Moving Towards Inclusion:

Servant Leadership and the Aged Care Resident

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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ABSTRACT

While it is accepted that the style of leadership in organisations has a profound effect on the welfare, satisfaction and productivity of staff, to date there has been little mention of the effect of leadership on the client stakeholder.

This work involves a large provider organisation in the not-for-profit Faith-based aged and community care sector, and the impact of Servant Leadership on the experience of residents in that organisation's care.

The leadership literature provided little evidence about leadership from the client stakeholders' or consumers' perspective.

I explored the origin and development of FaithCare, its adoption of a particular leadership model and how that leadership model is transmitted to the residents.

My philosophical stance was one of pragmatism because of its applicability to the real world and its outcome orientation. Pragmatism aims to create desirable communities. This is both the stated and implicit aim of FaithCare and it would be expected to be that of organisations generally.

The methodology adopted for this research rested on my pragmatic approach and involved mixed methods research, incorporating grounded theory into some of its elements. It is said that pragmatism has a philosophical foothold in the mixed methods research domain. Using mixed methods research enabled both qualitative and quantitative assumptions to be drawn, different world views to be taken into account and different forms of data collection and analysis to be used.

Residents' interviews exposed a lack of participation in areas they considered important to them, despite the feedback systems FaithCare has put in place to record residents' comments and complaints.

This thesis established that organisational culture is the way in which leadership is transmitted via the staff to residents in this organisation.

Analysis of the data collected revealed that although the leadership model adopted by FaithCare is ideal for staff, the contribution of today's residents in this not-for-profit Faith-based organisation is compromised by the model. Further, it was found that the residents of the future, the baby boomers, will expect a degree of empowerment that FaithCare seems not to be aware it should provide.

The outcome of this work is twofold:

- to add to the existing body of leadership research by placing the 'third-party stakeholder' within Russell and Morse's (2002) Servant Leadership Model; and
- to develop the idea of 'Successful Presence', in which residents are potentially able to achieve a feeling of quiet satisfaction and peace within their community.

Publications

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Chapter 1

APPROACHING THE RESEARCH

My interest in leadership in aged care arose from working as a Registered Nurse in residential aged care, specifically as a Nurse Educator, in a Faith-based not-for-profit organisation in Australia. When my research began in 2010, the organisation was a partner in an Australian Research Council (ARC) research project, 'An Innovative Model of Leadership Development for the Not-For-Profit Aged and Community Care Sector' (hereafter referred to as the ARC leadership research project), between three universities and two Faith-based not-for-profit organisations providing aged care and community care. The ARC leadership research project research sought to develop a leadership capability framework for not-for-profit Australian health and community care organisations (Cartwright 2013).

As I read the literature around leadership, I began to wonder how leadership was experienced by the most important people in aged care, the care recipients. Indeed, the literature revealed little about how leadership in any field flowed on past its followers to what I started to think of as 'third-party stakeholders'.

I have de-identified the organisation and its individual homes. I refer to the organisation as 'FaithCare', and to its three homes as *Greentrees*, *Goldtrees* and *Bluetrees.*

The literature sometimes mentioned third-party stakeholders, usually customers, in the context of how well the business served them and thereby retained their custom. However, care recipients in residential aged care are uniquely placed. They are not like patients in a hospital whose stay is relatively short; they are not like customers or clients of a business with whom contact is intermittent; they are not like students at a school who go home each night; they are not like boarding students at a school who go home for holidays; they are not even like people in detention who, while their 'home' is the prison, are rarely there out of choice and usually have the expectation that in time they will be released.

Aged care residents may often be reluctant to enter care but it is expected that the aged care home will become their community, that they will have the opportunity to form friendships, take part in activities, adjust their surroundings to suit themselves within limits and entertain their relatives and old friends.

They expect to be relieved of the day-to-day burdens that have become difficult for them to manage, like shopping, cooking, cleaning and bill-paying. Their clinical issues will be managed efficiently and thoughtfully and their loneliness alleviated.

While leaders and followers have been written about extensively, the effect that leadership has on the third-party stakeholders is not discussed. Care recipients are not followers; they are not thought to be part of the leadership dynamic. However, they experience its flow-on effect because of their proximity; they are the only people 'in the building' 24 hours a day.

All organisations of any size have a leadership model or style, whether rigid or laissez-faire, gradually evolved, imposed or driven by the personal style of each leader. This applies to FaithCare too where there is an imposed leadership style. FaithCare's leadership model was carefully chosen to reflect its existing culture and more will be written about this in Chapter 2.

The research problem was therefore to investigate the experience of the most important group in residential aged care, the care recipients. I decided to investigate the suitability of the chosen leadership model of FaithCare in addressing the concerns of the residents in its care by focusing on the research questions listed below.

To provide a historical context to the research, I wanted first to investigate how FaithCare chose its leadership model, by talking to the people who were instrumental in making the decision. This led to the first research question (RQ1):

- (RQ1) How was the leadership model of FaithCare chosen?

  Keeping in mind the problem of investigating how the leadership model affects the care recipients, I wanted to examine how the leadership model was transmitted throughout FaithCare, including to the residents. This led to the second research question (RQ2):

- (RQ2) How are the culture and the chosen leadership model transmitted throughout FaithCare?

  A large part of residents' experience is whether or not they feel in control of their situation and are active members of their community. While this has psychological foundations in differentiating between having basic needs met, and being able to influence how they are met, it was important to look at the broader picture and ask those in power in organisations generally whether 'third-party stakeholders' should have a say. While this may not directly impact residents, it provides a background sense of whether or not residents' voices should be listened to. Research question three (RQ3) addresses this:

- (RQ3) Does the wider business community acknowledge that 'third-party stakeholders' should have a say in any key aspects of organisations?

  Most important is the next question (RQ4), which asks what the residents themselves consider important to them:

- (RQ4) What is important to today's residents?

  Having established whether or not residents should have a say in their lives and what is important to them, the following question (RQ5) addresses whether the residents themselves consider that they have a say:

- (RQ5) Do today's residents have a meaningful say in decisions affecting them in their aged care home?

  To enable some ongoing continuity to this research and accepting that we are almost on the brink of a change from 'today's residents' to Baby Boomer residents, it was important to investigate whether these future residents will differ from the current ones:

- (RQ6) What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?

  The questions aim to allow discussion of the interdependence of leadership and culture and the wellbeing of the resident in twenty first century not-for-profit Faith-based aged care in Australia.

The structure of the thesis

This enquiry into the effect of leadership on aged care residents explores the leadership style and culture of FaithCare, the process of transmitting them from leader to resident, and their contribution to the life of the residents leading to the reframing of Servant Leadership to incorporate the 'third-party stakeholder'.
The work is grounded in pragmatism and developed its structure from the use of mixed methods to capture different aspects of the resident's experience. Aspects of grounded theory also assisted in the analysis of data.

The structure of the thesis is outlined below:

Chapter 1, *Approaching the Research*, introduces the research problem and places the research in context.

Chapter 2, *About Aged Care*, describes the state of aged care today and provides an insight into the residents, the workforce and the organisation.

Chapter 3, *About Leadership*, provides a review of leadership theories, the limitations imposed by Faith-based not-for-profit organisations on leadership and finally focuses on Servant Leadership.

Chapter 4, *About Organisational Culture*, gives an overview of organisational culture and its symbiotic relationship with leadership.

Chapter 5, *Approaching the Research Questions,* outlines my philosophical stance and rationale, the research method chosen, participant selection and research design, finally arriving at a restatement of the research questions.

Chapter 6, *The Leadership Model and Culture,* describes how the leadership model was chosen and how it is transmitted throughout FaithCare.

Chapter 7, *The Residents' View,* describes what is important to residents and explores whether they think their views are taken seriously.

Chapter 8, *The Baby Boomers' View,* defines baby boomers, describes the particular attitudes and perspectives they will bring to future care and provides a snapshot of what the boomers think will be important to them in the context of aged care.

Chapter 9, *About Successful Presence*, develops the concept 'Successful Presence', which enables the reframing of Servant Leadership to incorporate the 'third-party stakeholder'.

Chapter 10, *The Conclusion*, encapsulates the learnings from the research.

Chapter 2

ABOUT AGED CARE

'At no time have so many had to be helped by so few.' Resident 59

This chapter provides an overview of aged care today in Australia.

Not-for-profit organisations have increasingly taken over care of the aged from families and government agencies, a trend that has been seen throughout the western world and even in more traditional societies such as Asia (Huang, Thang & Toyota 2012). However, in Australia there has recently been a shift towards supporting older people to remain in their own homes and provide government-funded services to enable them to do so (Productivity Commission 2011).

The past 10 years in residential aged care have been tumultuous as there have been fundamental changes that impacted every aspect of the care given to older people in facilities around Australia. These changes have included the way the government funds aged care, the greater age, frailty and poorer health of people coming into residential care than previously, people living longer, the changing demographics of the Australian population with the influx of people from non-European cultures and staffing shortages. Aged care organisations have struggled to adapt their practice to these changes. In 2014 the 'dementia supplement' was withdrawn as a cost-cutting measure by the government and this placed many aged care organisations in crisis; the government had not foreseen the number of people affected by dementia.

Implementing the findings of the Productivity Commission report into Caring for Older Australians: Overview (2011), the frailty of new residents, the increase in demand for dementia and palliative care services and the impending entrance into the sector of ageing baby boomers, many of whom are well-educated, technology savvy and have high or different expectations, are some of the challenges facing aged care providers.

Government funding

The Australian Government spends more than $5 billion annually to support the care of older Australians living in aged care homes. In March 2008 the government introduced a new mechanism to allocate the government subsidy by replacing the Resident Classification Scale with the Aged Care Funding Instrument (ACFI). ACFI is based on the aged care provider's appraisal of each resident's care needs and aims to match funding better to the complex care needs of residents, reduce documentation created by aged care providers to justify funding and produce higher levels of agreement between aged care staff and departmental review officers (Australian Government 2009). The ACFI score is based primarily on the individual resident's dependency (need for care), rather than on care planning or the care itself provided by a residential aged care facility.

As a nurse, however, I believe that one of the anomalies in the ACFI system is that the funding received does not reflect what is actually done for a resident and/or how much time staff spend on that resident. For example, no funding is available for applying a moisturising cream to a resident's legs, but funding is available to apply a medicated cream prescribed by the doctor. It should be said that most aged legs have dry, thin skin and the application of moisturising cream is one of the best ways to prevent skin tears, a common problem induced by the slightest knock, which may in turn result in frequent dressings, infection, ulceration, pain and even hospitalisation (Carville, Leslie, Osseiran-Moisson, Newall & Lewin 2014). Thus, ACFI provides no incentive for preventive care or for staff to give better service to residents.

New measures arising from the Productivity Commission report (2011) saw funds made available to be spent by the aged on whichever services they decided they required. These measures began in July 2013 with the Aged Care (Living Longer Living Better) Act 2013 and were implemented in July 2014. Changes include the way government subsidies and resident fees are calculated and options available to care recipients to pay for their accommodation. These reforms aim to put older people at the centre of the aged care system.

The residents

In 2009-2010, Australian, state and territory government expenditure on aged care was $11 billion, with two thirds of that directed to residential aged care. As at 30 June 2010, more than 160,000 Australians were receiving permanent residential care, the majority of it high level care. By 2050 it is expected that there will be more than 1,800,000 people over the age of 85 in Australia, 700,000 of whom will need residential aged care (Productivity Commission 2011).

In the mid-2020s the first of the baby boomers will turn 80 and begin to enter residential aged care. Those with advanced chronic diseases such as dementia, Parkinson's and multiple sclerosis or requiring palliative care may have entered aged care at an earlier age. While further advances in the management of some diseases are expected, more people will require complex care for dementia, diabetes and other morbidities associated with longevity, as well as palliative care.

By mid-2010 45% of people in aged care facilities were less than 85 years of age. They were in many cases still mobile and able to care in large part for themselves (Productivity Commission 2011). Today, the Government encourages people to stay in their own home for as long as possible and provides care and support through community aged care packages.

Because almost everyone would rather live independently in their own home and neighbourhood, it is not until there is a considerable decline in health, or unmanageable incontinence, dementia, forgetfulness or falls, that people now enter aged care facilities, many close to the age of 90. A survey conducted by the Office for Older Australians in preparation for the International Year of Older Persons in 1999 found that older people want to 'remain in their own homes for as long as possible … and to be cared for as necessary by the family (specifically a spouse or daughter)' ('Productivity Commission and Melbourne Institute of Applied Economic and Social Research' 1999, p. 293).

While clinical issues often drive frail older people into residential care, loneliness plays a part too. Modern families can be scattered and are often unable or unwilling to do their part to support their aged relative at home.

Mitchell and Koch (1997) wrote of 'the ageist culture of well-meaning custodial care, and the institutionalized process of Australian nursing home residents' (p. 454). This has remained the model for residential aged care until now and is a result of the seemingly irreconcilable conflict between duty of care/financial considerations and individual freedom. Immanuel Kant believed that 'autonomy … gives people respect, value and proper motivation' (Rodgers & Neville 2007, p. 30). Quality of life is intimately bound to human freedom and potential, to Maslow's self-actualisation or Critical Theory's emancipation and enlightenment. Duty of care and financial considerations in aged care facilities thwart residents' personal freedom in practical ways, such as decisions made with very little, if any, consultation, about participation in outings, timing of meals, timing of showers vis-à-vis breakfast and permission to make a cup a tea for oneself, as examples.

The workforce

'Ageing in Place' is a policy that enables residents in low care facilities to remain there when their requirements become high care, providing responsive and flexible care in line with each individual's changing care needs in a familiar and appropriate environment. Ageing in place in an aged care home has only been a philosophy of care in Australia since the introduction of the Aged Care Act 1997 (Productivity Commission 2011); (Commonwealth Department of Health and Ageing 2002, p. 10). Previously when a resident moved into the high care classification, he or she would be moved to a nursing home. These older, frailer residents require higher staffing levels than is usually provided in low care facilities. When this is not forthcoming, staff struggle to provide quality care.

Historically, care staff in low care facilities were typically untrained. They were given one or two days of orientation to the organisation, some instruction about legislative requirements and worked for two or three days on 'buddy shifts'. This was quite low-paid and heavy work and it was not surprising that facility managers found it difficult to recruit and retain high-quality, dedicated staff (Productivity Commission 2011). More recently aged care organisations have trained carers to a level (Certificate 3 or 4 in Aged Care) to enable them to care safely for high care residents.

Registered Nurses (RNs) are in charge of the care staff. Most RNs working in aged care are over 45 years old and were trained under 'the old hospital system'. They work longer hours than they are paid for, are driven by a sense of duty and their retirement from the nursing workforce over the next two decades will coincide neatly and unfortunately with the arrival into care of the baby boomers. Younger, university-trained nurses typically have a different attitude to their work. They are difficult to recruit to aged care because of its low-tech, unexciting reputation and lack of obvious career path. The aged care workforce will need to expand at a time of 'age-induced' tightening of the overall labour market, an expected relative decline in family support and availability of informal carers, and strong demand for health workers from other parts of the health system (Productivity Commission 2011).

It is hoped that, as 'Ageing in the Community' becomes more prevalent than 'Ageing in Place', there will be less pressure on the number of places available in residential care. However, except for those older Australians with almost limitless wealth, few people can afford round-the-clock care and/or companionship in their own home. It is my view that mild to moderate dementia, incontinence, the need for palliative care and loneliness will remain major drivers in the push for residential care.

The organisation

FaithCare is one of the largest not-for-profit Christian aged care organisations in Australia. It was established more than 60 years ago by a group of church members who wanted to express the love of Christ in practical ways to people in need, particularly the aged and children. FaithCare now runs 160 facilities and programs across New South Wales and the Australian Capital Territory. It serves older and disadvantaged people both in the community and in residential homes.

The value statements of the organisation

FaithCare's various value statements are constantly stated, referred to and reinforced to staff and form part of a leadership development program specially devised and run for managers and potential leaders. Alvesson (2002, p. 76) warns that the meaning of the mission statement varies considerably between organisations, from being a public relations stunt to a mirror of what the company does or wants to accomplish.

Important aspects of FaithCare's value statements are an emphasis on service through Christ, mutual respect, high integrity, communication and commitment. The value statements of this organisation are displayed on walls throughout its offices and facilities, are printed in its publications and are discussed at length during each staff member's orientation and at staff seminars and meetings. This is an organisation that endeavours every day to 'walk the talk'.

This chapter described the state of aged care today and provided an insight into the residents, the workforce and the organisation.

The following chapter provides a review of leadership theories, the limitations imposed by Faith-based not-for-profit organisations on leadership and finally focuses on Servant Leadership.

Chapter 3

ABOUT LEADERSHIP

The literature on leadership has grown exponentially since the 1950s. This chapter provides a review of leadership theories and a discussion of FaithCare's chosen leadership model, Servant Leadership.

More than 50 years ago Bennis (1959) wrote that 'more has been written and less is known about leadership than about any other topic in the behavioural sciences' (p. 259). He added (p. 260) that 'the dialectic and reversals of emphases in this area very nearly rival the tortuous twists and turns of child-rearing practices'. Forty years later, in 1999, Bennis wrote, 'I think it is now possible to talk about the end of leadership without the risk of hyperbole. Some of this change is organic and inevitable. But much of it is the legacy of our times ignited by that dynamic duo: globalization and relentlessly disruptive technology' (p. 71). However, so much is still being written about leadership that it is far from at an end.

What followers want and need from leadership has, however, changed and continues to change. In times of crisis, when followers are not privy to the full picture, they feel more secure being led by a decisive leader. During the good times, followers can expect to have more input and leadership becomes more democratic. It is therefore unlikely that there is one definitive style or theory of leadership that fits every situation. Conger and Ready (2004) say that 'leadership requirements vary by level, culture, and situation' (p. 45) and Conger also writes of 'chameleon' capability as the way to adapt to 'today's pace of change and the complexity of leading in today's organizations, this capability to develop a highly versatile style of leadership' (2004, p. 139). During Steve Jobs' leadership of Apple, he demonstrated many aspects of leadership: brilliant creativity, ruthless culling of employees in tough times, remarkable energy, entrepreneurial skills and the ability to inspire others (Australian Institute of Health and Welfare 2012). Indeed versatility has become an important component of the debate about how leaders lead now. However, it doesn't answer the question 'what is leadership?'

There are many definitions of leadership and many lists of descriptive words have been produced to aid in its identification. Kouzes and Pozner write that 'leadership is the art of mobilizing others to want to struggle for shared aspirations' (1987, p. 30). However, while Ciulla (2002) says that 'leadership is about one person getting other people to do something', she adds 'it is time that leadership studies move forward to focus on a new set of questions because the question about what leadership is has simply been answered' (p. 340). It has been answered in many ways and there remains no one agreed definition. So the question now could be 'does it matter what leadership is?' The lack of a universal definition shouldn't impact on the continuing debate about what leadership should look like in the twenty first century.

Historical and cultural perspective

Leadership has been written about throughout history. Leaving aside the obvious and oft-quoted leaders who have influenced the west, such as Jesus of Nazareth Gandhi, Martin Luther King, and many other men and women, all societies throughout history have had leaders who provided for and protected members of their group, who journeyed to faraway lands and plundered the treasures of other groups, who displayed great wisdom or interpreted the will of God. Some were brutal, others measured and kindly. Many performed heroic deeds and were elevated, admired or feared by their fellows. These heroic leaders seemed somehow born to rule, larger than life, having innate qualities that set them apart from others. They were men or women for their time whose characteristics resonated with events of the day, much as Sir Winston Churchill's determination contributed so much to the survival of Britain in 1940 but whose obstinacy contributed to the mistakes of 1941 in failing to prepare Singapore adequately and committing British troops to unnecessary disaster in Crete and Greece (Bass 1985, p. 27).

Less famous leaders also displayed heroic characteristics. The stories of little-known leaders provide evidence that the leadership competencies and capabilities written about during the past century were evident in even more diverse times, locations and cultures.

In medieval Anglo-Saxon England activities in the mead-hall reveal a leadership style that very much reflects the brutality of the day. Through an examination of old

English verse tradition, Pollington (2011) describes the importance of the mead-hall to the 'social life of the individual settlement and to the community's situation within the wider society' (p. 32). It was a place for enjoyment, bonding and demonstrating solidarity with kin, and political leadership in a world that was generally non-inclusive to the point of hostility. The purpose of the ritual feast was to highlight and re-affirm the hierarchical structure of the group, the superiority of the leader and the subordination of followers. The community leader (lord) presided over these public ceremonies and offered gifts to his supporters, warriors, farmers and producers who in turn supported their lord by pledging their good deeds and good name to him, and handing him their material gains. The poetic tradition exalted the wisdom of elderly males and the courage of younger ones who, as heroes larger than life, 'swaggered through the halls, bound by terrible oaths, haunted by implacable nightmarish spirits, forsaken by loved ones and kin' (p. 29). Mead-hall lords as described by Pollington were heroic figures, responding decisively and harshly to life-threatening contingencies and taking a transactional approach to relationships with their followers.

Nyarroh of Bandasuma, Sierra Leone, was a woman chief in the pre- and post-colonial period (1880-1914) who was deeply embroiled in the power politics of her time and participated in the 'same system of alliances and warfare as the male chiefs in the countries around her. She signed treaties, participated in peace negotiations, received delegations, sent out war parties and was even attacked, captured and held for ransom' (Day 2007, p. 423). Nyarroh was a peacemaker who had a special relationship with the colonial government, was able to operate outside the confines of the rules set for male chiefs and self-reflexively positioned herself to respond to this pivotal moment in the history of the region. Although she assumed her position on the death of her husband, she demonstrated skill in leadership in the 'multi-layered, overlapping and fluid network of authority and political rule' of her land (p. 421). Thus, Nyarroh demonstrated skill in many of the leadership capabilities we value in the twenty first century, particularly interpersonal skills (peacemaking and diplomacy), resilience, intelligence, and the ability to self-reflect.

The Wagga Wagga Aboriginal Elders Group, established in 1999, illustrates different aspects of leadership. Aboriginal elders are not elected and leadership is not

hereditary but occurs when the need arises in ‘an idiosyncratic Aboriginal way’ (Milliken, Shea & Wagga Wagga Aboriginal Elders Group Incorporated 2007, p. 300). These modern indigenous leaders, the elders, are not necessarily old, but their skills are valued, their opinions and contribution to decision-making sought, they are respected, have a shared value base that is culturally focused and are committed to seeing their community grow and advance. This is a type of relational leadership, a fluid approach that enables anyone to step up as leader when required.

Review of leadership theories

A review of articles in the journal *Nonprofit Management and Leadership* over the past 15 years found that the majority of papers dealing with leadership focused on leadership at the board or governance level. Bush (2002) points out that leadership impacts on effective not-for-profit management. He argues that a not-for-profit organisation’s leadership should have a clear sense of vision, a clear mission and a set of objectives, but he does not discuss how these could be developed. Alexander et al. (2001) propose a leadership model for a community care network that is collaborative and not based on authority and hierarchy. None of the papers reviewed discussed a leadership framework for not-for-profit organisations (NFPs) specifically or leadership from the point of view of those ultimately impacted by it, that is, the clients.

The thinking around theories of leadership evolved during the twentieth century, considerably spurred on by the worldwide turmoil of wars, economic depression and recession, social and political instability and mass migration. The broad views of leadership discussed below have risen and fallen in favour in lockstep with improving educational levels coupled with a move from cottage- and factory-based industrial economies towards service-based economies.

Leadership research approaches have been broadly classified into four categories by Yukl (2006) – trait, power and influence, behaviour, and situation or contingency theories. Yukl (2006) also proposed an integrated model for leadership research that combines several of these approaches, as shown in Figure 3.1.

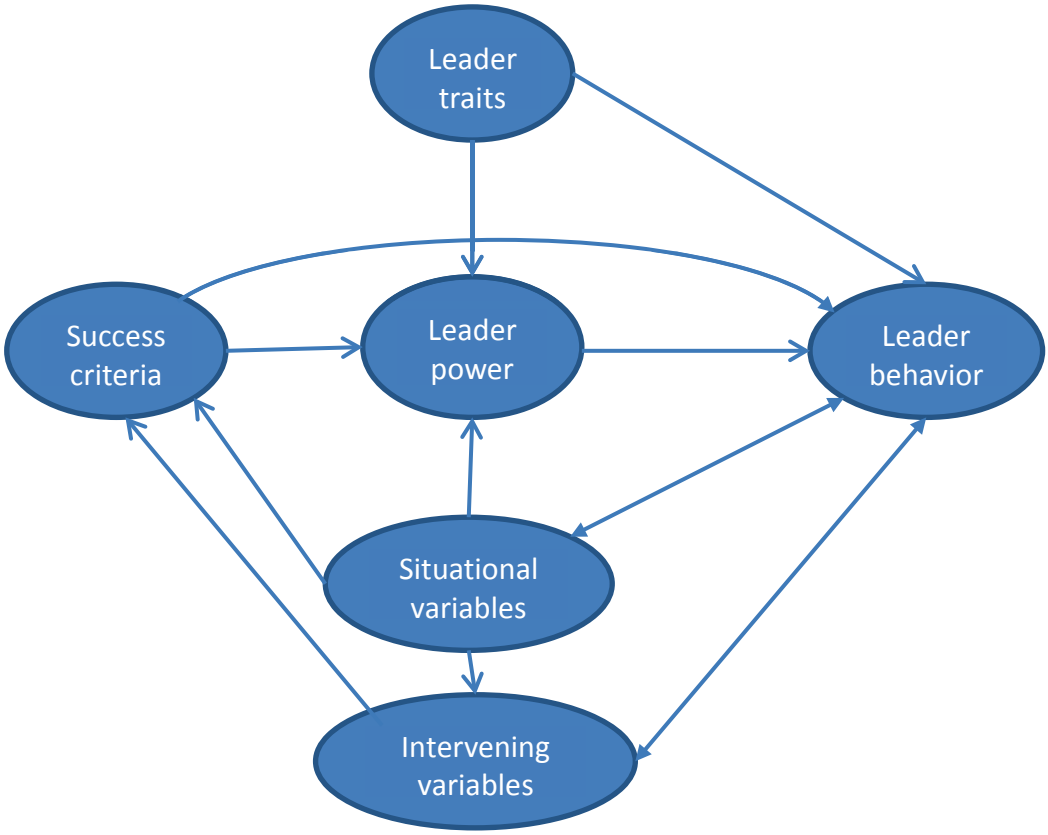

Figure 3.1: Integrated Leadership Model
Source: Yukl (2006 p. 493)

In addition to the four major approaches to leadership, two models are often used to differentiate between leaders who are closer to managers in the manager-leader spectrum and leaders who are at the other end of the spectrum. These are transactional and transformational leadership. While transactional leadership focuses on the relationship between leaders and followers in terms of task and reward, transformational leadership uses influence, consideration, intellectual stimulation and inspirational motivation to envision and transform organisations (Bolden et al. 2003; Yukl 2006).

