (Int-03).

Externalising

Another reframing response involved externalising incidents, events or situations – especially if they involved conflict. Externalising involved attributing responsibility to other people, such as other staff members or external agencies such as the government, and in some cases, to residents themselves. Generally, staff believed the government was responsible for the constrained nature of care, their devalued role, the need to adopt a risk-adverse approach to care, the need to focus on compliance and funding issues, and the associated documentation burden.

Furthermore, as previously indicated, RNs and ENs often blamed poor care on PCAs because of their limited educational background and English proficiency. Some claimed PCAs were only here [working in the facility] ‘for the money and don't care about the residents’ (Int-01). However, PCAs mainly attributed their inability to meet residents’ care needs to managers and senior staff whom they felt were not available, or did not ensure enough staff were on duty to address residents’ care needs, or provide them with enough equipment,
did not understand residents’ care needs, and who placed business interests ahead of resident care.

Some staff also attributed responsibility for adverse outcomes to the residents themselves. Hence, some staff framed adverse outcomes as residents’ responsibility. Staff described residents who ‘did not always follow staff advice; who sometimes insisted on doing things the way they wanted to do them; were difficult, lacking in motivation, attention-seeking, resistive to care and/or unable to do anything for themselves’. One staff member interpreted a resident’s fall, subsequent fractured hip and long-term use of an indwelling catheter as logical consequences of the resident’s failure to follow staff advice to wait for help to use the toilet. She stated:

*She signed a contract to say she wanted to do it all on her own [go to the toilet independently] and when I came back from holiday she had a broken hip...She [the resident] can’t get up now. She would have had to rely on staff...[She would have had] to ring the bell. So she opted to have an indwelling catheter. She had to do that. [Now] she doesn’t have to rely on [staff]. She opted for that [a catheter] because she can’t take herself [to the toilet] anymore* (Int-09).
Summary

The findings presented in the current chapter showed the basic social process staff used to deal with the constrained nature of care. The accommodating responses involved acquiescing to regulation, protective responses, prioritising care, delivering ritualistic care, drawing on different sources of knowledge, and accommodating a devalued role. These responses reflect an underlying sense of inevitability about the overall context of care and portray an environment in which many staff attempted to simply knuckle under and got on with the job as best they could. Also described were the self-protecting emotional and behavioural distancing strategies some staff adopted to help them deal with the overall constraints.
Chapter five

Discussion

An overview of the theory

The primary purpose of this research was to examine how residents’ continence care needs were determined, delivered and communicated from the perspectives of individuals who provided, assessed, or supervised such care. The rationale behind the research was that there was a need to further understand the issues that affect continence care, including the barriers and facilitators to such care in Australian residential aged care facilities.

As the researcher was interested in how staff cognitively and behaviourally provided continence care and in representing their reality, the research was conducted using grounded theory methods. The findings of the study resulted in a theory about how overall care, including continence care was delivered in residential aged care. The theory comprised: 1) a basic social problem termed ‘caring against the odds’ which described the main problem residential aged care staff experienced whilst performing their work, and 2) a basic social process termed ‘weathering constraints’ which explained how these staff grappled with, or responded to this problem.

Staff main concerns were about the difficulties they experienced addressing residents’ care needs in ways that were consistent with their values and beliefs. It
was apparent from the outset that it would not be possible to understand
continence care in isolation or without also taking into account the socio-political
context of carework in the residential aged care sector or the overall conditions
that affected care generally. Residential aged care facilities are highly complex
organisations, and in Australia they are also highly regulated. The findings reflect
this complexity. What emerged from data were findings about a basic social
problem that was characterised by broad contextual conditions as well as a basic
social process that described and explained how staff dealt with the problem.
Although many of the transcripts focus on continence care, the theory that
emerged was not limited to describing and explaining continence care.

The basic social problem staff experienced was being in a situation in which they
were ‘caring against the odds’. ‘Caring against the odds’ was characterised by
multiple constraints to care. The four subcategories that emerged from the data
analysis as having most impact on staff’s ability to perform their roles and deliver
care were: (1) the experience of working in a highly regulated work environment;
(2) encountering ethically challenging situations; (3) resident’s high levels of
dependence; and (4) a devalued role. How staff determined, delivered and
communicated residents’ care, including their continence care was influenced by
staffs’ experiences and interpretations of rules and regulation, ethical beliefs,
social beliefs and expectations, residents’ dependence, workforce constraints,
information about residents’ care needs, the predictability of the work
environment, and the devalued nature of their role.

The basic social process the staff members used to deal with ‘caring against the
odds’ was termed ‘weathering constraints’. Weathering constraints explains how staff responded to the constraints to care. It offers a theoretical explanation that accommodates the personal social, organisational and regulatory, factors that influenced overall care. The process was characterised by two sub-processes: 1) attempting to accommodate the context of care, and 2) adopting self-protective distancing strategies. Findings indicated staff attempted to address residents’ care needs, including continence care needs under highly constrained conditions that in turn, caused them to accommodate, acquiesce, conceal, protect, adapt, prioritise, normalise, compromise, ritualise, blank out, and reframe care. Figure 9 on the following page illustrates the overall theory about caring in residential aged care facilities.
Difficulty completing the Aged Care Funding Instrument
- Ambiguous Accreditation Standards
- Variability in Aged Care Assessors' expectations
- Adverse events and complaints
- Aged Care Assessors' visits
- Expectations to prioritise residents' cleanliness
- A competing duty of care
- Low staffing levels
- A low number of Registered Nurses employed in the residential aged care sector
- Staff with minimal educational preparation and English proficiency
- Inadequate information about residents' care needs
- An unpredictable work environment
- Highly dependent residents
- Stigmatised work
- Heavy workloads
- Lack of appreciation of role complexity
- Low wages
- Fear of being found non-compliant with regulations
- Multiple competing and conflicting expectations about residents' care needs
- Workforce constraints

Working in a highly regulated work environment
- Acquiescing to regulation
  - Developing a paper trail of evidence of regulatory compliance
  - Attending to cosmetic issues
- Protecting residents
  - Using conditioning techniques
  - Using skilled and therapeutic communication techniques
  - Using strategies that caused and/or exacerbated residents' distress
- Prioritising care
  - Prioritising residents' cleanliness
  - Compromising care
- Delivering ritualistic care
  - Problem-solving
  - Using written information
  - Drawing on medical understandings
  - Learning from others
  - Following rules
  - Using experiential knowledge and values
- Accommodating a devalued role
  - Seeking occupational status
  - Concealing care
- Blanking out
  - Maintaining emotional distance
  - Maintaining physical distance
- Using distancing language
  - Striving for the best
  - Framing care as a dignity measure
  - Espousing the greater good
  - Normalising and downplaying
  - Externalising
- Reframing care
  - Weathering constraints
  - Drawing on a range of sources of knowledge
  - Following rules
  - Using experiential knowledge and values
  - Seeking occupational status
  - Concealing care

Figure 9. A theory about caring in residential aged care facilities
The basic social problem: Caring against the odds

The finding of the basic social problem termed ‘caring against the odds’ is supported by a number of recent reports. Specifically, the Hogan Report (2004) titled *Review of Pricing Arrangements in Residential Aged Care* and the more recent Productivity Commission report (2011) titled *Caring for Older Australians* both highlighted the need for fundamental reform to the Australian residential aged care sector. The Productivity Commission (2011) stated the sector suffered key ‘weaknesses’, such as difficulty for older people and their carers to navigate the system, limited choice and services, and services that were of variable quality.

Contemporary research about providing care in residential aged care facilities also supports the finding from the current study about the constrained nature of care in Australian residential aged care facilities. For example, a recent qualitative study involving 58 nurses working in residential aged care facilities in Queensland identified a range of factors that restricted staff from caring practices and from creating a ‘home-away-from home environment that older people would find acceptable (Tuckett et al., 2009). Two such factors were under-staffing and the organisational imperative to complete documentation for regulation which eroded the time staff had available to provide care. Similarly, Edberg et al. (2008) conducted focus groups with 35 nurses who cared for people with dementia in day care centres, home care and residential care in Sweden, Australia and UK in order to explore their experiences of strain associated with care. Using qualitative latent and manifest content analysis, Edberg et al. (2008) identified three main themes: (1) ‘being unable to reach’, (2) ‘trying to protect’; and (3) ‘having to balance
competing needs’. As in the current study, a key source of strain was nurses’ inability to deliver care they thought individuals with dementia required.

Using a case-study approach about three residents, non-participant observation of the nursing care, and a discourse analysis of current documentation pertaining to the resident’s nursing care, De Bellis (2006) provided a more critical view of the residential aged care sector. She claimed a culture of haste and bustle in an extremely noisy and public environment created by unknowledgeable care workers led to custodial mechanistic care and to unsafe, unethical, unprofessional, and negligent practices, as well as fraudulent, illegal, and dangerously out-of-date documentation practices. Although the findings of the current study also showed documentation did not always reflect residents’ actual status and staff did not necessarily rely on documentation to guide their care, there are considerable differences in how such data were interpreted. Whilst De Bellis (2006) interpreted the data using a critical analysis framework, the grounded theory method employed in the current study involved interpreting data from an emic or insider's perspective. Therefore, the current researcher did not interpret the difficulties staff encountered as either illegal or fraudulent, but rather, showed the context that gave rise to constrained caring. One such context was the experience of working in a highly regulated work environment.

**Working in a highly regulated work environment**

The residential aged care work environment is characterised by multiple rules and regulations governing what staff feel they can and cannot do. Consistent with
Tuckett et al’s (2009) finding, the current study revealed working in a highly regulated work environment caused staff to be preoccupied with activities that would demonstrate their regulatory compliance and secure and retain funding for the facility. It also caused staff to be highly fearful about possible anomalies in documentation, complaints and adverse event that could result in sanctions and a corresponding loss of funding.

Regulatory pressures caused staff to perform onerous and intrusive checks of residents’ incontinence, develop overly-ambitious care plans, focus on the ostensive aspects of regulatory compliance, and adopt an overly-protective approach to resident care. Staff were powerless to alter the highly regulated nature of the workplace. Indeed, to rail against regulation was to bite the hand that fed them. Likewise, staff were caught between a rock and a hard place in terms of trying to comply with regulatory requirements and their duty of care to prioritise residents’ care.

The Hogan report (2004) and the Productivity Commission (2011) also identified a high degree of regulation and red tape within the residential aged care sector. For example, the Productivity Commission (2011) stated “some of the regulations imposed on the sector provide relatively little gain compared to the costs they impose…Getting the regulatory balance right is not easy, but there is a strong case that in some areas the balance has tipped too far toward over-regulation to the detriment of the efficiency and effectiveness of the system” (p. 127).
One of the consequences for staff of working in a highly regulated work environment was that they had an excessive paperwork to complete. The Productivity Commission (2011) cited excessive paperwork as an impediment to attracting and retaining staff, and identified the need to comply with regulations concerning mandatory police checks, reporting of missing residents, and mandatory reporting of assaults as factors that added to the regulatory burden. It stated:

*Like unannounced visits by the Aged Care Standards and Accreditation Agency, these [requirements to demonstrate compliance with government regulations] may be part of a well-functioning regulatory environment, but how they have been implemented is raising costs unnecessarily and limiting innovative alternatives* (p. 129).

Research from other countries indicated when staff perceive regulation as a barrier to care, it can inversely affect and interfere with staff ability to address residents’ social and emotional needs (Colón-Emeric et al., 2010; DeForge, van Wyk, Hall, & Salmoni, 2011; Foner, 1994). Using a critical ethnographic approach to examine the effect of introducing new legislation and a standardised resident assessment instrument into Canadian ‘nursing homes’, DeForge, van Wyk, Hall, and Salmoni (2011) found policy-driven structural mechanisms yielded unintended consequences that can have a major impact on frontline workers’ abilities to deliver care. The researchers stated “government initiatives designed to ensure accountability and transparent quality of care in ‘nursing homes’ can in fact, (re)produce conditions that result in staff being afraid and to feel as if they are unable to care, and thereby adopt a risk adverse approach to
care” (DeForge et al., 2011, p. 145).

Likewise, Colon-Emeric et al. (2010) examined the influence of regulation on the mindfulness of staff behaviour in eight ‘nursing homes’ in the US. The researchers claimed “facilities’ strong fear of citations [sanctions] could paradoxically reduce care quality” (p. 1292). It is possible the very policies and processes that are designed to improve the quality of care in the Australian residential aged care sector could, in fact; undermine care by driving the difficulties associated with complying underground. As such, Australian policymakers should be aware that a regulatory framework that staff find punitive may cause staff to shift focus from residents’ physical health and psychosocial wellbeing to practices that centre on securing funding and avoiding sanctions.

The effect of working in a highly regulated work environment on continence care

Working in a highly regulated nature of the work environment had an inadvertent effect of undermining residents’ continence care and potentially, other forms of care. This situation occurred because of the financial imperative for staff to secure funding for the facility and minimise the risk of being found non-compliant with the Accreditation Standards. Staff found themselves in a situation of having to prioritise the assessment activities to complete the ACFI and maintain evidence of regulatory compliance, rather than focus on assessment activities to guide residents’ clinical care. In practice continence assessments were a function of contested values about the need for funding, regulatory compliance and clinical
care. These contested values caused some staff to not only to believe they had to prioritize the ACFI assessment: but also to believe the ACFI assessment and the assessment to guide clinical care was one and the same activity. The net effect of combining data collection for ACFI with data collection to guide residents’ continence care was that staff focussed on obtaining information about two assessment factors only: 1) the frequency of residents’ incontinence and 2) the level of assistance residents’ needed to use the toilet.

Residents were therefore short-changed in terms of receiving a comprehensive continence assessment. Instead of conducting a comprehensive continence assessment that assisted staff identify reversible causes of incontinence and differentiate between residents with transient incontinence and those with established incontinence, many staff felt they only needed to assess residents’ incontinence frequency and need for assistance to go to the toilet, as this was the information they needed to complete the ACFI, and decide what pad residents’ required and when staff had to change the pad.

The lack of appropriate assessment to determine residents’ continence care needs in Australian residential aged care facilities is consistent with research conducted in other countries such as the US and the UK (Georgiou, Potter, Brocklehurst, Lowe, & Pearson, 2001; Pringle Specht, Salsbury-Lyons, & Maas, 2002; Rodriguez, Sackley, & Badger, 2007; Wagg et al., 2008; Watson, Brink, Zimmer, & Mayer, 2003). In the US, Watson, Brink, Zimmer, and Mayer (2003) reviewed the medical records of residents in 52 nursing homes to evaluate whether the US AHRQ guidelines for evaluating and managing urinary incontinence were used.
The researchers found 80% of residents had potentially reversible causes of urinary incontinence, however only 34% had all of the causes addressed promptly. A similar lack of assessment was found in a nation-wide audit of faecal incontinence in older people in the UK. Potter et al (2007) found patients with pre-existing faecal incontinence admitted to ‘care homes’ were managed using containment strategies, instead of being assessed for causes and possible treatment.

Whilst findings from such research suggests the lack of appropriate assessment of residents’ incontinence is due to a lack of staff knowledge and skill about assessing and managing incontinence, the findings from the current study suggest the lack of appropriate assessment of Australian residents’ incontinence may also relate to the funding model and accreditation framework. Policy-makers should consider disentangling assessment processes for funding purposes and assessment processes for clinical care.

The requirement to complete forms and comply with funding requirements also led to a situation in which staff felt compelled to check residents’ continence status as frequently as possible when assessing and reviewing residents’ continence care needs. The more frequently staff checked residents’ continence status, the more likely they were to find the resident incontinent and be in a position to claim a higher funding. Hence, the funding framework contained an incentive for staff to engage in care that could be considered unethical. The procedures involved in collecting data to complete questions four and five of the ACFI which relate to residents’ continence care needs, were difficult, onerous, and in some cases, caused residents deep distress. Given these findings, there is a
need to objectively measure the time and resources involved in collecting information to complete all aspects of the ACFI and determine whether they are actually needed. Moreover, as the procedures involved in collecting such information may be ethically questionable, it may be worth considering obtaining such information in a less onerous or intrusive manner – for example, by using an electronic monitoring device.

*The limitations of the accreditation framework to appraise continence care*

Ideally, any shortcomings in residents’ continence care should be identified by Assessors as part of standard accreditation process. One of the key objectives of the current study was to analyse and describe how Assessors from the ACSAA evaluated and documented the quality of continence care in residential aged care facilities. The content analysis of accreditation reports shed very little meaningful light on the quality of residents’ continence care. Most simply documented that the facility had systems or processes in place to meet residents’ continence care needs, or that residents were assessed to determine their continence care needs. Critical information was missing from reports about the factors that were assessed or the outcomes of such assessments. In the absence of such information, it is unclear what system, or process facilities had in place and what aspects of residents’ continence care needs were actually assessed.

Arguably, the lack of specificity about the Accreditation Standards creates uncertainty and the lack of specificity about Accreditation Standard 2.12 in particular, means it is possible that Assessors could be evaluating systems and
processes that inadvertently endorse, promote and reinforce passive continence care in Australian residential aged care facilities. Furthermore, facilities may be passing accreditation standards because they have a documented process or system in place, regardless of the quality of the process or system. A number of submissions to the Productivity Commission (2011) such as the following submission, also highlighted the possibility of such gaps in the existing accreditation framework.

Most facilities pass accreditation because managers and staff know how to subvert the process. It is not about care given, it is about having systems in place and on paper. It is irrelevant whether or not those systems are functioning because the real, tangible outcomes are not looked at, that is, the actual care delivered (or not) in the bathrooms and the bedrooms. (Submission no. 253) (p. 28).

However, the DoHA defended the lack of specificity about the Accreditation Standards and claimed the standards are not designed to be prescriptive. The DoHA stated “they [the Accreditation Standards] do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its residents. It is not expected that all residential care services should respond to a standard in the same way” (Commonwealth of Australia, 2008) (Part 3. Accreditation Standards, Section 18.9).
The proposed new Accreditation Standard

Recent government initiatives designed to strengthen the accreditation process and minimise inconsistent evaluation and reporting processes include a draft set of revised accreditation standards. The proposed new continence care accreditation standard advocates promoting continence and maintaining continence where possible. Staff will need to demonstrate they manage the resident’s continence condition and monitor and respond to residents’ needs in a way that promotes the resident’s privacy and dignity (Australian Government Department of Health and Ageing, 2011a).

The revised accreditation standard could help reframe language about care to incorporate terms like privacy and dignity; however, unless there is a way to measure such concepts, the accreditation process will continue to be open to misinterpretation. For example, data from the current study suggests the term ‘dignity’ is already open to use and misuse. Several staff equated dignified continence care with using pads. The lack of specificity about Accreditation Standard 2.12 (e.g. continence management) leaves open the possibility it will be subverted by the pad manufacturing industry that has a vested interest in promulgating and sustaining the belief that residents’ dignity is a function of selecting ‘the right pad’ and changing it at the ‘right’ intervals.

If dignity is to be used as an organising principle to guide care in residential aged care facilities, and particularly, continence care, there is a need to agree on its operational definition. Staff and service providers should not be left in a situation
of having to second-guess the accreditation goal posts and deal with standards and terms that are vague and open to subversion and misinterpretation.

**The need for clinical indicators of quality continence care**

One way to shift the focus from accommodating regulation to promoting an active approach to resident care could be for staff to use clinical indicators or outcome measures to guide resident care. The Productivity Commission (2011) also recommended what it called a ‘Quality and Outcomes Data Set’ to underpin the quality assurance framework for the aged care sector.

Considerable work has already occurred towards developing clinical indicators for use in the Australian residential aged care sector (Commonwealth of Australia, 2007, 2011; Courtney, O'Reilly, Edwards, & Hassell, 2007; Courtney, O’Reilly, Edwards, & Hassall, 2010; Courtney & Spencer, 2000; Department of Human Services, 2007; Nay et al., June 2004). Specifically, in 2007, Courtney, O'Reilly, Edwards, and Hassell (2007) developed a ‘Clinical Care Indicators’ (CCI) tool that addressed 23 areas of care within four care domains: (1) resident health, (2) personal care, (3) resident lifestyle, and (4) care environment. The CCI tool was developed with reference to the Minimum Data Set (MDS) quality indicators, which have been credited with improving quality in US ‘nursing homes’. Clinical indicators used in the MDS to rate the quality of continence care include:

1. Evidence that indwelling urinary catheters are only used for medically valid reasons.
2. The catheter is removed as soon as clinically warranted.
3. Efforts are made to restore or improve residents’ bladder function as much as possible.

4. Efforts are made to prevent catheter associated infection for residents with an indwelling catheter (Palmer, 2002).

Using the CCI tool, Courtney, et al. (2007) recommended that the quality of residents’ continence care be evaluated on the basis of two indicators. They include: (1) the prevalence of bladder incontinence and (2) the prevalence of bowel incontinence.

Whilst clinical indicators that measure the prevalence of incontinence may be beneficial in so far as they may provide an incentive for staff to adopt a more proactive approach to preventing or minimising residents’ incontinence, there is a need for agreement about what constitutes quality continence care and the best ways to measure it. Based on the findings of the current study, there are considerable barriers to obtaining accurate information about the frequency and severity of residents’ incontinence. Even if it were possible to obtain accurate information, another issue that needs to be considered is the lower threshold point that would indicate poor quality continence care.

A further consideration is that even with the best efforts, staff may be unable to reduce or prevent some residents from experiencing incontinence. For example, residents with severe dementia who do not respond to toileting programs are unlikely to regain continence. If the quality of continence care were to be judged on the basis of residents’ rates of incontinence, service providers may be less
willing to admit severely cognitively impaired and incontinent residents so that they would not to be regarded in a negative light.

In 2010, Hutchinson et al. (2010) conducted a systematic review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0 in order to assess the validity and reliability of the RAI-MDS 2.0 quality indicators. The reviewers identified 14 eligible articles and one report which examined (a) individual quality indicators and (b) multiple indicators. The researchers concluded although the quality indicators provide a useful tool for quality monitoring and to inform quality improvement programs and initiatives, there was inconclusive evidence for their reliability and validity. They recommended other sources of evidence of the quality of care processes should be considered in conjunction with quality indicator results.

Furthermore, findings from a study by Schnelle et al. (2003) raise concerns about the need to ensure quality indicators measure what they intend to measure. Schnelle et al. (2003) compared two groups of US nursing homes to see if there were differences in how staff delivered care in homes that scored well on the continence care clinical indicators compared to those that scored poorly. The researchers checked residents’ care plans, interviewed incontinent residents, and observed practice to see if residents’ documented care correlated with the care they actually received. A noteworthy finding was there was no difference in the frequency of toileting assistance received by incontinent residents who were rated on the MDS as receiving scheduled toileting compared to those who were rated as not receiving such assistance. In other words, “the MDS incontinence quality
indicators were not associated with clinically important differences in related care processes” (Schnelle, Cadogan, Yoshii, et al., 2003, p. 910) and chart documentation did not correlate with actual practice.

The findings from the current research and those from existing studies highlight the need for further research to inform the development of contextually appropriate quality indicators for continence care in residential aged care facilities. Ideally, such research should be underpinned by a research about residents’ preferences for continence care. Although the current study did not explore such preferences, the analysis of accreditation reports indicated 84% of reports contained a statement indicating that residents and their family members were satisfied with their continence care.

At the same time, it is unclear how Assessors selected residents or family members in order to elicit their opinion and how they framed questions about satisfaction. If findings from research conducted in US ‘nursing homes’ can be generalised to Australian residential aged care facilities, it is possible residents’ responses were influenced by fear, low expectations, and their vulnerable status (Simmons & Ouslander, 2005; Simmons & Schnelle, 1999). Another factor that could influence residents’ responses to questions about their satisfaction with continence care is the way in which such questions are framed. Open-ended questions about continence care preferences yield more accurate responses than closed questions that require a "yes" or "no" response (Simmons & Ouslander, 2005; Simmons & Schnelle, 1999).
It would also seem important to link quality indicators to evidence-based approaches to assessing and managing incontinence in residential aged care. As such, the ICI recommendations for managing incontinence in frail older adults (DuBeau et al., 2009) and the Continence Tools for Residential Aged Care developed by O’Connell, Ostaszkieiwicz and Hawkins (2011) could inform the development of continence care quality indicators. The Continence Tools for Residential Aged Care describe a standardised, evidence-based method of assessing and managing incontinence in the Australian residential aged care sector. They were designed to: (a) prompt staff to conduct an evidence-based and resident-centered continence assessment, (b) meet accreditation standards, and (c) assist staff to obtain information they require to complete the ACFI.