Recently, new models of leadership, for example, authentic leadership (Avolio & Gardner 2005), chameleon leadership (Conger 2011), relational leadership (Uhl-Bien 2006) and spiritual leadership (Fry 2003), have caught the attention of leadership scholars. In health care and other areas, rather than in aged care, distributed (Inglis &

Sarros 2003) and shared or collective leadership (Pearce, Conger & Locke 2008) have been studied. The relational leadership model described here is based on a servant leader model developed by Wright (2009), using Greenleaf's work from the 1970s. It has elements of spiritual leadership, as it is based on biblical models, as well as authentic leadership.

These six main models or approaches are reviewed below.

Trait theories – the qualities of leaders

The qualities of leaders led to the development of lists of specific traits, characteristics or qualities attributed to leaders (Stogdill 1974). Typically the following traits were included in most lists: intelligence, assertiveness, decisiveness, persistence, integrity, confidence and ambition. The thought was that if someone demonstrated these qualities, it followed that he or she would be a good leader. Trait theory was an early development that gradually lost prominence. However, it experienced a resurgence towards the end of the twentieth century with Kirkpatrick and Locke (1991) identifying six traits of leaders: drive, motivation to lead, honesty and integrity, self-confidence, cognitive ability and knowledge of the business.

There were several problems with trait theories. The first was that dozens of traits were identified and clearly not every leader had every trait, raising the possibility of a three-tiered system of essential, desirable and non-essential but handy traits. The second problem was that the qualities exhibited by leaders depended to a large extent on whom they were leading and the situation in which they found themselves. Further, just as a list of the characteristics of a cow could be interpreted as a horse, the sum of the leadership *parts* did not necessarily add up to a great leader. Finally, this view of leadership led to the myth of the *super boss*, exhibiting the perfect combination of leadership characteristics, who single-handedly turns the struggling company around, with all of those in the background who provided valuable support to the single hero being lost to view (McGee-Cooper & Trammell 2002). Even leaders like Steve Jobs and Richard Branson needed people behind the scenes, so perhaps part of their genius was in gathering the right team as well as being outstanding leaders with many good traits.

Power and influence theories – power and leaders

Power and influence theories sought to explain leadership effectiveness in terms of the amount and type of power possessed by a leader and how power is exercised. Power was viewed as 'important not only for influencing subordinates, but also for influencing peers, superiors, and people outside the organization, such as clients and suppliers' (Yukl 2006, p. 14). Different influence tactics were compared to gauge their relative effectiveness in carrying out the leader's desires and vision. These leaders spent much of their time 'watching their backs', as their power was often envied.

Behavioural theories

Behavioural theories sought to analyse what individual leaders do with the personal traits, skills and capabilities they have and attempted to identify and compare the behaviours of effective and ineffective leaders, especially relationship-oriented and task-oriented behaviours. This led to 'different patterns of behavior being observed and categorized as "styles of leadership"' (Bolden et al. 2003, p. 6). However, Robbins, Berger, Stagg and Coulter (2003) argue that these theories could not prove that specific patterns of leadership resulted in successful performance. Among these theories there was also a consideration of aspects of leadership that can be learned. The focus of behaviour theorists on situational influences led to the contingency theories of leadership.

Situational leadership and contingency theories

Situational leadership and contingency theories postulated that performance of a group was dependent on a leader's preferred style, the capability and behaviour of followers and the extent to which the situation was favourable to the leader. Contingency theories were based on Fiedler's (1967) contingency model, Hersey and Blanchard's (1974) situational leadership model, Vroom and Yetton's (1973) leadership participation model and House's (1972) path-goal theory. These models either matched leadership style to situations, matched leaders to the maturity of their followers, or integrated task, relations and change-oriented behaviours. Contingency theorists argued that there was no one best way of leadership as it depended on the

situation, that situational variables actually moderated the relationship between the leader's attributes and behaviours and the leader's effectiveness. In this model, context is everything. A leader who is highly successful in one situation might fail miserably in another, like Sir Winston Churchill. Although research into leadership has provided support for contingency theories, contingency theories do not take into account the possibility that a leader can also change the situation.

Transactional leadership

Transactional leaders and their followers are in an exchange relationship (Burns 1978). The relationship focuses on mutual benefits: rewards or recognition from the leaders, and commitment or loyalty from the followers (Bolden et al. 2003). Leaders typically concentrate on each follower's performance and take corrective action if the follower fails to perform, or do nothing until problems arise and they need to take corrective action (Bass & Bass 2008). The hallmark of transactional leadership is the followers' recognition of the leader and acceptance of authority in exchange for valuable resources.

Transformational leadership

Transformational leadership theory emerged in the late twentieth century. According to this theory, transformational leaders transform individuals, groups, organisations and societies (Bass & Bass 2008). By presenting goals to followers as a compelling vision, they inspire followers to put aside their self-interest for the sake of the organisation and can have a lasting impact on their value systems and ambition levels, leading to intrinsically sustained behaviour change among followers. The capacity to transform or act as a change agent seems to be a key requirement for modern leaders to lead organisations in today's changing environment.

Bass (1985) writes that transformational leadership is not a panacea and sometimes transactional leadership is all that is required. When the market, technology, workforce and environment are stable, management by exception works well. But when the firm is faced with a turbulent marketplace, when products are born, live and die within the span of a few years and when its current technology can become obsolete before it is fully launched let alone depreciated, then transformational

leadership must be fostered at all levels. This leads to a flexibility to forecast and meet new demands and changes as they occur.

Limitations of leadership in the not-for-profit sector

Not-for-profit Faith-based organisations have historically sought staff members who agree to work within, and indeed openly promote, their value statements. Membership of an appropriate church has often been highly valued when recruiting in Faith-based organisations, especially for higher level positions, with the hope that leadership potential can be fostered and brought to fruition.

The past few years in aged care in Australia have been tumultuous as there have been fundamental changes that have impacted every aspect of the care given to frail aged people. As discussed in Chapter 2, these changes have included the way the government funds aged care, the increasing age and poorer state of health of clients and staffing shortages. Supporting the ageing population has thus put increasing strain on the public purse. Managing change requires firm, strong, committed leadership.

Siddiqi (2001, p. 4) writes of the importance of non-government organisations to develop 'second-line leaders', 'leaders-in-the-wings' from within the organisation, already trained and developed to replace the existing leader. He explains that 'there is [a] need to maintain an optimum level of continuity of their vision, mission and values' (p.5). Succession planning is, of course, expensive but cost-effective in the long run. However, a delicate balance must be sought between ensuring that leaders-in-waiting are ready to take the reins and not making them wait too long for their chance to lead, thereby losing them to another organisation.

Servant and relational leadership

'Whoever wants to become great among you must be your servant.'
Matthew 20: 26-7

The emergence of servant leadership is attributed to Robert Greenleaf, a retired executive who proposed that service should be the distinguishing characteristic of a leader (Greenleaf 1977). In his seminal text on servant leadership he advocates that the primary purpose of business should be to create a positive impact on its

employees and community. The servant leader brings together service and meaning – the leader is attuned to basic spiritual values and, in serving them, serves others, including colleagues, the organisation and society. Fry (2003) outlines a framework for servant leadership that consists of 'helping others discover their inner spirit, earning and keeping others' trust, service over self-interest, and effective listening' (p. 708). Spears (2004), who did a study of Greenleaf's writings, concluded that a servant leader exhibits 10 characteristics:

- listening
- empathy
- healing
- awareness
- persuasion
- conceptualisation
- foresight
- stewardship
- commitment (earlier referred to as commitment to the growth of people (Meek 1988), and
- building community

to which Barbuto and Wheeler (2006) add the characteristic of a 'calling' (p. 304), following Greenleaf's early writings.

Russell and Stone (2004) reviewed the literature and found 20 distinguishable attributes of servant leadership and divided them into nine functional attributes and 11 accompanying attributes. Functional attributes include Greenleaf's original list and had prominence in the literature. They are 'the operative features belonging to leaders and observed through specific leadership behaviours in the workplace' (p. 146). They are:

- vision
- honesty
- integrity
- trust
- service
- modelling
- pioneering
- appreciation of others, and
- empowerment

Accompanying attributes supplement and augment the functional attributes. They are:

- communication
- credibility
- competence
- stewardship
- visibility
- influence
- persuasion
- listening
- encouragement
- teaching, and
- delegation

Greenleaf (1977, p. 24) wrote of

> 'the care taken by the servant first to make sure that other people's highest priority needs are being served. The best test [of servant leadership], and most difficult to administer, is this: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And what is the effect on the least privileged in society; will they benefit, or, at least, not be further deprived?

Hale and Fields (2007) make the point that 'a concept of leadership that focuses on the welfare of followers rather than glorification of the leader, and that emphasizes social contribution, has proven to be very appealing' (p. 397) and further that 'servant leaders are more concerned about followers receiving recognition for their achievements than receiving accolades for his or her successes' (p. 398). Thus, the emphasis is shifted away from the leader and onto the followers.

Wright (2009) further expanded and developed Greenleaf's ideas and wrote *Relational Leadership: a biblical model for influence and service*, first published in 2000. Wright identifies five principles of relational or servant leadership based on theology, some of which are similar to Greenleaf's writings. The principles listed by Wright are:

1. Influence and service. The influence must have a purpose that is often the shared mission of the group or organization.

2. Vision and hope, a relationship of influence that points people to a shared vision, empowering them.
3. Character and trust grounded in the faith, beliefs, commitment and values of a leader.
4. Relationships and power with a warning that power should not be misused but be directed towards the mission of the community.
5. Dependency and accountability, emphasising that leaders need followers.

Wright (2009, p. 8) defines leadership as 'a relationship in which one person seeks to influence the thoughts, behaviors, belief, or values of another person' and refers to leadership as 'a relationship of service' (p.43).

For Wright (2009), leadership starts with God, as theology shapes character which fuels leadership. Through the values and beliefs promoted by the leader, an organisation develops a culture to cope with its environment. The organisational culture clarifies the expectations of people who work for an organisation and results in action taken to deliver organisational outcomes. Leadership is also responsible for creating a vision and leading the organisation towards its mission through values and relationships.

Russell and Stone (2004) developed two practical models of Servant Leadership, the second of which appears below as Figure 3.2. Their first model included only the three left hand boxes in the figure (Values, Servant Leadership and Accompanying Attributes).

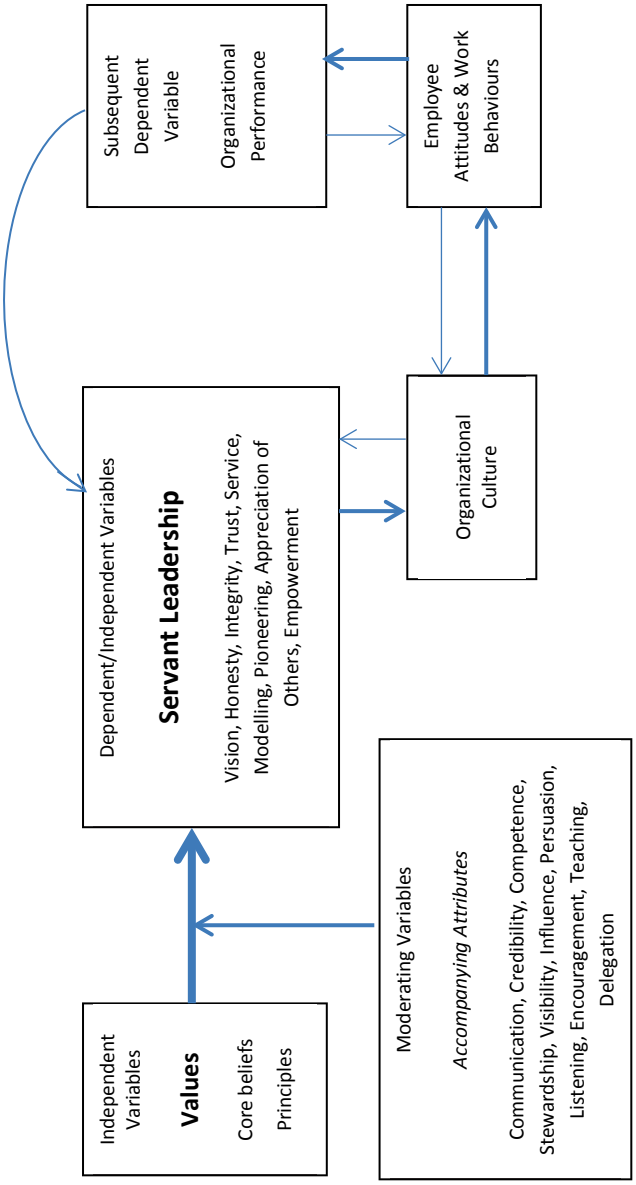

Figure 3.2: Servant Leadership Model 2
Source: Russell and Stone (2002, p. 154)

Russell and Stone explain the evolution of their model from their first simpler figure in this way. The model:

> '… looks only at the relationship between leader attributes and manifest servant leadership … servant leadership is a controllable variable that affects organizations. Consequently, servant leadership itself ultimately becomes an independent variable that affects the subsequent dependent variable organizational performance. However, mediating or intervening variables,

> such as organizational culture and employee attitudes, may influence the effectiveness of servant leadership and have a governing effect upon organizational performance. For example, an organization's established communication systems might intervene by facility or inhibiting the servant process. Likewise, pre-existing organizational values might promote or limit servant leadership. There may also be powerful persons or groups in organizations that mediate servant leadership. Consequently, …[Figure 3.2] is a more encompassing model for servant leadership' (p. 153).

Russell and Stone's model incorporates the variables associated with Servant Leadership. They began with the three left-hand boxes as explained above and this is the theoretical component of Servant Leadership. However it is the four right-hand boxes (Servant Leadership, Organizational Culture, Employee Attitudes and Work Behaviors, and Subsequent Dependent Variable) that are important for this research. This is where the concrete day-to-day takes place. The resident in aged care does not have a place in this Servant Leadership model and therefore Russell and Stone's figure will be re-visited in Chapter 9.

This chapter presented a review of leadership theories, the limitations imposed by Faith-based not-for-profit organisations on leadership and finally focused on Servant Leadership, the leadership model chosen by FaithCare to best reflect its culture. Russell and Stone's (2002) model of Servant Leadership was described and its lack of a place for the resident identified.

The following chapter gives an overview of organisational culture and its relationship with leadership.

Chapter 4

ABOUT ORGANISATIONAL CULTURE

FaithCare has endeavoured to change or influence its leaders by teaching a particular leadership model, Servant Leadership. The primary aim of this is to enable people in leadership positions or earmarked as potential leaders to reinforce the culture that has developed and is deemed desirable.

Leadership and organisational culture

Alvesson (2002) writes that leaders in large organisations lead small groups but that organisational culture 'typically refers to a larger context than a small group [and] it is not something that the typical small-group leader has a significant impact on' (p. 95). He says that the culture idea refers to wider and historically-related patterns of meaning and suggests that organisational culture may frame leadership to the extent that leadership is, by definition, seen as *cultural* and must be understood as taking place in a cultural context.

Organisational Culture

Leadership does not exist in a vacuum. It is both influenced by and helps to create organisational culture. Pacanowsky and O'Donnell-Trujillo (1983, p. 146) argue: 'Organizational culture is not just another piece of puzzle, it *is* the puzzle … a culture is not something an organization has; a culture is something an organization *is*'.

Cameron and Quinn (2011) write that the major distinguishing factor of successful companies, their most important competitive advantage, the most powerful factor they all highlight as a key ingredient in their success, is their organisational culture. Success has less to do with 'market forces than with company values, less to do with competitive positioning than with personal beliefs, and less to do with resource advantages than with vision' (p. 15).

Definitions

Cameron and Quinn (2011) state that most discussions about organisational culture agree that culture is a socially-constructed attribute that serves as a social glue binding an organisation together. Perhaps part of organisational culture is the social glue, but the elements being held together by the glue are surely more important. Organisational culture is more an expression of the company's philosophy, its way of presenting itself to the world or its way of treating its employees, and can be appreciated to some extent even by outsiders or onlookers.

Schein (1990) describes organisational culture as 'what a group learns over a period of time as that group solves its problems of survival in an external environment and its problems of internal integration' (p.111). He further defines culture as '(a) a pattern of basic assumptions, (b) invented, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaptation and internal integration, (d) that has worked well enough to be considered valid and, therefore (e) is to be taught to new members as the (f) correct way to perceive, think, and feel in relation to those problems' (p.111).

This describes the evolution of organisational culture within this organisation. The 'basic assumptions invented, discovered, or developed' include the theology used to underpin the organisation and the hope of doing good for those in society who are disadvantaged. The organisation 'learning to cope with its problems of external adaptation and internal integration' refers to becoming a cohesive organisation within the ever-increasing demands and restrictions imposed by regulatory authorities. The culture has undeniably 'worked well enough to be considered valid and … is to be taught to new members as the … correct way to perceive, think, and feel in relation to those problems'. As discussed previously, FaithCare has Vision and Values statements that are taught to all new staff members and reinforced to longer-term staff.

Glisson and James (2015) state: 'beliefs and expectations prescribe the way work is approached and are the basis for socializing co-workers in the way things are done in the organization' (p. 770). Thus organisational culture can consist of both explicit

beliefs and values and implicit expectations and norms**.** This is where an acquired leadership model and an organisation's culture become intertwined.

Cardador and Rupp (2011) state that organisational culture has several definitions, but 'most converge on the notion of culture as the taken-for-granted, underlying assumptions, expectations, and definitions present in an organization' (p. 158).

Manifestations of organisational culture

Research done by Denison (1990) showed that organisational culture has a close relationship with the effectiveness of companies. Denison cites Lundberg's (1985) four levels of culture:

1. Artifacts. These are the tangible aspects of culture shared by members of an organisation, their surface manifestations.
2. Perspectives. These are the socially-shared rules and norms applicable to a given context, the solutions to common problems.
3. Values. These are the evaluational base that organisational members use for judging situations, acts, objects and people, that is, the real goals, ideals and standards.
4. Assumptions. These are the tacit beliefs that members hold about themselves and others, their relationships to other persons, and the nature of the organisation, in other words, the unconscious underpinnings of the first three levels.

The first three of these four levels of culture would be accessible up to a point by outsiders having some interaction with the company.

Cardador and Rupp (2011) find that there are four recurring types of organisational culture:

1. Innovative culture − refers to those entrepreneurial businesses that foster new knowledge, products and services, and hold values, such as adaptability, flexibility, creativity and new ideas.
2. Bureaucratic culture − hierarchical and rule-bound. They typically have a high degree of structure with values related to maintaining efficient and reliable productivity.

3. Market culture – competitive and results oriented, with core values associated with productivity and profit.
4. Supportive culture – shows characteristics of shared values and goals, cohesion with core values, including employee empowerment, participation and commitment to the human work environment.

These organisational culture types mirror leadership styles, respectively the visionary or entrepreneurial leader, the authoritarian or autocratic leader, the task-oriented leader and the relational or democratic leader.

Alvesson (2011) uses the term 'organizational culture' as 'an umbrella concept for a way of thinking that takes a serious interest in cultural and symbolic phenomena or aspects in organizations' (p. 14). He notes features of organisational culture such as shared orientation to social reality created through the negotiation of meaning and the use of symbolism in social interactions, a system of common symbols and meanings rather than the totality of a group's way of life, and its close relationship to communication and language use, even though it means more than discourse. He views culture broadly as 'a shared and learned world of experiences, meanings, values, and understandings that inform people and that are expressed, reproduced, and communicated partly in symbolic form' (p. 15).

Alvesson (2002) looks at eight metaphors for culture, flowing from the highly functional to those that constrain:

1. Culture as exchange-regulator – here culture is a control mechanism. The culture can replace the need for close monitoring and direct control.
2. Culture as compass – the development of values that are long-lasting, reliable, relevant and capable of keeping people on the right course.
3. Culture as social glue – the most common view of culture, in which organisations are integrated and/or controlled through shared values, beliefs, understandings and norms.
4. Culture as sacred cow – organisational ideals and values are deeply ingrained in members of the group. These core values are almost impossible to change because of people's deep commitment to them.

5. Culture as affect-regulator – this refers to the control of employee emotions. Examples cited are Disney World and The Body Shop and their prescriptive expressed emotions.
6. Culture as disorder – this can occur where there is a discontinuity or lack of relevance, characterised by variations and contradictions between the business concept or mission statement, and operational issues.
7. Culture as blinders – this occurs where contradictions between the business concept (or mission statement) and what people actually did in their assignments cause blind spots, resulting in an inability to correct errors.
8. Culture as world closure – social reality is in principle open and negotiable, but culture can make it appear given, natural and impossible to question.

Organisational culture could potentially encompass several of Alvesson's metaphors at once, and also shift over time from the highly functional end of the spectrum to that of constraint. This would happen when the leadership changes or to reflect changes in the economic climate, such as high unemployment.

A culture that enriches the work experiences and lives of employees is important. Cameron and Quinn (2011) write that in addition to organisation-level effects, the impact of organisational culture on 'employee morale, commitment, productivity, physical health, [and]emotional well-being is also well documented' (p. 7). This is an area where Servant or Relational Leadership and organisational culture intersect. Aspects that enhance the meaningfulness of work are such things as skill variety, task identity, task significance, autonomy, group identity, shared goals and values, competence, enjoyment and challenge (Cardador & Rupp 2011, p. 160). In residential aged care, where long-term relationships between staff and residents are the norm, the meaningfulness of work is crucial to staff. Chores are repetitive and not always pleasant, so a supportive environment from the top down is crucial. Even though the work done by scholars in this area focuses primarily on employees' connections to their work rather than to other people, in aged care the work and the residents are intertwined such that the happiest carers are those who have a special connection with the residents. In addition, the support of colleagues, formally when help is sought or when handover given at the end of the day, or informally when staff members compare notes in the tea room, is a hallmark of nursing and caring.

Echoing Cardador and Rupp's (2011) innovative, bureaucratic, market and supportive types of culture, Cameron and Quinn (2011) outline four types of culture (hierarchy, market, clan and adhocracy). Of these, clan culture exhibits (p. 46) shared values and goals, cohesion, 'participativeness', individuality, and a sense of 'we-ness' that is typical of Servant or Relational Leadership. Describing organisations exhibiting a clan culture, Cameron and Quinn write that they 'seemed more like extended families'. The environment is 'managed through teamwork and employee development, customers are best thought of as partners – the main task of management is to empower employees'.

The strong similarity between Servant or Relational Leadership and clan culture is seen when Cameron and Quinn state that in times of rapid change and turbulence an effective way to coordinate organisational activity is to make certain that all employees share the same values, beliefs and goals. Leaders are thought of as mentors, and perhaps even as parent figures – team builders, facilitators, nurturers and supporters. 'In a clan culture the criteria of effectiveness ... are cohesion, high levels of employee morale and satisfaction, human resources development, and teamwork' (p. 55), as they are in Servant Leadership.

This chapter gave an overview of organisational culture and its relationship with leadership.

In the following chapter I describe my philosophical stance and rationale, the research method chosen, the participant selection and the research design.

Chapter 5

APPROACHING THE RESEARCH QUESTIONS

This chapter outlines my philosophical stance and rationale, the research method chosen, research design, participant selection, sampling, data collection methods, data analysis strategies, research rigour and ethical considerations, finally arriving at a restatement of the research questions.

Philosophy and methodology

Pragmatism

Pragmatism is a philosophical movement begun during the latter decades of the 19th century by the American philosopher Charles Sanders Peirce (1839-1914). This distinctly American philosophy was elaborated on by William James (1842-1910), John Dewey (1859-1952), George Herbert Mead (1863-1931) and Arthur F. Bentley (1870-1957), along with countless other academics and non-academics over the past century (Maxcy 2003, p. 52).

The founders of pragmatism grew up in rural America during a period of rapid social and cultural change (Maxcy 2003). The wholesomeness and practicality of rural life is reflected in the features of pragmatism that endure to the present day. There are links to those roots in Charmaz's (2006) description of pragmatism as:

> … an American philosophical tradition that views reality as characterized by indeterminacy and fluidity, and as open to multiple interpretations. Pragmatism assumes that people are active and creative. In pragmatist philosophy, meanings emerge through practical actions to solve problems, and through actions people come to know the world. Pragmatists see facts and values as linked rather than separate and truth as relativistic and provisional (p. 188).

Pragmatism as a philosophy has been adopted as a paradigm and, as Shaw, Connelly and Zecevic (2010, p. 518) explain, has specific implications for ontology, epistemology and methodology:

1. Ontology: The physical world is real and external to ourselves, and we are able to interact with and impact the external world just as it impacts and constrains our behaviour. The social world is constructed by each individual as s/he grows and develops, influenced by the social environment and arriving at a unique interpretation of people, society, and culture.
2. Epistemology: Knowledge is considered anything that can create a change in the physical or social functioning of an individual or the surrounding environment.
3. Methodology: There are multiple ways to identify the effects of objects and actions, all of which should be explored to understand a physical or social issue more thoroughly.

House (1992) wrote that pragmatists aimed to 'create desirable communities, be concerned about values and politics, and spend more time asking questions about ways of life' (p. 18). He goes on to explain that pragmatists reject the desire for objectivity in scientific research, wanting to replace it with a desire for community solidarity; they are disinterested in reality as a concept and have no conception of causation. By aiming to make beliefs and desires coherent, they choose explanations, theories and decisions by desires.

Thus, pragmatism is upbeat and modern, not mired by the constraints of post-positivism and constructivism. Crotty (1998) stated that 'the view of culture and society that pragmatism came to adopt is essentially optimistic and progressivist. The pragmatist world is a world to be explored and made the most of, not a world to be subjected to radical criticism' (p. 74).

Another feature of pragmatism is the importance of consequences. According to Creswell (2009), the major features of pragmatism are 'consequences of actions', and that it is 'problem-centered, pluralistic and real-world practice oriented' (p. 6). Cherryholmes (1994) also notes that pragmatists are interested in consequences but adds that consequences cannot be estimated outside of context (p. 16). Pragmatic research is driven by anticipated consequences. Cherryholmes (1992) writes that

'pragmatic choices about what to research and how to go about it are conditioned by where we want to go in the broadest of senses' (p. 13) and that our choice of approach determines how well we produce anticipated or desired outcomes.