Research about quality indicators for continence care in the residential aged care sector should also draw on the following existing body of research:

- A suite of outcome measures for measuring incontinence (Hawthorne, 2006; Sansoni, Marosszeky, Sansoni, & Hawthorne, 2006, 2007; Thomas et al., 2006).
- A suite of outcome measures for measuring dementia (Sansoni, Marosszeky, Jeon, et al., 2007).
Encountering ethically challenging situations

As described in chapter three, there were a number of interrelated or contextual factors that collectively caused staff to experience ethical challenges whilst performing their work. Such factors included (1) multiple, competing, and conflicting expectations about residents’ care needs, (2) workforce constraints such as low staffing levels, a low number of RNs, and a workforce with minimal education and English proficiency, (3) inadequate information about residents’ care needs, and (4) an unpredictable work environment.

Multiple, competing, and conflicting expectations about residents’ care needs

In the context of providing day-to-day care, staff had to deal with multiple, competing, and at times, conflicting expectations that set the scene for unethical care. For example, staff also had to find a way to reconcile the needs of individual residents with the needs of the many. They were expected to address residents’ physical needs as well as their psychosocial care needs. At the same time, staff were very aware that facilities had to operate within a budget and care had to be delivered in the most cost-efficient manner possible. Thus, staff had to balance the need for quality care with the need for cost-effectiveness and efficiency. They were also expected to meet and exceed a set of regulatory standards, but had limited information on how such standards should be implemented.

Expectations to prioritise residents’ cleanliness

Another condition that contributed to the ethically challenging care environment was the expectation to prioritise residents’ cleanliness whilst also meeting other
aspects of care such as residents’ psychosocial care needs. A clean body is a precondition for social interaction. Washing procedures had to be completed before residents could go to church, join in lifestyle activities, go on outings, etc. The imperative to clean residents and keep them clean gave order and structure to residents’ and staffs’ daily lives. However, residents’ incontinence constituted a symbolic and physical threat to residents’ cleanliness, and hence to their social appearance and status. Therefore, prioritising residents’ cleanliness could be seen as an attempt to achieve a sanitised and socially acceptable representation of residents that involved concealing their disability, dependence, and incontinence, and thereby restoring them to a socially acceptable status. The renowned sociologist, Erving Goffman (1959) first explicated this social phenomenon in his seminal sociology book, *The Presentation of Self in Everyday Life*. He claimed all participants in social interactions engage in certain practices to foster a good impression and to avoid discrediting or embarrassing themselves or others. As incontinence threatens or discredits a person’s social presentation, the work staff performed in order to ensure residents were clean and socially presentable, may represent an attempt to control or guide the impression that others might make of the resident. It may equally represent an attempt to influence other people’s opinions of staff members’ dedication to residents’ care.

As indicated in chapter three, residents voided a number of times a day and many were incontinent when they voided or defeacated. Specifically, as indicated in chapter one, 54% of residents experience more than three episodes of urinary incontinence a day, and 34% experience more than four episodes of faecal incontinence per week (Deloitte Access Economics and the Continence
Foundation of Australia, 2011). According to staff in the current study, almost all residents in high care were incontinent most of the time. Therefore it could be argued residents’ cleanliness and subsequent social status was a fragile and temporary state of affairs, and staff had to remain vigilant to identify when residents changed from being clean to unclean. Residents’ incontinence and need for assistance from staff to maintain continence add to the unremitting nature of carework and staff have no choice but to grapple with it. Whilst staff could defer addressing residents’ other care needs such as the need to socialise, staff could not easily defer or opt out of responding to a resident’s need for assistance with basic bodily functions.

The finding about the imperative to clean residents raises a number of questions, one of which concerns the paradoxical lack of social recognition and value of the work staff perform to assist residents with highly personal matters such as incontinence and other body care needs, especially given it consumed most of staff time. Curiously, despite the all-consuming and unremitting nature of the work involved in meeting residents’ need for personal care assistance, “accounts of carework have tended to play down the bodily aspects emphasising instead, the social, emotional and interpersonal aspects of the body and its decline” (Twigg, 2000, p. 394). Nursing texts for example are curiously silent about the care patients/residents may require to perform basic bodily functions. Indeed, in a review of literature which explores why faecal incontinence remains a taboo subject and why it is often so difficult for patients to discuss their bowel symptoms, Norton (2004) claimed although there are a small number of specialists texts about faecal incontinence, “prominent nursing texts that devote a
whole chapter to elimination, give no guidance, other than outlining the
practicalities of changing the incontinent person” (p. 88). In the current study,
staff indicated they learnt about managing incontinence from other staff and from
representatives of the pad manufacturing industry.

Twigg (2000) also suggested washing and other forms of personal care work
[otherwise termed ‘basic care’, ‘carework’ or ‘bodycare’], which are central to the
everyday work of staff working in residential aged care facilities, have received
little attention for two main reasons. The first reason is that discussions about care
have been subverted and substituted by a focus on ‘managerialism’, efficiency and
effectiveness. Secondly, the influence of social gerontology emphasises the
psychosocial elements of caring work and has retreated from a biomedical focus
on the body and its decline. A further reason why accounts of carework such as
continence care work are downplayed or absent could relate to broader social	
tabooes about touch and body work, and the stigma associated with incontinence.
These issues are discussed in a later section of the current chapter under the
subtitle ‘A devalued role’.

Although “nurses incorporate hygiene into their professional identity” (Wolf,
1993, p. 136) and are socialised to value cleanliness, the nursing profession has
demonstrated a certain ambivalence about performing tasks that involve cleaning
residents/patients. Ironically, although the nursing profession advocates
cleanliness and hygiene, contemporary nursing has increasingly distanced itself
from what some nurses call ‘bed and bath’ tasks. Indeed, nursing has increasingly
delegated personal care work to a non-nursing workforce, and has largely retained
authority and accountability for the quality of such care.

In the UK, a debate titled ‘too posh to wash’ suggested, today’s nurses retreat from basic care such as washing patients (Moore, 2005). Twigg (2000) described a hierarchy of care within nursing whereby staff move away from the basic bodywork of bedpans and personal care work towards care that involves using technology, and in so doing, they “progress from dirty work on bodies to clean work on machines” (p. 360). Some critics even argue the move to tertiary education for nurses and its tendency to academicise nursing, as well as the emphasis on patient’s psychological dimensions, represent a further flight from the body to pursue higher status forms of knowledge and practice (Dunlop, 1986).

The consequence of the ambivalence within nursing about performing tasks that involve cleaning residents/patients is that staff who perform personal care work are caught between a rock and a hard place in terms of their own and other people’s expectations about residents’ cleanliness. If, on the one hand they fail to keep residents clean, these staff, who are usually PCAs, can be criticised for neglecting residents’ basic care needs. However, these very same staff also come under criticism if they spend all their time performing personal care activities and have no time to address other aspects of residents’ care.

The researcher suggests there is a need to enhance the social status and value of the work staff perform to assist residents with highly personal matters such as incontinence and other body care needs by addressing the stigma associated with incontinence.
Another set of circumstances that contributed to the ethically challenging care environment was that staff often encountered competing responsibilities whilst performing their roles. The most problematic issue was the need to protect residents from harm whilst concurrently promoting their right to choice, autonomy and independence, which led to considerable tension between staff and residents. This tension was exacerbated when (a) residents were cognitively impaired and/or incontinent, and (b) when there was an inadequate number of staff available to meet residents’ care needs. In other words, staff found it difficult to uphold the principles of resident autonomy as well as those of beneficence.

Slettebø (2002) reported a similar challenge for staff working in ‘nursing homes’ in Norway. She conducted a grounded theory study about the social process between nurses and ‘patients’ when confronted with ethically difficult care situations. She interviewed 14 experienced RNs and conducted field observations focusing on examples of ethically difficult care situations and staff responses to such situations. The findings of the current study concur with those reported by Slettebø (2002) in so far as nurses [and by inference, other care staff] struggled to maximise patients’ [residents’] health outcomes because their day-to-day work brought them face-to-face with ‘ethically difficult care situations’. For example, in the current study staff found it difficult to perform their work in ways that respected cognitively impaired residents’ autonomy.

At the heart of the challenge to operationalise residents’ autonomy in the current study were staff concerns about the need to protect residents from adverse events such as falls, pressure ulcers, and death: all of which are reportable events, and
increase the risk complaints, litigation, sanctions, and loss of funding. Such concerns align with the findings of a recent analysis of discourses about optimising residents’ mobility in Australian residential aged care facilities. Taylor, Sims, and Haines (2012) suggested “goal based tensions such as safety versus resident mobility optimisation can exist when residents require staff assistance to move” (p. 1365). The suggested the issue was one of risk management, where the risk of resident or staff injury is considered against the risks associated with constrained approaches to resident mobility optimisation. Taylor et al (2012) based their findings on a narrative review of literature and thematic analysis of relevant discourses. They reported that discourses such as safe manual handling, falls prevention, palliative care and cost constraints to individualised care can negatively impact on the goal of optimising the resident’s mobility. Furthermore, discourses about protection fostered a routinised, passive, and dependency-promoting approach to resident care.

Therefore, it would appear that staff is in an impossible situation ‘no-win’ situation. If they emphasise residents’ autonomy and associated right to take risks, they could be held liable for any adverse event such as a fall. However, if they adopt an overprotective response to residents’ need for safety and protection, residents’ could progressively lose function and become more dependent. Such findings underscore the need to move away from the current punitive regulatory framework to one that supports staff to fulfil their duty of care to protect residents whilst they also promote resident choice, autonomy, and risk-taking.
**Workforce constraints**

Three main workforce issues contributed to staff members’ experiences of being ethically challenged whilst performing their roles. These issues included: (1) a low number of RNs employed in the residential aged care sector; (2) low staffing levels and (3) staff with minimal educational preparation and English proficiency. Although it was beyond the remit of the current study to validate staff reports about the effect of workforce constraints on residents’ care, there is a compelling body of research showing the quality of patient care in hospital settings is jeopardised by pressures on the nursing workforce. Specifically, a number of researchers in North America have shown that problems associated with the quality of care, patient safety, and staff retention are associated with organisational features of nursing care such as staffing ratios. (Aiken et al., 2011; Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Kelly, McHugh, & Aiken, 2011). Similarly, the Registered Nurse Forecasting (RN4CAST) project, which brought together researchers from Belgium, Finland, Germany, Greece, Ireland, Norway, Poland, Spain, Sweden, Switzerland, The Netherlands and England, the US, Botswana, China, and South Africa surveyed nurses and patients in 488 and 201 hospitals and demonstrated how features of the work environment impacted on nurse recruitment, retention and patient outcomes (Van den Heede & Aiken, 2013). It remains to be seen whether such findings can be generalised to Australian residential aged care facilities. The following section discusses findings about workforce constraints with reference to existing research and shows how workforce constraints led to a situation whereby staff felt they had to
engage in compromise and ritual that could subsequently compromise residents’ care.

_A low number of Registered Nurses employed in the residential aged care sector_

Another workforce constraint that arguably contributed to compromised care was a lack of RNs employed in the residential aged care sector. Staff described having ‘no-one’ to report to, facilities that had no RNs at all, or facilities that functioned with an RN who occasionally visited such as once a week. RNs who were interviewed described roles in which they were overwhelmed by administrative responsibilities. They described being unable to ‘get out on the floor’ in order to get to know residents, supervise staff, or provide hands-on care. Researchers from the US and UK have reported a similar loss of nursing expertise in residential aged care facilities (Allen, 2001; Budden, 2012; Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2012; Foner, 1994; Harrington, Olney, Carrillo, & Kang, 2011; Jervis, 2001).

The findings of the current study showed the apparent lack of RNs had direct implications for other staff (e.g. ENs and PCAs) as well as resident care. RNs attempted to accommodate the situation they found themselves in by reconfiguring staff roles and responsibilities. Specifically, the lack of RNs and subsequent need to reconfigure the residential aged care workforce resulted in a situation in which ENs, and at times PCAs made decisions about care that would previously have been made by RNs. Hence, an EN described being in charge of a facility that included high care residents who required complex nursing care and PCAs described being in charge of wards or units within facilities, having roles
that involved teaching other staff, and making decisions about residents’ health and wellbeing. As the current study was not designed to evaluate whether staff had the necessary educational training to perform their roles, it is difficult to comment on the safety and legality of their practices. However, De Bellis (2006) claimed non-nurses who are not educated, licenced or regulated were doing nursing work in Australian residential aged care facilities and were regarded by the nursing profession and the public as ‘nurses doing nursing work’.

It is particularly concerning that some staff in the current study described working in facilities that functioned without RNs and that staff felt unsupported when making decisions about care. Such findings concur with a recent survey of 3455 ‘unlicensed assistive staff’ working in ‘nursing homes’, ‘assisted living facilities’ and other ‘long-term care settings’, ‘home health’ and ‘housing for the aged and disabled’ in the US. The researchers found 19% of staff said their supervisor was never on site and 28% indicated they performed tasks they thought were beyond what they should be doing (Budden, 2012).

Associated with the apparent low number of RNs employed in the residential aged care sector is a loss of nursing knowledge and skill. Corazzini, Anderson, Mueller, Thorpe, and McConnell (2012) claimed “in the context of healthcare reform, professional nursing risks ceding jurisdiction permanently over how care systems are organised in nursing homes” (p. 36). They described a similar restructuring of the workforce skill mix in the US to that which has occurred in the Australian residential aged care sector whereby non-nurses organise and deliver nursing care, and RNs act as consultants. Ironically, the loss of professional nursing expertise in
the Australian residential aged care sector is occurring at the same time as residents’ acuity is increasing and the demand for skilled nursing increases.

As the role of RNs in residential care has come under increased scrutiny, there is a need to articulate the distinct contribution that nurses make to resident outcomes and to show how this contribution differs from that of non-nurses. Using a multi-method interpretive approach and grounded in the philosophical hermeneutics of Hans-Georg Gadamer, (2003), Heath (2010) investigated what RNs did and the impact of their work on outcomes for older people in ‘care homes’ in the UK. She found RN roles were broad and multifaceted and “outcomes for residents from RN work include enhanced personhood and wellbeing, improved health and function, the prevention of problems/adverse outcomes and enhanced quality of life. RN outcomes have a positive impact on relatives, staff and the homes in general” (p. 116). Heath (2010) concluded it was essential that RNs were present on a 24-hour basis especially given residents’ complex healthcare needs.

In May 2012 the Australian Government DoHA released a policy titled Living Longer. Living Better. Aged Care Reform Package (Commonwealth of Australia, 2012) which among other things, acknowledged there was a need for more nurses to respond to the increased demand for specialised nursing expertise and behavioural management skills in the residential aged care sector. It stated:

*There are limits on the extent to which the trend to employ a lower cost workforce, including substituting service provide by more highly qualified nurses with care*
provided by less qualified staff can continue without compromising service quality, particularly in view of the increasing acuity of care (Australian Government Department of Health and Ageing, 2012).

Theoretically PCAs provide care under the direct supervision of RNs. If RNs are not physically present in facilities, or if they are so consumed with administrative work that they cannot ‘get out on the floor’, it is difficult to determine how they can provide such supervision or meet their own ethical and legal responsibilities. Indeed, as one RN stated she felt ‘sick with worry’ at the end of a shift that her changed role meant she would no longer know residents’ care needs or be able to identify changes in residents’ wellbeing. According to the NILS (2008), “36% of RNs in Australian residential aged care facilities spend less than one third of their time providing direct care” (p. 29). Data from the current study revealed RNs felt powerless to alter how the facility was staffed and hence, it was just a matter of luck whether staff, for whom they were accountable, had the knowledge and skill to perform their roles effectively.

The expected outcome of Accreditation Standard 1.6 requires service providers to demonstrate “there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives” (Commonwealth of Australia, 2008). The findings of the current study and those from existing research beg questions about how Assessors determine whether staff have the requisite skills, knowledge and qualifications to perform their roles in order to meet Accreditation Standard 1.6, and how facilities currently pass the standard.
Low staffing levels

Staff perceived the main constraint to providing safe and effective care was the low staffing levels. With the exception of publicly-funded residential aged care facilities in Victoria, there is no minimum number of staff required or mandatory staff-to-resident ratios in the Australian residential aged care sector.

Responsibility for determining staffing levels such as the number and type of staff (e.g. skill mix) to employ rests with service providers. In the absence of a benchmark or an objective measure, it is unclear how service providers or Assessors determine what constitutes adequate staffing levels in residential aged care facilities.

The Productivity Commission (2011) also identified staffing levels as a reason why staff working in residential aged care facilities were under considerable pressure. It noted although there was an increasing number of residents with higher and more complex care needs, which increases staff workloads, staff-to-resident ratios had not changed. In fact, between 2003 and 2007, the ratio of residents to full-time equivalent direct care staff increased from 1.85 to 1.99 (The National Institute of Labour Studies, 2005, 2008). The ratio of residents to staff has a direct impact on the amount of time staff have available to address residents’ care needs. The NILS survey (2008) found only 23% of nurses (RNs and ENs) and 26% of PCAs felt they had enough time to spend with each resident.

The Australian Nursing Federation (ANF) has a longstanding history of advocating mandatory staff-to-resident ratios in all Australian residential aged care facilities to ensure safe and effective care. However, the question of what
constitutes safe and effective staff-to-resident ratios is highly contested. The Australian College of Nursing (ACN) supports an agreed ratio that is adapted to the resident mix but, in its submission to the Productivity Commission, ACN qualified its support and stated “that issues around staffing mix and levels will not be entirely addressed with a simple mathematical ratio of staff” (Commonwealth of Australia, 2011, p 369). Instead, it recommended a comprehensive review of care requirements and associated models of care/staffing skill mix. In reviewing the submissions before it, the Productivity Commission (2011) did not support mandatory staffing ratios in Australian residential aged care facilities. It stated: “at this stage, the imposition of a simple staff ratio is a relatively blunt instrument, particularly given that the care resident profile [residents’ care needs] of every facility will be ever changing” (p.370). In 2011, the Australian Government engaged the ANF to identify models of care and other factors that influence staffing and skill mix. So far, a review of literature and a consultative process involving residential aged care stakeholders have been completed.

Whilst policy-makers and professional nursing agencies argue about the relative merit of different models of care, staffing levels and skill mix, it is noteworthy that the Productivity Commission (2011, p. 351) recommended widening PCAs’ scope of practices as a strategy to respond to the needs of a rapidly ageing population: a trend that is arguably underpinned by the imperative to drive down the recurrent staffing cost (Harrington et al., 2011).

*Staff with minimal educational preparation*

According to the findings of the 2008 NILS survey (2008), 91% of ENs and RNs
and 93% of PCAs feel they have the skills they need to do their jobs, and they use these skills in their jobs. Although staff in the current study felt their own personal knowledge and skills were adequate for them to perform their roles, they expressed considerable concern about other staff members’ minimal educational preparation and English proficiency. Some staff expressed concern about the variability in the duration and quality of PCAs educational preparation to work in the residential aged care sector. Such concerns resonate with prior research. Based on interviews and focus groups with residential aged care staff in eight sites in New South Wales, Victoria, Tasmania and the Australian Capital Territory between February and May 2004, Booth et al. (2005) found managers were concerned that the Certificate III in Aged Care did not ‘reflect the complexity of the PCA’s role’ and there was a need to increase their generic skills in areas like ‘negotiation, decision-making, planning and time management’.

More recently, the Productivity Commission (2011) reported it received a large number of submissions that claimed there was considerable variability in the education and training of staff who completed a Certificate III or IV in Aged Care. The submissions contained concerns about the marked differences in the quality of trainers and Assessors, course length and the extent and nature of the practical experience included in courses delivered by RTOs. The Productivity Commission (2011) stated “it would appear that some RTOs are not delivering the desired outcomes for students or the aged care industry” (p. 378). It recommended a national audit to investigate the variability in courses and what improvements were necessary. The findings from the current study suggest the audit should also investigate the extent to which the courses prepare students to promote residents’
autonomy and independence in relation to personal care activities such as managing incontinence and promoting continence.

Staff in the current study did not perceive the need for additional education about incontinence beyond that which they received on-the-job or from the manufacturers of continence products. Indeed, most felt their knowledge about incontinence and continence care was sufficient to enable them to provide effective continence care. This finding corresponds with the results of a survey of nurses working in stroke units in the UK, Sweden and China (Booth et al., 2009). Booth et al. (2009) reported nurses felt they had the knowledge and skills they need to effectively promote patients’ continence following a stroke even though the researcher found there were no processes in place to systematically identify the types or causes of urinary incontinence and no individualised plans had been developed. The researchers claimed the approach nurses used to manage incontinence in patients’ following stroke was informed by ‘local custom and practice’.

The approach staff in the current study used to manage incontinence in residential aged care facilities was informed by two main sources. The first was education obtained whilst on-the-job where staff learnt from other staff. This approach may or may not promote an evidence-based approach to providing continence care. The second source of education was from in-service education provided by the manufacturers of continence products, mainly disposable pads. In both cases, staff recalled learning about pads, creams, and measures to protect residents’ skin. When staff did identify gaps in their knowledge about incontinence, it was mainly
about their lack of knowledge about using pads, creams, and measure to protect residents’ skin.

Ideally, any gaps in staff knowledge about incontinence should be identified by Assessors from the ACSAA whose role it is to determine if facilities meet Accreditation Standard 1.3. The expected outcome of Accreditation Standard 1.3 is that “management and staff have appropriate knowledge and skills to perform their roles effectively” (Commonwealth of Australia, 2008). The regulatory framework does not mandate necessary qualifications for any level of staff, including PCAs. As previously indicated, it is difficult to determine how Assessors know whether the skills knowledge and qualifications staff have are appropriate. There is a lack of transparency and accountability about staff knowledge, skills and qualifications, whether such knowledge, skills and qualifications match residents’ care needs, and the number of facilities that comply or do not comply with Accreditation Standard 1.3.

One indication of whether staffs has the requisite knowledge, skills and educational preparation to perform their role is the number of education sessions a facility convenes or the number of staff who have attended an education session. In the current study, staff placed considerable emphasis on keeping records of their attendance at education sessions which they believed they needed as evidence of ongoing learning and adherence to regulatory requirements. However, if staff experiences of education about incontinence can be generalised to education more broadly, the quality of education itself may be problematic, not the number of sessions staff attend. Further attention should be given to
developing rigorous methods to enhance the quality of the education staff actually receive as well as the utility and relevance of the assessment processes used to determine staff knowledge and competence.

Based on the findings from current study and those from two national projects funded by the NCMS, it is highly unlikely that the Australian nursing workforce (Paterson, May 2006) and/or the residential aged care workforce (Australian Government Department of Health and Ageing, 2006, p. 3) are adequately educationally equipped to proactively address residents’ continence care needs. The recent evaluation of phase three of the NCMS concluded “some groups… [including residential aged care staff] required a greater level of access to education to meet the aim of improving access to training and support and updating health professionals knowledge and skills about incontinence” (McCallum et al., 31st August 2010, p. 25).

Australia is certainly not alone in having a health workforce with limited knowledge and skill to actively prevent and manage incontinence. Chapter one identified a large body of research showing nurses and residential aged care staff lacked knowledge about incontinence and its management. It also showed education alone does not necessarily improve staff adherence to research recommendations to promote residents’ continence (Campbell et al., 1991; Lekan-Rutledge, 2000; Stevens et al., 1998). Based on the findings of the current study, it is probable the failure to demonstrate sustainable improvements in practice following education is related to an overreliance on education to effect a change in staff practice.
Staffs’ lack of uptake of research recommendations about continence care may also relate to the way in which the education is delivered. According to research conducted by Henderson and Kashka (2000) and Karlowicz (2009), education programs should incorporate experiential learning activities and target staff attitudes about incontinence. Staff should also receive ongoing on-the-job clinical support in order to implement continence care recommendations (Vinsnes et al., 2007). Evidence from the field of dementia care also supports the concept of small group experiential-training combined with ongoing on-the-job clinical support (Gee, Scott, & Croucher, 2011; Kuske et al., 2007; Mason & Adeshina, 2011). For example, the ‘Walking in Another’s Shoes programme’ developed by Maria Scott in the Canterbury District Health Board in New Zealand showed quantifiable changes in dementia carers’ attitudes and behaviours, as well as managers’ ratings of the person-centredness of the care provided (Gee et al., 2011). Similarly, in Australia, O’Connell et al. (2008) developed a model of care for the residential aged care sector based on the concepts of ‘partnership-centred care’, ‘positive work environment’ and ‘evidence-based practice’ that incorporates experiential learning into the model.

The findings from the current study and those from extant literature underline the need to ensure education programs prepare residential aged care staff to actively promote residents’ abilities to maintain or regain continence as well as manage intractable incontinence. Staffs require a multifaceted education program that targets their knowledge, attitude and behaviours about incontinence, and incorporates on-going clinical support. However, educational efforts will be
wasted if the systemic resource issues and structural barriers that give rise to compromised and ritualistic care are not addressed. Such effort will also be wasted if staffs’ main source of education about continence care continues to be the manufacturers of continence products. Policy-makers, educationists and service providers should recognise the inbuilt conflict of interest of relying on continence products manufacturers for such education.