Pragmatism is an emerging research paradigm in which practical consequences and the effects of concepts and behaviours are vital components of meaning and truth (Shaw, Connelly & Zecevic 2010). It offers a practical and outcome-oriented method of inquiry based on action and leads and offers a method for selecting methodological mixes that help us answer research questions (Johnson & Onwuegbuzie 2004). Tashakkori and Teddlie (1998) wrote that pragmatism is a very practical and applied research approach.

With its concepts of interaction between individuals' behaviour and their social world, the opportunity to arrive at a unique interpretation of society and culture, the aim to create desirable communities, and its emphasis on practical consequences and outcomes, pragmatism is the appropriate foundation for this research.

Mixed methods research

Definitions of mixed methods research centre on the gathering of qualitative and quantitative data and the integration of the two, to produce not simply a combination of results, but a synthesis into a new *being*. Most simply, Teddlie and Tashakkori (2003) state that 'mixed method research studies use qualitative and quantitative data collection and analysis technique' (p. 11).

Johnson and Onwuegbuzie (2004, p. 17) define mixed methods research as 'the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study' and Creswell et al. (2003) add the dimension of concurrent or sequential collection of data:

> A *mixed methods* study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process or research (p. 212).

Mixed method research has a short history as an identifiable methodological movement which can be traced to the early 1980s (Cameron 2009, p. 142). It is often referred to as the 'third methodological movement' (Tashakkori & Teddlie 2003, p. ix).

Newman and Benz (1998) consider qualitative-versus-quantitative approaches a false dichotomy and believe that from a scientific viewpoint the alleged dichotomy is 'not consistent with a coherent philosophy of science' (p. 9). The two approaches represent different ends on a continuum.

There is a distinction drawn between mixed methods as a collection and analysis of two types of data, and mixed methods as the integration of two approaches to research. Tashakkori and Creswell (2007) have defined mixed methods as 'research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or a program of inquiry' (p. 4). The key concept in this definition is integration.

Justification for using mixed methods

Onwuegbuzie and Leech (2005, p. 375) state that 'mono-method research is the biggest threat to the advancement of the social sciences' and 'the epistemological purity that was popularized in previous decades no longer represents best practices [*sic*] and, moreover, may now be considered inappropriate, unreliable, invalid or outmoded' (p. 382).

Johnson and Onwuegbuzie (2004) write that 'taking a … mixed position allows researchers to mix and match design components that offer the best chance of answering their specific research questions' (p. 15), while Morse (2003) states that 'the major strength of mixed methods designs is that they allow for research to develop as comprehensively and completely as possible' (p. 195).

Teddlie and Tashakorri (2003) write that there are three main areas in which mixed method research is superior to single-approach designs, as it can:

- answer research questions that other methodologies cannot, most typically complex social phenomena which cannot be fully understood using just

qualitative or quantitative techniques. Mixed methods provides a variety of data sources and analyses to completely understand multifaceted realities;

- provide better (stronger) inferences by providing an avenue for a diversity of opinion from different voices and perspectives; and
- provide the opportunity for presenting a greater diversity of divergent view.

Thus the major advantage of mixed methods research is that 'it enables the researcher to simultaneously answer confirmatory and exploratory questions, and therefore verify and generate theory in the same study' (p. 15). Further, it enhances the quality of inferences that are made at the end of a series of phases of study. Teddlie and Tashakorri (2003) define 'inference' as 'an umbrella term to refer to a final outcome of a study' (p. 35). The outcome may consist of a conclusion about, an understanding of, or an explanation for, an event, behaviour, relationship or a case.

Pragmatic research, combining quantitative and qualitative methods, is put forward as the solution to the weaknesses or deficiencies of the use of just one research method. Each approach has strengths and weaknesses and researchers should use the strengths of both techniques in order to understand social phenomena better. 'The integration of research techniques within a single project opens up enormous opportunities for mutual advantages in each of three major phases – design, data collection and analysis' (Sieber 1973, p. 1337).

Greene, Caracelli and Graham (1989, p. 260) outlined five broad purposes of mixed methodological studies:

- triangulation (seeking convergence and corroboration of results from different methods studying the same phenomenon);
- complementarity (seeking elaboration, enhancement, illustration and clarification of the results from one method with results from the other method);
- development (using the results from one method to help inform the other method);
- initiation (discovering paradoxes and contradictions that lead to a re-framing of the research question); and
- expansion (seeking to expand the breadth and range of inquiry by using different methods for different inquiry components).

Of these, complementarity and expansion were useful for this research. Different methods were used, for example interviews and analysis of residents' meetings minutes. Quantitative data from the ARC Leadership Survey were used to inform, give credence to and develop the qualitative data collection process. Because of the complexity of the study, results from the different collection methods could elaborate, enhance, deepen and broaden interpretations and inferences from the study – this is complementarity. There were also aspects of expansion used, in that the choice of methods was extended in order to expand the scope and range; for example, analysis of the staff survey data and the focus group were used to expand the data gleaned from staff.

Hansen (2007) notes certain shortcomings with regard to using mixed methods:

- The need for extensive data collection. This could not be called a shortcoming in this research as the number of different sources of data was finite. Also, the number of subjects used in, for example, resident interviews, was limited by the availability of suitable subjects and the continuation of interviewing further subjects only until saturation was achieved. Data were therefore collected as extensively as possible.
- Time-intensive nature of analysing both text and numeric data. This was overcome to some extent by using NVivo to analyse the textual data. The amount of numeric data was not great.
- Requirement for the researcher to be familiar with both quantitative and qualitative forms of research. In the initial phase of the research, I read literature about quantitative, qualitative and mixed methods before deciding to use mixed methods. Far from being a shortcoming, knowledge of both quantitative and qualitative forms of research adds interest and depth for the researcher.
- Everything becomes much more complicated in projects where a number of different data collection methods or data analysis approaches are being used. I overcame this shortcoming by making tabulated notes to enable me keep track of the process.
- Practical difficulties around collecting and analysing very different types of data. Again, my tabulated notes enabled me to keep track of the process..

- Difficulties when structuring research reports. I found this to be very difficult and I structured the thesis in at least four different ways during the last year until I was satisfied with the current structure and logical flow.
- Mixed methods research tends to take a long time to complete and to be more costly. My three years of candidature extended to five; however, this was due to outside factors as well as to my choice of mixed methods.

Mixed method researchers have the opportunity to use different methods to collect and analyse data leading to 'more generative, insightful understandings' (Greene & Caracelli 2003, p. 107) and 'to achieve a fuller understanding of a target phenomenon' (Sandelowski 2003, p. 328), with the goal of achieving 'a kaleidoscopic or prismatic view of a target event'. This goal reflects the pragmatic approach.

Pragmatism and mixed methods research

It has been said that 'pragmatism is a leading contender for the philosophical champion of the mixed methods area' (Greene 2008, p. 8).

Bryman (2007) interviewed mixed methods researchers and found that most depicted themselves as pragmatists, either using the term or employing self-descriptions that Bryman says were redolent of pragmatism. He concluded that mixed methods researchers do not dwell on epistemological and ontological issues and exhibit a clear pragmatism in their work.

Further, pragmatism is not committed to just one system of philosophy and it rejects the incompatability thesis (Tashakkori & Teddlie 1998). Thus, mixed-methods research enables researchers to draw from qualitative and quantitative assumptions, different world views and different forms of data collection and analysis (Creswell 2009).

There is a strong bond between pragmatism and mixed methods research. Pragmatism has a philosophical foothold in the mixed methods camp; it advocates the efficient use of both qualitative and quantitative paradigms (Cameron 2009), supports the simultaneous use of qualitative and quantitative methods (Shaw, Connelly & Zecevic

2010) and enables researchers to delve further into a dataset to understand its meaning (Onwuegbuzie & Leech 2005).

Moon and Moon (June 2004) explain that pragmatism forms a paradigm distinct from others – it allows the use of quantitative and qualitative methods in social and behavioural research. Also, to fully describe a phenomenon in the social sciences, it is necessary to supplement quantitative data with qualitative description. 'In that way a full and meaningful (rich) description of the phenomenon can be derived' (p. 3).

Positing a link between pragmatism and mixed methods, Howe (1988) explains that for the positivist paradigm, the view is that scientific knowledge is the paragon of rationality, based on pure observation free of the interests, values, purposes and psychological schemata of individuals. On the other hand, interpretivism recognises that observation cannot be pure in that sense, and that investigation must employ empathic understanding. Pragmatists recognise that the two paradigms are compatible and independently do not exhaust the possibilities. Further, there must be 'a mutual adjustment between the two such that practice is neither static and unreflective nor subject to the one-way dictates of a wholly abstract paradigm' (p.13).

The pragmatic mixed methods researcher is always seeking to maximise desired consequences or 'get the job done', so 'pragmatists characteristically mix different kinds of methods because the complexity of the contexts in which they work demands multiple methods' (Greene & Caracelli 2003, p. 101).

Researcher's prior relationship with participants

I had a professional relationship as a Registered Nurse until April 2009 with some of the aged care residents I interviewed. Between April 2009 and June 2011, I was a Nurse Educator (involved with the nursing staff rather than the residents) and therefore, by the time I began this research, I had had no direct professional contact with residents for more than two years.

I have a relationship as a fellow employee with some of the staff I interviewed. I no longer work at *Greentrees*, although I use their office space from time to time in my new role.

With regard to the baby boomers I interviewed, I have either a direct friendship, a connection with those who have knowledge of aged care through a relative living at *Greentrees* or no prior relationship at all.

I believe that none of my relationship/s described above would influence the participants' decision to participate or would create potential ethical conflict. I was not willing to compromise my research by placing a participant in a difficult situation or by risking any participants making a complaint about me to the organisation. At no time did I believe that anyone felt pressured to participate. Had that happened, I would have explained my concerns to them, thanked them for their willingness to be part of the research, and terminated the interaction. Had further problems arisen, I would have explained the role of the UTS Research Ethics Officer more fully than appeared on the consent form and again supplied the appropriate contact details.

The question of bias should be considered here. One way in which I overcame potential bias was to quantify the substance of the resident interview transcripts as much as possible. For example, in my analysis I added together the number of times a certain topic was raised and/or discussed by each participant. I chose to assume that the more frequently a topic was mentioned or discussed by each resident, the more important it was to the resident. This provided an unbiased view of the importance of each topic.

Because of my prior relationship, in some cases there may well have been 'a high level of rapport between interviewer and interviewee' (Bryman & Bell 2007). Where there was this degree of rapport, there was a facility of conversation, considerable trust and no discomfort with having an outsider there. The concern that the research outcomes may have been muddied by my familiarity with some of the participants was considered. It was believed that the participants would be more likely to open up to someone who was known to them to some extent than to a stranger. I hoped to gather richer data because interviewees were aware that I already had some knowledge of FaithCare and they could use their time with me to *cut to the chase* rather than explaining the background of what they are saying.

Participants

FaithCare agreed to the participation of three of its aged care homes and their residents, the baby-boomer relatives of residents, and staff, according to the ethics consent discussed later in this chapter. They also allowed access, after some negotiation and with some restrictions, to extant data collected by and on behalf of FaithCare and one of their homes, *Greentrees*.

Research design

The main focus

Qualitative data collection and analysis, incorporating elements of Grounded Theory, were the main focus, or core component, of this research. A number of methods were used, including convergent interviewing, focus group work and observation. The data used are discussed later in this chapter. My aim was to take advantage of every source of data that was relevant.

Mixed methods design

Johnson and Onwuegbuzie (2004) provide a mixed methods design matrix in four cells (Figure 5.1).

Paradigm Emphasis Decision	Time Order Decision: Concurrent	Time Order Decision: Sequential
Equal Status	QUAL + QUAN	QUAL ⟶ QUAN QUAN ⟶ QUAL
Dominant Status	QUAL + quan	QUAL ⟶ quan
	QUAN + qual	qual ⟶ QUAN QUAN ⟶ qual quan ⟶ QUAL

Figure 5.1: Mixed-method design matrix and research designs
Source: Johnson and Onwuegbuzie (2004, figure 2)

They note that one can easily create more user-specific and more complex designs than those shown in the above figure. The design proposed for this research, following their notation, is:

QUAL + quan

This is a qualitative-dominant concurrent design. The dominant qualitative phase is that of interviews, the focus group and observation. The non-dominant quantitative phase is the use of questionnaires and extant data collected by FaithCare.

The research design is a concurrent nested design (Morse 2003), that is, one data collection phase during which quantitative and qualitative data are collected concurrently. The quantitative method here has less priority and is embedded or nested within the predominant qualitative method. The embedded method seeks information from different levels – residents, staff and baby boomers. This helps the researcher to gain broader perspectives and enrich the description of the participants.

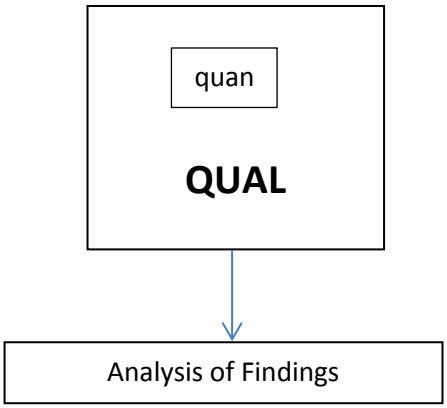

Figure 5.2: Concurrent Nested Design

Morse (2003, p. 193) notes four principles of mixed methods design, the following three of which were used for this research:

1. Recognition of the theoretical drive of the project. 'If the purpose of the research is to describe or discover, to find meaning, or to explore, then the theoretical drive will be inductive'.

2. Recognition of the role of the imported (non-dominant) component in the project. 'In a single project, the main project forms the theoretical foundation, and information obtained from other strategies will be used to supplement or inform the main project.' (p. 194)

3. Adherence to the methodological assumptions of the base (or core) method. 'It is important to be constantly aware so as not to violate the methodological assumptions of the core method but, at the same time, to respect the assumptions that underlie the supplemental strategy being used.'

Greene, Caracelli and Graham (1989) explain that in a mixed-method study, qualitative and quantitative methods are used to measure overlapping but also different facets of a phenomenon, yielding an enriched, elaborated understanding of that phenomenon.

The priority decision

Morgan (1998) writes that one of the methods is designated the principal means of data collection and the contrasting complementary method is brought in to assist the principal method. This offers a set of strengths that can add to the research design's overall ability to meet the project's goals. In this research, the principal means of data collection was qualitative (interviews) and the contrasting, complementary, method was quantitative.

First stage: secondary data QUAN

FaithCare conducts a client survey biennially, referred to from now as CS. The first stage in this research was to conduct a preliminary analysis of the client surveys so far conducted in order to develop themes that could suggest strengths and limitations of FaithCare's care and service provided at the time from the client's perspective and whether the residents were invited to comment on any aspect of leadership.

The scope and limit of questions used by FaithCare was appraised to obtain client feedback and to provide a basis for investigating the response of the organisation to feedback received. It was possible to judge whether residents' voices were heard and acted upon over time by comparing the results of consecutive surveys. This data was

compared with the minutes of residents' meetings in order to validate survey findings and identify areas of feedback that were not captured by the survey. Glaser (1998, p. 9) writes that 'secondary analysis of data already collected for other purposes is very worthwhile'. I observed residents' meetings to further validate the study with a better understanding of context. Prior to my attending a meeting for the first time, the manager asked residents whether they had any objections to a researcher being present at subsequent meetings as an observer. They had no objections.

The themes of leadership, organisational culture, strengths and limitations of care and service, and voice were also researched in other extant data - the Aged and Community Care Leadership Survey ('Productivity Commission and Melbourne Institute of Applied Economic and Social Research' 1999; Cartwright 2013), the recent evaluation of the organisation's Leadership Development Program and the Staff Satisfaction Survey.

Second stage: QUAL

The second stage of this research consisted of a series of interviews with residents of the home I was concentrating on (*Greentrees*), plus some residents in two of FaithCare's other homes, *Goldtrees and Bluetrees*. Residents without a diagnosis of dementia, as well as those who had mild cognitive impairment only (early dementia) formed the sampling frame for individual participants in the study. As reflected in the ethics proposals completed for FaithCare and the university, only cognitively intact or mildly impaired residents were invited to participate. This was to ensure that residents were capable of giving informed consent, and to allow residents to enjoy the interview experience without anxiety.

I liaised with senior staff members from each home in order to identify residents who met the above criteria. Residents were selected from the lists developed with senior managers. Eight residents from *Greentrees* were invited to participate in individual interviews and a further seven drawn from *Goldtrees* and *Bluetrees* chosen through theoretical (purposive) sampling to diversify the sample. Residents were given a written invitation, together with a written information sheet describing the purposes of the study.

During the interview, topics of discussion included, but were not limited to, the following: what really matters to residents in their care-home experience, formal and informal ways of having a voice, the feedback they receive and any changes they note as a result of their input.

Third stage: QUAN + quan + qual

The third stage of the research involved interviewing two sets of baby boomers, those with and those without knowledge of aged care, whom I refer to respectively as knowledgeable and naïve baby boomers. A convergent interviewing technique of data collection (Dick 1998) was used to probe for information on what would be important to baby boomers in the future. As the interviews progressed, the diversity of the sample was increased by purposive selection of further participants. This ensured that a diversity of views was captured. Finally, staff were asked to complete a questionnaire, the Organizational Culture Assessment Instrument discussed in detail below, and a focus group was also conducted.

Participants gave informed consent to being interviewed or taking part in the focus group (including digital audio recording) and for their de-identified comments to be used. Although this plan was presented in three stages, much of the data was collected concurrently.

Sampling - criteria and selection

Two groups of participants (residents and baby boomers) were interviewed and one group (staff) took part in a focus group. The first were residents of three of the organisation's aged care homes in New South Wales. The residents were chosen purposively with assistance from managers and senior staff to reflect as many different opinions of life in aged care as possible. Fifteen aged care residents were interviewed, eight from *Greentrees* on Sydney's fringe, three from *Goldtrees,* a home in rural New South Wales, and four from *Bluetrees* in suburban Sydney.

The residents selected had been in care for more than six months, as I believed that this was the minimum settling time after which each resident began to gain a bigger-picture view of life in the home, including aspects of FaithCare's culture. Participants included people of both genders and a spread of ages, life experiences and backgrounds.

The second group of twelve participants was baby boomers. They were also purposively chosen and fell into two categories equal in number of participants: those with knowledge of aged care such that they were or had been relatively frequent visitors to a relative or friend in care, and secondly, those without knowledge of aged care. It is acknowledged that almost no one has literally *no* knowledge of aged care because of its frequency as a topic in the media. Some baby boomers in the general population say that they would never enter aged care, despite having no first-hand experience of it; others come from cultures that have traditionally dictated that older people be looked after by family until their death (although this is now breaking down in some cultures) (Productivity Commission 2011).

The naïve baby boomer participants I sought had not visited an aged care home and had no close friend or relative in one and, by their own admission, had no special interest in or knowledge of aged care. The baby boomers group was made up of relatives or close friends of residents in care, people referred by those relatives or close friends, and people I knew. Some snowball sampling was used for the latter group.

During the referral process, participants were asked to invite someone to be interviewed who they thought would have different views to their own. The baby boomers were born between 1946 and 1964. However, two of the participants were born earlier in the 1940s but identified themselves as baby boomers. This occurred because sons of two residents were asked whether they were baby boomers to which the answer was *yes*. It was subsequently discovered accidentally that they were born one and two years respectively before the baby boomer period began. I decided to allow that data to remain for four reasons:

1. They identified as baby boomers;
2. Their position as child of a current aged care resident was an important criterion in their selection;
3. Authors vary in their view of when the baby boom began (Strauss & Howe 1991); and
4. Baby boomers are often defined as late- or post-war babies who were too young to have any personal memory of World War II.

All baby boomers were screened to eliminate those who worked or had worked in aged care.

The third group was staff members of one aged care home, *Greentrees*. They were chosen purposively for a focus group and another group was invited to complete the Organizational Culture Assessment Instrument (OCAI), a questionnaire. Focus group participants were chosen to reflect as diverse a range of opinions, attitudes and positions in FaithCare as possible. A small group of senior managers who had already participated in a leadership research project connected with this research was also used. Twenty one people completed the questionnaire.

Aged care homes

Three residential homes from one Australian Faith-based not-for-profit aged care organisation were selected for the purposes of this research, *Greentrees, Goldtrees* and *Bluetrees*, on the urban fringe of Sydney, in a rural area of New South Wales and in a suburb of Sydney respectively. The Regional Manager and local managers agreed to allow residents in the three homes to be part of the research. Although the bulk of the research took place in just one home (*Greentrees*), the wider sampling frame of three homes negated the possible influence of personal management styles in particular homes and captured a broader range of Australian viewpoints.

Data collection

Sources of data – extant data

Extant data were available for analysis from the ARC research group and from the organisation's sources:

1. The 2013 Aged and Community Care Leadership Survey, part of the ARC leadership research with which I was involved (Cartwright 2013). Five hundred CEOs in the aged and community care sector were sent the survey and encouraged to send it on to two board members and two senior managers. Three of the question sets in the survey gave respondents the opportunity to tick the *client/resident* box to indicate *who does/should have a role in* … aspects of the organisation's mission, organisational performance and strategic planning.

2. An evaluation of FaithCare's Leadership Development Program (LDP). The LDP deals with organisational culture and leadership development.
3. FaithCare's Consumer Survey, which is conducted every two years with all willing and capable residents. A comparison was done around the issue of food, a favourite topic in any institution and one that scores poorly in most consumer surveys. This would uncover whether consumers' voices on this important issue had been acted upon over the previous few years in the organisation.
4. The Staff Survey, also conducted every two years, which could highlight deficiencies in communication between residents and staff and aspects of organisational culture and leadership.
5. Complaints and Comments forms from *Greentrees*. These forms are filled out voluntarily by residents, staff, relatives and friends and gave another insight into what matters to residents and their supporters.
6. Minutes of residents' meetings. These were read and themes noted, to check that all themes were identified in interviews.
7. Observation of residents' meetings was also conducted to gather information relating to power relationships between residents and between residents and management.

Sources of data – primary qualitative data

Participants in the qualitative data collection fell into three major categories: residents of aged care homes, baby boomers and staff. Semi-structured interviews were conducted one-on-one with residents and baby boomers.

A focus group was conducted with members of staff.

Sources of data – new quantitative data

The Organisational Culture Assessment Instrument was used to collect data from staff members (Cameron & Quinn 2011).

Methods of collection

Interviews – residents and baby boomers

For individual interviews, a convergent interviewing technique was used as this provided scope for participants to express their views in an open way in response to a broad open-ended question; the interviewer did not limit the scope of discussion by asking set questions. Active listening and the suspension of personal judgement are the hallmarks of this interviewing technique (Attwater & Hase 2004). This technique also allows users to define the most salient issues in an organisation and is used especially when there is some doubt about the information to be collected (Dick 1998). It can yield good results from small, diverse samples and achieves this by leaving much of the content unstructured; the only predetermined question is the opening question. Later *probe* questions were determined from interview to interview, especially searching for non-confirmatory views about data previously collected. Data were analysed systematically as they were gathered and were used to guide subsequent interviews, helping to improve efficiency and reduce bias.

Focus group

A focus group is a planned discussion among a group of people with a certain experience in common, led by a facilitator aiming for a balanced conversation between all participants (Morse & Niehaus 2009). The focus group for this research was held informally over morning tea.

Observation

Observation methods are useful to researchers in a variety of ways. They provide ways for them to check for nonverbal expression of feelings, determine who interacts with whom, grasp how participants communicate with each other, and check for how much time is spent on various activities (Schmuck 1998).

We are all participants and observers in all of our everyday interactions, but social scientific researchers engage in the systematic use of this information. Dewalt, Dewalt and Wayland (1998) state that 'participant observation is a way to collect data in a relatively unstructured manner in naturalistic settings' (p.260). The authors

categorise moderate participation as follows: 'The ethnographer is present at the scene of the action but doesn't actively participate or interact, or only occasionally interacts with the people in it' (p. 262).

Dewalt and Dewalt (2011) encourage the novice researcher to practice self-reflexivity at the beginning of the research to help understand any biases on the part of the researcher that may interfere with the correct interpretation of what is observed. They consider that in participant observation, the researcher is the research tool, and the 'limits to objectivity flow from this fact' (p. 111).

Dewalt, Dewalt and Wayland (1998, p. 267) wrote that the basic elements of participant observation are:

1. having an open mind and a non-judgmental attitude;
2. showing interest in learning about behaviours, thoughts, and feelings;
3. being aware of the possibility of 'culture shock';
4. accepting that you will make mistakes;
5. being a careful observer;
6. being a good listener; and
7. being open to being surprised and to learning from the unexpected.

Ten residents' meetings were observed over one calendar year to provide a wider perspective, gauge power relationships and observe whether residents were encouraged to speak up and did not feel intimidated. Focused observation emphasises observation supported by interviews. This was a valuable way of observing the behaviour of residents and hearing their opinions first hand, rather than depending on the minutes, which may or may not have been somewhat interpreted by the minute-taker. Hansen (2007) makes the point that observation is also useful for building rapport and "getting to know" research participants' (p. 69).

Questionnaire

Staff were requested to fill in the OCAI, a tool for diagnosing organisational culture (Cameron & Quinn 2011). It provides data about how the culture of an organisation is perceived and part of it focuses on leadership. The OCAI is a validated instrument,

based on the Competing Values Framework (p.35), and is used by more than 10,000 companies worldwide. It measures the current as well as the preferred culture (Kikker Groep 2012). The OCAI report for this research is in Appendix 2. Chapter 6 contains a description of the results generated. Statistics around differences in responses according to age group were calculated using SPSS Predictive Analytics Software.

Data analysis

Grounded theory and qualitative analysis

Grounded theory method was developed in the USA in the 1960s in the fields of health and nursing studies by Anselm Strauss and Barney Glaser, who wanted to counter the dominance of positivistic research that tested existing theories (Gora & Kornilaki 2010).

Grounded theory is a way of identifying what is going on or what is happening (or has happened) within a setting or around a particular event. 'It makes possible the identification and description of phenomena, their main attributes, and the social or social psychological processes involved as well as their interactions in the trajectory of change' (Morse & Niehaus 2009, p. 94).

> According to Morse and Niehaus (2009), unstructured interviews are always used. Data are categorised and characteristics identified. Grounded theorists are interested in interactions and process. Importantly, grounded theory may use other data sources, such as observations, documents and so forth.