**Staff with minimal English proficiency**

Another workforce issue raised in the current study was staff concerns about other staff members’ minimal English proficiency. Staff expressed concerned other staff member’s lack of English language skills compounded the sense of isolation residents’ already felt, and triggered behavioural changes in cognitively impaired residents. According to the findings of the 2008 NILS survey (2008), 33% of the residential aged care workforce were born outside Australia. Asian and Islander born workers were the fastest growing group of overseas born workers. Twenty-eight per cent of the overall workforce spoke a language that is not English and almost half of them stated they used this ability in their jobs. Seventeen per cent of staff who were surveyed indicated that working with staff whose first language was not English caused difficulties in terms of communicating with management and other staff, residents, residents’ families, and caused problems related to occupational health and safety and in documentation.

The Nursing and Midwifery Board of Australia requires all applicants, including internationally qualified applicants, who seek initial registration in Australia, to demonstrate that they have the necessary English language skills, and may be
required to demonstrate English language proficiency in accordance with Board approved English language tests (Nursing and Midwifery Board of Australia, 2011). However, no such standard applies to the non-nursing workforce. Furthermore, despite the presence of English language testing procedures for internationally trained health professionals, research suggests a potential mismatch between linguistic criteria assessed by language professionals and clinical communication deemed relevant by health professionals (Jacoby & McNamara, 1999; O'Hagan, Pill, Elder, McNamara, & Woodward-Kron, 2011). The mismatch could partially relate to the finding that the English language testing procedures have poor reliability (Birrell, Hawthorne, & Richardson, March 2006).

Arguably, English language proficiency is an important issue for resident safety as the ability to speak the same language is critical to good communication. All staff needs to be literate in order to act as advocates for residents, read instructions, follow accreditation and documentation processes, and access information about medications and safety aspects of their job. The Productivity Commission (2011) noted that whilst Australia has increasingly targeted aged care workers from other countries, “language and cultural differences may adversely affect care quality due to communication barriers and lack of familiarity with equipment, medications or work practices“ (p. 381).

The challenge for service providers, policy makers and education providers is to find ways to support staff to develop a range of skills, including English language skills so that communication among all stakeholders is optimal, and so that
cultural background and language proficiency are not used as social markers of competence and commitment.

In summary, the preceding section discussed the specific findings about staffs’ experiences of being constrained in their roles and ability to deliver ethical care because of a limited number of staff to provide care; a low number of RNs; and a workforce with minimal educational preparation and English proficiency. The current study showed the way in which workforce constraints impact on staffs’ ability to deliver high quality continence care from staffs’ perspectives. Policy makers should use such information in its deliberations about the relative merit of different workforce models and when determining the best ways to meet residents’ increasingly complex care needs. They should also base such decisions on the findings of two recent systematic reviews about the structure, process, characteristics and composition of a nursing team that fosters a healthy work environment (Pearson, Doran, Craig, & Long, 2006) and the impact of nursing workload and staffing on establishing healthy work environments (Pearson, O’Brien Pallas, et al., 2006).

**Highly dependent residents**

Residents’ high levels of dependence also contributed to the challenges of meeting residents’ care needs. The prevailing understanding was that most, if not all residents were: incontinent, cognitively impaired, unable to make decisions that were in their own best interest, unable to walk, do anything for themselves, and in constant need of staff advocacy and protection. Tuckett et al. (2009)
reported similar findings from their e-cohort study of nurses working in residential aged care facilities in Queensland, as did Chung (2010) in her qualitative analysis of NAs’ beliefs and assumptions about caring in ‘nursing homes’ in the US. Staff understandings about, and experiences of residents’ high levels of dependence had a major influence on how they delivered care.

As it stands to reason that residents are not a homogeneous group and not all residents have dementia and lose decision-making capacity, the collective findings about staff beliefs about residents’ dependence warrant further investigation. Some researchers theorise that staff depictions of residents’ high levels of dependence epitomise negative broader cultural construction about the ageing person and the lack of value of the older people in western societies (Henderson & Vesperi, 1995). Negative constructions about residents may relate to myths, misconceptions and fears about older people and ageing, as evidenced by an attempt to deny the ageing body, its decline and death (Becker, 1973). In other words, it is possible that the way in which staff depicted residents’ and their care needs may reflect prevailing social attitudes about ageing which are in turn, sustained by mainstream media.

The Australian Human Rights Commission (2012) stated ‘ageism’, which is stigmatisation and discrimination on the basis of a person’s age, are two major impediments that hinder older people [including older people living in residential aged care facilities] from fully exercising their human rights. The problem with holding ageist attitudes is that individuals may attribute symptoms to the ageing process rather than to pathological and potentially treatable conditions. Older
individuals who make age attributions tend to: experience worse physical functioning, delay or not seek treatment for health problems, and have an increased risk of mortality (Rakowski & Hickey, 1992; Sarkisian, Hays, & Mangione, 2002; Williamson & Fried, 1995). For example, Locher, Burgio, Goode, Roth, and Rodriguez (2002) found women who attributed their incontinence to ageing were less likely to have engaged in self-management strategies and to have sought evaluation or treatment.

Staff in the current study also attributed resident’s symptoms to their age rather than to pathological and potentially treatable conditions. For example, staff cited old age as the main reason for residents’ incontinence. ‘After all’ said one staff member, ‘her bladder is 92 years old – what can you expect!’ They also accepted and interpreted residents’ actions such as hiding pads or washing and reusing disposable pads as feature of their dementia rather than as an attempt to self-manage incontinence and avoid being embarrassed or humiliated.

However, in interpreting the finding that staff depictions may reflect a deep-seated ageist perspective, it is also important that the complexities of caring for highly dependent individuals are not dismissed, sidelined or trivialised. According to the AIHW (2012) Australian residents are highly dependent and their level of dependence is increasing. The Australian Government’s Ageing in Place policy has resulted in a greater number of older people remaining in their own homes in the community as long as possible. Hence, by the time older people do enter residential aged care facilities; they are often very elderly, frail and many have a shortened life expectancy. In fact, in the twelve months from 30th June 2010 to
2011, 57% of residents were aged 85 years of age and over, and 76% of residents were classified as having high care needs, and almost 50% had high-care needs related to the behavioural domain (Australian Institute of Health and Welfare, 2012). Many residents were cognitively impaired. Specifically 52% of residents had a recorded diagnosis of dementia and 78% had a mental illness recorded. Two-fifths of residents had both dementia and a mental illness. All permanent residents had at least one health condition; the most common condition being a circulatory system disease (including stroke) and hypertension, followed by diseases of the musculoskeletal system and connective tissue such as rheumatoid arthritis, osteoarthritis and osteoporosis and then, endocrine, nutritional and metabolic disorders, such as diabetes (Australian Institute of Health and Welfare, 2012).

Furthermore, residents’ average length of stay in a residential aged care facility was 145.7 weeks (Australian Institute of Health and Welfare, 2012). The AIHW (2012) reported 56,420 permanent residents ‘separated’ from the facility in the twelve months from 2010-2011 and 91% of permanent residents who separated from the facility did so because they died. In other words, it would appear that 34% of the overall number of 169,000 residents died in the twelve months from 2010-2011. Arguably, dying is an acknowledged, but largely tacit expected outcome in residential aged care facilities.

Therefore, residential aged staff is immersed in an environment in which they are continually exposed to very elderly peoples’ dependence, dementia, decline and death. It is reasonable to expect such exposure will affect how they understand or
internalise old age. The researcher suggests staff face a difficult task in that they have to reconcile two divergent perspectives that may influence how they practice. At one end of the spectrum is a nihilistic or fatalistic belief and at the other end is an orientation that requires staff to adopt a rehabilitative focus and promote residents’ health, wellness and social vitality. It is highly unlikely the education staff receive, especially PCAs education, would prepare them to recognise residents’ need for support, or that it would equip them to adopt a rehabilitative approach to care. It is even less likely staff will adopt a rehabilitative approach or perspective given the funding model financially renumerates facilities for caring for residents’ with higher levels of dependence and not for restoring or promoting their functional status.

A devalued role

There is a considerable body of research showing that staff working in residential aged care facilities feel devalued (Commonwealth of Australia, 2002; Pearson, Nay, Koch, & Ward, 2002; Pearson, O’Brien Pallas, et al., 2006; The National Institute of Labour Studies, 2008). For example, the NILS (2008) reported 22.5% of PCAs do not feel that their efforts and achievements are respected and acknowledged. Most of this research attributes the devaluation to difficult working conditions and low rates of pay (Commonwealth of Australia, 2002; Pearson, Nay, et al., 2002; Pearson, O’Brien Pallas, et al., 2006).

The Productivity Commission (2011) recommended a coordinated approach to improving the attractiveness of the aged care sector and hence there was a need
for fair pay and competitive wages, better access to high quality education and training, well-articulated career paths, improved management, extended scopes of practice, reduced regulatory burden, and better use of technology. While staff in the current study also identified the need for improved working conditions and better pay, another factor that contributed to their sense of being devalued was the stigma associated with their work. The following discussion picks up on this finding.

Like the work of urogynaecology nurses, individuals who care for people with incontinence are tainted by association and their work has the dubious symbolic social distinction of being dirty work (Bolton, 2005). Bolton (2005) conducted a qualitative study about gynaecology nurses and identified that “many issues that they deal with on a daily basis are socially difficult and the tainted nature of gynaecology nursing gives it the social distinction of ‘dirty work’” (p. 169). As in the work of gynaecology nurses, the work residential aged care staff performs receives scant public recognition which relates to the private nature of bodycare work.

Roles that require individuals to attend to another person’s bodily function are consistently socially devalued and those who perform personal care work typically have low occupational esteem or status (Jervis, 2001; Lawler, 1991; Twigg, 2000). Similarly, Twigg (2000) claimed there is a certain social ambivalence about personal care work because, at times, it “verges on areas of taboo in connection with sexuality or human waste” and “lurking in the wings of any discussion about bodywork is the question of prostitution” (p. 390). According
to the findings of an ethnographic study by about caregiving in a US nursing home, “individuals who perform ‘dirty’ work are stigmatised or symbolically polluted because their role is “to clear away pollution, to bring order to the disorderliness that arises when excreta is out of place” (Jervis, 2001, p. 95). Jervis (2001) claimed “pollution beliefs are alive and well in the nursing home and figure predominantly in the occupational stigma of caregiving” (p. 94).

Furthermore, NAs frequent contact with contaminating substances affects their position within the workplace, their relationships with others, and their self-conceptions.

The current researcher contends that the negative status associated with personal care work or nursing in a residential aged care facility is symbolically related to staff occupational exposure to pollution [incontinence] and that it reflects inequalities within the facility, the nursing profession, and the society at large. In addition, staffs’ devaluation and perceived subordination and powerlessness may be associated with the stigma and fear of old age, frailty, disintegration, incompetence, dependence, death and, incontinence. Unlike people in general society, staff working in residential aged care facilities cannot escape the realities of the debilitation and death of the body. They are forced to grapple with the vulnerability of other people’s corporal existence, and by association, their own. They are also forced to grapple with the stigma associated with caring for people with stigmatising conditions such as incontinence.

Although there is a growing body of research about the stigmatisation of individuals with urinary incontinence and other related urinary symptoms
(Brittain & Shaw, 2007; Chiverton, Wells, Brink, & Mayer, 1996; Elstad, Taubenberger, Botelho, & Tennstedt, 2010; Garcia, Crocker, & Wyman, 2005; Mitteness & Barker, 1995; Mitteness, Barker, & Finlayson, 1995; Mitteness, 1987a, 1987b, 1990; Paterson, 2000; Peake & Manderson, 2003; Peake, Manderson, & Potts, 1999), most of this research focusses on the stigmatising effect of being incontinent, rather than the experiences of caring for a person with a stigmatised condition.

For example, Elstad, Taubenberger, Botelho and Tennstedt (2010) conducted in-depth interviews with 151 black, white and Hispanic men and women in the US who had urinary symptoms and found respondents felt stigmatised because of the loss of socially-expected control of the body. Women in particular felt stigmatised “based on having an unclean body and a compromised social identity” (p. 9), while men feared being viewed as impotent. Using social-psychological research, Garcia et al. (2005) hypothesised that stigmatised individuals defended themselves against possible rejection, by withdrawing from the situation, being more vigilant, and, if possible, concealing the stigma.

To the best of the current researcher’s knowledge, only one other publication describes the dynamics of stigmatisation whilst caring for individuals with incontinence from the perspective of individuals who are not stigmatised. Garcia et al. (2005) theorised that non-stigmatised individuals [which arguably includes residential aged care staff] engage in considerable emotional labour so that they are not seen by other people as prejudiced toward the stigmatised person [incontinent resident]. The researchers contended that the emotional suppression
of feelings such as disgust cannot be sustained in an ongoing manner. Hence, on both sides, the stigma cycle creates a lack of safety and trust.

The findings from the current study and other research about stigma and providing personal care indicate the need for education programs for nurses and the residential aged care workforce about carework and the interpersonal dynamics associated with caring for individuals with stigmatising conditions such as incontinence.

**The basic social process: Weathering constraints**

**Attempting to accommodate the context of care**

As mentioned in chapter four the researcher coined the term ‘accommodate’ to refer to a process in which staff adapted or conformed to, complied with, and buckled under in response to the constraints to care. Such processes contrast with active or open resistance, challenge, and defiance. The researcher suggests that accommodating responses were related to staff sense of powerlessness to alter the overall context of care. Staff were disempowered by the constraints or a highly regulated work environment, ethically challenging situations, workforce constraints, residents’ highly dependent status, lack of knowledge about residents’ care needs, an unpredictable work environment, and a devalued role. With the exception of three staff members, staff described a context of care they felt powerless to alter. ‘It’s just the way things are’ said a staff member as she described the constraints to care. ‘We have no choice’ said another as she defended the cleaning ritual. ‘It’s just how she [the resident] is’ was a common
way of explaining residents’ distress.

The finding that most staff felt disempowered raises a number of questions, not the least of which is whether staff did in fact have power to proactively deal with the day-to-day constraints to care, rather than adopt accommodating and self-protective distances responses. A sense of being empowered is important as empowered nurses are “highly motivated and are able to motivate and empower others” (Laschinger & Havens, 1996) (p. 28). They also experience less burnout (Laschinger, Finegan, Shamian, & Wilk, 2003) and less job strain (Laschinger, Finegan, Shamian, & Almost, 2001). However, feelings of disempowerment, or the inability to act, cause nurses to feel frustrated and to have a sense of failure (Laschinger & Havens, 1996).

Interestingly, almost thirty years ago Yarling and McElmurry (1986) commented on what they perceived was nurses’ lack of power. They claimed “nurses are not often free to be moral” (p. 63). What Yarling and McElmurry (1986) meant was not that nurses had no freedom of will, but they did not often have the freedom of action to practice nursing because of their role and social position relative to physicians’ role and social position and the organisational bureaucracy. Whilst research about nurses’ lack of power and control has been discussed in nursing literature since the 1970s (Kalisch, 1978), there is very little research about how non-nurses such as PCAs perceive and use or do not use power. Given PCAs role status relative to that of ENs and RNs and the fact that PCAs perceive they hold the lowest position in the staff hierarchy it is likely that that they would have a heightened sense of powerlessness.
Paradoxically, although most staff in the current study felt disempowered, the data also showed they also exerted both power and control over residents, albeit, with varying success. Dunham and Cannon (2008) also noted a similar dynamic into research into relations between care-recipients with dementia and their family caregivers. Drawing on Michel Foucault’s book ‘Madness and Civilisation’ (Foucault, 1967), Dunham and Cannon (2008) claimed ‘dementia caregiving’ in the context of family caregiving, ‘involves a complex relationship that is characterised as a paradox in which the exercise of power creates an experience of powerlessness on the part of the caregiver’. [In this relationship] “care recipients are not powerless, but encourage, as well as resist attempts at providing care” (p. 46). As such, “the person giving care is constrained as much as the person with dementia is being constrained by their care” (Dunham & Canon, 2008, p. 46).

Thus, it could be argued that both caregivers and care-recipients are powerless and powerful in the context of an interdependent relationship. Given the findings from the current study and those from existing research, there is a need to assist staff recognise the considerable power they have to influence how residents perceive and experience their care.

The current researcher argues that ‘weathering’ is a basic social process to real or perceived constraints that caused staff to feel disempowered. It is a response that enabled individuals to perform their roles in ways that were consistent with their own personal and professional needs, values, beliefs, and expectations. As such, the study findings are similar to those of Raffanti (2005) who conducted a grounded theory study entitled ‘Weathering change: Coping in a context of pervasive organizational change’. Raffanti (2005) found, rather than focusing on
the implementation of reform measures, teachers who were exposed to pervasive change environments were most concerned with various forms of survival. Not unlike staff in the current study, the teachers’ responses were characterised by acquiescence.

Raffanti (2005) also found that the basic social process was characterised by a sub-process termed ‘reinterpreting the situation’ which involved attempting to make sense of their situation. In the current study, the researcher also found staff attempted to make sense of their situation which she termed ‘reframing care’. Another finding in common with Raffanti’s (2005) study was that the teachers engaged in one or more behaviours with respect to the problems confronting them.

A further point that bears some consideration is that there is no intent in the current research to imply that weathering processes in themselves are either positive or negative. Rather, grounded theory does not label and judge people, but rather, names behaviours and links patterns of behaviour together to form a coherent and explanatory theory and therefore explains what is going on in the social context. The following section discusses the accommodating and self-protective responses that characterised weathering constraints.

*Acquiescing to regulation*

Acquiescing to regulation was characterised by an emphasis on developing a paper trail of evidence of regulatory compliance and a smokescreen of
acquiescence to regulation. Data from the current study provided numerous examples of attempts by staff to comply and conform for the sake of demonstrating adherence to rules and regulations. One such example was the expectation that staff conducts 15, 30 or 60 minute checks of residents and document their findings. However, staffing levels and workloads hindered staff from conducting such regular checks. Hence, staff completed forms when they could, or at the end of a shift. The result of this response was that documentation did not always reflect residents’ actual status, or experiences of care. In other situations, residents’ cognitively impaired status resulted in a situation whereby staff was unable to obtain the necessary information to complete ACFI forms, particularly forms about residents’ continence status. Therefore, information was often based on an estimate. As the quality of resident care, funding and accreditation all depend on an accurate assessment being completed for each resident, such findings are concerning. They also prompt questions about what factors inform staff decisions about care if documentation about residents’ care needs is not accurate.

The documentation burden and the way staff respond to this burden are well-established (Daskein, 2008; Pabst, Scherubel, & Minnick, 1996; Pelletier, Duffield, & Donoghue, 2005). Ironically, one of the main reasons for the move from the Resident Classification Scheme funding model to the ACFI was to reduce the level of documentation (Australian Government Department of Health and Ageing, 2009a). However, the current study showed there is still an excessive reliance on documentation which takes staff away from their core business.
One way to understand staffs’ acquiescence to regulation is by referring to organisational theories about responses to institutional pressures. One such theory posits that, in the face of regulatory control, “organisations tend to conform to at least the minimum standards of care and fiscal controls established by federal agencies” (Oliver, 1991, p. 154). Oliver (1991) claimed “an organisation that employs tactics typically mounts a minor level of resistance to institutional pressures, but devotes most of its energies to appeasing or placating the institutional source or sources it has resisted” (p. 154).

In the current study, staff devoted much of their time and resources to appeasing or placating regulation and attempted to accommodate and conceal the difficulties associated with complying with regulation. This response meant the contextual conditions that caused staff to contribute to a smokescreen of acquiescence remained hidden, and the degree of difficulty associated with adhering to regulatory expectations to document and implement care remained hidden. Hence, the stressors staff faced went unchallenged and unchanged. Another consequence of accommodating regulation by acquiescing was that staff had little faith in documents to guide their decisions about residents’ clinical care.

**Protecting residents**

As indicated in chapter four, the basic social process was characterised by a number of accommodating sub-processes. The researcher termed one such sub-process ‘protecting residents’ and argues the protective responses staff adopted were an attempt to accommodate underlying conditions they felt powerless to
Staff’s protective responses were related to a duty of care to protect residents, and an accompanying fear that any adverse events could result in an adverse event, complaints, litigation, sanctions and loss of funding. The researcher grouped the protective responses staff adopted into those that were characterised by: 1) conditioning techniques, 2) skilled and therapeutic communication techniques; and 3) strategies that caused or exacerbated residents’ distress. At best, the contextual conditions that caused staff to adopt protective responses caused them to use skilled and therapeutic ways of communicating and interacting with residents and strive to deliver the best care they could under the circumstances. At worst, staff used coercive strategies that caused residents deep distress and led to adversarial relations between staff and residents.

There are a number of different ways to interpret the strategies described under the category the researcher termed ‘protecting residents’. For example, instead of using the term ‘conditioning techniques’ to describe some of the protective strategies staff used, Tom Kitwood (1997) termed such strategies trickery, guise, coercion, or deception and a form of treachery. Kitwood (1997), whose ideas regarding the nature of dementia and the care of people with dementia transformed approaches to dementia care claimed caring for people with dementia is often characterised by care strategies that do not honour the dignity and personhood of the care recipient. At the same time, he acknowledged caregivers do not intend to be malicious but adopt these strategies because they are overwhelmed by the demands of the disease and lack sufficient support. Similarly, Dunham and Cannon (2008) found carers of individuals with cognitive impairment often used ‘techniques of deception,’ but “mostly in situations where
it was necessary to protect the safety and well-being of their family member” (p. 48).

Importantly, staff in the current study did not perceive or describe strategies such as gradually exposing residents to using pads as a form of trickery, guise, coercion, deception or treachery. Nor did they interpret them as a form of conditioning. Rather, staff adopted these strategies in an attempt to accommodate a situation over which they had little control. The findings indicated staff used both classical conditioning techniques and operant conditioning whilst performing their roles and attempting to address residents’ needs.

*Conditioning techniques*

The theory of classical conditioning is generally credited to the Russian physiologist Ivan Petrovich Pavlov (1849-1936). Pavlov described a form of learning in which a stimulus signals the occurrence of a second stimulus. Behaviours conditioned by classic conditioning techniques are elicited by antecedent conditions. In the current study, the resident who screamed and recoiled each time a staff member approached her, displayed a classical conditioning learned response that was consistent with Pavlov’s theory. Classic conditioning differs from operant conditioning. Operant conditioning can be traced to B.F. Skinner (1904-1990), who in 1937 conducted a number of experiments showing it was possible to modify an individual's behaviour by altering their consequential exposure to negative and positive stimuli. Operant behaviour operates on the environment and is maintained by its consequences. In the current study, such negative stimuli included chastising residents for their
incontinence, which arguably caused or exacerbated their distress and embarrassment.

Embarrassment is a powerful emotion and is often used as means of social control (Benedict, 1959; Lawler, 1991). It is likely residents’ anticipation or experience of being embarrassed, chastised, humiliated or disciplined for being incontinent, functioned as a powerful form of social conditioning that affected how they responded to staff attempts to assist them with their incontinence. Hence, staff described situations in which residents attempted to conceal and self-manage their incontinence and maintain independent bladder and bowel function, such as situations whereby residents hid wet or soiled pads, or attempted to wash and reuse them. In the general community the anticipation or experience of being embarrassed or humiliated for being incontinent also acts as a powerful deterrent for both men and women to seek professional advice, to conceal their incontinence, and to adopt a range of self-management strategies (Bradway & Strumpf, 2008; Hägglund & Wadensten, 2007; Teunissen & Lagro-Janssen, 2004; Visser et al., 2012). Some staff in the current study interpreted residents’ attempts to maintain autonomous bladder and bowel function as a psychological and behavioural symptom of dementia, rather than an attempt by residents to protect their physical, psychological and social integrity.

Chastising residents for being incontinent or for attempting to maintain independent bladder and bowel function is cause for concern. The use of such negative social conditioning strategies also raises questions about the appropriateness and effectiveness of any form of conditioning a) for individuals
with incontinence; and b) for cognitively impaired individuals.

Treating incontinence with conditioning strategies can be traced to the field of behavioural psychology and to Azrin and Foxx in particular. Azrin and Foxx (Azrin & Foxx, 1971; Azrin, Sneed, & Foxx, 1973; Azrin, Sneed, & Foxx, 1974) devised a series of experiments whereby they successfully toilet trained children with an intellectual disability as well as children with enuresis [bedwetting] by using punishment and reward. However, there is very little published research about using conditioning strategies to treat incontinence among cognitively impaired frail older adults.

The lack of research about using conditioning strategies for cognitively impaired frail older adults with incontinence may relate to the belief that cognitive impairment precludes the possibility of learning new knowledge and skills. One of the very few publications about using conditioning strategies among adults with incontinence and living in an institutional setting dates to 1960. Carpenter and Simon (1960) trialled several methods of training in a 92 individuals they called ‘long-term incontinent behaviourally regressed psychotic hospitalised patients’. The ‘patients’ ages ranged from 33-84 years of age and their average length of stay was 18.3 years (range 1-36 years). The researchers divided the patients into four groups. One group of patients received usual care. Another group received two-hourly toileting assistance during waking hours. Patients in the third group received two-hourly toileting assistance during waking hours and were verbally praised if found continent and received verbal disapproval if found incontinent. Group four patients received the same intervention as those in group three with
the addition of ‘material rewards’ if they remained continent. The material reward was they were allowed to dress in clothes of their choice rather than hospital ‘fatigues’. However, if they had an episode of incontinence, they had to wear the fatigues for the rest of the day. The researchers claimed patients who were materially rewarded had the lowest incontinence rates and those who received usual care had the highest incontinence rates.

Notwithstanding the paternalism that underpinned such early research, the study is noteworthy for two reasons. The first reason is the underlying assumption that the patient’s [resident’s] incontinence was necessarily behavioural in origin. The second reason is the assumption that the patient’s [resident’s] incontinence could be modified using operant conditioning strategies. Although it is tempting to dismiss such early research because the researchers did not consider the multifactorial aetiology of the patients’ incontinence and because of their paternalistic attitudes, it is possible that assumptions and beliefs about conditioning strategies continue to influence how staff determine, deliver and communicate residents’ continence care in contemporary residential aged care facilities.

Future research should determine how cognition affects cognitively impaired individuals’ responsiveness to interventions that involve using conditioning techniques. In the absence of evidence-based information about what conditioning techniques are appropriate, with which group of residents, and under what circumstances, care will be based on trial and error. Alternatively, staff might not even trial an intervention because of the belief it is futile, invasive, or causes
residents to feel distressed.

*Adversarial relations between staff and residents*

Another related way to interpret the findings about the negative strategies staff used to assist them address residents’ physical care needs is with reference to discourses about power. Within the sociological and anthropological literature, the use of power in a caregiving context or in an institutional context is well-established. Oliver (1991) contended that “several empirical studies conducted from an institutional perspective noted that the struggle for power and control often underlie institutional processes” (p, 158). A Foucauldian interpretation posits that “in order to be successful, caregivers [staff] must establish a relationship of power over care recipients in which they substitute their judgement and actions for those of their family members” [residents] (Dunham and Canon 2008, p. 140). The indefensible benefit of a compliant resident for staff was that staff was better able to minimise residents’ risks of falling, contain their incontinence, and keep them in a clean state. In other words, it is possible that using communication strategies that involve shame or force make it easier for staff to breach social taboos about touch in order to clean residents’ incontinence.

Such findings contrast with those of Lawler (1991) whose sociological examination of how nurses transgress social norms to perform carework found nurses recognise patients’ embarrassment and “by the way they manage their own responses and by their lack of embarrassment (affect), nurses re-define situations for patients so that the patient need not feel embarrassed” (p. 146). Lawler (1991) claimed nurses “negotiate the socially delicate territory of invading another
person’s space in intimate ways by using specific methods, which they employ within careful social boundaries associated with the patient’s level of dependence and illness” (p. 151). She developed the term ‘somology’ to describe a process by which nurses “not only take account of the physical body (a thing) and the body as it is experienced, lived and felt by the patients, but they also integrate these two aspects of human embodiment” (Lawler, 1991, p. 161). Lawler claimed this skilled way of working is only possible through experience. The findings from the current study suggest not all staff have such skills. Key issues that need to be considered for future research are whether education level predicts the skilled approach Lawler described, whether such skills can be taught, and if so, what teaching methods should be used.

The current study was not designed to compare staff beliefs and practices by their education, or indeed, by other variable such as their age and gender. However, according to Davies, Slack, Laker and Philip (1999), education level positively predicts staff use of strategies that support residents’ autonomy. Davies et al. (1999) surveyed 676 staff caring for older people in care homes in the UK to determine their educational preparation and the relationship between such education and residents’ autonomy. Residents’ autonomy was measured using an 18-item questionnaire which was completed by staff. The findings revealed wide variation in staffs’ educational preparation and statistically significant associations between such education and staff ratings of residents’ autonomy. Given the fact that most care is now delivered by a non-nursing workforce, there is a need to replicate the study in Australian residential aged care facilities.
Another possible reason why relations between staff and residents concerning continence care were sometimes adversarial and characterised by the inappropriate use of power may relate to the proposition that incontinence and caring for people with incontinence evokes difficult emotions. Arguably, what we see in the encounter between staff and residents is a shared anxiety. Incontinence confounds social expectations of bodily control and shared beliefs about appropriate behaviour. If, as some staff in the current study believed residents were voluntarily incontinent in order to gain staff attention, it is likely that interactions between staff and residents would be characterised by considerable tension. To the best of the researcher’s knowledge, the current study is the first to draw attention to the potential for continence care interactions to evoke a difficult and ethically challenging care situation.

Muller-Hergl (2004) claimed incontinence generates fear among carers’ and individuals with incontinent about dependence, and that these fears can lead to power fights between carers and care-recipients. She stated:

*Both faecal incontinence and dementia work on a hidden agenda: that of regression (i.e. inverted human development) and dependence in institutions. Both dementia and faecal incontinence revitalise themes of dependency for all parties participating and enmesh people with dementia and their paid carers in power fights concerning order and cleanliness. These power fights can be reminiscent of the power fights between parents and children. Generally speaking, dementia and incontinence highlight never-challenged or questioned relations*
As Muller-Hergl’s (2004) claim was based on opinion and remains untested, further research is required to explore how carers and care-recipients emotions about incontinence and the need for assistance with personal care affect carers’ abilities to deliver care, and the specific relationship between these emotions and the use of power.

Staff in the current study adopted a range of different strategies to respond to residents’ distressed reactions to receiving continence care. One such response was to persist in their endeavours, which involved over-riding residents’ resistance. In such cases, staff attempted to complete the task as quickly as possible, performed the task with the assistance of another staff member, or used force. Another approach staff adopted involved backing off or deferring care, and using therapeutic communication skills such as explanation, encouragement, humour, touch, and distraction. In such cases, staff made deliberate efforts to avoid confronting residents, and often relied on other staff with more experience to take over.

Hutchinson, Leger-Krall, and Wilson (1996) described similar caregiver strategies to those found in the current study. Hutchinson et al. (1996) conducted an ethnographic study of the natural conditions of providing continence care by formal caregivers to elderly individuals with AD in a Day Care Centre in the US.
In their study, different caregivers used different strategies and communication techniques in their efforts to assist individuals with AD use the toilet, or manage their incontinence. Consistent with the findings from the current study, when faced with the potential for residents to become highly distressed from receiving continence care, Hutchinson et al. (1996) reported staff had to choose between providing or deferring such care. Deferring continence care incurred the risk the individual with AD would be incontinent, develop IAD and pressure ulcers, and smell of urine or faeces. However, providing such care incurred the risk the person with AD would become highly distressed and potentially combative. In other words, caregivers had to judge whether or not to provide continence care.

The findings from the current study and those reported by Hutchinson et al. (1996) indicate providing continence care to cognitively impaired individuals is considerably more complex than hitherto described in existing literature. Education programs for the residential aged care workforce should include information about therapeutic communication and ethical, person-centred approaches to overall care. This education should accommodate the complexity of addressing the day-to-day physical care needs of cognitively impaired residents’ who may be distressed by their incontinence and care-dependent status.

Providing continence care involved physically touching people in highly private areas of the body and transgressing social norms. Parker (1997) pointed out that touch can be interpreted in different ways: as profound comfort or as “an invasion which reduces a person’s sense of being to that of an object or a thing, particularly
when one is feeling vulnerable” (p. 12). It is impossible from the current study to know some residents’ past histories or subjective experiences of being incontinent or receiving continence care. However, it is possible the way staff delivered highly intimate care had a profound effect on residents’ personal integrity. It is also possible that the way residents’ responded to touch during continence care depended on their prior experiences, and that touching residents to change their pads or clean them after incontinence episodes could have elicited painful memories for residents with a history of sexual abuse. In the current study Margaret [pseudonym] recoiled and screamed each time a staff member approached her. In order to clean Margaret following an episode of incontinence, staff had to physically prise Margaret’s legs apart. Hence, the reality of having to address some residents’ continence care needs thrusts staff into stressful and ethically challenging situations.

Anderson, Fields, and Dobb (2011) reviewed the literature about the impact that early-life trauma can have on older adults as their coping resources and capabilities erode with age-related changes. They claimed “providing assistance with bathing [and by implication, continence care] to an older adult who has experienced sexual abuse may be an incredibly difficult and stressful task” … “for both family and professional caregivers the entire process may be overwhelming, leading to negative outcomes for the caregiver” (p. 758), and arguably, for residents themselves. It is unlikely that nurses and PCAs current education adequately prepares them to deal with such complexities. Anderson et al. (2011) recommended that residential aged care staff should conduct an assessment to enquire about residents’ past trauma so that care planning can be sensitive to
trauma-survivors’ experiences. Interestingly, in the current study, staff were aware of the resident’s past history of sexual abuse, however such knowledge did not appear to help them in their approach to care.

According to Ishii et al. (2012) and Sloane et al. (2004), staff can reduce residents’ distress and subsequent resistant behaviours if they use therapeutic communication skills and adopt a person-centred approach to care. For example, research about bathing practices in residential aged care settings shows a ‘person-centred approach’ to showering and bathing residents can markedly reduce aggression and agitation among residents with dementia (Sloane et al., 2004). Sloane et al. (2004) stated a person-centred approach involves ensuring the physical environment for bathing is conducive to residents’ experiences of bathing, offering residents a choice about when, how, how much, and by whom they are bathed, using communication techniques such as a calm, personal, gentle manner, distraction, persuasion, rewards, positive feedback for cooperating, and using caregivers with whom residents have a positive relationship.

As continence care practices involve breaching social norms about an individual’s personal space, staff should anticipate and recognise it may cause residents to feel distressed. Staff should be empowered with the knowledge and skills to avoid such distress in the first instance and/or prevent it from escalating into a fight for power and control. Also, further attention should be given to (a) quantifying the prevalence of adversarial relations in Australian residential aged care facilities, (b) identifying associated factors, and (c) developing supportive interventions that help staff deal with some of the complexities of providing care described in this
thesis. Education programs should include information about strategies to provide continence care and ensure residents perceive care as supportive rather than as an intrusion and that they feel respected rather than objectified or violated.

Whilst the main concern associated with overprotective responses to resident care is that residents’ rights may be breached, another concern is that residents may develop a learned helplessness that would exacerbate their functional decline and set the scene for residents’ to ‘give up’ attempting to maintain independence and continence.

*Learned helplessness*

The concept of learned helplessness is commonly attributed to Seligman (1975) who theorised that learned helplessness occurs when people are continually and consistently exposed to uncontrollable events, believe that they can do nothing to change the outcome of those events, and develop inappropriate expectations that outcomes of future events will also be beyond their control. In a recent two-staged experimental study involving hospitalised older people in the UK, Faulkner (2001) found a relationship between dependence and learned helplessness. He also showed that increasing patients’ expectation of control could alleviate their dependence and learned helplessness.

The link between disempowering nursing practices and dependence in older people is also well documented in early nursing research (Avorn & Langer, 1982; Baltes & Serbe, 1976; Jirovec & Maxwell, 1993; Kayser-Jones, 1979; Langer & Rodin, 1976; MacDonald & Butler, 1974; Mercer & Kane, 1979). For example
seminal research found nurses did not praise older peoples’ independent acts, but praised their dependent acts (Baltes, Burgess, & Stewart, 1980; Baltes, Honn, Barton, Orzech, & Lago, 1983; Baltes, Kindermann, Reisenzein, & Schmid-Furstoss, 1987; Baltes & Wahl, 1987, 1992). Similarly, Avorn and Langer’s (1982) early research about the nature of care in ‘long-term institutional care settings for the elderly’ found excessive infantilisation of residents and overly-intrusive help with self-care beyond clinical requirements led to ‘learned helplessness’ and increased dependence.

However, these studies fail to show the conditions that cause staff to feel powerless or helpless, that may in turn cause or compound residents’ or patients’ learned helplessness. Moreover, although there is a need for education about strategies to promote residents’ independence, staff are not likely to implement such strategies if they are constrained by the fear that any adverse event, such as a fall, could incur a punitive regulatory response against the facility that could lead to complaints, litigation, sanctions, and loss of funding. Therefore, educational approaches should be accompanied by a shift away from the current punitive regulatory framework to one that supports staff to enhance residents’ psychosocial wellbeing, choice and functional status.

There is an emerging body of evidence showing residents’ rates of incontinence can be reduced if they have the opportunity to participate in training programs to improve their functional status (Jirovec, 1991; Ouslander, Griffiths, McConnell, Riolo, Kutner, et al., 2005; Sackley et al., 2003; Schnelle, MacRae, Ouslander, Simmons, & Nitta, 1995; Tak, van Hespen, van Dommelen, & Hopman-Rock, 321
2012; van Houten, Achterberg, & Ribbe, 2007; Vinsnes et al., 2012). However, as indicated in the current study, usual care staff are unlikely to support the uptake and ongoing use of such programs if they are insufficiently resourced to do so, and if regulation has the inadvertent effect of causing them to be afraid and adopt a risk-adverse approach to care.

Need to reformulate ethical guidelines for care in residential aged care

There is a need to rethink current ethical guidelines for care in the residential aged care sector to assist residential aged care staff effectively and compassionately deal with the day-to-day ethical complexities and challenges associated with providing care to a rapidly ageing population. Current ethical guidelines are largely underpinned by values about individualism: namely, the ‘autonomy paradigm’. The autonomy paradigm is characterised by the following three inter-related assumptions:

1. Illness is a threat to the individual and that it must be cured or compensated for by health intervention.
2. A relationship exists whereby clients submit to professional authority to combat illness.
3. The patient [resident] is an autonomous person, independent of the experience of illness and the caregiving process (Jennings, Callahan, & Caplan, 1988)

Given most residents’ high levels of cognitive impairment and poor prognosis, it is questionable whether the autonomy paradigm is, in fact, an appropriate guiding framework to assist residential aged care staff to provide ethical care and deal
with the day-to-day ethical dilemmas they encounter. It is difficult to imagine how the autonomy paradigm helps staff deal with the ethical dilemma they encounter whilst caring for residents like Margaret. In fact, current discourses about ethics in residential aged care tend to ignore the ethical challenges associated with providing day-to-day care and focus on end-of-life decisions such as questions about how to determine residents’ cognitive abilities and when to cease life sustaining support.

Nurse ethicists such as Johnstone (2002) recommend the *modus operandi* of contemporary health care ethics be ‘revisited, re-visioned, and revitalised’.

Johnstone (2002) claimed “contemporary health care ethics has become preoccupied with the issue of people's rights to and in health care: for example the right to informed consent, confidentiality, quality of life, and death with dignity” (p 215). Johnson (2002) acknowledged the achievements of the bioethics and health care ethics movements, but stated neither has succeeded at their most basic task: namely, to address issues of human vulnerability and suffering in relation to health or to remedy this state of affairs, especially for the most vulnerable and disadvantaged members of our society, including frail older adults. Johnstone (2002) suggested the emphasis on promoting autonomy and the older person's 'right to decide' may be misplaced, given they are at a point in their lives when their capacity to decide and advocate for their own best interests is tenuous.

Agich’s (2003) seminal publication about dependence and autonomy in old age in ‘long-term care’ also described the limitations of the autonomy paradigm to guide ethical practice in the residential aged care sector. Agich (2003) developed a new
way of thinking about residents’ rights and autonomy in ‘long-term care’ based on a phenomenological perspective that conceptualised autonomy as individuals’ essential interconnectedness and relationship with others and the world. Thus, Agich’s (2003) perspective of autonomy accommodates residents’ concurrent dependency and allows a degree of paternalism, which Agich redefines as ‘parentalism’. Because the findings of the current study indicated a tension for staff in terms of their dual responsibilities to protect residents and promote their autonomy, the researcher suggests there is some merit to Johnstone (2002) and Agich’s (2003) suggestions for a revisioning of the ethics underpinning care in residential aged care facilities.

In recent decades, the nursing profession has theorised, philosophised and proselytised about the concept of care. If care is the to be retained as the basis of nursing, it is important that the nursing profession engages in discourses about care, and contributes to the development of guidelines for ethical care for frail dependent individuals who are care-dependent and living in residential aged care facilities. The imperative to engage in ethical debates about the day-to-day ethical issues that arise in the context of providing personal care will take on increased significance as the population ages, the number of people with dementia grows and the demand for skilled nursing care increases.

**Prioritising care**

The findings from the current study showed that the basic social process staff used to deal with the constraints to care included prioritising care and compromising
care. The researcher suggests that prioritising and compromising were processes in which staff engaged in order to accommodate a context of care they were powerless to alter. For example, as indicated in the discussion about encountering ethically challenging situations, staffs was not in a position to alter the taken-for-granted social values and expectations that caused them to prioritise residents’ cleanliness. Equally, staff was not in a position to deal with prioritisation dilemmas that involved responding to two or more equally compelling ethical or duty of care responsibilities. Adhering to either one necessarily placed staff in a moral or ethical dilemma in terms of the other.

**Compromise in response to prioritisation dilemmas**

The findings revealed multiple factors that collectively contributed to a situation in which staff engaged in compromise. One such factor was an inadequate number of staff to meet residents’ care needs. Compromised care included rushing care, taking shortcuts, relying on lifting machines to transport residents, delivering care in a rushed and ritualistic manner, using sedation to preventively manage residents’ behaviours, etc. Whilst on one level, these approaches to care could be regarded as organisational efficiencies that allowed staff to address the needs of more individuals within a shorter timeframe; the negative consequence of too much compromise is that it could detract from the personal and emotional components of care.

The proposition that nurses and staff engage in compromise in the context of prioritising residents care needs and in response to unrealistic expectations, is not without foundation. Prior research indicates staff feel forced to lower their
standards and goals when overwhelmed by their workload and a lack of time (Haggstrom, 2005) and more frequent stressors and ethical challenges are associated with pressure to take shortcuts in the provision of care (VonDras, Flittner, Malcore, & Pouliot, 2009).

**Compromised continence care**

Compromised care also included practices that could have affected residents’ ability to maintain continence. For example, staff indicated staffing levels hindered them from assisting residents use the toilet at night as a matter of policy and practice. Similarly, a lack of staff hindered staff from providing residents with assistance to use the toilet as often as they required during the day. Staff claims that staffing levels mitigate against providing residents with consistent toileting assistance is supported by research from the US which indicated toileting assistance programs involve more time than usual care, and requires one staff member to every five residents (Schnelle et al., 2002; Schnelle, Keeler, et al., 1995; Schnelle et al., 1997; Schnelle, Sowell, Hu, et al., 1988; Schnelle, Sowell, Traughber, et al., 1988). If such findings can be generalised to Australian residential aged care facilities, there is a considerable costs and time disincentive for staff to implement toileting assistance programs.

Assuming staffing levels do in fact mitigate against providing residents with assistance to use the toilet, the current researcher suggests one of two strategies. Ideally, governments should fund facilities at staffing levels that enable staff to consistently implement such programs. Alternatively, staff should adopt a more informed and targeted approach to toileting assistance programs because
according to Schnelle et al. (1992), “only 25% to 33% of residents are appropriate for a form of toileting assistance termed prompted voiding” (p. 188) and not every resident has an individualised voiding pattern that staff can identify in order to develop an individualised toileting program (Colling et al., 1992). In other words, toileting assistance programs are not suitable for every resident.

Future researchers should identify the factors that predict which residents will respond to, or benefit from toileting assistance programs in Australian residential aged care facilities. Such research could be augmented by using non-invasive electronic monitoring devices to collect information about residents’ voiding patterns. The information from such research could be used to develop a user-friendly method to help residential aged care staff to better target individuals likely to respond to toileting assistance programs. Such research should also be informed by residents’ continence care preferences.

Another accommodating and compromised response to the difficulties associated with providing residents with regular assistance to use the toilet was to encourage residents to wear and use pads. Hence, the findings are consistent with those reported in the review of literature which indicated there is widespread reliance on absorbent pads to manage incontinence in residential aged care facilities (Brandeis et al., 1997; Omli et al., 2010; Pringle Specht et al., 2002; Rodriguez et al., 2007; Wagg et al., 2008; Watson et al., 2003). Further research should also explore residents’ experiences of wearing pads to determine the process by which they relinquish attempts to maintain continence. Significantly, staff in the current study did not perceive their reliance on residents’ use of pads as a compromise to being
unable to offer residents’ assistance to use the toilet. Indeed, staff often regarded pads as a necessary means to dignify residents.

In recent years, governments, professional interest groups, and consumers have taken a greater interest in health care that respects patients’ and residents’ rights to receive timely assistance to use their bladder and bowel in ‘dignified’ ways. For example, campaigns in the UK such as the ‘Dignity in Care’, ‘Behind Closed Doors’ and the ‘Do not forget the person’ campaigns champion patients’ rights to have access to assistance in order to maintain optimal levels of continence. In a case before the courts in the UK, a local council unsuccessfully defended it’s decision to refuse to pay a former ballerina for a care worker to help her use a commode at night. Instead it recommended she use pads. Consumer groups and the Equality and Human Rights Commission argued that “people have justifiable expectations of dignity and choice from a care system”…and…”rationing resources to a degrading level must not become an established pattern” (United Kingdom Homecare Association, 2011).

Similarly, the United Nations (UN) described a lack of toilet access in institutional settings such as prisons, detention centres, and psychiatric institutions as a human rights issue (United Nations, 2009). In Australia, Beth Wilson (31 Jan 2010), the Health Services Commissioner for Victoria also championed access to what she termed ‘dignified continence care’ as a human right, and called for additional staff in residential aged care facilities in order to offer residents ‘high quality, appropriate and dignified aged-care services’. Arguably, if individuals living in residential aged care facilities are acknowledged as full citizens, there is
a need to question the ethics and the human rights issues of resourcing facilities at levels that hinder staff from providing residents with basic care such as toileting assistance.

The compromises staff made in response to the constraints outlined in this study indicate there is a need to revise the management and evaluation of incontinence in residential aged care facilities in Australia. For example, Assessors should appraise the quality of continence care partially on the basis of evidence that staff have identified and acted upon residents’ continence care preferences, and have distinguished between residents who are suitable for a toileting assistance program, those who are suitable for a pad check and change program, and those who are suitable for both interventions.

The consequence of compromise

Consistent with the findings of research conducted by Hem and Heggen (2003), staff in the current study described considerable disparities between their personal and professional philosophies of care and the reality of the work environment. Some staff were distressed by their inability to provide the kind of care they wished to provide. Such disparities lead to role conflict (Hem & Heggen, 2003). The inability to perform one’s role in ways that align with one’s values and beliefs causes nurses [and arguably, other health care professionals] to feel morally distressed (Nathaniel, 2006; Stacey, Johnston, Stickley, & Diamond, 2011).

Freshwater and Cahill (2010) recently proposed the contentious idea that compromise itself can be utilised and adapted to both alleviate stress associated
with role conflict. They claimed the process of compromise was characterised by an adjustment to conflicting or opposing claims and a variation/departure from an original goal or desire. In the current study, this process was illustrated by a manager who described assisting a staff member to learn how to compromise in order to get through the workload. The manager recognised that, in order to be able to compromise, the staff member had to learn to let go of her original beliefs about care.

Similarly, staff described having to adjust their own expectations to meet organisational expectations to deliver care as a result of pressure from their co-workers. For example, although some staff member questioned the established routines of care, they felt pressured by either their peers or managers to deliver care as they did. Arguably, if staff does not learn to compromise, they cannot fulfil the organisation’s expectations; but in learning to compromise it they appear to relinquish their personal beliefs about ‘good care’ and thereby feel morally distressed.

Prior research shows when nurses are morally distressed, they may distance themselves from patients, become emotionally unavailable, avoid going in patients’ rooms, leave the unit, or leave nursing altogether” (Corley, 1995; Davies et al., 1996; Fenton, 1988; Krishnasamy, 1999; Viney, 1996). For example, the recent findings of a survey of 400 hospital-based nurses in New Zealand, showed almost 50% had considered resigning from their work due to moral or ethical difficulties that were beyond their control (Wood, 2012). Such findings are particularly salient in light of the Australian Government’s focus on recruiting and
retaining a skilled residential aged care workforce. The NILS (2008) reported that turnover in 2007 in the Australian residential aged care workforce was 25% and the Productivity Commission (2011) identified workforce constraints as a major challenge facing the residential aged care sector. Howe et al. (2012) conducted a secondary analysis of NILS (2008) data and found workers’ intentions to stay or leave the job were affected by a number of variables. They recommended further research to identify and realise workers’ intentions to stay and that policymakers should focus on factors affecting retention, and not just on recruitment.