Grounded theory methods were used for this research. Qualitative data were collected primarily from interviews and from a staff focus group, the evaluation of the leadership program, comments forms, minutes of residents' meetings and observation of residents' meetings. For purposes of comparison and to ensure that all points of view were included, quantitative data from other sources in the form of surveys already conducted by FaithCare and the OCAI filled in by staff members were also analysed.

Morse and Niehaus (2009) explain that the pacing of components is not a temporal assignment. In this research, the qualitative and quantitative data were collected simultaneously but the qualitative grounded theory provided the conceptual information that made sense of the quantitative data. The design is QUAL + quan, with the quan nested within the QUAL component.

Data analysis was an ongoing process extending from the beginning of data collection until after its completion, 'following a cyclical process of using early findings to shape the on-going data collection and analysis in order to develop a theoretical explanation of the phenomenon under study' (Gora & Kornilaki 2010).

The work of Creswell (2009), Birks and Wills (2011) and Charmaz (2006) was drawn on to provide a systematic 'routine' of analysis; this involved continual reflection about the data, asking analytic questions and writing memos, incorporating the steps of grounded theory analysis to direct the process. Once the raw data were collected, interviews and focus groups were transcribed by me, read to obtain a general sense of the material and re-read to reflect on its meaning.

Coding

The analytical process in grounded theory involves coding to reduce the raw data to units, uncover new concepts and relationships and so systematically develop categories that are then put back together to build a theory.

Qualitative coding (Charmaz 2006) is the process of defining what the data are about. Transcripts of interviews were copied into QSR NVivo. Segments of data were named with a label that 'simultaneously categorizes, summarizes, and accounts for each piece of data' (p. 43). Initial coding of the data was done by hand within NVivo and sentence-by-sentence in the first instance, assigning a descriptive term to each meaningful segment of material. Examples of these are *emotions* and *facilities*. My supervisor also coded one passage from each transcript to increase the coding reliability. This prompted discussion and further thought as I learned constantly about the process of coding. Coding was the first step in moving from the concrete to the interpretative. Questions about the codes arose from the data in line with the grounded theory emphasis on emergence. Charmaz (2006) states that 'coding is the

pivotal link between collecting data and developing an emergent theory to explain those data' (p. 46).

Throughout the process of analysis and further data collection, constant comparative methods were employed to find similarities and distinctions in the data.

Initial coding was followed by the emergence of descriptive themes in which the codes were grouped meaningfully. Examples of descriptive themes are *power* and *environment*. This process was similar to axial coding and helped to add depth and structure to existing categories (Gora & Kornilaki 2010).

The number of descriptive themes was reduced slowly by grouping similar topics together. Themes were developed and connections between themes were made. The themes were then grouped again into broader dimensions which were interpreted and a diagram produced.

Quantitative data analysis

Quantitative data were obtained from the Aged and Community Care Leadership Survey, and FaithCare's surveys of staff and residents.

Data were entered into a Microsoft Excel spread sheet. Data were cleaned prior to analysis. Descriptive statistics were calculated using SPSS Predictive Analytics Software. Finally, survey data collected were compared to the grounded theory categories identified in the interviews in order to support the analysis of findings.

Research Rigour

Validity refers to the extent to which a test or instrument measures what it claims to measure (Hansen 2007) – answering the question, 'Does the research reflect reality?' Reliability means that scores received from participants are consistent and stable over time. This is achieved by the use of statistical procedures (Creswell & Plano Clark 2007).

With regard to the OCAI, scores from previous uses were compared by the licensing company with the scores from the participants in this study. The scores from previous uses were found to be valid and reliable. The validity and reliability of the data collected from staff and residents for this study was achieved by: the use of this validated and

reliable instrument, by inviting as many participants as possible to complete the instrument, and by ensuring that they were as representative a sample as possible.

Validity is an important consideration in qualitative research. It is said to refer to the accuracy, trustworthiness and credibility of the participants' and researcher's accounts and can be assessed from the researcher's analysis and from the information gleaned while interviewing participants (Creswell & Plano Clark 2007). Creswell and Plano Clark add that reliability in qualitative research plays a minor part and refers to the reliability of multiple coders to agree on the coding of passages. This was not a consideration for this research as I did the coding, albeit with a small amount of coding of each interview by my supervisor to make sure that I, as a novice, was capturing all the codable information.

Morse, Barrett, Mayan, Olson and Spiers (2002) expressed concern that reliability and validity in qualitative research were sidelined in the last two decades of the twentieth century and replaced by the notion of *trustworthiness*, a term adopted to replace *rigour*. They give the example of keeping audit trails which, they assert, provide evidence of decisions made during research, but provide no evidence of the quality of decisions, the rationale behind those decisions, or the responsiveness and sensitivity of the investigator to data. In contrast, Birks and Mills (2011) contend that keeping audit trails satisfies the requirements of transparent accountability.

Morse et al.(2002) recommend that methods of ensuring rigour in the qualitative research process should include investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, an active, analytic stance and saturation. This was achieved by my constant reflection and analysis of the data collected, which in turn determined ongoing participant recruitment. I also remained open and responsive, and used sensitivity, creativity and insight, and was willing to relinquish poorly-supported ideas. Morse et al. (2002) consider this to be crucial to the attainment of optimal reliability and validity.

Ethical considerations

All ethics requirements were met by submitting ethics applications to UTS and the aged care organisation's ethics department. Organisational ethics approval was

granted in Spring Semester 2011 from both the University of Technology Sydney and FaithCare. Both approval documents appear in Appendix 1.

Overcoming ethical obstacles

Prior to each interview, ethical processes were observed by explaining the purpose of the interviews, seeking participants' agreement to be interviewed, choosing an appropriate location convenient to the participant and assuring anonymity. As the interviews progressed, probe questions were asked if necessary. The interviews lasted between 30 and 45 minutes, reflecting how much the resident wanted to say and his or her stamina. On one occasion, I used my professional judgement as a Registered Nurse to conclude that the resident was starting to tire, and the interview was terminated.

Brief notes were taken during the interview and, with permission, a digital voice recorder was used to ensure no salient points were missed. The interviews were transcribed, coded and compared, as described elsewhere, to discover common themes.

Participants were given the contact details of the UTS Research Ethics Officer, who acted as the Ethics Complaints Officer.

The three main ethical issues

The three main ethical issues in this research especially when dealing with aged care residents were privacy, respect for participants and the care of people in dependent or unequal relationships. Privacy and respect for participants remained relevant for the baby boomer and staff cohorts; however, the issue of unequal relationships was not applicable.

Respect

> It is important for all researchers to recognise the debt they owe to those people who agree to be subjects or participants of research, and respect them accordingly. This will include a respect for their right to protection of their privacy, and to protection from embarrassment or intrusion … Difficulties arise when researchers

concentrate on the desired outcome of their research rather than the possible consequences for subjects/participants. *(UTS Human Research Ethics Committee Policy for Undergraduate and Postgraduate Students)*

Respect for participants was achieved by making an appointment to see them rather than arriving unannounced and, if the participant was not known to me, arranging for a staff member to introduce us.

Privacy of information

> 'Privacy is a complex concept that stems from a core idea that individuals have a sphere of life from which they should be able to exclude any intrusion. Privacy can refer to the reasons on which individuals rely in reaching decisions about participation in research or in health care, the protection from interventions in the lives of persons who cannot make decisions or the freedom of individuals from observation or surveillance.
>
> 'A major application of the concept of privacy is information privacy: the interest of a person in controlling access to and use of any information personal to that person.' (*National Statement on Ethical Conduct in Human Research* 2007 (Updated May 2015))

The issue of privacy was addressed in part by issuing one invitation to participate (the Information Letter) and one reminder - it was up to each individual to respond. Assurance was provided in the letter of invitation that names would not be used, data were de-identified and no personal details were used that could identify them.

Research involving persons in dependent or unequal relationships

> '7.1 It is not possible to define exhaustively all types of dependent relationships, but they include situations where unequal power relationships exist between participants and researchers or where participants occupy junior or subordinate positions in hierarchically structured groups. Examples [relevant to this research] include: persons with chronic conditions or disabilities and their carers; patients and health care professionals.

‘7.2 Where it is proposed to involve persons in dependent or unequal relationships in research, the possibility that their relationship may impair their consent requires additional attention from the Human Research Ethics Committee (HREC) in order for the HREC to be satisfied that their consent is both adequately informed and voluntary.

‘7.3 Where research involves persons in dependent or unequal relationships the researcher must give an assurance that refusal to participate in, or a decision to withdraw from, the research will not result in any discrimination, reduction in the level of care or any other penalty.’ *(National Statement on Ethical Conduct in Research Involving Humans (1999))*

The issue of dependent or unequal relationships was handled by an awareness that the relationship between the participant and the researcher, although not strictly one between a patient and a health professional, was close to that. Informed and voluntary consent was obtained, and both the Information Sheet and the Consent Form explained clearly that the participant could withdraw from the research without repercussions at any time. This last point was repeated verbally before each interview commenced.

Other ethical issues

Informed consent

Written informed consent was sought from each participant and the purpose of the research, the time commitment and the process were explained verbally and in writing.

Anonymity

Each participant was assigned a code number by me. The *code book* was kept under lock and key so that participants could remain anonymous. The age and gender of each resident was borne in mind by me during the sampling process to ensure a spread of ages and representation of both genders, but this information was not recorded apart from an approximation of the age participants. The age of the baby boomers was relevant to the extent that the term *baby boomer* is generally applied to

people born between 1946 and 1964 but once it was established that a participant fitted into the baby-boomer category or into my extended category dates as explained above, their age became irrelevant and was not noted.

Confidentiality

Participants in the focus groups were asked to give an undertaking that they not divulge any personal or sensitive information that arose during the session to anyone not attending the focus group. Confidentiality during interviews was assured so that respondents felt free to express any view.

Voluntary participation

Participation was voluntary. Each person was invited and then, if necessary, reminded once. If there was no response, it was assumed that the invitation had been declined.

Recording of interviews

Participants were asked to give permission for the interviews to be digitally audio recorded. They were able to ask for the recorder to be switched off at any time during the interview. It was explained that they were free to withdraw at any time with no questions asked and with no negative impact on them.

Storage of data

Data collected were stored securely in electronic form on hard disc with backup for seven years. They will be destroyed in accordance with the UTS Records Management Policy.

Special care taken by this researcher

As noted previously, I am a Registered Nurse working in the aged care sector and therefore am very sensitive and responsive to the emotional and physical needs of frail older people. Interviews were mainly conducted mid-morning when everyone was fresh. It was stated in the Ethics Application that if participants became distressed, tired or uneasy, the session would be terminated by the interviewer and resumed on another occasion if deemed necessary for the research and safe for the participant. If distressed, the participant would be offered a chance to debrief, and

counselled if necessary, and the incident would be reported to the Registered Nurse on duty at the home, to the manager of the home and, in the course of normal progress reporting, to the Ethics Committees of UTS and the aged care organisation. With the exception of one participant who became tired, no adverse events occurred. In this case, the interview was terminated.

Avoiding prejudice

I was aware of the need for constant vigilance: to have no preconceived ideas, to leave prejudices at the door and to be objective at all times, both in gathering the data and in their interpretation.

The research problem

My research problem was identified and informed by:

- my work as a Registered Nurse and Nurse Educator in aged care;
- my participation in the ARC research which was led by senior academics;
- my reading of the literature around leadership;
- my choice of pragmatism and mixed methods; and
- my observation during the past two years of my mother's transition into residential aged care.

The last point provided a lens through which my view of the *resident experience* was sharpened over time. Although I have not used the minutiae of my mother's journey as data, her experiences and mine have perhaps coloured my assumptions and expectations. As my time as a researcher passed month by month, the question of how leadership in aged care is experienced by the most important people in aged care, the care recipients, became even more important to me.

As I wrote in Chapter 1, the way I decided to investigate the *flow* from leadership to followers to care recipients was by considering these questions:

- (RQ1) How was the leadership model of FaithCare chosen?
- (RQ2) How are the culture and the chosen leadership model transmitted throughout FaithCare?

- (RQ3) Does the wider business community acknowledge that ‘third-party stakeholders’ should have a say in any key aspects of organisations?
- (RQ4) What is important to today’s residents?
- (RQ5) Do today’s residents have a meaningful say in decisions affecting them in their aged care home?
- (RQ6) What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?

Chapter 6, 7 and 8 explore research questions 1 and 2, questions 3, 4 and 5, and question 6 respectively.

Chapter 6

THE LEADERSHIP MODEL and CULTURE

'All is data', BG Glaser 1978

This and the following two chapters - *The Residents' View* and *The Baby Boomers' View* – describe the collection of the data that addresses the six research questions first stated in Chapter 1.

This chapter begins with a description of the collection of data pertaining to FaithCare and endeavours to answer the first two research questions, namely:

(RQ1) How was the leadership model of FaithCare chosen?

FaithCare's servant leadership model and how it was chosen by the organisation will be described by the managers in their interviews.

(RQ2) How are the culture and the chosen leadership model transmitted throughout FaithCare?

FaithCare's culture, as the mode of transmission of the leadership model, will be assessed using data from responses to the Organisational Culture Assessment Instrument (OCAI) completed by staff, including managers.

The use of the OCAI, the analysis of data and the formal report were purchased for this research from the licensed company that runs it.

Data were accessed using Staff Survey (SS) results and outputs from a staff focus group. These demonstrate how staff believe the culture is transmitted to the residents.

In Chapter 7, *The Residents' View*, the collection of data from residents is described to address the following three research question:

(RQ3) Does the wider business community acknowledge that 'third-party stakeholders' should have a say in any key aspects of organisations?

Data from the IBM CEO Study and the Aged and Consumer Care Leadership Survey are examined.

(RQ4) What is important to today's residents? and

(RQ5) Do today's residents have a meaningful say in decisions affecting them in their aged care home?

The long-term view of these questions is approached by examining FaithCare's Client Survey data from three separate surveys, and the Comments and Complaints data collected since *Greentrees* opened in 1998.

The short-term view is approached using three sources of data:

The minutes of residents' meetings at *Greentrees*
Observation of residents' meetings at *Greentrees*, and
Interviews of residents from three of FaithCare's aged care homes: *Greentrees, Goldtrees* and *Bluetrees*.

Finally in Chapter 8, *The Baby Boomers' View*, the final research question is addressed:

(RQ6) What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?

Data are collected from two sets of baby boomer interviews, from knowledgeable baby boomers and naïve baby boomers.

Table 6.1 Visual depiction data sets

Chapter number	Data set
RQ1 How was the leadership model of FaithCare chosen?	
Chapter 6	Manager interviews **Managers**
RQ2 How are the culture and the chosen leadership model transmitted throughout FaithCare?	
Chapter 6	Focus Group **Staff**
	OCAI **Staff**
	Staff Surveys **Staff**
RQ3 Does the wider business community acknowledge that 'third-party stakeholders' should have a say in any key aspects of organisations?	
Chapter 7	Aged and Consumer Care Leadership Survey **Managers**

	IBM CEO interviews **CEOs**
RQ4 What is important to today's residents?	
Chapter 7	Resident interviews **Residents**
	Client surveys **Residents**
	Comments and Complaints forms **Residents**
	Observation of Residents' Meetings **Residents**
	Minutes of Residents' Meetings **Residents**
RQ5 Do today's residents have a meaningful say in decisions affecting them in their aged care home?	
Chapter 7	Resident interviews **Residents**
	Client surveys **Residents**
	Comments and Complaints forms **Residents**
	Observation of Residents' Meetings **Residents**
	Minutes of Residents Meetings **Residents**
RQ6 What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?	
Chapter 8	Interviews **Knowledgeable Baby Boomers**
	Interviews **Naïve Baby Boomers**

The organisation's leadership model

The data in this chapter relate to the leadership model chosen by FaithCare and its transmission as organisational culture, through the managers and staff, to the residents.

Research Questions 1 and 2 are:

- (RQ1) How was the leadership model of FaithCare chosen?
- (RQ2) How is the leadership model transmitted throughout FaithCare?

Four sets of data were collected and analysed, as set out in Table 6.2.

Table 6.2 The leadership model and the culture

Name of Data	*n=xx*	Collected by
Leadership Development Program (LDP) – Manager interviews	4	The researcher within FaithCare
Organizational Culture Assessment Instrument (OCAI) – Staff	21	The researcher at *Greentrees*
Staff Surveys (SS) - Staff	*n* not made available	FaithCare
Focus Group – Staff	14	The researcher at *Greentrees*

FaithCare agreed to the participation of staff and also to access, after some negotiation with FaithCare's ethics department and with some restrictions, to extant data collected by and on behalf of FaithCare and one of their homes, *Greentrees*.

I first undertook interviews with several managers who were familiar in different ways with the Leadership Development Program (LDP). This program is taught within the organisation. The interviews were conducted to gain an understanding of managers' knowledge of and compliance with the leadership model and their opinions about its effectiveness. Responses to the OCAI were then used to assess the type of culture that exists in FaithCare.

Concurrently, aspects of FaithCare's own biannual Staff Survey, conducted to gauge levels of staff satisfaction, were considered. The responses to certain questions addressed in FaithCare's survey provide an indication of the effects of the leadership model and culture on the staff. Finally, a cross-section of staff participated in a focus group, during which they were invited to consider the ways in which they had learned the culture of FaithCare and whether, and how, they transmitted this learning to the residents in their care.

The Managers

The first step towards developing an understanding of FaithCare, its leadership model and culture and its relationship to residents, was to talk to key managers, each of whom has a special interest in FaithCare's LDP. It was hoped that they would have a thorough knowledge of FaithCare's culture, its relationship to the leadership model and its impact on residents.

The LDP developed and used by this Faith-based organisation is derived from relational leadership, which is founded on Servant Leadership and was implemented by FaithCare around 2007. It was initiated by the then CEO as a Christian values-based program to develop emerging young leaders. It was soon expanded to include senior managers. The program is underpinned by the ideas of Relational Leadership as espoused by Walter Wright (2009). Relational Leadership in turn draws on the Servant Leadership of Greenleaf (1977).

In 2011 a case study was conducted by me and three others and developed into a conference paper; it sought to explore the effectiveness of the LDP as seen by a selected pivotal and influential group. Four of FaithCare's senior managers were invited to be interviewed for the conference paper (Vindin-Illingworth et al. 2011) and all agreed. This section includes the responses from those interviews.

The managers had very different perspectives and experiences of the LDP and were well placed to present an all-embracing snapshot of the program. Thus, they were chosen purposively to capture a rich and diverse variety of information and opinions.

The interview subjects were homogenous in that they were practising Christians with local church involvement, a requirement of FaithCare for managers at this level. Furthermore, the interviewees were in roles considered to be leadership roles and had hands-on experience of the LDP.

However, the subjects were also chosen for the potential variation of their viewpoints on the LDP. They included a senior manager and an aged care home manager, both of whom have taken part in the LDP, the education manager who implements the program, and the past CEO who was instrumental in instigating and then encouraging development of the program. Variation was also achieved by selecting both genders and different age groups.

Table 6.3 Demographic details of LDP Managers

	M2 *	M3 *	M4 *	M5 *
Gender and approximate age	Male 45+ years	Female 50+ years	Female 40+ years	Female 60+ years
Position	Senior Manager	Manager of Aged Care Home	Manager Education Unit	Past CEO
LDP status	Completed parts 1 and 2 of the program	Completed part 1 of the program	Involved in implementation	Involved in development
Length of time with FaithCare	4 years	3 years	6 years	14 years
***Managers' code numbers**				

The manager interviews presented an opportunity to gain an understanding of the leadership style and culture of FaithCare from the perspective of senior managers.

Interview technique

Separate interviews were conducted using a convergent interviewing technique. This technique allows researchers to define the most salient issues and is used especially when there is some doubt about the information to be collected (Dick 1998). It can yield good results from small, diverse samples.

Prior to the interviews, ethical processes were observed by explaining the purpose of the interview, seeking interviewees' agreement to be interviewed, choosing an appropriate time convenient to the participant and assuring anonymity. The managers were interviewed by telephone at a time that suited them. As the interviews progressed, probe questions were asked. Each interview lasted between 30 and 45 minutes.

The procedure followed was designed to set the person being interviewed at ease, ask the opening question, keep the person talking, invite a summary, follow up on doubtful or ambiguous issues and ask probe questions to seek out further information if necessary. The questions asked are in the text box below.

I transcribed the interview questions and responses from the detailed notes I took throughout the interview. The interviews were individually analysed by me, then coded, compared and discussed before arriving at common themes.

Questions for Managers

Open question:

- Tell me about the leadership program that FaithCare offers.

Possible prompts or focus questions:

- What difference do you think the program has made to you and the way you think about and do your job?
- What difference do you think the program has made to staff as a result of your participation?
- What difference do you think the program has made to our residents/clients?
- Will the program be altered in any way by the new CEO? Is the CEO the main driver or does the program have its own steam now?
- Does the program help in recruitment of senior staff?

Is there anything else you want to say or add to the discussion?

Convergent interviewing worked well for this study. It enabled the use of only a small sample and yet gave insight into the effect that the LDP has had on its participants, including what they gained from it, its future development and the impact it is having on FaithCare as a whole. Dick's (1998) enjoinder to use a small but diverse sample did indeed yield good results. The population that has experienced the LDP is a relatively small one of approximately 200, the managers in FaithCare. Each of our subjects was in a different management role. Possible bias was addressed by choosing as diverse a sample as possible, bearing in mind, and as explained above, that these people are not, overall, a very diverse group. The possible bias introduced by the researcher was addressed to a large extent by the interviewing technique. Probe or follow-up questions are used only to prompt if the subject is not addressing the research aims or meanders off the point. As saturation was reached by the conclusion of the fourth interview, it is unlikely that a larger sample size would have yielded further information.

Results – LDP Manager Interviews

After analysis of the interviews, four major themes were identified. The first such theme (Table 6.4) was that the program was designed to teach a leadership model that would shift the emphasis of the culture of FaithCare from one that paid lip-service to

Christianity to one with a prominent Christian culture, largely through study of Wright's (2009) text *Relational Leadership*: *A Biblical Model for Leadership Service*. This is directly related to the vision of FaithCare, 'to be a passionate innovative Christian organisation bringing life-transforming care to our clients'.

Table 6.4 Shifting the emphasis towards a Christian culture

Representative data
The need for it grew out of the first staff survey – leadership wasn't as effective as it could be, not walking the talk. – M2
Working within a Christian organisation … what FaithCare is striving to be, to operate in accordance with its mission. – M2
Making the mission and values tangible. – M2
It has become very much a part of how we do everything. - M2
Drawing upon Biblical characters who demonstrate leadership. – M2
There's this desire to serve God and to serve man, and give good care to the elderly. – M3
The basic philosophy of the program was to change the culture of FaithCare. – M4
We needed to be unashamedly Christian, this was the language I used. - M5
It's a Christian organisation and this is how we expect everybody to behave. – M5
… to make sure all managers shared the same vision for FaithCare. – M5

A second major theme (Table 6.5) was the immense support of and satisfaction with the program across all levels of FaithCare, the championing of it by the past and present CEOs and the training manager, and support from participants and even other staff. The manager involved in developing and delivering the program talked about its success and noted that the program was retained after the CEO who initiated it left FaithCare. It enjoyed the full support of the new CEO, who had been one of its supporters under the previous CEO.

Table 6.5 The success of the LDP

Representative data
Its success has been reflected in the Staff Surveys. – M2
… as a result of the LDP I have blossomed as a person. – M3
I'm getting affirmation that people are responding well to my leadership style. – M3
… the people who participated loved the program. – M4
The program is well supported. – M4
People have been passionate about the need for an LDP. – M5
… the Christian foundations … are so embedded now that I don't think that will change. – M5

A third major theme (Table 6.6) was that the program helped managers to identify their own leadership style, it helped them move towards becoming a relational servant leader, it helped them incorporate the vision and values of the Faith-based organisation strongly into their unique leadership style and it improved their ability to lead effectively. Further, as two managers had come from a for-profit background, the

program helped them adapt to a different culture where the bottom line was not the dominant driver. Rather, 'expressing Christ's love' was fundamental, as stated in the values of FaithCare. In addition, LDP participants were able to adapt more readily to working with people whose leadership style was at variance with their own.

Table 6.6 Identifying leadership style

Representative data
An inventory was used to highlight leadership, management and interpersonal style. – M2 *Managers now know their strengths and weaknesses. – M2* *I had issues with my leadership … [that] I needed to address … I was encouraged that I could change my leadership style. – M3* *… made me stop and think about some of the ways I'd managed. - M3* *Zeroing in on the Mission and Values, but even more on Servant Leadership. – M3* *I did a lot of growing and learning. - M3* *I'm a pastoral leader. – M3*

Each management interviewee mentioned each of the three major themes. Overwhelmingly, the shift in organisational culture to an overtly Christian organisation one was most strongly voiced. This has implications for other organisations with a Christian or other religious background in that it is possible and even desirable to focus on the mission and still lead a thriving organisation. There appeared to be no mission-market tension.

Other important themes were raised (Table 6.7), but not by all participants. Although all agreed on the benefits to FaithCare of the LDP, it was not clear that the benefits flowed on to the residents/clients. The issue of benefits from the LDP flowing on to the residents or clients became an important aspect of this research. One participant stated that there was a need for an ongoing mentoring program for leaders to provide further direction along the leadership path, for further knowledge and for reassurance. Three subjects noted the continuity in support for the LDP despite the change of CEO. It was explained by the education manager that the program had up to that time emphasised organisational culture and personal development.

Table 6.7 Secondary themes

Secondary themes	Representative data
Flow-on of benefits from the LDP through Managers to residents	*[Has there been a tangible change in the way residents are treated?] I don't know … the answer is maybe, but not by design. Our mission statement is about fulfilling unmet needs so I think it would, being more Christ-like. So if we're operating that way, it would have an impact on our residents. – M2* *Good care of my carers can only give better care to my residents. – M3*
Mentoring	*I'm passionate about it. I am starting a mentoring course [soon]. The need to come alongside our leaders to skill them, debrief them. The management role is tricky – emotional, and emotionally draining. We counsel grieving and troubled relatives and staff, and have to be good clinicians. – M3*
Continuity of support for LDP from new CEO	*The old CEO was passionate, and the new one is equally passionate about it. – M3* *The change of CEO has made no difference. – M2* *The new CEO was a sponsor in an earlier program and supports the program strongly. – M4*
Future direction of LDP	*The basic philosophy of the program was to change the 'culture' of FaithCare. – M4*

From the discussion with the participants, it became clear that while the program was based on Wright's (2009) writing on Relational Leadership, Servant Leadership was the specific model emphasised. There were also elements of Authentic Leadership (Avolio & Gardner 2005) and Spiritual Leadership (Fry 2003) embedded in the program. Furthermore, an organisational culture encompassing Servant Leadership was seen to be an effective way of nurturing not only staff or followers, but the leaders themselves.

Based on these findings, Relational Servant Leadership is a suitable framework for leaders to provide a supportive environment. Whether or not it enables leaders to handle and guide change remains to be seen. If, in the future, the LDP is supplemented by an ongoing mentoring program for leaders, this will strengthen the foundation already laid.

There is strong support for the LPD from its participants and there is generally a positive flow-on effect to the staff. The LDP model exhibits synergy with FaithCare's Christian values and vision. The program seems to work well across a range of managers based on their roles and age. Indeed, one of the themes that emerged from the interviews was that managers who undertook the program were challenged to

discover their leadership style and to move towards the Servant Leadership style, especially if they tended towards an authoritarian style. M5 made the point that historically health services have been run in an authoritarian way, reflecting the origins and development of nursing, a very hierarchical profession.

Active participation in the leadership development program by senior management has been instrumental in gaining organisation-wide support for the LDP. There is scope for implementing a new phase that concentrates on the impact of this leadership model on stakeholders across the board.

Whereas 60 years ago a culture was able to develop from the theology of FaithCare, more recently a leadership model was found that fitted with FaithCare's culture and formally put in place. The LDP reinforces the theological underpinning of FaithCare and supports a culture of service to others.

In order to discover how FaithCare's culture and leadership model affected residents, it was important to consider what sort of culture FaithCare had and whether the staff were aware of that culture within the organisation.

The Staff

There were 50 members of staff at *Greentrees* at the time the research was undertaken. Of those, 15 were either on leave, had been on staff for less than one year or worked exclusively on night duty. In the recent past there had been some turnover of staff and it was decided that the more established members of staff would have a better awareness and understanding of the FaithCare culture.

Organizational Culture Assessment Instrument (OCAI)

Only staff with more than one year's experience with FaithCare were invited to complete the OCAI, (as described in Chapter 5, *Approaching the Research Questions*). Of 23 staff members invited to complete the OCAI, ranging in age from 21 to 65, 21 completed the task, a response rate of 91.3%. They represented every area of staffing at *Greentrees*.

Table 6.8 Staff OCAI participants

Number of participants	21
Gender	Female – 20 Male - 1
Age range	20 – 65 years
Years of service with FaithCare	1 – 12 years
Position in FaithCare	- Manager of *Greentrees* - Care staff - Registered Nurses - Activities Officers - Nurse Educators - Chaplain - Visiting contractor who worked with staff and residents at the home twice a week - Handyman - Administration staff - Kitchen staff - Cleaning staff

The 14 focus group participants represented fewer occupational groups than in the OCAI but nonetheless were a diverse group in terms of their position in FaithCare.

There was one male participant in the OCAI and another in the focus group. The remainder were females. This reflected the typical low percentage of males (6%) compared to females (94%) working in residential aged care in Australia (Healy & Moskos 2005).

The participation of staff in the OCAI provided an opportunity to quantitatively assess the culture of FaithCare within the framework of a validated tool. Their participation in the focus group, however, provided an opportunity to discover how they believed FaithCare culture was transmitted to residents.

OCAI Questionnaire method

Staff members at *Greentrees* were invited to fill in a paper and pencil version of the OCAI in their own time. As suggested in the instructions accompanying the OCAI, they were encouraged to think of *Greentrees*, a discrete section of the FaithCare organisation, as 'the organisation' itself. Although the OCAI was produced so that each participant could fill it in directly online, this was not possible in this case

because several staff members either did not have access to a computer or were computer illiterate. The instrument is only available for use online by each purchaser for two weeks. As was envisaged, it took longer than two weeks to collect sufficient manual responses for the results to be viable. The information collected was entered into the OCAI site for analysis, great care being taken to enter it accurately and each participant given the opportunity to verify the accuracy of their responses. When all participants' responses had been entered, the analysis was completed by the company in the United States and a document containing results and conclusions was emailed to me directly.

Reliability of the OCAI

Quinn and Cameron (Cameron & Quinn 2011, pp. 175-8) cite many examples of the consistency of results achieved by researchers using the OCAI, showing that most organisations have developed a dominant culture-style. Among studies using the OCAI is one completed by Quinn and Spreitzer (1991, p. 119) in which 796 executives from 86 public utility firms ranked their organisation's culture. Cameron and Quinn (2011, p. 176) state that the results of this research indicate that respondents tended to rate their organisation's culture consistently across the various questions in the instrument. Zammuto and Krakower (1991, p. 109) used the instrument to investigate the culture of higher education institutions among more than 1,300 subjects and, again, demonstrated a high degree of reliability.

Validity of the OCAI

Cameron and Quinn (2011, pp. 178-83) cite examples of testing of the OCAI that indicate the instrument is indeed testing what it sets out to test. A sample of 3,406 individuals at 334 institutions of higher education, representative of the entire population of four-year colleges and universities in the United States, was tested by Cameron and Freeman (1991, p. 31). Evidence for the validity of the OCAI was found when the culture type was matched with the domain of effectiveness in which FaithCare excelled, for example those institutions that exhibited clan culture were most effective in the performance domains of morale, satisfaction, internal communication and supportiveness (p. 45). Quinn and Spreitzer (1991, p. 121) also found evidence of convergent validity and discriminant validity. Cameron and Quinn

conclude (p. 183) that 'the empirical evidence suggests that the OCAI measures what it claims to measure: key dimensions of organizational culture that have a significant impact on organizational and individual behaviour'.

The Competing Values Framework

From a list of 39 indicators of effectiveness within FaithCare, two important dimensions were identified by the statistical analysis conducted by Cameron and Quinn (2011, p. 39) and four quadrants were described, corresponding to the four organisational cultures that differ strongly.

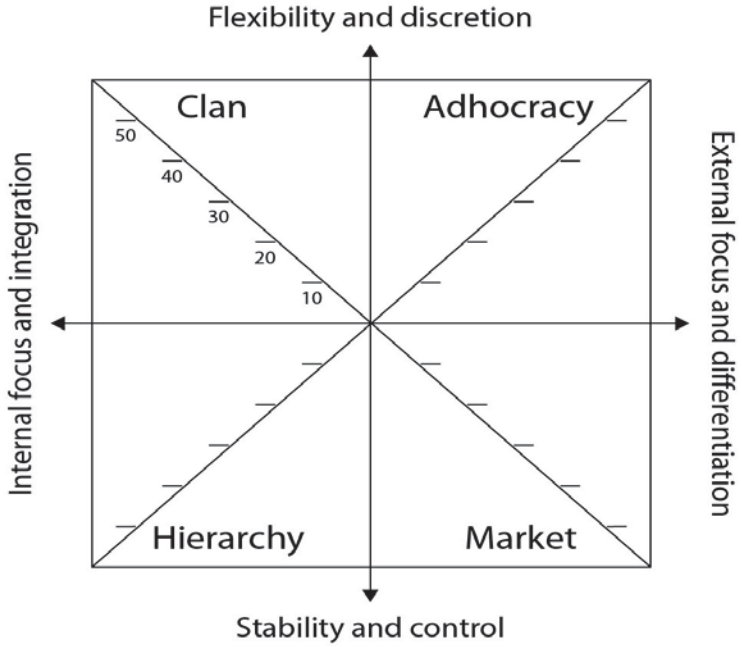

Figure 6.1 Competing values quadrants and their culture
Source: Cameron and Quinn (2011, page 39)

To the left in the figure, the organisation is internally focused (what is important, how they want to work) and to the right, the organisation is externally focused (what is important for the outside world, the clients, the market). At the top of the figure, the organisation desires flexibility and discretion, while at the bottom, the organisation wants the opposite values: stability and control.

Description of the four culture types

The following is a brief description of each of the four culture types. More detailed information may be found in the report in Appendix 2.

1. The Clan Culture

An organisation with clan culture is a very pleasant place to work, where people share a lot of personal information, much like an extended family.

Table 6.9 Clan culture

Elements	Descriptors
Leader Type	Facilitator, mentor, team builder
Value Drivers	Commitment, communication, development
Theory for Effectiveness	Human development and participation produce effectiveness
Quality Strategies	Empowerment, team building, employee involvement, Human resource development, open communication

2. The Adhocracy Culture

This provides a dynamic, entrepreneurial, and creative place to work. People are expected to take risks.

Table 6.10 Adhocracy culture

Elements	Descriptors
Leader Type	Innovator, entrepreneur, visionary
Value Drivers	Innovative outputs, transformation, agility
Theory for Effectiveness	Innovativeness, vision and new resources produce effectiveness.
Quality Strategies	Surprise and delight, creating new standards, anticipating needs, continuous improvement, finding creative solutions

3. The Market Culture

This points to a results-oriented organisation whose major concern is getting the job done. People are competitive and goal-oriented.

Table 6.11 Market culture

Elements	Descriptors
Leader Type	Hard driver, competitor, producer
Value Drivers	Market share, goal achievement, profitability
Theory for Effectiveness	Aggressive competition and customer focus produce effectiveness
Quality Strategies	Measuring customer preferences, improving productivity, creating external partnerships, enhancing competitiveness, involving customers and suppliers

4. The Hierarchy Culture

This provides a very formalised and structured place to work. Procedures govern what people do.

Table 6.12 Hierarchy culture

Elements	Descriptors
Leader Type	Coordinator, monitor, organiser
Value Drivers	Efficiency, punctuality, consistency and uniformity.
Theory for Effectiveness	Control and efficiency with appropriate processes produce effectiveness
Quality Strategies	Error detection, measurement, process control, systematic problem solving, quality tools

The OCAI promises to provide the user with:

- an impression of what the staff considers important and in that sense it can be used to gauge whether employees are content;
- a zero measurement (baseline) preceding any company changes which can be useful if conducting a second assessment to gauge the effects of the change;
- the basis for producing a step-by-step systematic change management plan;
- the tools to improve internal communication, if different cultures are mapped between different departments or locations;
- a useful tool in mergers or reorganisations;
- useful information if there is a high staff turnover or absence through illness; and

- the possibility of initiating change through discussion of the outcome, dialogue and awareness and initiation of the mental processes required to bring about lasting change by turning intentions into behaviour.

Some of the following information is drawn from the final OCAI report received (Appendix 2). The participant is asked to divide 100 points among four alternatives that correspond to the four culture types, representing the present organisation. This is repeated six times for the six dimensions of FaithCare. This method measures the extent to which one of the four culture types dominates the present organisational or team culture. By taking the test a second time, this time dividing the 100 points among the same alternatives according to what the test taker would like to see in the company, the desire for change can be measured. The questionnaire, which is included in the OCAI, can be found in Appendix 2.

Participants are asked to judge the following six dimensions of their organisation:

1. Dominant characteristics
2. Organisational leadership
3. Management of employees
4. Organisation glue
5. Strategic emphases
6. Criteria of success

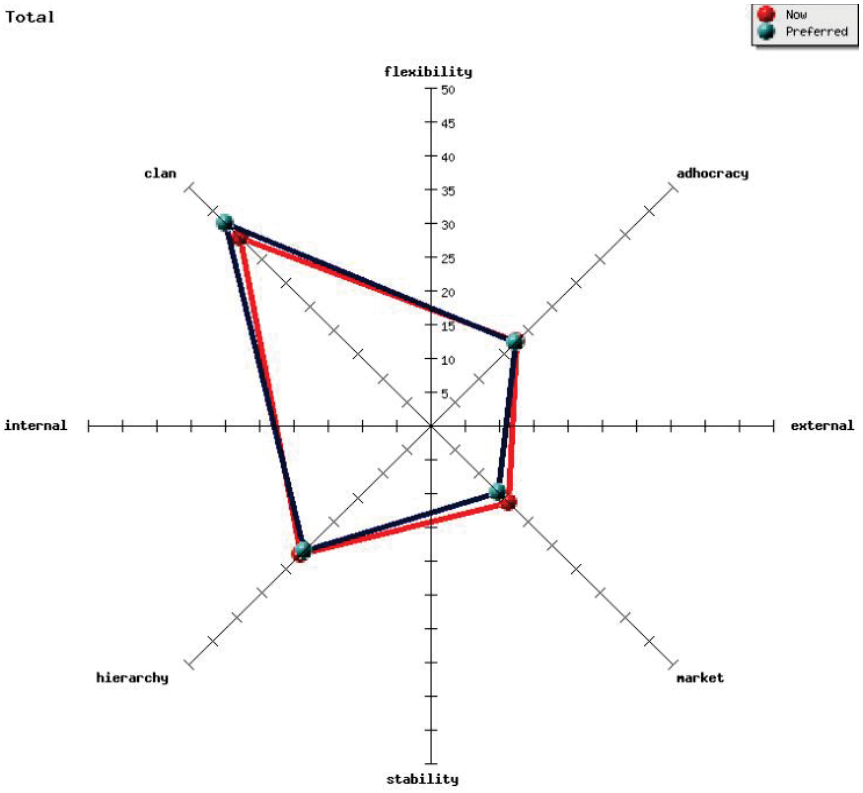

Figure 6.2 Comparison of Now and Preferred cultural archetypes

Table 6.13 Data for total scores

Data Graph	Now	Preferred
Clan	39.33	42.42
Adhocracy	17.77	17.52
Market	16.05	13.90
Hierarchy	26.85	26.16
Total	100	100

The radar chart above presents a profile of the results from the 21 participants at *Greentrees*. The cultural profile is a mix of the four cultural archetypes. The red lines represent the current culture and the blue lines represent the preferred culture.

Table 6.13 contains the scores for the overall data. From the chart and the table, it is clear that the overall preference among the participants is for an increase in the emphasis on clan culture (from 39.33 to 42.42), and a concomitant decrease in the emphasis on market culture (from 16.05 to 13.90). The two remaining sets of scores, for adhocracy and hierarchy cultures, remain stable.

The dominant culture

The strength of an organisation's culture is determined by the number of points awarded to a particular cultural type; the higher the score, the more dominant the cultural type. Research has shown that strong cultures correspond with homogeneity of efforts, a clear sense of direction, an unambiguous environment and services (Cameron & Quinn 2011, p. 83). The extent to which a company needs a strong, homogenous culture (instead of a varied, balanced mix of cultures) often depends on the environment, including such features as the complexity of the environment and how flexible it should be to respond effectively to a changing situation. If a culture is strong, changes will require more effort.

The dominant culture is the type that scored highest. For this organisation, the dominant culture is clan culture (39.33 points). Therefore, it is a very pleasant place to work, one where people share a lot of themselves and commitment is high. The second most dominant culture is hierarchy culture (26.85 points), in which structure, procedures, efficiency and predictability are key. Third is adhocracy culture (17.77 points), indicating elements of a dynamic, entrepreneurial and creative place to work. The market culture is present as well (16.05 points) with its result-oriented production, goals and targets and competition.

It can be concluded that in this organisation there is a mixture of cultures with an evident emphasis on a people-friendly working environment where co-workers and teamwork are important. It is not unexpected that the second highest scoring culture is hierarchy. This fits into the hierarchical nature of most health care organisations, in which the manager or director of nursing is at the top of the hierarchy, followed by registered nurses, care staff and ancillary services. The staff perceive that the least dominant cultures are adhocracy and market culture, indicating that the entrepreneurial and results-oriented sides of the business are less apparent to them. Staff are less aware of the mission/market tension that most not-for-profit organisations face.

Discrepancy between present and preferred culture

The red lines on the chart represent the current 'Now' culture, blue represents the preferred culture. Differences of over 10 points are especially relevant and, state

Cameron and Quinn (2011, pp. 82-3), should induce FaithCare to take urgent action. If there were a larger discrepancy between current and preferred cultures, this would provide important information about preferred changes and the direction in which FaithCare should move.

In the case of this organisation, we can see that the largest preferred difference is in clan culture, with an increase of 3.09 points - the staff's preference is that the focus on people could be enhanced. Simultaneously, market culture with a decrease of 2.15 points indicates that FaithCare, in the opinion of the staff, could be less focused on results and competition. Hierarchy culture and adhocracy culture both decrease slightly. Clan culture remains dominant in the preferred situation remains, followed in order by hierarchy, adhocracy and market culture.

Cultural Congruence

Congruence among the six aspects of the organisation (dominant characteristics, organisational leadership, management of employees, organisational glue, strategic emphases, criteria of success and congruence) means that the strategy, style of leadership, reward system, management of employees and organisational characteristics are based on the same values, and fall into the same cultural quadrant. Research shows that successful organisations often have a congruent culture (Cameron & Quinn 2011, p. 85). They experience fewer inner conflicts and contradictions. A result of cultural incongruence would have indicated an awareness of a need for change. This type of change would take a lot of time and debate. It leads to differences in values, views, targets and strategies. Sometimes the incongruence specifically occurs between different departments or people.

After closely studying all six aspects, it can be seen that the current working culture is reasonably congruent. Only five of the 24 differences are larger than or equal to 5 compared to the average culture, and only one is larger than or equal to 10 – clan culture, at 50.24 for Dominant Characteristics, deviates from the total average (39.33) by 10.91 points. In five of the aspects, clan culture is the dominant culture type; the exception is Management of Employees, in which hierarchy is first. This would seem to mirror the hierarchical nature of a team of nurses and carers.

Drawing on the statistics provided in the OCAI report, the following table brings the results together in one place.

Table 6.14 Changes under culture headings

Culture	Aspects					
	Dominant characteristics	Organisational leadership	Management of employees	Organisation Glue	Strategic emphases	Criteria of success
Clan ***The average*** *of the six aspects of Clan culture- Now 39.33 Preferred 42.42*	**Now** 50.24	38.57	31.81	38.14	35.33	41.90
	Preferred 46.33	42.67	40.00	39.24	35.48	50.81
	Change -3.91	+4.1	+8.19	+1.1	+0.15	+8.91
Adhocracy ***The average*** *of the six aspects of Adhocracy culture - Now 17.77 Preferred 17.52*	**Now** 17.38	22.62	19.05	15.90	20.43	11.24
	Preferred 18.76	16.86	18.33	16.81	21.67	12.67
	Change +1.38	-5.76	-0.72	+0.91	+1.24	+1.43
Market ***The average*** *of the six aspects of Market culture - Now 16.05 Preferred 13.90*	**Now** 13.81	12.38	16.19	15.29	20.62	18.00
	Preferred 16.10	9.52	12.95	18.05	15.00	11.81
	Change +2.29	-2.86	-3.24	+2.76	-5.62	-6.19
Hierarchy ***The average*** *of the six aspects of Hierarchy culture - Now 26.85 Preferred 26.16*	**Now** 18.57	26.43	32.95	30.67	23.62	28.86
	Preferred 18.81	30.95	28.71	25.90	27.86	24.71
	Change +0.24	+4.52	-4.24	-4.77	+4.24	-4.15

In this table the higher scores for clan culture illustrate dominance of clan culture across all aspects.

OCAI – staff

The Organizational Culture Assessment Instrument (OCAI) was used to study the culture of FaithCare as viewed by the *Greentrees* staff, to establish what the culture of FaithCare was and whether staff were aware of the culture. According to the

results of this research, contained in the final report, (Appendix 2), the OCAI was based on the Competing Values Framework which itself was developed initially from research conducted on the major indicators of effective organisations (Cameron & Quinn 2011, p. 38). The Competing Values Framework consists of four competing values that correspond with four types of organisational culture. Every organisation has its own mix of these types, identified by completing a short questionnaire.

The staff who used the instrument found FaithCare to be predominantly one culture, that is, clan culture. Clan culture would seem to be a good fit with Servant Leadership since its key indicators are:

- leaders who facilitate, mentor and build teams;
- values of commitment, communication and development;
- a belief that the development of people and their participation in FaithCare leads to effectiveness; and
- quality strategies that embrace empowerment, team building, employee involvement, human resource development and open communication.

This is a culture that puts people first. Clan culture provides a very strong base among staff who work as a team with a common goal, that is, the care of the residents. It is also a good fit with the vision and values of FaithCare and its philosophy. FaithCare is person-centred for staff and their wellbeing is high on FaithCare's agenda.

The FaithCare leadership dimension of OCAI indicated that although the leaders are considered to be mentors and parent figures, staff generally wanted these characteristics to increase in strength. The leaders who were least favoured by staff were hard drivers, producers and competitors. An explanation of these results may be that staff spend their day nurturing the residents and need to be supported themselves by leaders who mentor and parent. A leader who is driving, producing and competing would be less likely to be people-centred.

Managing employees was a dimension where staff noted the culture was slightly more hierarchical than clan-based. Staff indicated that they would prefer a less hierarchical culture and more of a clan culture, thereby reducing the features of security, conformity, predictability and stability in exchange for an increase in teamwork, consensus and participation. The importance of participation emerged as a

theme throughout this research, especially with regard to the residents themselves. More will be said about participation, or having a say in what happens to you, as this chapter progresses.

Based on the evidence from the survey, it can be safely concluded from the OCAI results that the staff at *Greentrees* had a good understanding of the FaithCare culture. All who were offered the opportunity to take part accepted and they all completed the OCAI independently. There was no dissenting group. The results indicate that the staff's views were surprisingly homogenous within and across age groups and, although no statistical test was performed, it can be said with certainty that the homogeneity extended within and across position types. It can also be concluded that the leaders and managers who exhibited and taught the leadership model adopted by FaithCare were reinforcing the existing culture. Further, the staff saw no disparity between the leadership model and the culture of FaithCare.

Participants would have liked to see some adjustment across the aspects of clan culture, particularly an increase in the areas *management of employees* and *criteria of success* and, to a lesser extent, *organisational leadership*. Facilitation, mentoring and team building were facets of organisational life that could be improved. Participants wanted less emphasis on market culture, particularly in *strategic emphases* and *criteria of success*, but hierarchy and adhocracy seem to be fairly stable.

In a later section, this chapter will discuss the findings from the focus group in which staff were given the opportunity to talk openly about the transmission of the leadership model via FaithCare's culture to the residents.

Comparison of age groups

The difference between the present and preferred cultures was minimal overall. A further analysis of the data was done, this time dividing the participants into two groups, depending on age, and comparing the results. The younger age group was more representative of the future staff in aged care and the older group represented the *old guard*. The older group (*N=9*) ranged in age from 50 to 60 years of age. The younger group (*N=12*) ranged in age from 20 to 48. The older group consisted of four people in management positions and five in non-management positions. The younger group consisted of six people in each position. A management position, for this

purpose, is a position in which the person directs or has responsibility for other people. The radar chart in Figure 6.3 and Table 6.15 illustrate the figures for the older and younger groups.

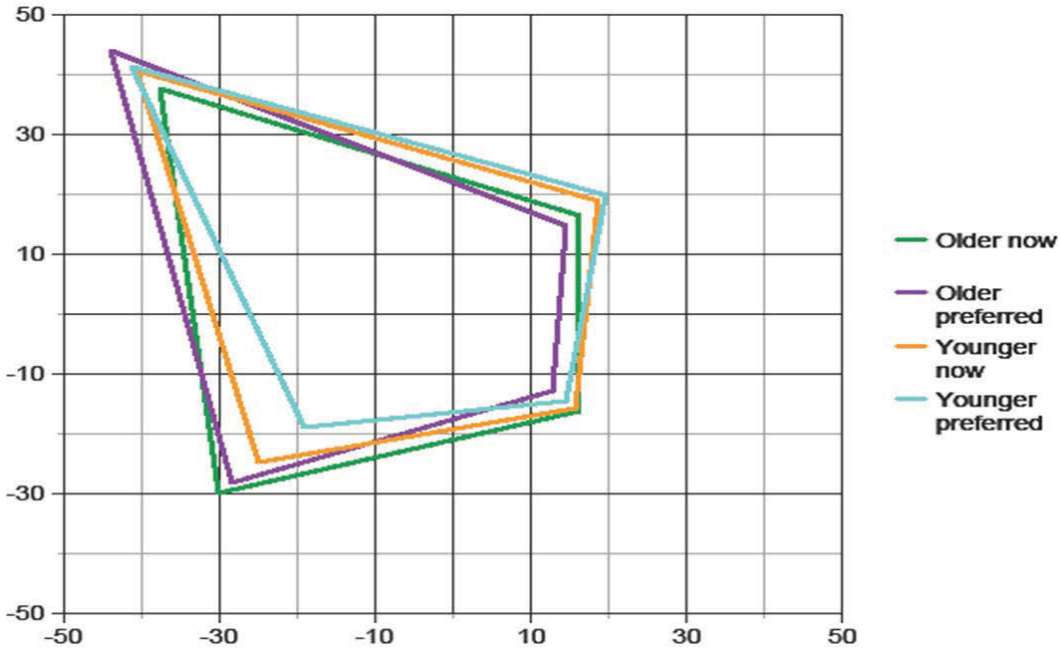

Figure 6.3 Comparison of older and younger age group scores

Table 6.15 Comparison of older and younger groups

Culture type	Older group *(N=9)*		Younger group *(N=12)*	
	Now	Preferred	Now	Preferred
Clan	37.5	43.8	40.6	41.33
Adhocracy	16.26	14.65	18.90	19.67
Market	16.24	12.98	15.97	14.60
Hierarchy	29.96	28.24	24.79	18.92

Findings

The data from Table 6.15 above were entered into SPSS and the following results emerged:

Table 6.16 Group statistics for older and younger age groups

	Age group	N	Mean	Std. Deviation	Std. Error Mean
Clan now	1	9	37.5322	9.05304	3.01768
	2	12	40.6275	20.93842	6.04440
Adhocracy	1	9	16.2578	5.97701	1.99234
now	2	12	18.8325	9.93343	2.86753
Market now	1	9	16.4267	9.09667	3.03222
	2	12	16.0483	8.52264	2.46027
Hierarchy	1	9	30.1500	5.91233	1.97078
now	2	12	24.3042	9.62339	2.77803
Clan	1	9	43.9978	8.39273	2.79758
preferred	2	12	41.2350	8.88365	2.56449
Adhocracy	1	9	14.6100	8.98696	2.99565
preferred	2	12	19.1800	5.90000	1.70318
Market	1	9	12.9256	7.66324	2.55441
preferred	2	12	14.8742	4.78912	1.38250
Hierarchy	1	9	28.4611	9.71803	3.23934
preferred	2	12	24.5417	6.14255	1.77320

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Clannow	Equal variances assumed	1.877	.187	-.413	19	.684	-3.09528	7.48759	-18.76698	12.57643
	Equal variances not assumed			-.458	15.816	.653	-3.09528	6.75583	-17.43055	11.24000
Adhocracynow	Equal variances assumed	1.054	.317	-.687	19	.500	-2.57472	3.74603	-10.41526	5.26581
	Equal variances not assumed			-.737	18.315	.470	-2.57472	3.49173	-9.90154	4.75209
Marketnow	Equal variances assumed	.369	.550	.098	19	.923	.37833	3.86673	-7.71482	8.47149
	Equal variances not assumed			.097	16.728	.924	.37833	3.90478	-7.87026	8.62693
Hierarchynow	Equal variances assumed	1.562	.227	1.604	19	.125	5.84583	3.64517	-1.78359	13.47525
	Equal variances not assumed			1.716	18.437	.103	5.84583	3.40609	-1.29795	12.98962
Clanpreferred	Equal variances assumed	.001	.980	.722	19	.479	2.76278	3.82767	-5.24862	10.77417
	Equal variances not assumed			.728	17.901	.476	2.76278	3.79513	-5.21366	10.73922
Adhocracypreferred	Equal variances assumed	3.542	.075	-1.408	19	.175	-4.57000	3.24516	-11.36219	2.22219
	Equal variances not assumed			-1.326	13.019	.208	-4.57000	3.44598	-12.01350	2.87350
Marketpreferred	Equal variances assumed	2.525	.129	-.717	19	.482	-1.94861	2.71843	-7.63835	3.74113
	Equal variances not assumed			-.671	12.588	.514	-1.94861	2.90454	-8.24444	4.34722
Hierarchypreferred	Equal variances assumed	3.130	.093	1.132	19	.272	3.91944	3.46113	-3.32479	11.16367
	Equal variances not assumed			1.061	12.684	.308	3.91944	3.69291	-4.07884	11.91773

This output (a 2-tailed t test) indicated that there was no significant difference between the two age groups ($p < .05$ statistical significance).