**Delivering ritualistic care**

As indicated in chapter four, another accommodating response staff used to adapt to the constraints to care was to ritualise care. The current researcher contends that ritualising residents’ care, particularly their personal care was one way staff attempted to accommodate to a context they felt powerless to alter. Ritual was characterised by rushed care, predictability, rules, and routine. It is probable that knowing night-time continence care rounds occurred at set times, were conducted in a certain way, and involved a certain number of staff and a certain group of residents, conferred a sense of familiarity and predictability that made it easier for staff to perform their roles. Consequently, these rules and routines led to predictable, highly structured resident care that was fragmented into a series of clearly defined tasks.

The need to adhere to ritual could explain why staff in the current study provided continence care to most residents at night, even though 67% of such residents
were not incontinent and may not have needed continence care. Other researchers have also found that night-time continence care is delivered in a routine or ritualistic manner. Specifically, Cruise, Schnelle, Alessi, Simmons, and Ouslander (1998) reported continence care rounds in US ‘nursing homes’ were conducted at pre-defined schedules and did not take account of residents’ sleep/awake status. Such findings indicate the need to audit continence care practices in residential aged care facilities to determine if: (a) they are necessary in the first instance, (b) they are resident-centred, b) they optimise residents’ abilities to maintain continence, and (c) are based on sound ethical and evidence-based guidelines.

According to the ICI (Cottenden et al., 2009), night-time continence care [and arguably day-time] in nursing homes should be individualised and based on an assessment of the residents’ risk of skin breakdown, preferences, ability to spontaneously move in bed, and sleep/wake status, rather than a standard [or ritual] approach. Indeed, the findings of an experimental study challenge the time-honoured practice of checking and changing residents’ pads two to four hourly during the night. Fader et al. (2003) compared a four-hourly pad changing regimen with an eight-hourly regimen involving 81 residents in UK ‘care homes’. At the end of four weeks, although some residents on the eight hourly regimen had wetter skin (P=0.01; 95% CI: 2.89-21.39) and five residents developed grade two ulcers, there was no statistically significant difference in residents’ skin erythema or on skin pH between the four and eight hourly regimens.

Theoretical explanations about the purpose of ritual vary. The anthropologist, Mary Douglas (1966) claimed rituals represent a higher social function that
symbolises order, solidarity and purity, and are regarded as rites of passage. Douglas’ anthropological interpretation of ritual is particularly valid for rituals that centre on cleaning. Douglas (1966) claimed cleaning rituals were related to the need to find a symbolic way to deal with disorder, abnormality, incompleteness, ambiguity, and symbolic danger. For example, urine, faeces and other body products that issue from body margins breach body completeness. The breach represents disorder and the body margin represents the source of disorder. Both symbolise power and danger. According to Douglas (1966) “if uncleanness is matter out of place, it must be approached through order” (p. 40).

It is also possible that ritual operates as a defence against personal involvement that enables nurses [and other care staff] to manage difficult situations. For example, Menzies (1960) theorised that nurses are continually faced with situations that might be expected to cause them to feel extreme anxiety [for example, situations where they had to deliver care that residents’ resisted], for which they are usually given no emotional support. Menzies (1960) suggested nurses’ seemingly irrational’ responses served a defensive function against anxiety (Menzies, 1960). Kitwood (1997) made a similar claim when he stated defence processes operate in care settings. Another related proposition is that ritual enables staff to have some control over the overall context of care and meet their own and other peoples’ expectations about care. According to Colón-Emeric et al. (2010) ritualistic care “enable[s] cognitive efficiency because they connote repetitive actions requiring little thought” (p. 1291) and early research suggests routine, a feature of ritual, encouraged inertia (Hannan & Freeman, 1983), automated thinking, and maladaptive responses to unexpected situations (Gersick
Another noteworthy feature of ritual is that the beliefs and values that give rise to ritual are largely concealed from the individual’s awareness. In other words, ritual is not necessarily apparent to the individual engaged in the ritual. Staff in the current study was not aware of and did not challenge the ritualistic manner in which they delivered personal and continence care, possibly because, their beliefs and practices were so accepted and ‘validated’, they become invisible to them. Specifically, “their ‘social fact’ quality rendered them the only conceivable, ‘obvious,’ or ‘natural’ way to conduct an organisational activity” (Oliver, 1991, p. 148). According to Oliver (1991), certain institutional practices attain the status of a social fact through a process in which individuals are complicit in “reproducing actions and practices of an institutional environment that have become historically repeated, customary, conventional, or taken-for-granted” (p. 152). Oliver (1991) argued over time, institutional norms become so embedded as institutional values, that they block consideration of any alternative options.

Rytterström, Unosson, and Arman (2011) examined the significance of routines in nursing. The researchers distinguished between institutional routines that are in harmony with the cultural pattern on which the nursing work is based, and those that are obstructive, have negative consequences for nursing practice and are characterised by nurses’ loss of humanity. They recommended leaders needed to assess routines from patients’ perspectives to determine whether they are pragmatic, meaningful or obstructive.
In the current study, the researcher contends ritualistic care was an accommodating or adaptive response by staff to a series of constraints to care, over which they felt they had little control. Therefore, a multipronged approach is required that includes, but is not limited to staff education. However, as staff may not necessarily discern ritual in their day-to-day care or perceive the taken-for-granted values and beliefs and internal and external pressures that give rise to ritualistic care, educational efforts should focus on raising staff awareness of ritual. Moreover, staff should be assisted to differentiate between pragmatic, meaningful and obstructive institutional rituals, rules and routines.

One method that could be used to raise staffs’ awareness of ritual is to encourage them to systematically audit how care is delivered. For example, in order to determine if night-time continence care practices are pragmatic, meaningful or obstructive, staff could audit which residents’ have their pads checked, whether residents are continent or not at the time of the check, and the rationale for conducting the check. Ideally, staff should also record residents’ preferences for care and their responses to care. Another method to raise staff awareness of ritual is to invite residents’ and/or their family members to openly share with staff their experiences of being dependent on them for assistance.

**Drawing on a range of sources of knowledge about residents’ care needs**

A lack of information about residents and their care needs contributed to the challenges of providing holistic care. Staff attempted to accommodate the situation by drawing on different sources of knowledge about residents’ care needs and by conducting a nursing assessment. Ostensibly, nursing assessments
and residents’ care plans are underpinned by a theoretical framework and problem-solving approach termed ‘the nursing process’ which informs nursing standards, competencies, practice, and educational curricula.

All levels of staff in the current study described using a problem-solving approach to determine what care residents required. However, staffs’ problem-solving skills appeared to be relative to their educational background. For example, whilst all PCAs described ways to problem-solve the best methods to contain residents’ incontinence, only one staff member, an RN with an extensive background in urology nursing, described problem-solving the *causes* of residents’ incontinence. Having conducted an assessment to determine residents’ care needs, residents’ care should be delivered based on information contained in their individualised care plans. Although some staff in the current study indicated they referred to residents’ care plans to determine what care to deliver, the forms were not always completed accurately. Therefore, care plans did not necessarily reflect residents’ actual care needs. Consequently care plans had limited clinical usefulness. Indeed, observations of practice indicated most staff members commenced their shifts without referring to any documentation and because some did not attend a handover, they received no oral information. This finding suggests staff decisions about residents’ care were based on other sources of information.

Prior research identified several problems with the clinical application of the nursing process. O’Connell (1997) conducted a grounded theory study of the clinical application of the nursing process in acute care hospital settings and found the nursing process was incongruent with how nursing was actually practiced.
Specifically, O’Connell (1997) found nurses actually drew on a number of factors, such as prior knowledge, experience and intuition to determine patient care and collected information from various sources. The latter finding is consistent with the findings from the current study, which indicated staff attempted to accommodate the situation of not knowing residents’ care needs by seeking information from different sources.

*Medical understandings*

One source of information about residents’ care needs was staffs’ own understanding of residents’ medical conditions. Most staff believed residents’ incontinence was a medically-related and intractable. Therefore, it was largely futile to pursue treatment for residents’ incontinence. Staffs’ medical understanding about the intractable nature of residents’ incontinence had a major influence on how staff determined and delivered care. Sociological studies about ageing highlight the dangers of relying on medical understanding to explain and subsequently dismiss patients’ behaviours and/or symptoms. For example, within the field of dementia care, researchers caution pathologising symptoms and behaviours (Dupuis, Wiersma, & Loiselle, 2012; Eastes & Binney, 1989; Kitwood, 1997; SixSmith, Stillwell, & Copeland, 1993). As early as 1989, researchers claimed that social, behavioural, and physiological constructs of old age as pathological, derived from a medical model that emphasised clinical phenomena, resulting in a dominant paradigm in which old age was seen as pathological and the problems of old age could best be achieved through medical management (Eastes & Binney, 1989)
Kitwood’s (1997) seminal research also challenged the dominant biomedical paradigm that conceptualises dementia in terms of neurodegenerative pathology, decline and loss. He claimed the danger of relying on a biomedical interpretation of dementia is that a cognitively impaired person’s personhood would be undermined because they would be transformed from a being regarded as a spouse, parent or friend to a ‘wanderer’ or ‘demented’. Similarly, SixSmith, et al. (1993) argued that the “biomedical model of dementia is a powerful force that not only shapes the way dementia is defined and conceptualised, but also sets the parameters for the treatment of the condition” (p, 993-994). SixSmith et al’s (1993) comment could equally apply to staff understandings about incontinence. Over twenty years ago, Burgio, Engel, McCormick, Hawkins, and Scheve, (1988) claimed “incontinence has been recognised as a potentially treatable symptom” [however], “historically, it has been recognised as an unfortunate consequence of old age, and the nonsurgical interventions [such as toileting assistance programs] emphasise management and not treatment of the problem” (p. 346). Similarly, DuBeau and Resnick (1995) asserted the reason caregivers focus on containment or ‘mopping up’ strategies rather than adopting active management approaches to incontinence, was because of ‘therapeutic nihilism’, particularly in relation to incontinence in people with dementia.

It is possible that having a biomedical interpretation of incontinence helped staff affectively deal with the work associated with managing incontinence. For example, staff described tolerating faeces when it was everywhere because residents had dementia and ‘couldn’t help it’. By interpreting incontinence as a pathological symptom of a residents’ disease, rather than a consequence of a lack
of timely staff assistance to use the toilet, staff could distance both themselves and residents from personal responsibility for the resident’s incontinence. The danger of accepting the pathological view of incontinence in old age is that approaches to care will continue to emphasise palliation and not active prevention or treatment.

*Learning from the manufacturers of continence products*

Although staffs’ beliefs about the intractable nature of residents’ incontinence in the current study were influenced by biomedical discourses about age and incontinence, they were also influenced by continence products manufacturers’ education and marketing messages. In Australia, the Therapeutic Goods Administration (TGA) (Australian Government Department of Health and Ageing Therapeutic Goods Administration, 2012b) regulates how certain medicines and therapeutic devices (e.g. goods) are manufactured, packaged, labeled, sold and distributed. The advertising of such items directly to consumers and health practitioners is controlled by a combination of statutory measures administered by the Therapeutic Goods Advertising Code Council (TGACC), and self-regulation through Codes of Practice administered by the relevant therapeutic goods industry associations.

Although the TGA is the regulatory body for therapeutic goods, the TGA does not consider continence care products such as pads, mattress overlays or mattress protectors to be therapeutic goods (Australian Government Department of Health and Ageing Therapeutic Goods Administration, 2012a). Therefore the manufacturers of continence products are not subject to government regulation about how continence pads are manufactured, packaged, advertised, and sold. As
a consequence of this regulatory omissions, service providers are responsible for
determining how much support and educational influence they want from
representatives of companies that manufacture pads. Whilst managers in the
current study were generally aware there was a conflict of interest in seeking staff
education from the pad manufacturing representatives, they also considered the
support to be invaluable.

The use of continence products such as pads is not subjected to the same type of
checks that apply to certain medicines and therapeutic devices; therefore, it could
be appropriate for service providers and managers of the residential aged care
sector to develop their own in-house codes of conduct or practice to guide
interactions between staff and representatives from companies that produce
continence products. For example, the Newcastle-upon-Tyne Hospitals NHS
Foundation Trust in the UK proactively developed a Code of Practice based on
the ‘Pharmaceutical Code of Practice for Continence Company Representatives
and Staff with whom they interact’. Among other things, the Newcastle-upon-
Tyne Hospitals NHS Foundation Trust code of practice cautions that company
representatives must not offer refreshments as an incentive to access time with
district nurses, practice nurses and/or hospital nursing staff. Similarly, training
sessions must be scheduled outside staff breaks, and sample products must not be
left with medical, nursing or any other member of the multidisciplinary team
unless their use has been specifically approved.

In the current study, staff views and understandings about continence care were
largely filtered through a lens in which they equated continence care with pad
care. Although continence products manufacturers play a key role in supporting the residential aged care sector and may provide staff with education and resources to assist them conduct a continence assessment, staffs who were interviewed equated a continence assessment with an assessment to determine the number and type of pads residents required.

There are two key reasons why policy makers and service providers should take note of the influence of the pad manufacturing industry. Firstly, it is probable the educational dominance of the pad manufacturing industry in the residential aged care sector will disseminate messages about continence care that keep pads at the forefront of continence care, and displace attempts to minimise pad use and/or replace pads with active interventions. Secondly, there is an economic imperative for policy makers and service providers to ensure that pads are used wisely and that decisions about their use are informed. Pads consume a significant proportion of the residential aged care budget. Any expense is wasted if decisions about their use are based on trial and error as some staff in the current study suggested.

Experiential knowledge and personal values

Another source of knowledge was staff’s own experiential knowledge and personal values. Some staff in the current study drew on their experiential knowledge of methods they used to train toddlers to use the toilet. Dealing with incontinence evoked memories of methods to manage menstruation. It also evoked memories of toilet training children. Garcia, Crocker, and Wyman (2005) claimed parents maintain their child’s compliance about where and how to void and defeacate through shame and embarrassment. It is doubtful that interactions
that cause residents to feel ashamed or embarrassed, or resorting to metaphors of children or menstruation to manage care-dependent adult incontinence are appropriate.

Anderson et al. (2005) found CNAs in a ‘nursing home’ in the US largely relied on experiential and personal knowledge to guide their actions in care situations. The researchers described the mental model of ‘the Golden Rule’ which prompted CNAs to respond to residents as they would want someone to do for them”.

Another mental model was termed ‘mothers’ wit’ which was “a mental model that guided CNAs to treat residents as they would treat their own children” (p. 1006). The researchers noted that although CNAs mental models engendered self-control and affection, they also caused them to adopt infantilising approaches to care and to misinterpret potentially undiagnosed conditions.

Staff in the current study felt their personal and experiential knowledge about residents facilitated care, particularly when residents were cognitively impaired. For example staff members were mindful of the need to watch for cues that would indicate if a cognitively impaired resident had the beginnings of a UTI or needed to use the toilet. As previously discussed, Hutchinson et al. (1996) reported a similar dynamic whereby staff were vigilant about residents’ individual cues and toileting patterns in order to manage toileting and avoid accidents. They noted that new staff had to learn the variety and idiosyncratic nature of cues and appreciate the importance of assisting individuals with dementia to the toilet.
Accommodating a devalued role

Although there is a considerable body of research that has drawn attention to the fact that staff working in residential aged care facilities feel devalued (Commonwealth of Australia, 2002; Pearson, Nay, et al., 2002; Pearson, O’Brien Pallas, et al., 2006; The National Institute of Labour Studies, 2008), there is very little research about what this devaluation means for how staff perform their roles. This is an important question which may have implications for the quality of residents’ care, staff satisfaction and staff retention. The findings of the current study revealed staff attempted to accommodate the negative stereotyped and stigmatised nature of their roles in three main ways: firstly, staff attempted to secure roles within the facility that conferred a certain level of status as discussed in an earlier section of the current chapter; secondly by adopting self-protective distancing strategies which are discussed in a later section of the current chapter; and thirdly; by concealing care, as discussed below.

Concealing care

Jocelyn Lawler (1991) was one of the first nurse researchers to highlight the concealed or hidden and silent character of some aspects of nursing practice. Lawler (1991) was interested in how nurses negotiated carework and how they transgressed normal social rules about touch and body care. She claimed western ways of dealing with the body, sexuality, and dirt involved taking them into a privatised context where they were rendered relatively inaccessible to use as a subject for social enquiry. Indeed, as previously indicated, Lawler (1991) linked the concealment, silence and lack of visibility about ‘the body’ and bodily issues to social taboos and stigma. Oring (1979) also attributed such matters to the
negative attitude our culture holds towards bodily exuviae and exudations. Arguably, carework evokes images of substances and matter that are regarded as dirty and defiling such as faeces, urine, sperm, ear wax, mucus, spittle, sweat and dandruff, and as such, they are to be matters to avoid and conceal. Oring (1979) claimed individuals tend to conceal such substances when they are of their own making, and avoid them in others.

Based on the findings of the current study and those from extant literature, the current researcher suggests that socially constructed taboos about contaminating body matter and elimination render carework a stigmatised subject as well as a stigmatised occupation, and that such taboos typically prompt avoidance and concealment responses. Such taboos mean that care in residential aged care facilities is underpinned by a set of tacit rules about the need to present a sanitised and socially acceptable representation of residents, which involves concealing their disability, dependence, and incontinence as well as the work staff performed to foster residents’ social appearance. Twigg (2000) stated, “bodywork [personal care and continence care work] is potentially demeaning work, and nurses go offstage to perform it” (p. 405) … and ‘the dirty work of care is hidden in order that the institution can display the ‘product’ of its caring regime in the form of the ‘lounge standard resident’” (p. 406). The researcher argues that the concealment of carework in the residential aged care sector may represent a broader social concern about the denial of death, and a retreat from the front-line realities of caring for people who often describe being in ‘Gods’ waiting room’ For example, working with older people brings problems of ageing to the fore and makes staff afraid of their own ageing process.
In the current study, concealment also operated on another level. Curiously, in and of itself, residents’ incontinence was not a source of concern for staff. It only became a source of concern when it became malodorous or visible. In such cases, staff had to respond immediately, particularly if residents were incontinent of faeces. Moreover, staff felt compelled to ensure residents’ incontinence was invisible to others. Elstad et al. (2010) noted a similar dynamic when they conducted in-depth interviews with 151 black, white and Hispanic men and women with urinary symptoms in the US. “Respondents observed that their condition was only stigmatising when visible. Thus, the fear of stigmatisation for urinary incontinence is in fact a fear of visibility -“the fear not that you have contaminated yourself, but that others will notice” (Elstad et al., 2010, p. 2465). Indeed, within the broader community, the social consequences of failing to conceal one’s leakage are pronounced and include strained relationships and social isolation (Mitteness & Barker, 1995). In the current study, failure to conceal a residents’ leakage could incur disapproval from one’s supervisors as well as one’s peer and would generate additional cleaning work for staff.

The consequence of having a role that involved concealing one’s work was that staff felt frustrated, undervalued, disempowered, subordinate, marginalised, contaminated, and limited to ‘just doing dirty work’, or ‘just doing the wees and poos’, or just helping residents get ready for lifestyle staff. By contrast, other activities which were socially visible such as the work performed by lifestyle staff were privileged over personal care work. To date, research about continence care in residential aged care facilities has largely ignored the socio-psychological
dimensions of carework described in the current study. Arguably, by incorporating the findings from the current thesis about the social dynamics within the residential aged care facilities, staff may be better placed to meet residents’ personal care needs.

**Adopting self-protective distancing strategies**

A major finding from the current study concerned how staff internalised or made sense of the overall constraints to care, and in particular, how they cognitively reconciled the ethically challenging care situations they encountered in their roles, especially given their powerless to alter the context of care and/or residents’ health status. The findings indicate that, in addition to the previously discussed accommodating responses, weathering constraints was characterised by three main self-protective distancing strategies: (1) blanking out, (2) using distancing language, and (3) reframing care.

The proposition that self-protective distancing strategies are a means by which individuals attempt to deal with difficult situations is by no means new. In fact, emotional detachment and distancing were valued ideals traditionally upheld by the nursing profession (Menzies, 1960). Williams (2001) reviewed intimacy in nursing, and traced detachment and distancing values to Florence Nightingale who promoted nursing as a vocational service and attempted to desexualise the nurse-patient relationship. Similarly, Isobel Menzies’ (1960) seminal work on nursing, suggested detachment and distancing strategies were basic psychological defence mechanisms nurses employed to deal with situations that could provoke
extreme anxiety. Menzies (1960) claimed nurses were constantly exposed to anxiety providing situations such as having to “carry out tasks which, by ordinary standards, are distasteful, disgusting, and frightening” (p. 98) and deal with people who are highly vulnerable, sometimes in pain, often anxious and alone, and who are facing death. Such situations are likely to evoke a mix of powerful and sometimes, contradictory emotions: compassion, pity, fear, disgust, envy, sexual desire. Menzies (1960) also asserted nurses generally had no emotional support to deal with such situations and therefore adopted a set of largely unsuccessful evasive or avoidance responses. Furthermore, they were socialised to maintain an almost inhuman self-control. More recently, Lawler (1991), Bolton (2005), Jervis (2001), and Twigg (2000) also found professionals who work closely with the body employed distancing strategies to manage the stigma and taboos associated with the work they perform.

Although contemporary nursing eschewed using distancing strategies many years ago and now espouses person-centred relationships (Kitwood, 1997) that are based on professional closeness (Peplau, 1969), partnership, reciprocity, and intimacy (Muetzel, 1988), the data from the current study, particularly with regard to managing residents’ incontinence was highly suggestive that distancing strategies still occur. The following section describes each of these strategies with reference to extant literature.
Blanking out was characterised by emotional and physical distancing strategies.

Maintaining physical distance

As noted in the preceding section of this chapter, one way staff attempted to protect themselves from the stigma associated with performing so-called bed and bath work [dirty work] was by seeking roles that did not involve such work. However, for those staff that had to grapple with aesthetically unpleasant and ‘dirty’ work such as incontinence, the findings showed staff attempted to create physical distance between themselves and residents and protected themselves by using gloves, plastic aprons, masks, rubber boots, plastic bags, and sprays. At a pragmatic level, staff was required to adopt these strategies in order to meet other people’s expectations, and adhere to infection control policies, occupational health and safety policies, and regulatory guidelines. Indeed, infection control policies required staff to use protective measures in order to minimise the potential for cross-infections such as gastroenteritis. The researcher argues that the protective measures staff adopted also have symbolic significance and represent a form of physical distancing.

Drawing on the findings from her study about helping people bath and wash, Twigg (2000) claimed “gloves were used by workers to protect themselves from the full intimacy of bathing work [and arguably, continence care work], and to put up a barrier of professionalism between the client [resident] and worker” [staff member] (p. 404). She suggested that “gloves operate as a mark of
professionalism and distance … evoking a sense that the person being handled is contaminated or subhuman” (p. 404). It is unlikely staff in the current study were aware of the symbolic significance of adopting physical protective measures that generated a physical distance from residents, or how residents’ themselves felt about being the subject of distancing strategies.

As the researcher did not explore residents’ perspectives, it is not known how residents interpreted staffs’ use of gloves and other forms of protective clothing when they attended to their body care needs. Future research should explore residents’ experiences of receiving personal care such as continence care, in order to identify factors that affect their emotional responses to such care. According to the findings of a qualitative study conducted in Sweden (Bjurbrant Birgersson, Hammar, Widerfors, Hallberg, & Athlin, 1993), the way staff interact with residents about residents’ incontinence and dependence on staff to change their pads has a considerable effect on residents’ intrinsic sense of value. Bjurbrant Birgersson et al. (1993) found residents’ feelings alternated between shame and guilt, dependency and independency, security and insecurity, and discomfort and comfort. The researchers stated the residents were in a continuous state of vulnerability concerning their sense of value and autonomy. It is probable that physical distancing strategies some staff use would exacerbate incontinent residents’ distress by reinforcing their feelings of being ‘contaminated’ or ‘dirty’.

Maintaining emotional distance

In addition to the physical distancing strategies described in the preceding section, findings showed staff also dealt with negative emotions or difficult situations by
maintaining emotional distance: a situation which sometimes meant staff had to engage in pretence. A staff member who stated she had to ‘take herself [metaphorically] away from it [incontinence]’ in order to deal with the disgust she felt from having to deal with a residents’ incontinence, showed how some staff generated emotional distance from aesthetically unpleasant and ‘dirty’ work.

Prior research drew attention to the fact that providing intimate hands-on care that includes touching, seeing, and smelling unpleasant body products is extremely difficult for caregivers and care-recipients alike (Applegate & Kaye, 1993; Isakson, 2002; Wrubel & Folkman, 1997). Staff are expected to project a caring approach whilst at the same time, they are also expected to conceal and manage negative emotions. The visceral emotion of disgust “is rooted in fear of contamination, whether directly through oral incorporation or touching, or more remotely through visual images or moral pollution” (Twigg, 2000, p. 395). Arguably, it takes considerable emotional labour for staff to transcend a sense of disgust, especially when they have to grapple with situations when ‘shit is everywhere’.