The younger group perceived a greater emphasis at present on adhocracy culture (dynamic, entrepreneurial and creative) – its score for this dimension was 18.9, compared to the older group's score of 16.26. It also preferred a greater emphasis on adhocracy culture – the score for this dimension rose from 18.9 now to 19.67 for preferred, compared to a fall to 14.65 for the older group. This indicated that the younger group saw dynamism, creativity and entrepreneurial activity as the way forward.

The younger group perceived less emphasis (24.79) on hierarchy culture (formalised and structured) now than the older group (29.96). The younger group would prefer even less emphasis on hierarchy culture (18.92). Perhaps the older group accepted that a hierarchical system was an efficient way for healthcare to run or at least was the way that healthcare had always operated. Furthermore, the older age group was more used to hierarchical cultures, from their earliest home life and school days onwards, particularly if they trained as nurses under the old hospital system with its emphasis on complete obedience by junior nurses to senior nurses and doctors.

The younger group accepted the current level of market culture and wanted only a slight reduction from its 'now' score of 15.97 to its 'preferred' score of 14.6, whereas the older group wanted substantially less emphasis on market culture, a change from 16.24 to 12.98.

The younger group perceived a higher level of clan culture and preferred a slight increase – from 40.6 to 41.33. The older group perceived a lower level at present, although still quite high compared to the other cultures, and preferred a substantial increase – from 37.5 to 43.8.

Staff Surveys

One way in which FaithCare monitors the transmission of its culture to employees is by use of staff surveys. Every staff member of FaithCare is invited to complete the staff survey every two years. The staff survey is conducted by an external specialist survey organisation based at an Australian university.

The staff survey consists of 117 questions arranged in categories that are changed only slightly from survey to survey. While many categories remain the same (for example, job satisfaction, change and innovation, diversity), some are changed to reflect a shift in emphasis in FaithCare (for example, organisational direction disappeared after 2009 to be replaced by organisational commitment).

The survey is provided as both a paper-and-pencil instrument and online for those who have access to FaithCare's intranet. The online version is available for a couple of weeks, after which access closes. The paper-and-pencil version is available to each employee via their manager, with a due date by when the survey should be posted. Employees are encouraged to complete the survey in FaithCare's time. A reply-paid envelope addressed to the survey organisation is provided to each member of staff to ensure confidentiality.

The results of the staff survey are distributed by post to all staff members in a simplified form to demonstrate changes from survey to survey, areas for improvement and areas that have improved.

It was made clear to me by FaithCare that information pertaining to the staff survey and more especially the results of the staff survey could be discussed here in only the most general terms. Therefore, in the data analysis, instead of using the percentages derived from each question, a percentage range has been given. Although not as precise, the available information provides an overview of the survey findings whilst maintaining the directive of FaithCare and ensuring the confidentiality of results. Other discussion highlights only general trends from survey to survey for the same reason.

Areas that reflect leadership and culture

The staff surveys conducted in 2009 and 2011 show a very high belief (around 90%) by staff in the overall purpose, values and work of FaithCare, under the heading 'Vision and Values'. Staff also feel strongly that teamwork is a hallmark of FaithCare. The only area of dissatisfaction in this area for staff was *involvement*. This was an interesting finding, as involvement should be a strong indicator of the type of culture that FaithCare has endeavoured to create. Sixty per cent of staff in 2009, falling to 50% in 2011, indicated that they were not involved in everyday decision-making, with similar scores for the specific question relating to decisions that affected them directly. It was noted in Chapter 2 that having a voice is very important to wellbeing and that humans do better when they derive power through having a voice that is heard and acted upon.

It can be seen even from this very general overview of the staff survey that the culture of FaithCare, its Vision and Values, and Servant Leadership, were felt and understood by staff members who completed the survey. However in some areas, for example *involvement*, staff do not find themselves part of the decision-making process.

Staff Survey results

Percentage results are arranged in groups of 'Strengths', 'Development areas' and 'Significant changes since the last survey'; the last group was initiated at the time of the 2011 Staff Survey, reflecting on the 2009 results in this area. The Strengths are easily understood, as can be seen from the example in Table 6.17; nearly all staff like the work they do.

Table 6.17 Excerpt from Staff Survey Summary, February 2010

Strengths		
Job Satisfaction	Employees report that: • they like the kind of work they do	*95-99%
*percentage amended – see explanation above		

In 'Development Areas', Table 6.18, the figure of 45-49% represents those staff members who are dissatisfied with their income.

Table 6.18 Excerpt from Staff Survey Summary, February 2010

Development Areas		
Rewards & Recognition	Some staff do not report that: • they are satisfied with their income	*45-49%
*percentage amended – see explanation above		

The response rate to the staff survey, the completion of which is voluntary, rose from 33% in 2009 to 55% in 2011. Despite this limitation, the surveys revealed valuable information about how staff perceived FaithCare, in particular around leadership and culture.

Recapping the data presented above, 60% of staff in 2009, falling to 50% in 2011, indicated that they were not involved in everyday decision-making, with similar scores for the question relating to decisions that affected them directly. Although this was a significant improvement (a shift from 60% not feeling involved to 50% over two years), it still represented a large number of people who felt uninvolved both in everyday decision-making and in decisions that affected them directly. This perceived lack of involvement points to FaithCare's failure to apply in practice its stated values, including *mutual respect and trust*, *consistent and open communication* and *co-operation and commitment in the workplace*. The words 'mutual', 'co-operation' and 'two way' imply a flat structure in which everyone's opinions are equally important. The staff's perceived lack of involvement also fails to support three of FaithCare's values statements that focus on respect, enabling and person-centredness.

There was minimal correspondence between the lack of involvement the staff expressed in the staff survey and the Quality Strategy descriptor of Clan Culture in the OCAI which they had unanimously agreed was the culture of FaithCare. The clan

culture descriptor is 'empowerment, team building, employee involvement, human resource development, open communication'. This was quite a striking difference.

One explanation could be that the sample group for each survey was different in some respects. The group that took the OCAI was only 21 people strong, compared to the staff survey with its more than 1,000 participants. The OCAI group came from one residential facility and the staff survey group came from every sector of FaithCare: residential, community care, corporate/support staff and others. However, it is unlikely that the two groups would have produced such different results in the area of involvements/empowerment.

Second, the questions in the survey about involvement were short and targeted and required only yes/no answers; however, they were somewhat complicated in the OCAI where the questions were presented as four two-sentence statements requiring a distribution of 100 points in order of importance among the four (see Table 6.19 below). This more complicated approach could have rendered respondents unwilling to make the mental effort to weight the answer adequately.

Table 6.19 Questions from the staff survey and OCAI

Survey	'Involvement' questions
Staff Survey	• I have input into everyday decision-making • I am encouraged to give feedback about things that concern me • I am consulted before decisions that affect me are made
OCAI	• The management style in the organization is characterized by teamwork, consensus, and participation. • The organization emphasizes human development. High trust, openness, and participation persist.

Third, and most likely, is that the *involvement* part of each question in the OCAI (the word *participation* was used) was given equal weighting with other words such as teamwork, consensus, trust and openness and in each question, the word *participation* came last on the list. So if a respondent agreed with *teamwork* or *trust* they were likely to weight that statement highly even though they may not have agreed completely with *participation*. It is a general flaw in the OCAI that it is difficult for

people to weight a statement accurately when they may agree strongly with one of the descriptors but not agree at all with another. In the staff survey, each *involvement* question was only about involvement.

A fourth explanation could be that the staff survey came directly from FaithCare and presented staff with an opportunity to tell management what they thought, whereas the OCAI was completed as a favour to me and respondents were unsure whether they would ultimately benefit from the results of the survey.

A fifth explanation for the difference between the results of the two surveys could be that respondents were concerned about confidentiality. Staff had usually completed earlier staff surveys and knew there were no unfavourable repercussions. Although OCAI participants know me, perhaps they were less sure of confidentiality, even though their anonymity and safety had been assured.

There are other possible explanations, such as the two surveys having different aims and being completed at different times. It may be argued that the different aims (to gauge staff satisfaction or dissatisfaction in the case of the staff survey, and for staff members to give their opinion of the culture of the organisation in the case of the OCAI) made the two unable to be compared. However, it is worth pondering how the one parameter (involvement/participation) yielded such different results.

Taking all of the above into account, it would seem that staff were likely to view their participation in decision-making as less than they would like. The staff survey gave a far more accurate and reliable indication of this. The purpose of the OCAI was not to tease out opinions about individual organisational traits, but to give an overview or almost a gut feeling about the type of culture across the organisation. The OCAI revealed that FaithCare had a clan culture and the staff survey revealed that staff wanted more involvement in decision-making. Where the word *participation* was used in the OCAI, it was nested within a more generalised but complex sentence and was therefore not revealing about the amount of involvement the staff felt they had or wanted to have.

Focus group

A staff focus group was held during a break period in the middle of the morning shift at *Greentrees*. All members of staff who were on duty at the time (14 in total), with the exception of a skeleton staff in the dementia unit, were invited to attend and all were happy to participate.

Participants in the focus group (Table 6.20) ranged from 18 to 62 years of age and consisted of a mix of long-standing and new, and permanent and casual staff. There was some crossover between participants in the OCAI and the focus group, and the staff survey.

Table 6.20 Focus group participants

Number of participants	14
Gender	Female – 13 Male – 1
Age range	18 - 62 years
Years of service with FaithCare	8 months – 12 years
Position in the organisation	- Registered Nurses - Care staff - Activities officers - Nurse Educator - Administration staff - Kitchen staff - Cleaning staff

The time for the focus group was chosen because of the number of staff on duty who could be available to take part, the diversity in potential views among the staff working that day, and when staff could leave their duties. It was the usual practice at that time for staff to leave the low-care area unattended mid-morning. The focus group participants included staff from every occupation at *Greentrees*. The informal situation was found to be helpful to participants who had the confidence to discuss ideas freely. Hansen (2007) wrote that research can 'make use of interaction as a way of triggering discussion' (p. 70) so a focus group could help people who would usually hold back, to express opinions.

The aim of the focus group was to explore if and how the culture of FaithCare was transmitted to the residents in their care. Participants' verbal consent was obtained prior to the start of the focus group. Permission was also sought and obtained to record the session digitally for later transcription to ensure that no important points were forgotten. Participants were also invited to read the transcription if they wanted to, but none did.

During the focus group, participants were invited to:

- reflect on the information that they learned at their initial orientation about FaithCare's culture,
- consider how culture affected their day-to-day interactions at work, and
- suggest ways in which the culture of FaithCare was transmitted through them to the residents.

At the end of the focus group, participants were thanked and asked whether they had any questions. Transcription was completed within two days and the transcript entered into NVivo 9 for later coding. Responses from staff members in the focus group were coded into 10 areas, as can be seen from Figure 6.4.

Good communication with and about the residents was clearly the most important factor to *Greentrees* staff for transmitting FaithCare's culture from management to residents via staff. The subject of communication took up 34.52% of the discussion time at the focus group.

Communication with and about residents, nurturing of residents and each other, respect for residents and care of them at end of life were talked about the most – these four aspects together totalled 84.94% of the discussion time. All these were similar to the descriptors of Clan Culture in the OCAI – open communication, commitment, participation, team building. Other areas combined to take up only 15.06% of the discussion time.

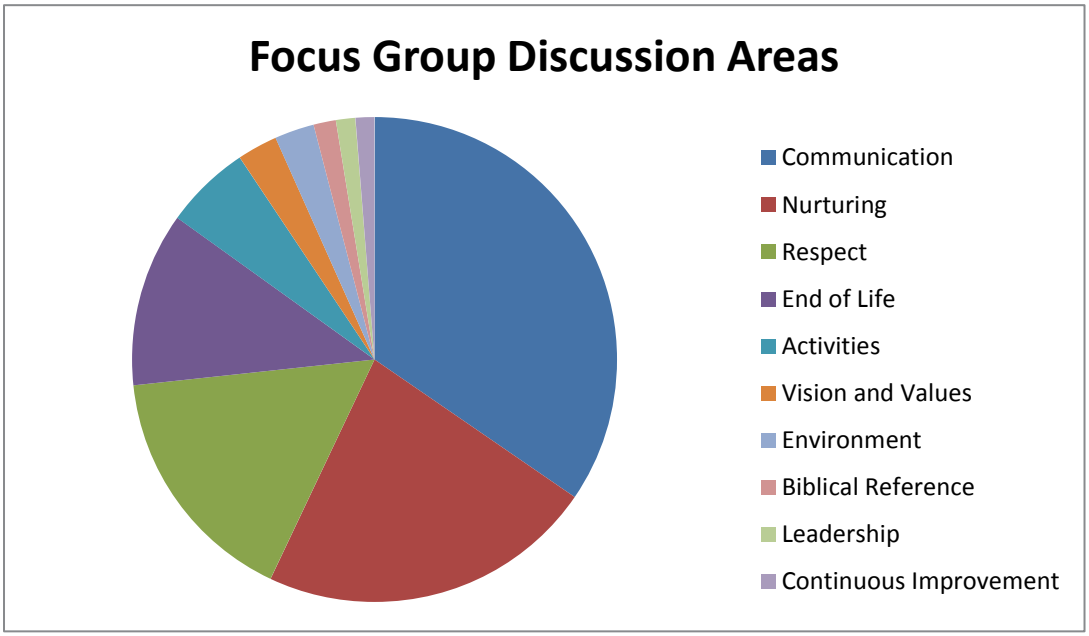

Figure 6.4 Focus group discussion areas

Communication

When assessing the staff focus group outcomes, communication was found to be the dominant factor for transmitting organisational culture from management to the residents via the staff. In a survey conducted for the ARC Leadership Research project, communication was found to be the highest on the list of essential leadership capabilities (Cartwright 2013). The relevant question and answers are given in Table 6.21 below.

Table 6.21 Question and answers from leadership survey

What are the five most essential capabilities for a person to have if they are to provide effective leadership within your present organisation?
1. Clear communication – ability to communicate this vision to all levels of the organisation
2. Build and motivate a high-performing team
3. Honesty and integrity
4. An ability to communicate and establish effective communication systems
5. Effective interpersonal communication and listening skills

In fact, answers 1, 4 and 5 in the above table all relate to communication. All participants in the survey were managers and above (for example CEOs) and

therefore in leadership positions. The FaithCare staff focus group participants talked about different aspects of communication – the importance of communication itself, the way staff communicated, listening for complaints and wanting to communicate better with each other about the residents. The last two of these areas mirrored the fifth answer given in the leadership survey.

Of the staff who took part in the FaithCare focus group, only three could be said to be in management positions. Their insight into what was important (communication) was quite striking and pointed to a connectedness between management and staff in the broader context. Within the focus group though, their emphasis on the importance of communication was in answer to my request to discuss the transmission of the culture from management to residents via staff. Good communication for participants included listening, and communication among each other about residents; it was these two that reflected the organisation's values of quality interactions and relationship-building.

Staff expressed the importance of communication in different ways (Table 6.22): the importance of communication itself, the way staff communicated, listening for complaints and wanting to communicate better with each other about the residents.

Table 6.22 Focus group categories and representative data

Categories	Representative Data
Communication	
The importance of communication itself	*We communicate with them. – S22* *… resies do get ignored in some nursing homes. You see them sat there doing nothing every day and they don't do anything, they get ignored. No one gets ignored here. – S20*
The way staff communicate	*… the way you speak to them, the way you treat them, we don't ignore them. – S23* *… we give them eye contact when we talk to them. We wait for them to respond, and then listen to them, talking with a clear loud voice when we respond. – S22* *I think the way we touch them is very important. They can sense a lot of things through the way we touch them, like just by being next to a person they can sense … - S24*
Listening for complaints	*… we want to hear everything they say. We have a good complaints system and we encourage complaints because then we improve. – S1*
Wanting to communicate better with each other about the residents	*I think we should communicate a bit better. Sometimes. With the whole team. Sometimes someone may be sick for instance, and no one knows, or if someone passes away, no one knows. Someone needs special care. – S1* *… we used to have resident info times and it was so good because we all knew it was happening, everyone told everyone what was happening with everyone. – S1* *… the handyman is very busy but he needs to know. It would be good to have resident info time. We used to pick whoever was on assessment. – S1* *… we used to do it on Tuesdays because we had devotions. – RN1*
Nurturing	
Nurturing the residents	*I think it's good to adapt to them, to reach out to them. It takes a few minutes, and I know we're all busy. Let them know that they're cared for. – S24*
Nurturing each other	*We support each other because we all grieve when we've been close to the residents. – S23* *I think we look after each other pretty well. – S1* *… we're like family. – S1* *I think it [nurturing] has to be within you to begin with to seek out a profession in this area and then it's reinforced by the people you work with, and for. – S22* *We're very well nurtured by each other, very much. - S25* *… that's the reason I stay here. – S26*
Respect	
Listening	*… we listen to them, we give them choices and we respect them. – S1* *… some of these residents have got some great advice [to give]. – S20*
Showing love	*… we show them love and respect. – RN1* *… we treat our residents as if they are our own grandparents. – RN1*
Person-centred care	*… person centred [care]. – S23*
Valuing feelings	*… we value their feelings. – S22*
Being respectful	*… respect. – S23* *… our everyday actions. Just the way we go about our jobs, always mindful of the residents. Our connections and relations with them and our duties towards them. – S20* *… we give them dignity. – S20*

End of life	
	… we do it in a special way, we make them feel as comfortable as possible, get the families involved. - S20 *… we keep them here. That's important not to send them off to somewhere strange. Strange for the families as well as for the residents. – S1* *I think that although not everyone is involved necessarily directly in the palliative care, everyone is aware of it, and is respectful of it, and mindful of it. – S20*
Activities	
	… we just got a new resie and she came from another nursing home and she never did activities. We have lots of activities. - S20 *… we encourage families to be involved, with barbeques and a cricket match coming up. – S1*
Vision and Values	
	I think the Mission and Values should be part of our whole lives, not just while we're at work. – S25
Environment	
	… we make sure the environment is safe and secure. – S22 *… we make the families that come to visit welcome. – S23*
Biblical reference	
	… we're Christians. – S1 *… it's more than a job, it's a vocation. – S23*
Leadership	
	… we work as a team. – RN1 *… M1 has an open door policy. – RN1*
Continuous Improvement	
	… we're always improving, continuous improvement. – S1

Nurturing

Nurturing the residents and each other, at 22.44%, was the second most frequently talked about aspect of transmission of organisational culture. Most comments were about nurturing each other but it would be expected that kindness between staff members would be felt by the residents. Nurturing each other also reflected the Clan Culture of the organisation.

Respect

The third most frequently talked about aspect of organisational culture at *Greentrees* was respect, which scored 16.22%. When staff members said 'respect' they were using the word in the usual sense of *esteem*, *admiration* or *reverence*. However, there was another meaning they would have alluded to which was particular to their workplace. FaithCare introduced a program about respect that arose as a means of training staff to deal compassionately with residents living with dementia. The program is now offered to all staff and its lessons have been expanded to cover the

treatment of all residents and staff themselves. The program of respect encompassed:

- the uniqueness of each person;
- the importance of the development of self-esteem, choice, purpose and self-expression;
- person-centredness and a focus on enabling well-being in a supportive environment;
- a secure and rich environment;
- the development of trusting relationships through good communication; and
- teamwork and service

It was therefore not surprising that respect appeared quite high on the list as the program was taught to staff and actively promoted through repetition of the formal sessions and the display of posters throughout the buildings. The ways in which the staff said that they transmitted the culture of FaithCare using respect to their residents were through listening, showing love, demonstrating person-centred care, valuing feelings and being respectful.

End of life

The end of a resident's life is often hard for staff to deal with. Because of the long-term nature of residential aged care, staff and residents get to know each other well and sometimes form deep attachments. It has been helpful to staff and relatives that *Greentrees* has developed special end-of-life procedures, apart from clinical palliative care procedures, that make this sometimes difficult transition as smooth and pleasant as possible for the dying resident, their relatives and the staff themselves. Some of the methods that are initiated by staff are aromatherapy, soft music, a relatives' pack containing tea and snacks that can be prepared in the resident's room and the provision of a fold-out bed for a relative who wishes to stay the night. It is a comfort to the staff to know how to make someone's last days special and end of life scored 11.76% of the time spent during the focus group.

Activities

Staff appreciate the importance of keeping residents occupied with activities they enjoy. This is another way of passing on the organisational culture to each resident by personalising their care and fostering a feeling of inclusion.

Vision and Values

As was explained in Chapter 2, the vision and values are at the forefront of the push to reinforce culture on an almost daily basis. They are explained one by one at staff orientation, appear on posters on the walls around FaithCare's homes and are referred to during challenging times.

Environment

Staff acknowledge that the environment is important in transmitting the FaithCare culture. Residents and friends must feel safe and welcome.

Biblical reference

An explanation was given by some members of staff for the culture of FaithCare. It was framed in terms of Christianity and of their work being a vocation.

Leadership

Leadership itself was almost at the bottom of the list of ways to transmit the culture to the residents, but where mentioned, a consultative approach was valued.

Continuous improvement

Lastly, continuous improvement was brought into the discussion. Continuously striving to improve in every way is a method of reflecting statutory and organisational requirements in aged care, and of recognising and acting on the preferences of residents.

The focus group demonstrated a strong understanding of the importance of staff in transmitting the culture of FaithCare to the residents. Communication was the key component, scoring over 50% more than the next aspect, nurturing.

Staff showed by their descriptions of interactions with residents (Table 6.22) that Servant Leadership was the modus operandi of staff-resident and staff-staff relationships. Their language was very much about 'us' and 'them':

'*we communicate with them'*
'the way you speak to them, the way you treat them, we don't ignore them'
'we wait for them to respond'
'the way we touch them is important'
'we wait to hear everything they say'
'I think it's good to adapt to them, to reach out to them'

This organisation seeks to impart its culture to its staff overtly during orientation, staff seminars and performance reviews and more discreetly through the display and living of its Vision and Values statements daily and the way in which it handles staff and resident issues. The Servant Leadership model has been specifically chosen by FaithCare as the one to best reflect and enhance its culture.

Servant Leadership is seen to exemplify the organisation's position as Faith-based and overtly Christian and enables the culture to be passed from leaders to residents via management and staff using an organisational culture model devised and grown by successive leaders in senior management.

The data collected for this research enabled as many facets of leadership and organisational culture in this organisation as possible to be examined, culminating in a complex and illuminating picture of a residential faith-based, not-for-profit, aged care organisation today.

The following chapter describes what is important to residents and explores whether they think that their views are taken seriously.

Chapter 7

THE RESIDENTS' VIEW

'The more say the residents have, I feel, the better.' Resident 31

The previous chapter provided evidence of a strong link between FaithCare's chosen Servant Leadership model and its clan culture, and the transmission of that leadership model via the staff's expression and living of the culture to the residents in their care.

This chapter describes what was important to residents and explores whether they thought that their views were taken seriously.

It was essential for current residents to be involved in this research; it was important to discover the their experience of leadership by investigating the issues that really mattered to them; whether their day-to-day problems were addressed by the organisation, how the culture of FaithCare was transmitted to them, if at all, and whether they felt empowered to direct their own lives as best they could.

As discussed in Chapter 3, there is a scarcity of literature both on the role of the client as stakeholder in the leadership and management of residential aged care and on the effect of the aged care leadership model on the resident. This is not surprising as the client/stakeholder is rarely mentioned even tangentially in the literature on leadership in any organisation, aged care or not.

Table 7.1 Research questions and data sources

Research Method and Chapter	Data source and Participants
RQ3 Does the wider business community acknowledge that 'third-party stakeholders' should have a say in any key aspects of organisations?	
QUAN **Chapter 7**	Aged and Consumer Care Leadership Survey **Managers**
QUAL **Chapter 7**	IBM CEO interviews **CEOs**
RQ4 What is important to today's residents?	
QUAL **Chapter 7**	Resident interviews **Residents**
QUAN **Chapter 7**	Client surveys **Residents**
QUAN **Chapter 7**	Comments and Complaints forms **Residents**
QUAL **Chapter 7**	Observation of Residents' Meetings **Residents**
QUAL **Chapter 7**	Minutes of Residents' Meetings **Residents**
RQ5 Do today's residents have a meaningful say in decisions affecting them in their aged care home?	
QUAL **Chapter 7**	Resident interviews **Residents**
QUAN **Chapter 7**	Client surveys **Residents**
QUAN **Chapter 7**	Comments and Complaints forms **Residents**
QUAL **Chapter 7**	Observation of Residents' Meetings **Residents**
QUAL **Chapter 7**	Minutes of Residents Meetings **Residents**

The third research question is:

- (RQ3) Does the wider business community acknowledge that third-party stakeholders should have a say in any key aspects of organisations?