According to the findings of a sociological examination of the effects of social norms and cultural symbols that surround the intimate part of the body on the structure of family caregiving, family caregivers experience a range of emotions associated with the caregiving task, including:

- Disgust at the need to handle body products such as urine and faeces.
- Embarrassment at the care-recipients nakedness or need for help with basic bodily function.
Hurt from the care-recipients’ frustration and anger (Isakson, 2002).

Isakson (2002) stated that these family caregivers typically attempted to conceal these emotions in an effort to protect care-recipients’ feelings of powerlessness and helplessness. Thus, caregiving occurred against a backdrop of what the researchers termed ‘silent and noisy silences’ (p. 794). The researchers claimed “one type of emotional response when confronted with the existence of other people’s body fluids and products may be to protect oneself by putting up affective walls between oneself and the person(s) that exposes them” (p. 793). The current researcher posits that the emotional labour residential aged care staff performs in order to deal with residents’ incontinence, and indeed, other difficult conditions and situations, mirrors a broader tacit expectation to manage feelings in order to create a publicly observable facial and bodily display of coping.

Seminal research conducted by the sociologist Arlie Hochschild (1983) about flight attendants’ work, and more recent research about emotions in nursing (Gray, 2010; Hayward & Tuckey, 2011; Mazhindu, 2003, 2009) examined the dynamics involved in having to project outward displays of emotion in certain jobs. Hochschild (1983) coined the term ‘emotional labour’ to describe the management of feeling to create a publicly observable facial and bodily display so that they are consistent with organisational or occupational display rules, regardless of whether such displays are congruent with internal feelings or not.

The benefit of such public expression is that it produces a corresponding change in the emotional state of the observer (Pugh, 2001). Arguably, staffs’ concealment
of their own negative emotions associated with having to handle other people’s urine or feaces would reduce that person’s distress and embarrassment. However, the process of concealing emotions and sustaining an outward display of emotion that is not consistent with one’s feelings, may lead to an employee feeling emotional exhausted and over time, and result in reduced job satisfaction and burnout (Brotheridge & Grandey, 2002; Grandey, Fisk, & Steiner, 2005). To date, the emotional labour of caring for individuals with incontinence has received scant attention. This is an important issue for future research and education.

**Using distancing language**

Distancing language involves using patronising or infantilising ways of speaking to residents, and using infantilising language, labels, codes and abbreviations to refer to residents or to their care needs. Although staff did not malign residents, using terms such as ‘the CVA’ or ‘the dementias’, reorder, and arguably objectify and depersonalise people. Similarly, descriptions of care such as ‘doing the feeds’ or ‘doing the hygienes’ reduce residents to a set of tasks and undermines the complexity involved in providing such care and also disassociates the caring task from the resident.

Nurses’, and arguably other care staff interactions with residents have a profound effect on whether residents feel dehumanised or not and using infantilising language can objectify and depersonalise individuals and change them from their original status and identity (Bartlett, 1993; Bjurbrant Birgersson et al., 1993; Nay, 1998). Infantilising language involves speaking to or labeling older adults as if
they were children (Tuckett, 2003) and includes baby-talk, nicknames, using toys, reprimands, and child-oriented physical environments, in aging service environments (Salari, 2005). Some researchers even argue that using infantilising language with older people represents a form of psychological mistreatment (Salari, 2005).

In the current study, an incident from the observations of practice raised questions about whether using patronising or infantalising approaches are, in fact a form of psychological mistreatment, particularly if residents respond favorably to such approaches. For example, a resident laughed when tickled and when she was called ‘my little rabbit you’. Whilst on one hand, the staff member’s behaviour and terms of endearment could be interpreted as genuine familiarity and warmth; staff need to be mindful of the power relations that can influence residents’ responses. Specifically, staff needs to be aware that residents’ lives are often entirely dependent on them for otherwise taken-for-granted activities such as eating, drinking, using the toilet, and mobilising. Specifically, the care-dependent person may be afraid of the power staff wield over them (Koch, 1994) and respond positively because they need to keep staff on-side (Nay, 1998).

The tendency for some staff to use distancing language might also be underpinned by a deep-seated ageist attitudes (Nelson, 2005) and a tendency to label minorities or those seen as deviant from standard cultural norms. For example, discourses about dementia, and arguably incontinence, are largely underpinned by a biomedical paradigm that medicalises and labels socially unaccepted behaviours (Guendouzi & Miller, 2008). Furthermore, Goffman (1963) suggested labels often
accompany stigmatising conditions or behaviours. From a socio-psychological perspective, incontinence and dementia are stigmatising and marginalising conditions that evoke tacit socially-constructed distancing responses.

Reframing care

The self-protective distancing strategies staff adopted were additionally characterised by staff’s cognitive efforts to make sense of the situation of providing care in a constrained context. For example, staff framed their ability to deal with the aesthetically unpleasant aspects of care, such as continence care work, as a virtue. Reframing care was characterised by beliefs about: (a) striving for the best, (b) believing care was a dignity measure, (c) the greater good, (d) normalising and downplaying, and (e) externalising. The researcher proposes that reframing care could offset some of the anxiety and moral distress associated with the gap between staff care aspirations and actual practice. As such, it may represent a staff defence mechanism or a way of avoiding or distancing themselves from difficult emotions or situations so they could perform their roles. In other words, staff formulated accounts to make sense of the conflict [strain] they experienced by being unable to live up to their ideals about care.

Striving for the best

Striving for the best was a cognitive process that was characterised by aspirations and rhetoric about ideal care, but tempered by the belief that it was also not possible to provide such care, and reconciling or coming to terms with providing less aspirational care. As indicated in chapter three, staffs were not necessarily
able to live up to their ideals about care. Edberg et al. (2008) who conducted focus groups with 35 nurses in Sweden, Australia and UK, also found staff felt unable to provide the kind of care they wanted and this constraint was a major source of strain. As in the current study, staff perceived themselves to be powerless to alter the context of care that caused them to feel constrained. The findings of the current study showed some staff made sense of the situation they found themselves in by adopting the attitude that that the best thing they could do under the circumstances was to strive to provide the best care they could under the circumstances. As such, staffs’ efforts could be viewed as an attempt to find a cognitive balance in order to accommodate the multiple constraints to care.

In striving for the best, many staff, particularly managers, attempted to project a positive and ideologically acceptable representation of themselves, the care they provided, their colleagues, the facility, and the residential aged care sector more generally. Positive portrayals emphasised staffs’ caring nature and conveyed messages about resident choice, autonomy, quality of life, and functional health and wellbeing. They typically concealed the negativities of residents’ dependence, ill-health, decline and death, and the messy and confronting nature of what frontline staff actually did to provide care. The pressing need to project the residential aged care sector as a desirable environment has gained considerable impetus and support from governments whose agenda is to attract and retain a skilled workforce.

The researcher proposes that positive representations served three fundamental purposes. They align with the organisation’s marketing goals. They also bolster
the appearance of compliance to regulation. They may also represent an attempt to reject the stigmatisation and negative stereotypes associated with carework.

According to the findings of a qualitative study from 87 focus groups with CNAs in 16 nursing homes in Massachusetts in the US, CNAs cast themselves as nurturing, caring, the last line of defence for residents, as the ones doing good work, and asserted their worth and technical expertise (Pfefferie & Weinberg, 2008). The researchers theorised that such assertions helped CNAs reconstitute their stigmatised identities.

The negative aspects of concealing care and projecting an idealised image about care are that it conceals actual care as well as the day-to-day difficulties associated with providing such care. Framing care as a dignity measure represents one way of portraying a positive and ideologically acceptable representation about care.

_Framing care as a dignity measure_

Staff unequivocally framed the systemic use of pads as a dignifying measure, and some staff felt different pads had different dignifying effects. Indeed, the term “dignity” was part of staffs’ everyday language. It is likely that staffs’ interpretation of pads as a dignity measure were related to the marketing influence of the pad manufacturing industry which, as previously stated, has positioned itself as a key provider of incontinence education in the residential aged care sector in Australia. The word ‘dignity’ is commonly found in manufacturers’ promotional materials about pads.
Hutchinson et al. (1996) also found staff understandings about providing continence care to individuals with AD were influenced by their beliefs about dignity. However, unlike staff in the current study, Hutchinson et al. (1996) operationalised dignity by protecting residents from embarrassment such as: whispering to the client about toileting needs; keeping secret the fact they needed assistance to use the toilet; and acting in a natural manner when taking a client to the toilet. Data from the current study indicated some staff compartmentalised the abstract concept of resident dignity into a series of discrete tasks such as: choosing the ‘right’ pad; checking and changing residents’ pads regularly; and ensuring toilet and bathroom doors were closed.

Although regulatory and organisational policies emphasise the need for staff to treat residents with respect, in practice it is often up to staff and Assessors to interpret what dignifying care actually is. The term ‘dignity’ resonates with many layers of depth and meaning, however, there is no agreed definition of the word as it applies to care in residential aged care facilities (Seman, 2005). As previously indicated, there is a need to develop an operational definition of dignified continence care in residential aged care facilities.

*Espousing the greater good*

Analysis of staff accounts of care also revealed some staff appealed to utilitarian principles to rationalise or make sense of difficult situations. According to utilitarianism, the moral worth of an action is determined only by its resulting outcome; and actions are right when they increase the happiness of the community as a whole or diminish its misery, and are wrong when they have the opposite
effect (Bentham, 2001). John Stuart Mill (1863/1910) who coined the phrase ‘the end justifies the means’ described utilitarianism in terms of measuring acts according to the end results. The researcher posits that utilitarian beliefs helped staff make sense of carework in situations such as Margaret’s, where they felt compelled to override residents’ resistance to care. Delivering care that was in conflict with residents’ preferences was accompanied by the belief that staff had no choice but to substitute their judgement and care for resident’s judgement. It was also characterised by concerns about residents’ safety and by a ubiquitous fear of complaints, adverse events, and regulatory sanctions.

Given the design of the current study, it is not possible to show whether the care staff gave did justify the means. However, what the findings show is the complexity of the decisions staff, including PCAs, made when determining, delivering and communicating residents’ care. The complexity of decisions about the greater good associated with some forms of nursing care was put under the spotlight in a recent case posted on a website from the Division of Medical Ethics at the NYU Langone Medical Center in New York. The ethicist, Arthur L. Caplan, questioned whether patients had the right to choose to die from bedsores [pressure ulcers] by declining to be repositioned. Caplan claimed that just as patients have the right to cease life-sustaining support, they should also have the right to refuse care to prevent and treat pressure ulcers. At the same time, Caplan asserted “autonomy and patient rights may have some limits when they begin to affect others and the care that others can get” (Medscape Nurses, 2012). Such findings highlight the need for ethical guidelines to assist frontline staff deal with the day-to-day complex ethical decisions they need to make in order to deliver
care in a way that optimises residents’ rights.

**Normalising and downplaying**

Reframing care was additionally characterised by attempts to normalise and downplay situations or phenomena. For example, many staff spoke about residents’ incontinence, confusion, resistance to care, dysphagia, altered sleep/wake cycle, distress, and aggression, as if they were ‘normal’ situations or phenomena. Moreover, staff portrayed having to deal with such issues as a normal and unavoidable aspect of their work. Staffs’ everyday work involved repeated exposure to these phenomena, which in any other social context, would be considered highly abnormal, socially unacceptable, and indeed, taboo.

Mitteness and Barker (1995) were among the first researchers to describe the process of normalising incontinence in their paper titled ‘*Stigmatizing a “normal” condition*: Urinary incontinence in late life’. They claimed “incontinence is a cultural symbol for the increasing dependencies of old age, dependencies that are much feared and resented in U.S. society, where tremendous emphasis is placed on independence even into advanced old age” (p, 188). As such, they suggested individuals with incontinence adopted several strategies to manage their incontinence so as not to compromise their competence in the eyes of others. Such strategies include concealing the condition and reframing it as a ‘normal’ condition. Skoner and Haylor (1993) described similar responses among women with incontinence. The findings from the current study extend such findings and showed residential aged care staff also adopted several strategies for managing residents’ incontinence and these strategies also included normalising the
It seems likely that staffs’ beliefs about the normality of residents’ incontinence were related to broader social beliefs that incontinence in the elderly is an inevitable and intractable condition of old age: that it is ‘normal’, rather than a symptom of potentially treatable underlying set of conditions. Again, it is probable such beliefs were reinforced by staffs’ repeated exposure to education from the pad manufacturing industry. However, staff beliefs about residents’ inability to maintain or regain independent bladder and bowel control were just part and parcel of a broader condition that was characterised by low expectations.

The current researcher theorises that normalising and downplaying the highly abnormal, socially unacceptable, and taboo situations, events or phenomenon may serve to protect staff from the full horror of the reality of what they encountered in the context of performing their roles, and thereby lessened their own anxiety. After all, staff could not remain in a permanent heightened state of anxiety. Another possibility is that staff normalised the abnormal or confronting situations they encountered in an attempt to protect residents and their relatives and thus, minimise their emotional responses, as previously discussed.

May and Finch (2009) developed a ‘normalisation process model’ that articulates how and why certain things such as complex interventions become, or don’t become, routine and embedded in healthcare settings. In other words, the model is concerned with how things become normal or normalised. The researchers claimed: (1) “practices become routinely embedded – or normalised – in social
context as a result of people working, individually and collectively, to enact them; (2) the work of enacting a practice is promoted or inhibited through the operation of generative mechanisms through which human agency is expressed; and (3) the production and reproduction of practice requires continuous investment by agents in ensembles of action that are carried forward in time and space” (May et al., 2009, p. 2). Drawing on such understandings, the findings from the current study suggest residents’ care is characterised by low expectations and normalising processes. The problem with normalising incontinence and the practice of containing incontinence is that residents may not receive a comprehensive assessment to identify and treat potentially reversible causes of their incontinence.

Externalising

In the current study, staff often attributed their inability to meet residents’ care needs to other people or factors over which they had no control. Given the design of the current study, it is not possible or appropriate to comment on staffs’ actual control. However, it should be noted that displacing responsibility for situations is a common socio-psychological response and nursing literature is rich with information about externalising. Farrell (2001), who conducted a critical analysis of conflict within nursing, suggested displacement [externalising] that manifests as conflict within ones’ own ranks could be related to “the fear of reprisal or because of the fruitlessness of previous attempts to effect change” (p. 31).

A concerning finding from the current study was that some staff attributed responsibility for residents’ incontinence to the residents themselves, and did not consider the many contextual factors that could have caused some residents’
incontinence. For instance, staff indicated some residents were deliberately incontinent in order to gain staff attention. Whilst it is tempting to dismiss this belief as erroneous, the proposition that incontinence can be used to communicate a need for attention has some support within sociological research. Van Dongen (2000) conducted a sociological examination of how disgust and contempt structured the social and moral ordering within geriatric wards in a mental health setting. He claimed some patients with mental health problems used excreta as ways to communicate. Similarly, Muller-Hergl (2004) suggested in environments where human interaction and contact are limited to episodic servicing and cleaning the body, faecal incontinence and smearing [and by inference, urinary incontinence] could represent an attempt by care-dependent persons to elicit much-needed attention such as touch and contact (Muller-Hergl, 2004).

Muller-Hergel (2004) attributed incontinence to the underlying conditions that led to residents needing to elicit staff attention. She claimed “clients [residents] can use their deficits at least in part excessively to demonstrate power, to enforce nursing contact” … [after all], “when are touches, attention to body contact given, other than within functional contexts (p. 116)”? Muller-Hergl (2004) theorised that incontinent care-dependent individuals wield a certain kind of power over carers because carers cannot simply ignore their incontinence - particularly when there is ‘shit everywhere’. The current study showed staff had to grapple with residents’ incontinence. Therein lies the source of the problem because “this hidden power within smearing [incontinence] violates the power of the caring role”… and …”become a source of agitation for the carer” (Muller-Hergl, 2004, p. 114).
Therefore, a complex set of inter-related factors appear to cause some staff to regard incontinence as attention-seeking behaviour and such beliefs sets the scene for difficult and potentially unethical care. Current standards and guidelines do not accommodate the view that incontinence could have a psychosocial aetiology. There is a need to revise standards and guidelines to ensure they accommodate some of the complexities of providing continence care to individuals with cognitive or mental health disorders.

Summary

The findings of the current study offer a comprehensive and explanatory theory about caring in the residential aged care sector. This theory indicates residents’ continence care is subject to the same influences as other aspects of residents’ care; however, it is additionally subject to staff beliefs, values and expectations about incontinence, ageing, dignity, and cleanliness. Such beliefs, values and expectations are arguably transmitted and reinforced by the continence product manufacturing industry using marketing strategies that ensure continence pads remain at the forefront of continence care in residential aged care facilities. It is also possible that the accreditation framework inadvertently validates the belief that continence care equates to pad care because the Accreditation Standards are ambiguous and open to distortion.

The extant literature based upon substantive research overwhelmingly supports the findings and theory that emerged from the present study. Based on these findings and the research presented in the review of literature and discussion
chapters, the following recommendations are made for education and practice, and research and policy.

**Recommendations for education and practice**

The findings of the study identified many areas that could be improved in education and practice. Firstly, continence care and education in residential aged care facilities should be individualised and based on a comprehensive, evidence-based clinical assessment. The assessment should prompt staff to assess residents’ bladder and bowel care needs with reference to the ICI recommendations for managing incontinence in frail older adults (DuBeau et al., 2009). It should also counter ageist perspectives. Decisions about night-time continence care should take account of residents’ risk of skin breakdown, preferences, ability to spontaneously move, and accommodate their sleep/wake status, rather than a standard approach. The findings highlight the need for staff to gain the knowledge and skills to conduct a comprehensive and evidence-based continence assessment.

What was particularly disturbing in the study was the finding that most staff equated continence care with using pads effectively and felt their knowledge about incontinence was sufficient to enable them to provide care; particularly given they felt well supported by representatives of the pad manufacturing industry. Staff, service providers, Assessors and policy-makers should recognise the conflict of interest inherent in relying on the pad manufacturing industry to provide education about incontinence and its management.

There is a need for a multifaceted educational strategy that enhances ethical and
person-centred approaches to assisting residents to maintain continence and manage incontinence so that residents perceive care as supportive and feel respected. Continence content should be included in education programs for nurses and midwives as well as programs that target the residential aged care workforce. These education programs should also include information about the front-line realities of performing carework and managing the interpersonal dynamics associated with caring for individuals with stigmatising conditions such as incontinence.

**Recommendations for research and policy**

The data reported in this thesis raise an important policy and ethical issue. If residents’ are acknowledged as full citizens, then the ethics of an inadequate number of staff to meet residents basic care needs such as their need for consistent toileting assistance, should be questioned. However, if resources are not commensurate with residents’ basic right to access such support, policy makers should rethink the rhetoric and goal of attaining the highest level of functioning for all residents. A pragmatic and cost-effective way to ensure ethical continence care would be to adopt a targeted approach to care. However, this targeted approach needs a stronger evidence-base than currently exists.

Specifically, there is a need for further research to identify factors that predict residents who will respond to toileting assistance programs and those who will not. Such information could be used to develop a user-friendly method to help residential aged care staff to better identify residents who would be likely to
respond to toileting assistance programs. Researchers should also investigate residents’ preferences for continence care and compare their preferences with the care they actually receive.

Lack of staff, insufficient time, and the labour intense nature of providing toileting assistance were regarded as key barriers to providing residents with assistance to use the toilet. Further research is required to determine how frequently residents actually receive toileting assistance, and the time and cost involved in such care in Australian residential aged care facilities.

The findings also showed the inadvertent effect of the funding model and the accreditation system on how staff determined, delivered and communicated continence care. Residents’ clinical care could be undermined by the fact that funding and accreditation assessment and documentation requirements are combined with the assessment and documentation requirements for clinical care. Thus, policy-makers should consider disentangling the two processes. Additionally, Australian policy-makers should be aware that a punitive regulatory framework may cause staff to shift focus from residents’ physical health and psychosocial wellbeing to practices that centre on securing funding and avoiding sanctions. The regulatory framework should adopt a more supportive role so that staff do not adopt accommodating, acquiescing, concealing, risk adverse, and maladaptive protective processes that may compromise residents’ care.

Another situation that requires urgent attention is the need to enhance the clarity of Accreditation Standard 2.12 and potentially, other standards. Current
approaches to funding and appraising continence care in the residential aged care sector should ensure standards of care reflect actual care, and that they are contextually appropriate, achievable, measurable, understandable, and evidence-based. The quality of care and the appraisal of the quality of care in the residential aged care sector should also be guided by appropriate, relevant quality indicators. Such indicators could help shift the focus from accommodating regulation to promoting an active approach to resident care. However, as there is a lack of consensus about the most appropriate quality indicators to evaluate and guide continence care in residential aged care settings, further research is required to determine what constitutes quality continence care in the residential aged care sector and the best ways to measure it. Based on the finding that many staff in the current study equated ‘dignifying continence care’ with using a ‘dignifying’ pad, adopting quality indicators and/or standards of care that are open to misinterpretation and distortion must be avoided.

As this study showed continence care is a common antecedent to residents’ distressed behaviours that can escalate into an adversarial relationship between residents and staff, there is a need to formulate an ethical framework to assist staff to model ethical care and deal with the day-to-day complex ethical issues that arise when providing continence care.

The study findings showed that workforce constraints led to situations whereby staff felt they had to engage in compromise and ritual that could subsequently compromise residents’ care. The lack of RNs, the reliance on staff with minimal education preparation and English proficiency should be a cause for public
concern. Policy initiatives should redress this situation as a matter of urgency and nursing professional bodies should respond to the loss of nursing expertise within the Australian residential aged care sector with alarm.

Finally, testing the theory was beyond the scope of the current study. The validity of the findings should be interpreted in light of the extent to which they resonate with individuals in a similar setting and context.

**Limitations of the study**

As with every study, the findings of the current should be interpreted in light of the methods used to achieve the study objectives. The study findings are based on a grounded theory analysis of the perspectives of 18 staff members, the researcher’s observations of 88 hours of practice in two residential aged care facilities, and a content analysis of 87 accreditation reports.

Although the researcher theoretically sampled for diversity in terms of staff roles, it is possible that staff who self-selected to be interviewed may represent a group of people who wished to convey a particularly positive or negative set of attitudes about their work. Another consideration with respect to the sampling frame is the findings could have been strengthened by including more staff who did not have English as their first language and from diverse cultural backgrounds, especially given the cultural diversity of the Australian residential aged care workforce. Similarly, the review and discussion of the literature was largely based on research conducted in western countries, and in some cases, was conducted many
years ago. When building on the findings of the current study, it is important to consider how age, gender, cultural status, educational background, and publication bias can influence the results. In the current study, sixteen of the eighteen interviewees were aged forty years and older and there are generational (societal) issues beyond the aged care setting that could account for perspectives and beliefs.

Because the current study primarily focussed on staff members’ understandings about their role in providing continence care, it does not include residents’ perspectives or the points of view of physicians or other staff members such as domestic or lifestyle staff. The lack of information about these staff members’ perspectives could be viewed as a limitation.

The rigor and validity of the study should be considered in light of the information presented in chapter two about the epistemological differences that underpin qualitative and quantitative research. In keeping with grounded theory principles, the proposed theory emerges from the experiences of the study population. Therefore, the applicability of the findings to another context is not claimed. In addition, the grounded theory methods involved using deductive and inductive analysis, hence, the interpretation of the data such as the naming of categories and how the categories and their properties were linked, was a product of the researcher’s prolonged mental effort and select words and transcripts were used to illustrate meaning and the derivation of this meaning. The limitations associated with the human element of the process are acknowledged. At the same time, the
process of conducting credibility testing revealed the theory resonated with key informants.

It should be noted the design of the study did not involve quantifying residents’ autonomy, continence status, and dependence, or determining whether the care residents received was in fact holistic, individualised, ethical, and/or resident-centred. Similarly, it was beyond the scope of the study to investigate or validate the causes of residents’ incontinence or comprehensively quantify how frequently staff provided toileting assistance, changed pads, or conducted a continence assessment. Further research should be conducted to objectively explore the association between such care practices and residents’ functional status, autonomy and continence.

Another limitation of the study was that fact that the study did not differentiate between the care of residents with urinary and those with faecal incontinence. Participants’ responses reflected a concern with incontinence, rather than type of incontinence. Therefore, it difficult to determine whether the same caregiving issues apply to both urinary and faecal incontinence. For example, it is not clear whether staff view managing faecal incontinence differently from managing urinary incontinence care. It is also unclear if staff has different concerns about residents’ dignity depending on the type of incontinence they have. These issues should be investigated in further research.