Two pieces of research are considered in this section: the IBM CEO Study (English 2011; IBM Corporation 2004, 2012) and the Aged and Consumer Care Leadership Survey (Cartwright 2013).

The IBM CEO Surveys

In 2010, 1,541 face-to-face interviews of chief executive officers (CEOs) were conducted globally by IBM, including 81 in Australia and New Zealand. This was IBM's fourth biennial survey of CEOs, its purpose being to provide a comprehensive assessment of each CEO's agenda for the following two- to three-year period (IBM Corporation 2004).

Evidence from the 2010 IBM CEO Study (English 2011) indicated that the challenge for the future was complexity. It was found that one of the three ways in which *standout* organisations capitalised on complexity was by reinventing customer relationships.

Recommendations from this survey about customers (their third party) included honouring customers above all else by providing an unprecedented level of focus and measuring what they valued. They also suggested using two-way collaboration to *sync* with customers by making them part of the team and soliciting customer wants.

The IBM findings and the actions suggested above point to a potential increase in the role of the client-as-stakeholder in decision-making across all industries. The same survey acknowledged that this was a direct result of greater complexity in the world and in business. It was furthermore a result of the change in client requirements, from relatively passive in the case of yesterday's clients, to actively lobbying and information-seeking in the case of tomorrow's clients. In the context of aged care, this represented the difference between our current residents, born between 1900 and the 1930s, and our future residents, the baby boomers, born between the mid-1940s and mid-1960s.

In its 2012 survey, in which 1,709 CEOs representing 18 industries from 64 countries took part, IBM found that engaging customers as individuals, improving understanding of individual customer needs and winning over the empowered consumer were among key points (IBM Corporation 2012). The insight gained from this is that it will become increasingly important for organisations to listen to their customers, understand their message and act upon it.

Aged and Consumer Care Leadership Survey

As discussed previously, FaithCare was a partner in an Australian Research Council leadership project which commenced in 2010 with the involvement of three universities and two faith-based not-for-profit organisations providing aged and community care. The purpose of this ARC funded research was to develop a leadership capability framework for not-for-profit Australian health and community care organisations. A survey of Australian aged and community care CEOs was conducted in 2011 as part of this research. This represented an opportunity to compare more relevant industry-based Australian results with the IBM global CEO survey.

The Aged and Community Care Leadership Survey was sent to 500 Australian CEOs by email, using Qualtrics® online survey software. The CEOs were asked to complete the survey themselves or pass it to a board member or senior manager. Two email reminders followed where necessary. The questions were developed from the analysis of focus group and pilot study data. Results of the pilot and focus groups are available elsewhere (Shaw et al. 2013).

My contribution to the ARC research was very small; however three questions in the survey were of special relevance to this research and I had the opportunity to request that a *client/consumer* response column be added to the following questions:

1. What is the existing role of stakeholders in crucial management decision-making?
2. Which stakeholders should have a role in management decision-making?
3. Which stakeholders should have a role in decision-making around the mission of the organisation?

It was important for me to investigate whether CEOs and senior managers in aged care considered that there was a place for the consumer's voice to be heard and acted upon.

Survey responses were automatically entered into a password-protected, de-identified database, a feature of the Qualtrics® software. Results were analysed using SPSS for Windows Version 15. Of 500 CEOs who were sent the survey182 responded (a

response rate of 36.4%). The respondents were CEOs (46%), senior managers (40%) and board members (13%). Ninety five per cent of respondents worked in the aged care sector.

From Table 7.2 it can be seen that 36% of respondents believed that clients (community clients or residents in aged care) already had a say in strategic planning in their organisations.

Table 7.2 Stakeholders' decision-making now

What is the existing role of stakeholders in crucial management decision-making?					
	Stakeholder groups				
Decision-making areas	CEO	Board	Senior Manager	Local Manager	Client
Strategic planning	**84%**	**87%**	**77%**	**43%**	**36%**
Defining organisational performance goals	**88%**	**74%**	**68%**	**32%**	**17%**
Defining organisational performance measures	**84%**	**63%**	**71%**	**29%**	**11%**
Determining how to balance competing demands of stakeholders	**80%**	**48%**	**75%**	**45%**	**8%**

This result was only seven percentage points below the response of 43% for *local manager*. In the other three categories under the existing role of stakeholders in management decision-making – defining organisational performance goals, defining organisational performance measures, and determining how to balance competing demands of stakeholders – the results for client involvement in management decisions were 17%, 11% and 8% respectively. While the overall strategic plan is, in the opinion of CEOs and senior managers, something that client stakeholders had some input into, the areas of performance goals and measures and balancing competing demands of stakeholders were not areas in which there was substantial input. These last three were operational issues and less likely to be accessible to clients than the more vision-oriented first category, strategic planning.

From Table 7.3 it can be seen that 53% of respondents felt that clients (community clients or residents in aged care) should or could have a role in strategic planning as part of management decision-making in their organisations.

Table 7.3 Management decision-making

Which stakeholders should have a role in management decision-making?					
	Stakeholder groups				
Decision-making areas	**CEO**	**Board**	**Senior Manager**	**Local Manager**	**Client**
Strategic planning	**85%**	**85%**	**78%**	**63%**	**53%**
Defining organisational performance goals	**85%**	**70%**	**73%**	**53%**	**30%**
Defining organisational performance measures	**83%**	**70%**	**74%**	**50%**	**33%**
Determining how to balance competing demands of stakeholders	**84%**	**56%**	**76%**	**53%**	**26%**

Surprisingly, results in all categories for client stakeholders were substantially higher than for the previous question, indicating that many respondents considered that client stakeholders should have a greater voice in all these areas of management decision-making. However, it was interesting that only a third of respondents said that clients should have a role in defining organisational goals and measures and of determining how to balance the competing demands of stakeholders when it would seem that clients were well placed to provide input into defining goals and developing tools or measurements that would determine how well an organisation was performing with regard to their needs. Indeed, the development of performance measurements without the input of clients would suggest that the organisation is focusing only on part of the overall picture.

From Table 7.4 it can be seen that 38% of respondents believed that clients should have a role in determining the mission of their organisation.

Table 7.4 Decision-making around the mission

Which stakeholders should have a role in decision-making around the mission of the organisation?					
	Stakeholder groups				
Decision-making areas	CEO	Board	Senior Manager	Local Manager	Client
Determining the mission	**89%**	**97%**	**69%**	**42%**	**38%**
Supporting achievement of mission	**97%**	**82%**	**93%**	**83%**	**36%**
Monitoring organisational progress against mission	**93%**	**87%**	**73%**	**29%**	**20%**
Interpreting the mission where concrete decisions have to be made	**97%**	**65%**	**69%**	**18%**	**6%**

Thirty-six per cent felt that clients should have a role in achieving the mission in their organisation, indicating at the very least that clients would be expected to have an understanding of FaithCare's mission. Twenty per cent of respondents thought that clients should have a role in monitoring organisational progress against the mission of their organisation. The interpretation of the mission where concrete decisions had to be made, with only a 6% positive response, was seen as best left to others. This may indicate that concrete decisions were made by managers on the run and day-by-day.

These data support the view that the client- or resident-stakeholder has a role to play in aspects of management decision-making around strategic planning and the mission of the organisation. It points to the CEO/board member/senior manager group being prepared to give a stronger voice to the resident-stakeholder and is in line with the IBM CEO Survey findings.

Table 7.5 sets out the source and origin of data pertaining to residents. This data set addresses the fourth and fifth research questions:

- (RQ4) What is important to residents?
- (RQ5) Are residents' comments and concerns listened to and acted upon?

Table 7.5 Data relating to residents

Name of data	Collected by …
Resident Interviews	The researcher at *Greentrees*, *Goldtrees* and *Bluetrees*
Client Surveys (CSs)	FaithCare
Comments and Complaints Forms	*Greentrees*
Minutes of Residents' Meetings	*Greentrees*
Observation of Residents' Meetings	The researcher at *Greentrees*

Revisiting the OCAI

The OCAI (Chapter 6) was considered a valuable way of capturing a snapshot of FaithCare's culture and leadership. I wondered whether the OCAI could be completed by the residents to indicate their awareness of the organisation's culture.

Two of the most able residents were invited to complete a modified version of the OCAI. Instead of asking them to allocate 100 points to each domain, the task was simplified by asking them to allocate just 10 points. Despite their best efforts, they found it too difficult. From observation it was decided that the problem stemmed from having to hold four quite complex, two-sentence descriptions in their thoughts simultaneously while deciding how many of the 10 points to allocate to each.

A different attempt was made with a third resident. Key words were chosen from each descriptor in each domain; these were typed onto individual cards and the resident was asked to sort them by importance and relevance to *Greentrees*. This yielded no useable data because the resident weighted almost all words equally and provided a long verbal description of the meaning of each word. The idea of asking residents to take part in the OCAI was then abandoned.

Resident interviews

Each resident who participated in an interview was chosen purposively in consultation with the home manager and with the help of senior administration or care staff. The consultation process took into account the health and strength of the resident, their cognitive status and willingness to participate; it also sought to provide

as wide a range as possible of interests, background and potential attitudes about each interviewee's present life situation.

An information sheet (see Appendix 1) was provided and the selected residents were invited in writing to participate. If necessary, one reminder call was made. If there was no response after that, it was assumed that the resident did not wish to participate. Residents who did wish to participate completed their name and phone number on the slip attached to the information sheet and gave it to the receptionist or a staff member. I collected the slips from reception and telephoned residents to make an appointment at a mutually convenient time.

As the interviewing proceeded, each subsequent resident, following Dick's (1998) strategy, was contacted by telephone to make an appointment. All but two residents were interviewed by me in their rooms; one chose to be interviewed in the communal lounge area and another, who lived in a share room, was interviewed in the chapel. There was no one else present at the interviews.

After a brief introduction and answering any questions, I requested that the Consent Form be read and signed. This happened in all cases without incident. For the first few minutes the resident and I engaged in informal conversation about the weather or what they had been doing lately. The resident was then asked if they were ready to begin and each interview started with the same broad opening question (see text box below). The resident was encouraged by the use of eye contact, nodding and interested vocalisations, to keep talking for as long as possible. It had been decided in consultation with nursing staff before completing the ethics applications, that 45 minutes would be the maximum duration of any interview. After 30 minutes, or if the resident was wandering off-topic, I began to introduce prompts if any points had not been covered.

The questions and word prompts appear in the text box below.

Questions for residents

Open question:

- Tell me about what it's like for you to live here.

Possible prompt words:

- Food, activities, entertainment, visitors, communication, facilities, staff, accommodation

Possible prompts:

- Following Dick's point 10 (below), seek information around previous interviewees' points of agreement and disagreement.

Residents were interviewed until saturation was reached, but keeping to the suggested timeframe of 45 minutes so as to avoid tiring them. At the end of the interview, each resident was thanked for their participation and, if appropriate, accompanied to their next activity. The interviews were transcribed as soon as practicable afterwards and entered into NVivo9 for coding.

The residents who were interviewed live in three aged care homes owned and run by FaithCare. Table 7.6 shows details of the three aged care homes used in this research.

Table 7.6 The three aged care homes used in this research

Location	Km from centre of Sydney	Number of residents	Level of care	Code name
Urban fringe	100	65	Low care Ageing in place + Dementia wing	*Greentrees*
Suburban	17	65	Low care Ageing in place + Dementia wing	*Bluetrees*
Rural NSW	350	50	High care + Transitional care	*Goldtrees*

Residents who participated in interviews ranged in age from 80 to 95 years and had lived in their aged care home for between six months and 12 years. Fifteen residents were interviewed, nine women and six men (Table 7.7).

Table 7.7 Code numbers and demographics of residents

Resident Code	Gender	Approximate age	Home code
R8	M	Mid-80s	*Greentrees*
R9	M	Mid-80s	*Greentrees*
R13	F	Early 90s	*Greentrees*
R15	F	Early 90s	*Greentrees*
R31	M	Late 80s	*Greentrees*
R36	F	Mid-80s	*Greentrees*
R40	F	Mid-80s	*Greentrees*
R48	F	Late 80s	*Greentrees*
R58	M	Mid-80s	*Goldtrees*
R59	M	Early 80s	*Goldtrees*
R60	M	Mid-80s	*Goldtrees*
R61	F	Mid-80s	*Bluetrees*
R62	F	Late 80s	*Bluetrees*
R63	F	Mid-80s	*Bluetrees*
R64	F	Late 80s	*Bluetrees*

All participating residents had been married and, with one exception, were widowed. Most had the support of their children, albeit intermittently, two were childless and two were estranged from their children. This information was offered by the residents during their interviews.

Convergent interviewing was used for the resident interviews. The interviewing followed many of Dick's (1998) 13 defined steps. These 13 steps follow, with my comments or modifications in parentheses:

1. Choice of the reference group drawn from the group under investigation (residents from three of FaithCare's aged care homes were chosen).
2. Information to be collected defined in general terms.
3. The target population is defined.
4. Inform the stakeholders.
5. The sample is chosen – the most representative of the population is the first to be interviewed. (I was helped in my choice of residents by the manager and senior staff. The first resident interviewed was the most representative.)
6. Select and train interviewers. (Selection of interviewers was not done as I was the only interviewer, despite Dick's advice to work in pairs to reduce bias.)

7. The interview is planned by deciding on the opening question and then determining some possible probe questions.
8. The interviews are conducted. The procedure to be followed is to set the person being interviewed at ease, ask the opening question, keep the person talking, invite a summary, follow up on doubtful or ambiguous issues and ask probe questions to seek out further information if necessary.
9. Interpret each interview in writing as a report. (The interviews were audiotaped and then transcribed and entered into NVivo. I took some notes during the interview and these highlighted to me points for follow-up at the end of the interview.)
10. Compare interviews, paying particular attention to information occurring in more than one report. Devise a probe question based on the following: when the reports agree, attempt to find out what circumstances would lead to disagreement; when the reports disagree, seek to explain the discrepancy.
11. Review the process and modify the approach. (My approach was modified only slightly as a result of questioning about previous information gathered – step 10 above.)
12. Recycle by returning to step 8. This is the central cycle of the technique. Keep going until two succeeding interviews have added no significant information. (I refer to this as saturation.) Then go to step 13.
13. Compile a combined report. (I combined residents' responses into nodes and then themes.)

The following provides an analysis of themes that came to light during resident interviews. This data set relates to the fourth and fifth research questions:

- What is important to today's residents?
- Do today's residents have a meaningful say in decisions affecting them in their aged care home?

A summary of themes appears in Table 7.8, after which each theme is examined in more detail.

Morse (2003) p. 194 warns that:

> … when using qualitative data, researchers are often tempted to count – to know exactly how much or how many – which gives the appearance of rigour. But this is actually a perilous activity if assumptions are not adhered to. Ask "Were all of the participants asked the same question?" If not, then such data cannot be quantified in a meaningful way. What is the *significance* of such quantification?

The significance for this research of quantifying the data in terms of number of responses and number of sources (different residents) is to show how many participants (sources) mentioned the subject and how many times the subject was mentioned in total. This is important because if only one resident mentioned a subject many times, the interpretation would not be the same as if all, or almost all residents mentioned the subject on fewer occasions.

Table 7.8 Themes - Residents

Themes	Number of sources *Resident n=15*	Number of responses
Activities	15	56
Staff	14	52
Food	14	45
Environment	12	35
Quality of Care	12	31
Emotions	12	28
Communication	11	31
Other themes:		
Organisational Culture... Vision & Values	9	18
Independence	8	25
Change from the past	8	22
Leadership	8	14
Feeling at home	5	15
Change into the future	5	11
Power	4	5
Self-denial – thinking of others	3	6

The seven top themes are discussed below. These were mentioned by most residents many times. This is followed by a shorter discussion of the remaining eight themes which were mentioned by fewer residents and less frequently.

Activities

The theme of 'Activities' was mentioned most frequently by residents. Fifteen residents made 56 comments (the responses) about activities and they fell into seven nodes.

Table 7.9 Activities

Nodes	Responses
Sympathy and appreciation for the activities staff who coordinate activities.	*S1 finds it difficult now to get people out of their rooms. – R13* *One commends the effort to provide a program with activities and outings. – R9* *It's hard to stimulate them. – R31*
Some of the history of activities at the home.	*We eventually got a bus here and we'd go out in the bus. – R13* *We'd go away on little holidays each year. – R13* *Before, we were playing games after tea. – R13*
Activities conducted at the home that are enjoyed at present.	*I go on the shopping bus. It's only for an hour. – R15* *I think the availability of a library is a good thing. – R9* *Yesterday I went to the church service here. – R36* *They play cards. I haven't been down there. – R58* *I do bingo, indoor bowls, carpet bowls. – R59* *A lady came and arranged a penfriend for me. – R60* *They organise excellent activities. – R58* *They have garden walks, men's club, set things, the hairdresser comes. – R61* *They have movies. Multicultural Day. – R61* *If you don't have anyone to take you shopping, they will take you. – R61* *They take us on bus trips. – R63* *V1 [volunteer] is starting a men's club. – R8*
Disappointment about activities.	*I thought the bus would be great, but they haven't used it much. – R13* *Sometimes the shopping bus gets cancelled. – R15* *They try to get me to go to Bible Study but I can't see to read the Bible. It's very difficult. – R15* *In the holidays there's a period of inactivity. – R31* *A lot of the activities that we had, we don't get them the same as what we used to. – R40* *We used to go out and have lovely picnics which of course you can't do with the weather at the moment but we used to have nice times but now they are curtailed. – R40* *I get bored at times. – R62* *There's not enough outings. – R8*
Activities they do under their own steam.	*I find myself a little embarrassed by not wanting to be involved in the activity, not because of the activity but because of course I've got other things to do. – R9* *I do a lot of reading, and I do a lot of writing. – R9* *I make a point of going out one day a week, simply to get outside. – R9* *I do my painting here in my room. – R36* *I've got my sewing machine and I've got the computer. – R64* *I keep myself occupied. That's the secret of the whole thing. – R8*

Increasing frailty of residents.	*You see a lot of people aren't up to it now. – R13* *I'm not as free to do the things that I used to do such as walking up the shops. – R31* *I used to do a lot for the craft but I haven't done any for quite a while because I just haven't been in the mood to put a stitch in. - R48*
Suggestions about future activities.	*I think we could expand the facilities of the shopping bus and getting out onto picnics and things like that. – R31* *More outings. – R60* *Childish things like Bingo, I don't think the Baby Boomers are going to be interested, to keep them interested. – R61*

The activities provided by aged care homes are very important to the residents. The responses above indicate that residents want variety and lots of things to do. They acknowledge the increasing frailty of people in aged care and problems such as poor vision. There seems to be a need to provide activities as people become less able to get out or join in.

Staff

Fourteen out of the 15 residents made 52 comments about the staff. These comments fell into four nodes.

Table 7.10 Staff

Nodes	Responses
Positive comments about the staff and the environment they create.	*The girls here are very good, they do all the dusting and everything. – R15* *One never gets the impression that you're a nuisance. – R9* *[S1] is very good at stimulating people and she goes around and she raises her voice in a good way. – R31* *I feel quite happy that they do try to respond. – R36* *A lot of the old staff, they're very good and you don't have to tell them what to do because they've been trained so well. – R40* *I found the staff the same, excellent. – R58* *The things they do for you. They help you out when you're crook or anything. – R60* *The nursing staff are always on hand. – R61* *They're very fond of me. – R62* *It's not an easy job the way they have to contend with us, we get old and we get a little bit difficult don't we. – R63* *They have a nice attitude to each other. – R63* *You wouldn't get a better crew. – R8* *Every one of them is beaut. – R8*
Lack of staff.	*The girls haven't got time. – R13* *I said again and again she should have had a person with her. They'd say we can't afford the staff. – R13* *I don't think there's enough staff. There should be a lot more staff I reckon. – R48* *They've got to fly up to one place and fly down to another. – R48* *I said it's the staff – there's not enough of them and then they're not managing what they've got either. – R58*

	They have lack of staff. The government cuts down on staff. – R59 *It's lack of staff. They're willing but there are only so many of them. – R59* *At no time have so many had to be helped by so few. – R59*
Understanding the difficulties faced by staff.	*She hasn't had the experience and it's not an easy job. – R13* *Sometimes I think there are too many chiefs and not enough Indians.- R36* *I feel the present Chaplain's got far too much to do. – R40* *You can't tell one [member of staff] from another now. – R40*
Dealing with difficult staff	*If you don't get on with them, it's a real problem. - R58* *I said it's not going to work and she grabbed hold of me by the arm, she was told not to come near me. – R58*

The residents were, on the whole, very happy with the staff and understood the difficulties faced by their carers, especially when carers were very busy. Eight residents talked about their perception of understaffing. One resident noted the difficulty of telling one level of staff member from another when all staff wore the same uniform.

Food

Fourteen out of 15 residents made 45 comments about food and these fell into four nodes.

Table 7.11 Food

Nodes	Responses
The way the food is presented.	*The lady who did our meal today said there were a lot of complaints about the beans today and there would have been. They don't use soda so they're not a good colour and the people won't eat them. – R8* *I don't hear complaints or criticisms, except for a passing reference to whether the meals are hot enough. - R9* *Although we've got heaters to keep meals hot, meals get cold. – R31* *No more quiches with half an inch of sopping wet pastry at the bottom. – R36* *It's terrible steak sometimes. You'd swear blind it's 20 years old. When it's cooked it goes almost black. – R62* *They could improve a little bit more – sweet and sour pork or curried prawns and rice. – R60* *Usually it's all the same. If you don't like it, you leave it. – R62* *But the other things that I'm not particularly happy at times is the food. – R63* *For a month now I've had a permanent order for salad and I like a bit of meat and there's very little comes up with it but I've got my niece to bring me in slices of ham and I've got them in individual packets in the fridge there and I just take it out.- R64* *It would be nice if you had a choice, which isn't always possible. – R13*
The lack of a home-cooked style of food.	*Well, I wouldn't say we're ill fed or anything, it's good food, but we never get anything home cooked and the food comes up and it's warmed up. – R13* *Just lately we've had a lot of, the meat is usually stewed – we haven't had the baked dinners that we used to have. – R40*

	You couldn't get a crumbed cutlet. - R13 *The only other thing I've found hard getting used to is the meals. – R31* *You become fond of something at home but when you come here you get it every day. It's not cooking, it's just putting it out. – R62* *If I was living by myself still, I would choose another style of menu. – R9* *There should be provision for a relative or next of kin to come and have a meal privately. – R8*
Positive comments about the food.	*A couple of times they've brought me dainty little sandwiches. – R13* *I can't complain about the food, the food is really good food. – R61* *We had lamb yesterday and it was absolutely beautiful. – R15* *People have a regular seat in the dining room. I think it's good to have a regular seat in the dining room. – R31* *I haven't got any complaints about the food. – R58* *They take into account what a particular resident likes. – R59* *No complaints about the food but I have put on weight. – R64* *I have no complaints because the meals are lovely. I eat everything and they know it too! – R8*
Understanding about the problems with food	*They haven't got any control over it because it comes from the kitchens down [the hill]. They've got the facilities to cook here but they don't. – R15* *With regard to meals, I think I recognise that catering for an institution cannot produce … the same quality. – R9* *[Baby Boomers] might have to accept a change of diet. That's where you've left your home and your own cooking... – R9* *It would be better to have the meals cooked on-site but I don't think it's practical. I think the quantity of the meals have improved. – R31* *It would be lovely if it [cooking] was done here. – R36* *It's unfortunate that they have to bring it in but you have to have that. – R36*

Residents complained about the quality, presentation and temperature of the food and lamented the lack of 'home-style' cooking. Four of the eight positive comments were from residents who lived in a home where there was a cook or chef. While many were grateful for the efforts made to provide good food, they acknowledged that the external catering used in one of the homes did not allow much scope for improvement and they would prefer an on-site cook. One resident mentioned that the food would not be what the baby boomers were used to.

Environment

Twelve residents made 35 comments about the environment of the home; these fell into three nodes.

Table 7.12 Environment

Nodes	Responses
Dissatisfaction with the environment	*Now when they decided they'd put in all new curtains, I would have liked a say. – R13* *The curtains – they changed them, I know they had to be fireproof, but they could have matched. They don't match our lounge room. – R15* *When I was confined to my bed, I lost some clothes because I didn't have them marked. – R31* *They say we'll make the staff room the palliative care, take the craft room and make it into a staff room and we'll enlarge the coffee shop and then six months later nothing's done. – R36* *They could make a lot of changes. Bigger beds. – R60* *The laundry is very bad. I've lost about nine new nighties since I've been here. – R62* *I don't like the carpet on the floor because with my wheelchair, I can't turn it around. It clogs the castors. – R64* *I said, 'Well, at my expense can I have it taken up and lino or boards put down?' No, it'll upset the décor of the place. The décor of this place is how they sell it. – R64*
Suggestions for improvements.	*To alter the buzzer system. It would be a good thing. – R13* *They had rooms for couples too. – R13* *They were lovely, it was nice for the couples - they'd lived together all their lives. – R13* *She could have stayed overnight on a little stretcher bed and gone back the next day. – R31* *Married couples wanted to be in a place on their own. – R40* *There's so many people that are around now, workers. I know they've got to come in but you don't really know who they are. And visitors come and go. – R40*
Satisfaction with the environment.	*The volunteers have been very good. They've raised a lot of money. – R13* *Those stained glass windows, things like that, were all by volunteers' money. – R13* *I think the grounds are spacious enough for people to stretch their legs. – R9* *In fact I think I've got the best room in the whole set-up, I look out on a beautiful garden. – R9* *It's a nice room. - R36* *I've brought all my own pictures, I lie in bed and I look at those. – R61* *You stay in the same room forever. – R61* *It's very, very clean, they look after the place. – R63* *Now concerning the place – delightful! – R8*

Two residents commented that they would have liked a say about new curtains but were not asked for their input. Others complained about the laundry losing their clothing. One resident cynically noted that she had requested different flooring so she could manoeuvre her wheelchair but was refused because 'the décor of this place is how they sell it'. The residents had many ideas about how to improve the home. Many people were positive about their environment. They appreciated the fund-raising efforts of the volunteers. They appreciated being able to bring things from home, the cleanliness of their rooms and the gardens.

Quality of care

'Quality of care' was mentioned 31 times by 12 residents and the comments fell into two nodes.