The strength of the study lies in the use of grounded theory method to discover a theory about providing care in residential aged care facilities. The end-point of the
study was the development of a theory that was grounded in staff members’ experiences. It provides in-depth patterned information about a set of linked constructs that describes and explains care in residential aged care facilities and offers the potential for hypotheses or propositions that might be open to further investigation.

**Concluding remarks**

The subject matter for the current study was how residents’ continence care needs were determined, delivered and communicated in Australian residential aged care facilities. This topic is important and timely, particularly as national and international governments are faced with the urgent need to respond to older citizens’ increasingly complex care needs and expectations for skilled nursing care.

The findings provide a grounded theory about providing overall care in the Australian residential aged care sector. This theory posits that staff encounter multiple constraining factors in the context of providing care, and adopt a range of accommodating and self-protective distancing strategies to help them weather these constraints. The constraints include: rules and regulation associated with a highly regulated work environment, ethical challenges including multiple, competing and conflicting expectations about residents’ care needs, highly dependent residents’, workforce constraints, inadequate information about residents’ care needs, an unpredictable work environment, and a devalued role that is characterised by heavy workloads, stigmatised work, a lack of appreciation
of the complexity of the role, and low rates of pay. The processes or strategies staff adopt to help them weather such constraints are characterised by accommodating strategies such as acquiescing, concealing, protecting, adapting, prioritising, compromising, and ritualising, as well as distancing strategies such as blanking out, and reframing care.

Residents’ continence care is affected by the very same factors that influence the overall delivery of care. However, continence care is additionally influenced by the marketing messages of the manufacturers of continence products, and the pervasive and underlying belief that residents’ incontinence is an inevitable and intractable medical condition. As such, how staff manage incontinence is underpinned by a socially-constructed belief about the need to conceal and contain incontinence in order to ‘dignify’ residents and minimise the potential for adverse event such as falls and pressure ulcers.

As a theory, weathering constraints provides concrete and pragmatic information about the factors that influence continence care in residential aged care facilities, and how such factors are linked to exert their influence. The findings extend current understandings about providing care and continence care in residential aged care facilities which tend to focus on individual factors such staffs’ lack of training and/or motivation. As such, efforts to date to improve continence care have mainly centred on awareness-raising strategies such as education and the development and dissemination of guidelines. Notwithstanding the need for guidelines and staff education, the findings highlight the need to also attend to the wider cultural and organisational context that gives rise to problems that cause
staff to accommodate the context of care and adopt self-protective distancing strategies. The complex issue of ensuring quality care in residential should not be reduced to a simple matter of staff education and information.

The findings of the study underscore the importance of attending to the ways in which regulation, changes to workforce numbers and skill mix, and stigma impact point-of-care decisions about care. They also indicate the need for a comprehensive multifaceted strategy that will establish the necessary conditions for ethical, person-centred care, particularly in relation to personal care issues such as residents’ continence care. This strategy should ensure standards of care are achievable, measureable, easy to understand and outcomes-based. It should also incorporate education for all residential aged care staff about conducting a comprehensive continence assessment, and implementing person-centred approaches to continence care. Policy makers and service providers should not rely on staff obtaining knowledge and skills about active approaches to managing incontinence from the manufacturers of continence products.

As the population ages and consumer expectations increase, the need to attend to point-of-care decisions about care and contextual factors that influence such decisions, will take on increased importance. By showing the overall interrelated and contextual factors that influence how staff determine, deliver and communicate residents’ care, the findings from this thesis provide a theoretical basis for education, regulation, practice, and research initiatives to enhance care in the residential aged care sector.
Appendices
### Appendix A. Projects focusing on continence care in residential aged care facilities and funded by the Australian Government through the National Continence Management Strategy

<table>
<thead>
<tr>
<th>Researchers</th>
<th>Aim of project</th>
<th>Project outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Brookes, Verbeeck, Fonda, &amp; Torrance, 2001)</td>
<td>To evaluate a model of support and resource sharing to address the needs of residential aged care staff to improve continence management practices.</td>
<td>Continence care and treatment practices improved as did participants’ understanding of incontinence-related issues.</td>
</tr>
<tr>
<td>(Watt, Powell, Morris, &amp; Nay, 2003)</td>
<td>To develop a CD-ROM based interactive computer learning to provide instruction on best practice continence management, as well as challenge commonly held myths about incontinence, especially in the frail and demented older population and provide knowledge and skills to enhance their quality of care.</td>
<td>This project resulted in a computer-assisted learning package for ENs and PCAs who provide continence care to older people living in residential facilities or at home with community support to promote continence and manage incontinence.</td>
</tr>
<tr>
<td>(O'Connell et al., 2005)</td>
<td>To evaluate resources for the promotion of continence in residential aged care: a national consultative approach.</td>
<td>This project identified gaps in existing resources and barriers to implementing existing strategies.</td>
</tr>
<tr>
<td>(O'Connell et al., 2011)</td>
<td>To develop continence screening and assessment tools for use in the residential aged care sector</td>
<td>This project resulted in a suite of continence assessment and management tools, and an education guide for use by RNs, ENs and PCAs in Australian residential aged care facilities.</td>
</tr>
</tbody>
</table>
Appendix B. International Consultation on Incontinence

recommendations for assessing and managing incontinence in frail older adults

1. The frequency of incontinence
2. Personal goals of care or treatment preferences
3. Haematuria
4. Co morbid conditions
5. The psychosocial impact of the condition
6. Functional status
7. Environmental factors
8. Medications that could cause or worsen incontinence
9. Depression
10. Cognitive status
11. Faecal loading or impaction
12. Post voiding residual volume
13. Nocturia / nocturnal polyuria / primary sleep problems (DuBeau et al., 2009).
Appendix C. Demographics form

Date:

Name ........................................................................

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<td>□ NUM</td>
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<tr>
<td>□ RN Div 2/EN</td>
<td>□ ANUM</td>
</tr>
<tr>
<td>□ PCA/NA</td>
<td>□ Clinical Nurse Educator</td>
</tr>
<tr>
<td></td>
<td>□ Clinical Nurse Specialist / Consultant</td>
</tr>
<tr>
<td></td>
<td>□ Care worker</td>
</tr>
<tr>
<td></td>
<td>□ Accreditor</td>
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<tr>
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<td>□ Year 12</td>
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<tr>
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<td>□ TAFE</td>
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<tr>
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<tr>
<td>□ Part-time</td>
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<table>
<thead>
<tr>
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<th>Length of time employed in aged care sector</th>
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</thead>
<tbody>
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<td>□ Not applicable</td>
</tr>
<tr>
<td>□ &lt; 1 year</td>
<td>□ &lt; 1 year</td>
</tr>
<tr>
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<td>□ 1-3 years</td>
</tr>
<tr>
<td>□ 4-6 years</td>
<td>□ 4-6 years</td>
</tr>
<tr>
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<td>□ 7-10 years</td>
</tr>
<tr>
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<td>□ 11-15 years</td>
</tr>
<tr>
<td>□ 16-20 years</td>
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<tr>
<td>□ &gt;20 years</td>
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<table>
<thead>
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<td>PM Staffing levels</td>
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<td>Night Staffing levels</td>
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<td></td>
<td>□ 50-59</td>
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<td></td>
<td>□ 60-69</td>
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<tr>
<td></td>
<td>□ &gt; 70</td>
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Appendix D. Interview schedules

First interview schedule – June 2009

1. Can you describe some of the things that you do to help residents to maintain continence?
2. Tell me about what happens when you provide continence care to residents
3. What things help you manage providing continence care to residents?
4. What sorts of problems do you encounter?
5. Tell me how you go about deciding who needs what type of care
6. How do you find out about the type of continence care the resident needs? For example, how do you decide which residents to assist to the toilet and which residents not to assist?
7. How do you document the continence care that you provide to residents?
8. Does the residents’ care plan help you to provide continence care?
9. What do you believe are the most effective ways to communicate residents’ continence care needs?
10. What do you think are the best ways to manage incontinence for residents?
11. Is there anything you would like to change about the way residents’ continence care is provided?
12. What is your experience of how residents respond to incontinence and/or to their need for you to help them with bladder and bowel management?
13. What is your experience of how residents’ family members respond to resident’s incontinence and/or to residents’ need for you to help them with bladder and bowel management?

Additional issues for second set of interviews – March 2010

1. I am interested in your thoughts on how providing continence aids does or does not promote resident's dignity.
2. What is your opinion about the usefulness of teaching residents to strengthen their pelvic floor muscle exercises?
3. It seems the case that some residents get repeated bladder infections. I am interested in your thoughts as to why this might be the case?
4. Tell me about the support provided by product suppliers.
5. Describe for me how residents respond to being assisted with changing pads, being taken to the toilet and cleaned after incontinent episodes? How do they feel about wearing a pad for example?
6. Do you think there are any differences in the continence care needs of different groups of residents – for example, do high and low care residents continence care needs or need for pads differ – or for that matter, the care needs of residents with dementia?
7. How do staff remember who needs to go to the toilet and at what time? Do you have a reminder system for example?
8. Are there some residents who do not respond to being assisted to the toilet? How do you know which residents to take to the toilet?
9. What are your thoughts about how residents may feel about the fact that they are dependent on staff for assistance to get to the toilet, to change pads and to be cleaned after an incontinent episode?

10. Can you tell me about how residents get their continence aids and who pays for them?

Additional issues for third set of interviews – July 2010

1. What activities are involved in providing continence care to residents?
2. What do staff do to manage incontinence and to promote continence?
3. To what extent does residents’ continence status influence whether or not they have a bath/shower?
4. Is there a set number of residents they need to wash/shower/bath within a given timeframe? Who sets the rules? What are the challenges involved in this work? When residents have had their shower/bath/sponge, what happens to them next?
5. How do residents respond to being incontinent or to wearing pads and being dependent?
6. Are there any cultural differences in how residents adjust to being incontinent or to wearing pads and being dependent? Are there differences in men and women’s’ adjustment? If so, what are they and why?
7. What factors influence whether or not residents are given pads?
8. What factors influence whether or not residents are assisted to the toilet? What are staff members’ opinions about the effectiveness of toileting assistance programs? Which residents do they work for and which ones don’t they work for?
9. Do some residents elect to use pads when they are in fact, capable of going to the toilet? If yes, what do you think is going on that leads them to prefer pads? Explore proposition that some residents use incontinence as a means to gain attention as indicated in prior interviews.
10. What are some of the challenges involved in getting residents to accept using pads and how do staff go about encouraging them to use pads?
11. How do staff interact with residents they’ve had an incontinent episode and require help with pads, changing, washing etc?
12. What makes for a ‘good resident’ or a ‘bad resident’ in relation to continence and continence care?
13. How well prepared did the interviewee feel prior to working in the residential aged care sector to manage incontinence? What was/is their main source of support and education about managing incontinence?
Additional issues for final interviews – May 2012

Satisfaction with the job
1. How do you feel about working in the aged care sector? What kinds of things keep you in the job? What things do you like and what things don’t you like?
2. What do other people think about your job and why? How do you think other people think about the residential aged care sector?
3. Do you feel you can talk easily about your job to other people? If not, why not?

The effect of government regulation
1. Tell me about your experiences of accreditation, and complaints and government rules and regulations? What are some of the things you have to do to meet government requirements?
2. The Toileting Checklist requests information about the levels of care residents need to use the toilet and for ‘toilet completion’. According to the ACFI User Guide (2007), use of toilet refers to ‘setting up to use the toilet’ and the term ‘toilet completion’ refers to ‘the ability to appropriately manage the toileting activity’. What information do you collect in order to complete the checklist? How do you distinguish between toilet use and toilet completion?
3. In order for facilities to claim funding, the government requires information about the frequency of residents’ urinary incontinence (UI) over a consecutive three day period and their faecal incontinence (FI) over a consecutive seven day period. How do you identify changes in the level of wetness in residents’ pad?
4. What do you do when you do a continence assessment? How often do you have to check residents’ pads? How often are you able to do this?

Ability to meet residents care needs
1. What things do you do to meet residents’ continence care needs?
2. Do you feel you are able to meet residents care needs adequately? How do you feel if you can’t meet their needs?
3. How do you feel about having to do things to residents that they don’t like - like washing them or changing their pads when they don’t want that care?
4. What are some of the day-to-day issues associated with trying to keep residents with dementia continent?

Deciding continence care
1. Which residents get toileted? How do you make decisions about which residents you assist to use the toilet? How feasible are toileting programs in practice? What barriers are there to toileting – what factors enable toileting?
Learning the job
1. Can you tell me about the day-to-day workload? How do you cope with the workload? How did you learn to cope with it?
2. How well prepared did you feel to do the job when you started?
3. How well prepared do you think other staff are to do the job?
4. How do you feel about handling incontinence/dealing with urine/faeces and naked bodies? How did you learn?
5. How well supported do you feel in the job?

Residents’ perceptions/responses
1. How do you think residents’ feel about being cared for, about incontinence and about having to use pads and having to accept help to use the toilet?
2. What are some of the things that you believe help incontinent residents feel dignified?

Residents’ dependence
1. Can you describe residents and their care needs? How dependent are residents?
2. What do you think are the causes of residents’ incontinence?
Appendix E. Example of transcript from field observations

Friday 10/09/2010

**2200hrs** – The first staff member for the night shift arrives. Mary [pseudonym] emerges from her room and sits in her usual spot near the front door. The PCA (an older experienced staff member) tries to coax her back to bed, but Mary refuses. The PCA doesn’t argue with her. She says to me that she has always wondered why people attempt to argue reality with people with dementia. We get chatting and she tells me that behavioural management has always been one of her key interests and that she has attended a number of courses on the topic. She states that she had originally intended to work with troubled teens or children, but decided that she would *not be able to let it go*. I enquire what she means and she says indicates that ‘elderly people have lived their lives and although it is sad about their losses, it is good to be able to make a difference’.

**2220hrs** – Staff members discuss a resident whose health status has deteriorated. The staff member conveys the facts that the resident has a high temperature and is sweating profusely. The staff member communicates the following information about the resident - *'he was seen by the doctor. He’s ordered antibiotics. We need to get a urine sample. There are no uridomes [external catheters]. He’s not for ‘recuss [resuscitation]. His palliative care orders are done. He doesn’t want active treatment. His meds need to be crushed. X (his relative/guardian) knows what’s going on’.*

**2300hrs** – The staff check all the doors of the facility to ensure they are locked. The staff work in pairs. They use this opportunity to also conduct a quick check of residents. The check involved closing curtains and ensuring that residents have not fallen. They find Amy [pseudonym] on all fours at the entrance to her room. They return her to bed with a minimum of fuss.
In one room, they spend more time than usual – when they emerge they say ‘she likes things just so’. Their next task they perform involves filling the pockets of the pad hangers with residents’ pads. The staff member has a list of each resident’s individual pad requirements (i.e. the number of pads they require for the following 24 hours and the type of pads).

One of the staff members reviews each resident’s bowel chart. She advises that each resident has a bowel chart which indicates their normal frequency of bowel action and the maximum number of days they should go without being given suppositories. She states that no resident exceeds four days of bowel not being opened. She makes a list for day-staff of residents who require suppositories and says they are given by morning staff at 0800hrs. Residents’ bowel management charts also indicate each resident’s recommended individual fluid and dietary intake. I enquire about performing rectal examinations to diagnose constipation/rectal loading. The RN advises that inserting the suppositories involves doing a rectal examination, but she is not sure what happens if staff find the residents’ rectum empty.

The next job for the staff after developing a list of residents to receive suppositories is to review other charts and to develop other lists of activities that are needed. One of the staff members notes that there are new charts termed ‘Pressure Area Turn Charts’. She enquires about these. Another staff member tells her the charts have information on the times staff have to reposition certain residents and that staff have to tick and sign that they have provided such care. I review the chart and note the chart prompts staff to indicate the Norton Scale score for each resident, the date/time the resident was repositioned, whether or not any creams or emollients, or aromatherapy oils were used, whether or not the residents’ pad was changed and the position in which the resident was repositioned (i.e. left, right or back). One of the staff members indicates that the form was introduced subsequent to the death of a resident who had a wound. The staff member who has just been informed about the new form expresses concern that its use will result in the practice of
turning residents every two hours at night. Other forms that the night staff review include:

- Food and fluid charts
- Palliative care directions/plan/record for a resident whose health has recently deteriorated
- 24 hour resident behaviour charts
- Pain intensity instrument charts
- Catheter output charts
- Weekly restraint checklist (type of restraint and time checked).

2400hrs – An additional staff member arrives. All three staff start to prepare the breakfast trays. Mary is still up. The buzzer in one of the rooms alarms regularly and the staff tell me it is a sensor alarm which is too sensitive.

0115 - 0140hrs. The three staff commence the first continence care round at one end of the ward. They transport a linen skip with a supply of pads and night bed pads as well as the rack with the pad pockets for each resident. I remain in the corridor. They enter rooms, turn a light on and close doors behind them. From the corridor I hear staff speak in soft to normal tones. They do not enter every room, but are selective in which rooms they enter. I hear loud cries from one room as a resident is being attended. I learn later that it is the resident with the contracted legs and with a past history of abuse. I wonder how staff feel about having to perform a personal care task such as changing her pad that seems to be the cause of her crying out.

In some rooms, the main light is turned on and in others, a night light is used. I enquire later about whether or not using torches would be a good alternative to turning lights on. A staff member states ‘torches are difficult and may get lost’. Staff do not discuss between them which rooms they will enter – they seem to know in advance. They tell me later that they base their decision on who to change on the appearance of the writing on the pad. If it is ‘smuggy’, then it is wet. This implies the need to visually inspect the pads of each
resident on each occasion to determine if it requires changing. Staff remain in each resident’s room no longer than two minutes. The entire round is finished by 0140hrs. Thus a round for 50 residents with variable needs is completed within 25 minutes. Staff say they reposition some residents at the same time as they check their pads. I enquire how they decide who they turn and they advise that residents who are not checked and turned are those who are at less risk of skin breakdown and/or who indicate a desire to be left undisturbed.

As the night progresses, Amy’s confusion increases. On four occasions staff find Amy on her hands and knees at the entrance to her room. On each occasion, her clothes and bed linen and the floor are wet with urine. Two staff members enter the room. Each time, they pick Amy up, clean the floor, change Amy’s pad and return her to her bed. There is minimal interaction. They tell me Amy sleeps and other nights she doesn’t and convey the impression that the situation is normal.

The staff later tell me about how they make decisions about which residents they reposition and change at night. They tell me that some residents require their bed linen to be changed additional to their pads because of the volume of incontinence. This appears to be the case for one resident in a shared room. The main light is turned on above his bed and I am told later that this is because there could be urine on the floor which staff need to be able to see.

Another task undertaken during the round is to place residents’ individual pad pockets back in their rooms. They are placed either on the door of each room or in positions in the residents’ rooms that aims to minimise residents’ sleep. I am informed that day staff will place the pockets in the residents’ wardrobes.

After the round, staff position themselves in one of the lounge rooms. The TV is on. Two of them talk about social and family issues. One of the staff members has had a recent holiday and she shares her photos. They seem to know each other very well. The third staff member (a PCA) is not part of the
conversation and doesn’t initiate any discussion. I learn later he has limited English and has medical qualifications from his country of origin, but is unable to obtain registration as a doctor in Australia. I wonder how he feels about his role and about not being invited to be part of the social interaction. One resident is up. As the resident approaches the lounge room, he says ‘I’m lost’. The PCA encourages him back to bed whilst the other staff continue to talk.

**0200-0500hrs** The staff members offer me a blanket. They include a mismatch of crocheted blankets and hard stiff woollen blankets. Neither type seems very cosy or clean for that matter. I try to find a comfortable chair to rest. Most chairs seem stained and I very conscious of my own sense of repulsion at the thought they are stained from urine or faeces. I use my scarf to protect myself from any potential contaminated areas. Although the main lights in the lounge room have been turned off, it is nevertheless still light in the facility. The external lights are on as are night lights in the corridors. It is difficult to sleep under these circumstances. I wonder how residents adapt to the environment.

**0500hrs** – The second continence care round commences. The procedures of this round seem to mimic the last round however staff bypass Masie’s room this time. The door to her room is now closed. I enquire why they do not attend Masie and they advise that she continued to be restless for most of the night and only settled about 4am, so they wanted to give her a chance to ‘catch-up’ on sleep. The area now smells of concentrated urine – especially near the linen skips. I wonder if residents go back to sleep after being checked, changed and/or turned. I wonder what they think about being woken during the night. I suspect some residents don’t like it. Some have signs on the doors indicating they don’t wish to be disturbed – even though staff feel some are at risk of developing pressure ulcers. In fact a staff member says staff will have to override residents’ requests if they develop pressure ulcers. I wonder what happens to residents who are unable to verbalise that they don’t want to be disturbed. I enquire from the staff what they think about how residents feel
about being woken during the night. One says ‘well we try to do it as quickly as possible so they are not disturbed. Some of them grumble a bit’.
Appendix F. Example of open coding procedures

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Int 05</th>
<th>Code assigned</th>
</tr>
</thead>
</table>
| **What are your thoughts about how residents respond to firstly, being incontinent and secondly, to pads?** | I think it’s a huge loss of *dignity*. Um, I think especially sometimes with women, we are more…. kind of *accepting* of the situation [incontinence and needing assistance from staff to use their bowel and/or bladder] really. Oh well, you know whatever, its fine. I think sometimes with men especially, it can be very difficult for them. Men as part of their nature have a lot of pride and that sort of thing and so I think that when they do get ..you know….elderly and if they do lose urine, lose their continence and have to wear pads, it is very very difficult for them and a big *adjustment* for them. | **Expecting**  
**Difficulty accepting**  
**Adjusting** |
| **You’ve mentioned differences between men and women in coping. Tell me more about such differences?** | As a personal experience, my grandfather is now in the dementia section (high care). He doesn’t really have dementia – he did for a while but he’s now on medication and he is now 110% so he is perfectly aware of where he is and everything that is going on. He is still in the dementia unit and is still classified as high care because he is incontinent – so he does have continence issues. He seems alright with it now, but I know at first it was *very very difficult*. He was always – he had a lot of pride and very independent and always, grew up looking nice and being strong independent male to having to rely on his daughters or granddaughters to take him to the toilet when he goes out. So that is *very difficult*, especially at first. He seems to accept it a lot more now. I think *over time, you get used to it* I suppose. *So all this is what happens so therefore* I’ve got to *adjust to it* | **Accepting**  
**Adjusting** |
| **So do you think that is a cultural factor or because of being a male, or as you say, his personality?** | I think it probably a bit of both. I know like you can get Asians…my understanding is of that sort of community…the family member is the one to look after the incontinent person…nurses don’t do that. I think that *culturally, it is very different* for them because [in their culture] the family member changes their pads, takes them to the toilet – whereas in Australia, *the nurses do it. That’s their role, that’s what they do.* | **Expecting**  
**cultural differences** |
Appendix G. Example of a memo

‘Expecting’, ‘accepting’, ‘adjusting’, and ‘difficulty accepting’

Some staff empathised with residents and described them as being vulnerable, dependent, helpless and powerless. Int-03, whose mother had been admitted to a residential aged care facility, equated residents’ overall situation with that of prisoners, in so far as both were institutionalised. She described a rigid schedule to which residents adjusted – and compared residents’ situation with prisoners’ situation. She perceived that residents had little choice and sometimes lacked the freedom even to go to the toilet or to access staff assistance. The participant was visibly distressed as she reflected on residents’ situation with regard to her mother who had been a resident. It would appear that residents’ lack of choice is something the staff member accepted happened, and over which the participant felt she had little control.

Other staff referred to residents’ situation as one in which residents were in their final stop or in ‘Gods’ waiting room’. What does it mean for staff to work in a place where one expects individuals are just waiting to die? Is it possible that staff accept [give up] as well? Does a sense of hopelessness underpin care in residential aged care facilities? If so, show does a sense of hopelessness affect the overall delivery of care. I need to explore this more. Do staff feel they make a difference to residents’ lives, and what keeps them in the job? Explore ‘giving up’.
Appendix H. Ethical approval letter from Deakin

From: Human Research Ethics [research-ethics@deakin.edu.au]
Sent: Wednesday, 12 August 2009 2:22 PM
To: Beverly O'Connell; Joan Ostaszkiewicz
Cc: Mari Botti
Subject: EC 109-2009: Providing continence care in residential aged care settings: A grounded theory study

Dear Bev and Joan

EC 109-2009 – Providing continence care in residential aged care settings: A grounded theory study

Thank you for your amendments in response to the Committee’s concerns in relation to the above project, received on 10 August 2009. These have been considered and the project is now approved to commence. However, prior to distribution of the PLS to prospective participants please ensure that you change the DU-HREC contact details in the complaints section (section 11) to “The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au” and that the correct project number (EC 109-2009) is inserted into that section. The approval period is for three years and you will receive a letter of approval shortly confirming this.

It is the researcher’s responsibility to request an extension for an additional year beyond the three-year approval period granted. The conduct of research without approval may result in the researcher being unable to use data collected beyond the approval date. Please be reminded that any modifications that you wish to make in the future must first be approved by the Committee. You are also required to report any adverse events immediately. You will be
required to submit an annual report giving details of the progress of your research. Failure to do so may result in the termination of the project. Once the project is completed, you will be required to submit a final report informing the Committee of its completion. Please be reminded that the project number must always be quoted in any communication with the Committee to avoid delays. All communication should be directed to research-ethics@deakin.edu.au. It is the researcher’s responsibility to advise the Committee of changes to the research team or changes to contact details. The Deakin University Human Research Ethics Committee may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

If you have any queries in the future, please do not hesitate to contact the Human Ethics Unit.

We wish you well with your research.

Vicky

**Vicky Bates**

Human Research Ethics Officer

*Office of Research Integrity*

*Research Services Division*

*Deakin University, Burwood VIC 3125*

Tel: 03 9251 7123 International: +613 9251 7123

Fax: 03 9244 6581 International: +613 9244 6581

E-mail: vbates@deakin.edu.au

Deakin University Website: <http://www.deakin.edu.au>

Deakin University CRICOS Provider Code 00113B
Appendix I. Participant Information and Consent Form for participant interviews

DEAKIN UNIVERSITY
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

To: Interview participants

Plain Language Statement for Interview Participants

Date: …/…/…

Full Project Title: Providing continence care in residential aged care settings: A grounded theory study

Principal Researcher/s: Professor Bev O’Connell & Professor Trisha Dunning

Student Researcher: Ms Joan Ostaszkiewicz

This Plain Language Statement for Interview Participants and Consent Form is 5 pages long. Please make sure you have all the pages.

1. Your Consent

Thank you for your interest in this study which explores how continence care is provided in residential aged care settings. This Plain Language Statement for Interview Participants contains detailed information about the research and explains as openly and clearly as possible, all the procedures involved so that you can make an informed decision about whether or not you would like to participate. We invite you to read this document carefully and ask questions about any information contained in it. You may also wish to discuss the project with a relative or friend. Once you have the information you need to make a decision about whether or not to participate, if you agree to participate, we invite you to sign the consent form and send it to us in the reply-paid envelope. We will give you a copy of the Plain Language Statement for Interview Participants and a copy of the consent form to keep as a record.
2. **Purpose and Background**

This research is being conducted by Professor Bev O’Connell, Professor Trisha Dunning and Ms Joan Ostaszkiewicz (PhD student) from Deakin University, School of Nursing. We are all nurses who have an interest in continence care and aged care. Although many individuals in residential aged care settings require support with bladder and bowel management, there is little published research about the day-to-day practical aspects of care. Because of this, there is little practical information available to assist staff members to provide this care.

This study will help increase knowledge about the issues encountered by direct care staff when providing continence care to residents and the things that assist staff to provide this care. We aim to interview an initial sample of 20 individuals who currently work or who have worked in roles that include providing, supervising or evaluating continence care in residential aged care settings. This includes:

- Division 1 & 2 Registered Nurses - currently working or who have worked in the residential aged care sector in any of the following roles (i.e. clinical, management, education or consultation);
- Personal Care Workers, Nursing Aides, and Nursing Assistants; and
- Individuals who have been employed or who are currently employed in roles that involve evaluating the quality of care.

3. **Funding**

This research is funded by Deakin University.

4. **Procedures**

One of the researchers (JO) will contact you to arrange a time to interview you about your experiences of providing continence care. The interview will be tape-recorded and will occur at a time and place that best suits you outside your work hours. Each interview would last from 40 minutes to 1 hour and some participants might be invited to be interviewed more than once. Examples of the types of questions include:

- Can you describe some of the things that you do to help residents to maintain continence?
- Do you encounter any difficulties in providing continence care and if so, what are these difficulties?
- What things help you provide continence care to residents?

5. **Possible Benefits**

We hope that the findings of this research will help us identify strategies to educate and support other residential care staff to provide continence care to individuals living in residential aged care settings. There will be no immediate or individual benefits however to individuals who offer their time to participate in this study. The results of this research may also be used to help one of the researchers (JO) to obtain a PhD degree.
6. Possible Risks
This research project will be overseen by experienced researchers from the School of Nursing - Deakin University and the Human Research Ethics Committees from Deakin and from your Health network, (as appropriate). As nurses, we understand that issues related to bladder and bowel function are sensitive and private and that some people may feel uncomfortable talking about it. As with any research involving interviews, this research carries a slight risk that people who agree to participate in interviews may become distressed by the nature of the information they provide during interviews or that they may feel professionally harmed by disclosing information. If this occurs, we would invite you to take a break or to withdraw from the research. If you required counselling, we would refer you to a publicly funded Counselling Service in a Community Health Service. We would invite you to suspend or end your participation in the interview at any time.

7. Privacy, Confidentiality and Disclosure of Information
Any information obtained in connection with this project and that could identify you will remain confidential. Similarly, we request that any information you choose to share with us, remains confidential. The data collected will be analysed for a PhD thesis and the results may appear in publications. The results will be reported in a manner which does not enable you to be identified. Thus the reporting will protect your anonymity. During and after the study, the data will be securely stored and accessible only to the researchers. Six years after the publication of the PhD thesis, the data will be destroyed.

8. Results of Project
When the research is finished, a full copy of the thesis will be available in the residential aged care facility.

9. Participation is Voluntary
Your participation in this research project is entirely voluntary. We would be grateful if you did participate in the study but you are under no obligation to do so. If you do decide to participate, you may withdraw at any time without consequence. Because of the methods used to analyse the findings, if you decide to withdraw from the study, it will not be possible to withdraw your data however transcripts of the interview will be destroyed.

We aim to conduct the research openly and in a way that respects your rights to privacy. Please feel free to contact us if you have any queries about the research and only sign the Consent Form when you feel satisfied that you have all of the information you need. If you decide to withdraw from this project, please notify a member of the research team or complete and return the Revocation of Consent Form attached.

10. Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethics aspects of this research project have been approved by the Human Research Ethics Committee of Deakin University.
11. Complaints
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact: The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au”. Please cite project number (EC 109-2009).

12. Reimbursement for your costs
We do not anticipate any costs associated with your participation in this study. There are no financial incentives attached to participation.

13. Further Information, Queries or Any Problems
If you require further information, wish to withdraw your participation or if you have any problems concerning this project you can contact the principal researcher or Ms Joan Ostaszkiewicz, Deakin-Southern Health Nursing Research Centre, Ph 9594 4142 (BH) or 0414975 440 (AH)

The researchers responsible for this project are:
- Professor Bev O’Connell, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152. Ph 9594 4240
- Professor Trisha Dunning, School of Nursing, Deakin University, Waterfront Campus, Ph 5246 5113
- Ms Joan Ostaszkiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152. Ph 0414 975 440
DEAKIN UNIVERSITY
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

To: Interview Participants

Consent Form

Date: …/…/…

Full Project Title: Providing continence care in residential aged care settings: A grounded theory study

☐ I have read, and I understand the attached Plain Language Statement for Interview Participants.

☐ According to the conditions in the Plain Language Statement for Interview Participants, I freely agree to participate in being interviewed.

☐ I have been given a copy of the Plain Language Statement for Interview Participants and a copy of the Consent Form to keep.

☐ The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant’s name (printed)

.................................................................

Signature .................................................. Date

Please mail this form to:
Ms Joan Ostaszkiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152 in the reply-paid envelope.
To: Interview Participants

Revocation of Consent Form

(To be used for participants who wish to withdraw from the project)

Date: ..../..../....

Full Project Title: Providing continence care in residential aged care settings: A grounded theory study

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University.

Participant’s name (printed) …………………………………………………….

Signature ……………………………………………………………….

Date ………………………

Please mail this form to:
Ms Joan Ostaszkiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152.
Appendix J. Introductory letter for managers of residential aged care facilities

Dear ………………………………

My name is Joan Ostaszkiewicz. I am a Registered Nurse who is undertaking a PhD study about continence care in residential aged care settings in Australia, under the supervision of Professors’ Bev O’Connell and Trish Dunning from the School of Nursing at Deakin University. Although urinary incontinence affects more than 50% of the resident population and 10-30% experience faecal incontinence there is a lack of in-depth information about the care associated with these conditions. In order to address this gap in information we wish to conduct field observations of practice. Approval to conduct this study has been obtained from the Deakin University Human Research Ethics Committee. We are currently seeking to recruit two residential aged care facilities in Melbourne’s outer eastern suburbs for participation. The purpose of this letter is to invite you to seek further information about the study so that you can make an informed decision about whether or not you would like to nominate your site for participation.

It is hoped that the findings of the study will help us to identify strategies to educate and support residential aged care staff to provide continence care to individuals living in residential aged care settings. If you would more information about the study, please feel free to contact me directly on 0414 975 440 or by email: joan.ostaszkiewicz@deakin.edu.au or to complete the attached expression of interest form.

Thanking you,

Joan Ostaszkiewicz (RN, MNurs, PhD candidate)
School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152

Expression of interest form (managers)

Your name (printed) ............................................. Date …./…./.....

☐ Please phone me on .............................................between the hours of

☐ Please email me on .............................................

Please mail this form to: Ms Joan Ostaszkiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152 or fax it to 03 9594 6306
Appendix K. Participant Information and Consent Form for field observations

DEAKIN UNIVERSITY PLAIN LANGUAGE STATEMENT AND CONSENT FORM

To: Residential Aged Care Managers

Plain Language Statement for Residential Aged Care Managers

Date: .../.../

Full Project Title: Providing continence care in residential aged care settings: A grounded theory study

Principal Researcher/s: Professor Bev O’Connell & Professor Trisha Dunning

Student Researcher: Ms Joan Ostaszkiewicz

This Plain Language Statement for Residential Aged Care Managers and Consent Form is 6 pages long. Please make sure you have all the pages.

14. Your Consent

Thank you for your interest in this research study, which explores how continence care is provided in residential aged care settings. This Plain Language Statement for Residential Aged Care Managers contains detailed information about the research and explains as openly and clearly as possible, all the procedures involved so that you can make an informed decision about whether or not you would like to nominate your facility to be a research study site. It also provides information on how to contact us if you have any queries. We invite you to read this document carefully and ask questions about any information contained in it. You are welcome to discuss the project with others. Once you understand what the study is about and if you agree to take part in it, you will be asked to sign the organisational consent form that is attached to this document. By signing the consent form, you indicate that you understand the information and that you give your consent for your facility to participate in the research project. We will give you a copy of the Plain Language Statement for Residential Aged Care Managers and a copy of the consent form to keep as a record.

15. Purpose and Background

This research is being conducted by Professor Bev O’Connell, Professor Trisha Dunning and Ms Joan Ostaszkiewicz (PhD student) from Deakin University, School of Nursing. We are all nurses who have an interest in
continence care and aged care. Although many individuals in residential aged care settings require assistance with bladder and bowel management, there is little published research about the day-to-day practical aspects of care. Because of this, there is little practical information available to assist staff members to provide this care.

This study will help increase knowledge about the issues encountered by direct care staff when providing continence care to residents and the things that assist staff to provide this care. We invite you to participate in field observations and in a review of resident medical records.

To conduct field observations, one of the researchers (JO) would visit your facility at different times throughout the day over a period of approximately 3 months to observe how staff identify and respond to residents needs for continence care.

To conduct the review of resident medical records, one of the researchers would visit your facility to extract information from resident medical records about their age, gender, medical diagnosis, overall health status and continence care needs. The medical records would remain at the facility and any information that is collected would be deidentified to maintain residents’ privacy. We aim to review an initial sample of 5 resident medical records so that we can understand how continence care is documented. Resident consent would be sought to review their medical records.

16. Funding
This research is funded by Deakin University.

17. Procedures
Information about the research and about the field observations more specifically, will be available to staff, residents and other people who visit the facility and who use the areas to be included in the research. This information will be available through information sessions and a promotional flier. The field observations would be limited to areas of the facility that are shared and used as public spaces (i.e. dining rooms and living rooms) and will take place at different times throughout the day over a six-month period. The researcher will take detailed field notes. No video or tape recording will be used.

To seek resident consent for us to conduct a review of their medical records, we would ask that you identify residents who are cognitively able to provide informed consent provide and give them an introductory letter on our behalf. You are welcome to have a copy of this letter for your files.

These procedures for contacting potential participants and for seeking consent have been developed to meet ethical requirements concerning the rights of individuals to privacy and to optimise a consent process that is without influence.
18. Possible Benefits
We hope that the findings of this research will help us identify strategies to educate and support other residential care staff to provide continence care to individuals living in residential aged care settings however there will be no immediate or individual benefits to individuals who offer their time to participate in this study. The results of this research may also be used to help one of the researchers (JO) to obtain a PhD degree.

19. Possible Risks
This research project will be overseen by experienced researchers from the School of Nursing - Deakin University and the Human Research Ethics Committees from Deakin and from your Health network (as appropriate). As nurses, we understand that issues related to bladder and bowel function are sensitive and private and that many people may feel uncomfortable talking about it. Also, we appreciate that some people may be uncomfortable with the presence of a researcher in the facility.

We will attempt to be open and transparent about what we wish to do and why and will take cues/advice from you, other staff members, residents and visitors regarding the appropriateness of our presence in the shared areas at any particular point in time. If any individual appears uncomfortable with the presence of the researcher during field observations, we will discontinue the observations and seek advice from you or your nominee about the appropriateness of resuming them at a later time.

Similarly if residents wish at any time to withdraw their consent for their medical records to be reviewed, we would respect their right to withdraw and remind them that their withdrawal would have no affect on their residential or care status.

20. Privacy, Confidentiality and Disclosure of Information
Any information obtained in connection with this project and that could identify you or your facility would remain confidential. The data collected will be analysed for a PhD thesis and the results may appear in publications. The results will be reported in a manner which does not enable you or the facility to be identified. Thus the reporting will protect your anonymity. During and after the study, the data will be securely stored and accessible only to the researchers. Six years after the publication of the PhD thesis, the data will be destroyed.

21. Results of Project
When the research is finished, we will provide you with a full copy of the findings in the form of a bound thesis.

22. Participation is Voluntary
Your participation and the participation of residents is entirely voluntary. We would be grateful if you did provide organisational consent for your facility to be one of research sites for the field observations but you are under no obligation to do so. Individual residents who provide consent for their medical
records to be reviewed may withdraw at any time without consequence. Because of the methods used to analyse the findings, if individuals do withdraw, it will not be possible to withdraw their data however transcripts of their interviews will be destroyed.

We aim to conduct the research openly and in a way that respects your rights and the rights of all residents and staff to privacy. Please feel free to contact us if you have any queries about the research and only sign the Organisational Consent Form when you feel satisfied that you have all of the information you need. If you decide to withdraw from this project, please notify a member of the research team or complete and return the Organisational Revocation of Consent Form attached.

23. Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethics aspects of this research project have been approved by the Human Research Ethics Committee of Deakin University.

24. Complaints
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact: The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au and cite project number (EC 109-2009).

12. Reimbursement for your costs
We do not anticipate any costs associated with your participation in this study. There are no financial incentives attached to participation.

25. Further Information, Queries or Any Problems
If you require further information, wish to withdraw your participation or if you have any problems concerning this project you can contact the principal researcher or Ms Joan Ostaszkiewicz, Deakin-Southern Health Nursing Research Centre, Ph 9594 4142 (BH) or 0414975 440 (AH)

The researchers responsible for this project are:
- Professor Bev O’Connell, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152. Ph 9594 4240
- Professor Trisha Dunning, School of Nursing, Deakin University, Waterfront Campus, Ph 5246 5113
- Ms Joan Ostaszkiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152. Ph 9594 4142
DEAKIN UNIVERSITY
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

To: Residential Aged Care Managers

Organisational Consent Form

Date: ...

Full Project Title: Providing continence care in residential aged care settings: A grounded theory study

☐ I have read, and I understand the attached Plain Language Statement for Residential Aged Care Managers

☐ I freely agree for ……………………………………………………………. (name of organisation) to participate in the abovementioned study according to the conditions in the Plain Language Statement for Residential Aged Care Managers.

☐ I have been given a copy of the Plain Language Statement for Residential Aged Care Managers and a copy of the Organisational Consent Form to keep.

☐ The researcher has agreed not to reveal my identity and personal details, the details of this organisation or any staff member or resident, including where information about this project is published, or presented in any public form.

Organisation’s name (printed) ……………………………………………………………
Manager’s name (printed) ……………………………………………………………

Signature ……………………………………………………………. Date …………..

Please mail this form to: Ms Joan Ostanuskiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152 in the reply-paid envelope.
DEAKIN UNIVERSITY
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

To: Residential Aged Care Managers

Organisational Revocation of Consent Form

Date; …/…/….

Full Project Title: Providing continence care in residential aged care settings: A grounded theory study

I hereby wish to WITHDRAW my consent for ………………………to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University

Organisation’s name (printed) ………………………………………………….

Manager’s name (printed) ………………………………………………….

Signature ……………………………………………………….. Date

Please mail this form to:
Ms Joan Ostaszkiewicz, School of Nursing, Deakin University, Burwood Campus, 221, Burwood Hwy, Burwood, 3152. Ph 9594 4142
## Appendix L. Core units for Certificates III and IV in Aged Care

### Certificate III in Aged Care - CHC30212

<table>
<thead>
<tr>
<th>Unit code</th>
<th>Core competency</th>
<th>Unit description</th>
<th>Incontinence information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCAC317A</td>
<td>Support older people to maintain their independence</td>
<td>This unit describes the knowledge and skills required by the worker to support the older person to maintain their independence with activities of living</td>
<td>No</td>
</tr>
<tr>
<td>CHCAC318B</td>
<td>Work effectively with older people</td>
<td>This unit describes the skills and knowledge required by the worker to perform work that reflects understanding of the structure and profile of the residential aged care sector, the home and community sector and key issues facing older people in the community</td>
<td>Yes</td>
</tr>
<tr>
<td>CHCAC319A</td>
<td>Provide support to people living with dementia</td>
<td>This unit describes the knowledge and skills to support to clients with dementia in a variety of settings including family homes, community day settings and residential aged care facilities.</td>
<td>No</td>
</tr>
<tr>
<td>CHCCS411C</td>
<td>Work effectively in the community sector</td>
<td>This unit of competency describes the skills and knowledge required to work effectively in a community work or service delivery setting with communities, clients, carers, staff, visitors, suppliers and others to meet established work requirements</td>
<td>No</td>
</tr>
<tr>
<td>CHCICS301B</td>
<td>Provide support to meet personal care needs</td>
<td>This unit describes the knowledge and skills required by workers within their designated role and responsibilities to support or assist a client with their personal care needs within the framework of an individualised care support plan</td>
<td>Yes</td>
</tr>
<tr>
<td>CHCICS302B</td>
<td>Participate in the implementation of individualised plans</td>
<td>This unit describes the knowledge and skills required to provide support for people to sustain quality of life according to individualised plans</td>
<td>No</td>
</tr>
</tbody>
</table>
### Appendix L. Core units for Certificates III and IV in Aged Care (cont’d)

**Certificate III in Aged Care - CHC30212**

<table>
<thead>
<tr>
<th>Unit code</th>
<th>Core competency</th>
<th>Unit description</th>
<th>Incontinence information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCICS303A</td>
<td>Support individual health and emotional well being</td>
<td>This unit describes the knowledge and skills required by the worker to support a client’s health and emotional well being</td>
<td>No</td>
</tr>
<tr>
<td>CHCWHS312A</td>
<td>Follow WHS safety procedures for direct care work</td>
<td>This unit specifies the workplace performance required by an individual involved in following work health and safety procedures for direct care work. The unit focuses on maintaining safety of the worker, the people being supported and other community members</td>
<td>No</td>
</tr>
<tr>
<td>CHCPA301B</td>
<td>Deliver care services using a palliative approach</td>
<td>This unit describes the awareness, knowledge, skills and values required of a worker in contributing to the care of clients with life-limiting illness and/or normal ageing process within a palliative approach</td>
<td>No</td>
</tr>
<tr>
<td>HLTAP301B</td>
<td>Recognise healthy body systems in a health care context</td>
<td>This unit of competency describes the basic knowledge of anatomy and physiology required to recognise body systems and their components and to identify and refer alterations associated with the functioning of the human body in the context of health care work</td>
<td>No</td>
</tr>
</tbody>
</table>


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### Certificate IV in Aged Care - CHC40108

<table>
<thead>
<tr>
<th>Unit code</th>
<th>Core competency</th>
<th>Unit description</th>
<th>Incontinence information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCAC319A</td>
<td>Provide support to people living with dementia</td>
<td>This unit describes the knowledge and skills to support to clients with dementia in a variety of settings including family homes, community day settings and residential aged care facilities.</td>
<td>No</td>
</tr>
<tr>
<td>CHCCS411B</td>
<td>Work effectively in the community sector</td>
<td>This unit of competency describes the skills and knowledge required to work effectively in a community work or service delivery setting with communities, clients, carers, staff, visitors, suppliers and others to meet established work requirements.</td>
<td>No</td>
</tr>
<tr>
<td>CHCICS303A</td>
<td>Support individual health and emotional well being</td>
<td>This unit describes the knowledge and skills required by the worker to support a client’s health and emotional wellbeing.</td>
<td>No</td>
</tr>
<tr>
<td>CHCPA301B</td>
<td>Deliver care services using a palliative approach</td>
<td>This unit describes the awareness, knowledge, skills and values required of a worker in contributing to the care of clients with life-limiting illness and/or normal ageing process within a palliative approach.</td>
<td>No</td>
</tr>
<tr>
<td>HLTAP301B</td>
<td>Recognise healthy body systems in a health care context</td>
<td>This unit of competency describes the basic knowledge of anatomy and physiology required to recognise body systems and their components and to identify and refer alterations associated with the functioning of the human body in the context of health care work.</td>
<td>No</td>
</tr>
</tbody>
</table>
## Appendix L. Core units for Certificates III and IV in Aged Care (cont’d)

<table>
<thead>
<tr>
<th>Unit code</th>
<th>Core competency</th>
<th>Unit description</th>
<th>Incontinence information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCAC412A</td>
<td>Provide services to older people with complex needs</td>
<td>This unit describes the knowledge and skills required to provide services to the older person with complex or special care needs under supervision of a relevant professional.</td>
<td>Yes</td>
</tr>
<tr>
<td>CHCAC416A</td>
<td>Facilitate support responsive to the specific nature of dementia</td>
<td>This unit describes the knowledge and skills required to develop and implement support plans for clients with dementia in a variety of settings.</td>
<td>No</td>
</tr>
<tr>
<td>CHCAC417A</td>
<td>Implement interventions with older people at risk of falls</td>
<td>This unit describes the knowledge and skills required by the worker to work in partnership with older people and their carers to implement interventions in the context of an individualised plan to reduce the risk of falls.</td>
<td>Yes</td>
</tr>
<tr>
<td>CHCAD401D</td>
<td>Advocate for clients</td>
<td>This unit describes the knowledge and skills required by the worker to support clients to voice their opinions or needs and to ensure their rights are upheld</td>
<td>No</td>
</tr>
<tr>
<td>CHCCS400B</td>
<td>Work within a relevant legal and ethical framework</td>
<td>This unit describes the knowledge and skills required to work within a legal and ethical framework that supports duty of care requirements</td>
<td>No</td>
</tr>
<tr>
<td>CHCICS401B</td>
<td>Facilitate support for personal care needs</td>
<td>This unit describes the knowledge and skills required by workers to develop, implement and monitor support of client personal care needs through the framework of a personal care support plan</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Appendix L. Core units for Certificates III and IV in Aged Care (cont’d)

<table>
<thead>
<tr>
<th>Unit code</th>
<th>Core competency</th>
<th>Unit description</th>
<th>Incontinence information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCICS402A</td>
<td>Facilitate individualised plans</td>
<td>This unit describes the knowledge and skills required to develop, implement and monitor support requirements for people to sustain quality of life according to individualised plans.</td>
<td>No</td>
</tr>
<tr>
<td>CHCINF403D</td>
<td>Coordinate information systems</td>
<td>This unit describes the knowledge and skills required to coordinate all aspects of information management including collection, collation, storage and preparation of information in different formats depending on client needs</td>
<td>No</td>
</tr>
<tr>
<td>CHCNET404A</td>
<td>Facilitate links with other services</td>
<td>This unit describes the knowledge and skills required to liaise and facilitate linkages between community services including specialist and generalist services in the community to ensure support of people in need.</td>
<td>No</td>
</tr>
<tr>
<td>CHCORG406B</td>
<td>Supervise work</td>
<td>This unit describes the skills and knowledge required of a worker with responsibility for supervising the work of workers who are part of a team/workgroup or working alone It includes induction of new staff, planning work, monitoring performance and supporting workers to manage their workload</td>
<td>No</td>
</tr>
</tbody>
</table>

References


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