Table 7.13 Quality of care

Nodes	Responses
Satisfaction with the quality of care	*I remember when I was in hospital once, RN1 rang every day to see how I was. – R13* *From what I hear of other places I think we are very well looked-after. - R15* *I admire the way the staff look after the elderly ladies especially. – R9* *We are well looked-after and I have no doubt about that. – R31* *I get helped with a shower if I want it. I don't always want it. – R36* *I think working with old people, you've got to be very careful. – R40* *I've always had people to look after and now people are looking after me. – R48* *The things they do for you. They help you out when you're crook or anything. – R60* *I have a physio that comes twice a week, and I feel a lot better since the stroke. – R63* *A couple of things have happened to me … and here I am and what happens? – it's attended to on the spot, you're not chasing doctors and appointments, your medical care is excellent. – R8*
Dissatisfaction with the quality of care	*I don't think the staff here realise how lonely it is. – R15* *The people that are well have to let go of a lot of things because the staff can't do it for everyone. – R4* *A couple of times I fell out of bed and I was on the floor and I had to ring the bell. – R48* *They don't cut your fingernails here. - R62* *The girls don't always come straight away if you buzz because I realise there are only 2 or 3 of them and 18 or 19 of us. – R64* *All that's so embarrassing that when I first came here I think they almost gave up on me. I still don't like it. When the men were doing it [the personal care], the bottom fell out of my world. – R64*

The quality of care was mainly good but the residents perceived several areas for improvement, mainly to do with having their call bell answered quickly and having their expectations met by staff. They tried to be understanding about the number of staff members trying to deal with many frail people. Two residents mentioned the difficulty they had accepting personal care from male carers.

Emotions

The theme of 'Emotions' was mentioned by 12 residents 28 times and the comments fell into two nodes.

Table 7.14 Emotions

Nodes	Responses
Feeling positive emotions	*I've been very happy here. – R13* *Since I've been here I've enjoyed it really. – R13* *I'm a very contended man here. – R9* *I came of my own will of course, nobody forced me into it. – R40* *I love living here. – R48* *They said that it'd be better for me to come here, I'd be safe here. I was happy with that decision. – R48* *I think it's your attitude mainly. – R61* *And I thought I must try to be contented here, they do all they can to make you happy. – R63* *I feel secure here.- R63* *I'm reasonably happy. You get used to circumstances. – R64* *And I call it home because I'm quite happy. I'm very fortunate. – R8*
Feeling negative emotions	*I hated it, I didn't want to leave my home. – R15* *You never get used to it. It's pretty lonely. – R15* *I liken this to being in gaol because your freedom is restricted. – R3* *It was quite a shock because I never ever thought that I'd be coming to a home. – R61* *I was very annoyed when I first came. – R62* *I find it hard to adjust but I'm slowly adjusting to it. – R63* *I've just accepted what has to be. It was inevitable that I'd come in to one of these places. Because I knew that I couldn't go on forever. But it came quicker than I expected. – R64*

Seventeen comments indicated happiness, contentment or an acceptance of the inevitable. Residents in this age group seemed to be a stoical group and talked in terms of 'attitude' and getting used to 'circumstances'. Only 11 responses indicated discontentment, unhappiness and the difficulty of entering and getting used to living in an aged care home. Loneliness was mentioned by one resident.

Communication

'Communication' was mentioned by eleven residents who made 31 comments about it. The responses fell into four nodes.

Table 7.15 Communication

Nodes	Responses
Communication generally	*I read most of it [the monthly magazine]. – R40* *I think that knowing what's happening is the most important thing. – R40* *If we're not happy, you tell them and they do their best to make it good. – R63* *If there's anything I'm not happy about I ask the person direct. I feel that they follow it up. – R63* *If anything is wrong, they fix it up. – R63* *That would be a very good idea if we were able to voice our opinion. – R8*

Lack of communication	*It isn't easy to find out how someone is when they're in hospital. – R13* *That was another thing that M1 cut out, committee meetings. M6 used to come and tell us what was happening. Now we don't know what they're doing. We always knew what they were going to do and what it was going to cost. She was always so open about it all. Now that doesn't happen anymore. – R15* *S9 just disappeared and that was it. Nothing was said. – R15* *I think there's a weakness there [communicating to residents about their hospitalised friends]. – R9* *We have had some feedback about her [a resident in hospital] but I wouldn't say there has been a lot. – R9* *Information about our friends who go to hospital or even if they're badly sick here. – R31* *There could be more communication, I think that's very important. – R40* *The new staff that come, for a little while, someone used to bring them around and introduce them at each mealtime but that seems to have fallen away now. We just see these new faces and we've got no idea who they are. – R40* *You never get to know anything here. – R62* *I don't think they listen to you very much. – R62*
The Residents' Meeting	*You don't get many to the meeting. – R13* *They have an opportunity at the Residents' Meeting to provide input and they can also use the pink form which some of them do. – R9* *We get a good attendance and good participation. – R31* *There are some people who tend to hold the floor more than others. But still that's the province of the chairman. – R31* *It's an information thing rather than a decision thing. We could give an opinion. It's up to the top management [of the organisation] to decide. – R31* *I used to go [to the residents' meetings] regularly and then I realised they were a farce and I no longer go. – R36* *I've been to about four [residents' meetings] since I've been here. They're very good. I don't see too many [residents] put themselves out. – R63*
Comments and complaints forms	*We've got the pink slips and if they do them the way they're supposed to, this is RN1's province, she does that. Sometimes it's a bit slow in collecting all the complaints or compliments, but I haven't had any experience much. – R31* *We've got those pink slips and I've used them to great effect. The pink slips are successful. – R36* *I don't know what happens to it, I have never heard anything about a complaint. – R62* *They ask you to fill in a complaint form. – R63*

Many examples of lack of communication were mentioned by residents and they had strong opinions about the subject. It was very important to them to be told how their fellow residents were if they were unwell or in hospital and they said that this did not happen. One resident mentioned a greatly loved staff member who disappeared without warning or explanation. This was as a result of a disciplinary matter and could not be discussed with residents or staff. One resident wished they could voice their opinion. The opportunity to participate in the Residents' Meetings was appreciated, although one resident called them an 'information thing rather than a

decision thing'. Another resident called them 'a farce'. Overall, the residents said that communication could be improved. Opinion was divided about the usefulness of the pink Comments and Complaints Forms (discussed later in this chapter).

Other themes:

Organisational culture

Nine residents gave 18 responses about the organisational culture, including the vision and values, and there was only one node. Residents were shown a copy of FaithCare's vision and values statement during the interviews and some chose to discuss aspects of it. As explained previously, the vision and values were in evidence all around the home both in printed form and discussed and followed by staff members.

Table 7.16 Organisational culture

Node	Responses
Organisational culture, prompted by reading the 'Vision and Values' statement	*If you can read it, it's good. They put one up in the hall down in [a section of the home] near the kitchen but you'd have to stand on your toes to see it. – R13* *I was very pleased with this because people coming in will see this and read it and it would set the level for them as it were. – R9* *M1 expresses herself through [the monthly magazine] and she has an emphasis there that's consistent with the message. – R9* *I love the new Chaplain. I love that it's a Christian place. – R36* *I think if they're nice sweet people they behave sweetly, and if they're not they don't. I don't think they think about the mission and values. – R36* *And I wanted to go into a … [church run] place … down the far south coast at Bega, there wasn't any really. – R40* *Communication that is open and on a two-way basis, I don't think we've had that really. – R40* *They do have messages up on the different walls, in the Chapel they have them – maybe the wording isn't exactly the same – mutual respect and trust, I've seen that. – R61* *I dare say it's the Christian part because it's not an easy job, the jobs they have to do, it's not easy. – R63* *They work as a team together. – R63* *There's something like that in reception downstairs, not worded like that, but that's what it means, mutual respect, that's it. – R64* *I'm in favour of that. … you know where you stand … Everybody knows how far they can go. – R8*

Residents were interested in the vision and values of FaithCare. Reading through them gave these residents the opportunity to comment on them and prompted

discussion about the Christian emphasis of the organisation, communication, teamwork, behaviour and the chaplaincy. One resident said that communication could be improved.

Independence

The theme of 'Independence' was mentioned by eight residents whose 25 comments about it fell into two nodes.

Table 7.17 Independence

Nodes	Responses
Maintaining independence – making your own decisions	*I was told in Sydney that I could come and go from here. I could have my independence. And that in a sense became my rule of guidance. – R9* *I can't write. I can write on the computer. – R59* *It's just like being home and no shopping and no worrying, I can come and go as I like. – R61* *I thought while I can do something I'll do it. – R61* *You tell them what you want – they have an idea of what you want for your breakfast. – R61* *It's up to the individual. – R61* *At home I did all my own housekeeping and gardening and now I don't do a darn thing. – R64*
Losing independence	*The only thing you miss is not having a home base, you have to go to the children if there's anything important, but before they would come to you. – R13* *Even the carpet could just have been dry cleaned* [the home made a decision contrary to the wishes of the resident]. – *R13* *I had a problem with not being able to see, they don't want me to do my own medication. I'm capable because it comes in blister packs.- R15* *I got into trouble one night when I got back after 7 o'clock but I hadn't signed the book and they phoned my daughter. – R9* *I would not choose to live here were I not in no condition to live alone. – R36* *It's been very hard to get over that because I thought I'm no longer a real person. – R36* *My problem is I'd like to get up early but I realise I can't do that because at that time there are only five of them in the whole place. It's about 10 o'clock when they get me up. – R59* *The physiotherapist wants me to do this both arms 10 times, four times a day. It's sodding useless, I can't even brush my own hair. – R64* *I hate the fact that I've got to get undressed in front of them and they have to wash me and clean me up because I can't lift myself up on the toilet. – R64*

In some instances a loss of independence arose from the person's medical condition – one resident has a long-term chronic physical challenge. Other residents actively tried

to maintain their independence. One resident mentioned their blindness and having to be helped with his/her medications, despite a preference to do things independently. Those who could remain independent in any way would rather do so.

Change from the past

Eight residents made 22 comments about the changes they had experienced from the past; these comments fell into one node.

Table 7.18 Change from the past

Node	Responses
Changes from the past	*When we came in we were reasonably well. – R13* *I came here because my family said I couldn't live on my own anymore and I had to be looked after. – R15* *When I was outside I used to forget my medication and this upset my daughters greatly. – R9* *I have found this rather difficult to get used to but it's one of the things I realise I just have to do it as I said because of my ageing it brings it about. – R31* *Things change. – R40* *I know that if I got old and couldn't do things for myself I'd need a place. – R40* *It was much nicer when I first came here about six years ago. – R40* *More and more there's less people that are coming in here that can do things for themselves. – R40* *There's been so many changes. – R40* *I have never been in a place before, I've always been at home and it's a very hard transition. – R63*

Residents acknowledged the change that had taken place in aged care homes over the previous decade from a home for relatively independent people to a place for the frail older person. They also spoke about their own ageing and loss of autonomy.

Leadership

'Leadership' was mentioned by eight residents 14 times; the responses fell into one node.

Table 7.19 Leadership

Node	Responses
Leadership	*She [M1] hasn't had the experience and it's not an easy job. – R13* *I haven't got any opinions for or against M1. She's been different to, different characteristics to M6. – R31* *It could improve by installing a way of informing every little carer of what she's supposed to do. – R36* *But you felt for her [M1] really and I suppose she had to get to do what the bosses said. She's got a young family which doesn't help, does it? – R40*

	I don't think she's [M1] had the time to get to know us really. M6 knew everything in the place that was happening. – R40 *I think the first lady, the head lady [M6], I thought she was lovely. – R48* *You gotta have someone who's a leader, somebody that you can talk to which is good. – R48* *I don't think the new one [M1] has as much discipline to make the girls do what they're supposed to do because I don't think they're doing their job good enough. – R48* *It is a well-run place. They change things quite often to make it easy for the staff and the workers. – R58* *M6 always said you are a family, you live in* Greentrees *, you are a member of a family and this is your home. – R8*

Some residents compared the previous manager of *Greentrees* to the current manager. The previous manager [M6] came on board as the home was being built and it developed under her guidance from the arrival of the first resident to the full complement. As a result, she knew every resident very well. The new manager of course arrived to take over a full home with over sixty residents and several residents noted the differences in leadership between M6 and M1.

Feeling at home

Five residents made 15 comments about feeling at home; these fell into one node.

Table 7.20 Feeling at home

Node	Responses
Feeling at home	*I got to choose my room which was fortunate. – R13* *A lot of things should be in the hands of the residents because it's our home. – R13* *It is my home. And I want to think of it as my home. – R36* *From the time I came here I felt at home. – R61* *It's just like being home. – R61* *I did feel at home, they made me feel very welcome. – R61* *Naturally as you would understand it's very hard to leave your home and come here and get used to being away from home. – R63* *I'd like to be home and I'd have to have people to look after me 24 hours a day and I don't know how that would work out. – R63* *I feel secure here. – R63* *When I first came here it was very homey. The atmosphere. – R8* *This is not only a place for aged care people but it's a home. – R8* *M6 always said you are a family, you live [here], you are a member of a family and this is your home. – R8*

The residents liked the home-like atmosphere and the attempts made by management and staff to encourage the resident group to think of themselves as a family. One long-standing resident appreciated being able to choose her own room – this occurred

because she was one of the original residents.

Change into the future

Eleven comments were made by five residents about 'Change into the future'; these fell into three nodes.

Table 7.21 Change into the future

Nodes	Responses
The future of aged care generally	*I think these places will be eventually phased out and it'll be all nursing homes, they'll keep people in their own homes. – R13* *How well are they going to be, people are living so much longer. – R13* *The government wants to keep people in their homes, but it wasn't any good for me. – R40*
Requirements for the future	*Even this oxygen business - they'll have to have that coming out of the wall. – R13* *They'll need computers so they can send emails. – R13* *It's on its way. The younger generation will change it. – R58* *Childish things like Bingo, I don't think the Baby Boomers are going to be interested, to keep them interested. – R61* *Married couples wanted to be in a place on their own. – R40* *Baby Boomers will. I think they'll be quite demanding. – R13* *They're [boomers are] used to having everything. – R13*
Concern about their own future	*My trepidation is that I'll lose my memory and personality and become, I suppose demented is too strong. My inner self will fade. – R36*

Residents mentioned practical things like the need for piped oxygen, email access, changing interests of future residents, accommodating married couples and baby boomers being more demanding. One resident expressed an awareness of the changing policies of the government.

Power

Four residents commented five times about power; these comments fell into one node.

Table 7.22 Power

Node	Responses
Power	*It would be nice if they kept that money separate and at the meetings they said in our volunteers fund we have so much money. – R13* *The more say the residents have, the better, I feel. – R31* *You tell them what you want. – R61* *What I don't like is my loss of independence. – R64* *I said, 'Well, at my expense can I have it taken up and lino or boards put down?' No, it'll upset the décor of the place. The décor of this place is how they sell it. – R64*

Power itself was mentioned infrequently. Ideally the residents could derive a sense of power from having a say in the running of the home, maintaining their independence and being able to personalise their care and their room. These comments reflect a feeling of powerlessness, of a lack of independence and of wanting to know more about the running of the home.

Self-denial – thinking of others

Three residents talked about going into care for the good of their family. Six comments were made about this aspect of self-denial; these fell into one node.

Table 7.23 Self-denial

Node	Responses
Self-denial	*I think mainly because when I was living in my own home, after a few times I wasn't well and the family was racing up from Sydney. – R13* *I thought well if I'm here they're [the family] free. – R13* *It was the best thing for the family and my wife particularly it affects most although she's marvellous and she comes in nearly every day. – R58* *My son lives at Lindfield and my daughter's at Eastwood and I didn't want to ruin their lives. – R63* *And I don't think it's right to spoil your children's lives. – R63*

This group of residents could be considered self-sacrificing, going into care for the good of their families.

Client Surveys (CS)

The Client Survey (CS) is a written survey conducted every two years by FaithCare. The data obtained from it were analysed because it provides a formal avenue for feedback from residents, in addition to the Comments and Complaints Forms, which residents are free to use at any time. Data from these forms are discussed later in this chapter.

This Client Survey was initiated in 2007 as part of the business planning for that year. Its purpose was to develop an integrated, structured, consistent feedback system for clients; its purpose was *not* to address the issue of client loyalty or to provide a feedback tool for clients in respite care. It was acknowledged that consumer participation was important for a number of reasons:

- it leads to more effective and accessible health services;
- it facilitates decision-making and involvement in care which may lead to improved health services; and
- it enables consumers to participate more actively in service planning, delivery and improvement processes.

The CS consists of 71 statements across nine major service areas (statement sets) to be answered on a Likert-type scale – strongly disagree, disagree, neutral, agree and strongly agree. The service areas were developed as a result of focus groups held by FaithCare. The service areas are:

- Overall satisfaction
- Welcome
- Spiritual life
- Cleaning
- Assessing and delivering care
- Facilities
- Laundry
- Meals
- Activities

The survey is distributed to the residents of each home in a group setting. Completing the form is voluntary, although residents are encouraged to do so.

Staff from the head office of the organisation provide each resident with a paper copy of the survey and a pencil. All residents are invited to respond to the survey. Those with high care needs or functional limitations, including dementia, may be assisted by a relative or carer, a volunteer or delegated staff member. In addition, relatives are also invited to complete the survey. Participants are provided with verbal instructions before they commence on how to complete the survey. Staff members collect the completed surveys which are then forwarded to the FaithCare head office, where they are entered into a proprietary database before analysis.

Residents are given a written commitment that all response details will be kept confidential and used only for research purposes. I applied to the Ethics Committee of FaithCare for access to the data files of the 2008, 2010 and 2012 surveys. As the survey questions were commercial in-confidence, access to the survey instrument and

the results of the analysis for each of the questions individually was not given. However, data for specific categories were made available.

Findings from the Client Surveys

Twenty nine residents (48%) at *Greentrees* participated in the survey in 2012 and approximately the same percentage took part in the previous surveys although the exact figures were not available to me. Their ages and gender were not made available. The *Greentrees* results for the CS in 2008, 2010 and 2012 appear in Table 7.24.

Table 7.24 Percentage of residents who agreed with statements

Service Area	2008 Average %	2010 Average %	2012 Average %	Change from 2010 to 2012
Overall satisfaction	92.5	93.2	89.6	-4.0%
Welcome	91.3	92.9	88.8	-4.6%
Spiritual Life	93.6	90.7	82.2	-10.3%
Cleaning	88.4	93.4	95.9	2.6%
Care	89.4	88.6	85.1	-4.1%
Facilities	96.9	94.0	91.2	-3.0%
Laundry	93.3	89.3	91.7	2.6%
Meals	83.5	81.4	77.9	-4.4%
Activities	83.6	80.2	69.8	-14.8%

Adapted from data released to me by the organisation

Table 7.24 above represents agreement and strong agreement to positive statements or questions and therefore a negative change in the responses indicates a diminution in satisfaction in these areas. It can be seen that out of the nine service areas, there was a positive change (+2.6% each) from 2010 to 2012 in only two areas - Cleaning and Laundry.

Two service areas recorded a large negative change – Spiritual Life and Activities -10.3% and -14.8% respectively. I noted that during the period 2010-2012, a greatly loved and admired chaplain retired to spend more time with her family which may have led to the poorer result for Spiritual Life. Although the new chaplain was a warm and highly-regarded person, she was a generation younger than her predecessor, which may have had an impact. In addition, it takes residents some time to establish rapport with any new member of staff and this would have been

especially evident in chaplaincy with its emphasis on personal relationships and trust-building.

The overarching change during this period was the increasing age and frailty of not only the existing residents but also new residents coming into care for the first time at an older age (Productivity Commission 2011, p. 26). This change led to a greater need for chaplaincy services which was addressed by doubling the chaplaincy hours. This greater age of the newcomers also flowed to the Activities sector. Generally speaking, as the age and frailty of residents increases, so too does the requirement for more personalised activities. There are fewer residents who can enjoy a bus outing or other activities together and more activities are required on a one-to-one basis. This may account for/explain the decrease in satisfaction with Activities.

At FaithCare, residents' opinions from the CS are acted upon at the individual aged care home level. Once the results from each survey are available, an improvement action plan is developed by the manager of each home in the organisation. The plan addresses the main areas requiring improvement, is presented at a meeting to the residents and affords them the opportunity to ask questions and express their thoughts about the findings and actions.

Some typical actions/improvements undertaken are shown in Table 7.25.

Table 7.25 CS - actions undertaken

Areas for improvement - statement	Actions undertaken
Activities provided over the weekend	A weekend activities officer was employed
Information given regarding changes, for example, changes in the health of residents	Communicating day-to-day changes was prioritised to include updates given by staff in person to residents.
Food - regular changes to menu	Residents were involved in the choice of menu items at a meeting conducted by the catering service in May and November *
Inclusion in care conferences	Residents and relatives were encouraged to take part in care conferences and meeting times were arranged to suit all parties
Spiritual Life	The Chaplain was employed for an extra day per week A Catholic priest now gives Communion at the home more regularly
*Meetings are no longer held in May and November for residents to help choose menu items. This has been replaced by the attendance at a Residents' Meeting twice a year of a representative of the catering division at which complaints and comments about food are discussed.	

From Table 7.25 it is clear that the manager and members of the continuous improvement team made an effort to act on the findings of the CS. In 2010 residents lost their involvement in the choice of menu items, and dissatisfaction with food generally remains an issue. There are budgetary constraints around the supply, preparation, quality, quantity and serving of food. Anecdotal evidence suggests an on-site chef or cook may be engaged in the future. This may lead to the use of fresh ingredients rather than frozen, and perhaps a more personalised choice for the residents.

Comments and Complaints Forms

The Comments and Complaints Form (CCF) provides an easy, non-threatening way for anyone connected with the aged care home (resident, staff, relative or visitor) to assist in the ongoing effort to improve all facets of the operation of *Greentrees* and FaithCare. The form enables residents and others to have a voice in any aspect of care, including but not limited to, their physical environment and its maintenance, problems with staff and other residents, medical care and food.

Comments and Complaints Forms (CCFs) are available to everyone who lives, works at or visits *Greentrees*. And their use is encouraged by management. The forms are

pink, easy to spot and to fill in and they may be signed or anonymous. A sample copy of a CCF appears in Appendix 1. Completed forms may be handed to a member of staff, placed in the Administration Letter Box, handed in at the front office or posted from outside the home. Every month completed forms are gathered together and information transcribed onto an Excel spread sheet kept on *Greentrees'* intranet site, by the Continuous Improvement officer (RN1). The Excel spread sheet is a record of:

- the date the CCF was filled in;
- the nature of the comment or complaint;
- whether it was a comment or a complaint;
- the type of person who made the comment (staff, visitor, resident or relative);
- the action to be taken;
- date of action; and
- date of further action, if required.

The information from submitted CCFs is analysed and reported to the manager (M1) and the Continuous Improvement Committee monthly and to the regional general manager every three months. All comments and complaints are acknowledged and the results and a note of thanks are communicated to the person who completed the form, if it is signed.

Data from the Comments and Complaints Forms submitted between 1998 and 2012 were analysed by me in the expectation that they would provide an indication of the issues that mattered to residents. It was also expected that this analysis would reveal whether problems identified by residents were followed up by management and corrected. This follow-up, if evidenced, would in turn provide an indication of the power of the residents and whether their voice was heard and acted upon.

For this research, complaints and comments (suggestions) were grouped according to themes. An initial analysis revealed that simple comments mostly reflected small personal kindnesses that had been performed by staff or volunteers. These simple comments were eliminated from the data analysis, as they were not relevant to this research. Rather, this research which covered the remaining 165 forms, concentrated

on areas for improvement, and on comments that would generate action by management.

Although most forms were signed, it was deemed unnecessary to assign people individual code numbers; such coding was limited to data collected especially for this research, not extant data.

Findings from Comments and Complaints Forms

All resident complaints and suggestions for the period 1998 to 2012 were recorded in NVivo9. Entries were coded into nodes according to the subject of the complaint or suggestion and six themes emerged from the data. These appear in Table 7.26 following.

Table 7.26 Residents' complaints and suggestions at *Greentrees*

Nature of complaint (or suggestion) Themes	Number of complaints / suggestions	Per cent of the total number of complaints / suggestions
Food	96	58%
Environment & Maintenance	39	24%
Quality of Care	11	7%
Health and Safety	10	6%
Staff	5	3%
Problems between residents	4	2%
Total number of Residents' Complaints	165	100%

It can be seen from this table that the food offered in the home was overwhelmingly the subject most complained about via the Comments and Complaints forms. Food accrued 58% of the total number of complaints, followed by environment and maintenance at 24%; all the other categories scoring less than 8% each.

Some typical complaints drawn from the forms follow in Table 7.27.

Table 7.27 Typical complaints from the CCFs

Category	Representative data
Food	*Pork too tough – R21* *Plum sauce didn't taste like plum sauce - R21* *Beetroot juice leaking through salads – R43* *Why do we not have boiled eggs for breakfast? – R11Dinner was cold – R19* *The evening meal is being served prior to the agreed time – R3*
Environment and maintenance	*Trees rubbing on windows – R11* *Garden bed needs weeding outside dining room – R37* *Lighting outside Room 5 needs fixing – R2* *[Wing] heating not working – R46*
Quality of care	*Chemist very expensive – R17* *Complaint – no cuppa offered when ill – R29* *Staff did not respond to her needs appropriately – son upset – R13* *Complaint re buzzer not being answered – R43*
Health and safety	*Residents using tea towels to wipe their hands in [wing] kitchen – R3* *Resident drinking from milk bottle – R21* *Do the heaters need vacuuming? Heavy build-up of dust – R7*
Staff	*Disturbance at night due to staff talking in Nurses' Station – R18* *Staff entering resident's room without permission – R18*
Problems between residents	*Respite lady upsetting other residents – R26* *Resident hassling her – R27*

Complaints about food most frequently included the toughness of the meat, the quality of the meals, the temperature of the meals and the timing of meal service. Food was the main issue for the residents and the incidence of food-related issues increased from six in 1998-2002 to 51 in 2008-2012. A further breakdown of the data was carried out to indicate trends in five-year periods from the opening (1998) of *Greentrees* to 2012.

Table 7.28 Number of residents' complaints in five year groupings

	1998-2002	2003-2007	2008-2012	Number of residents who complained
Food	6	39	51	37
Environment & Maintenance	6	9	24	22
Quality of Care	2	5	4	5
Health and Safety	1	3	6	10
Staff	3	0	2	4
Problems between residents	0	4	0	4
Total number of complaints	**18**	**60**	**87**	

From Table 7.28 it can be seen that from its very beginning, *Greentrees* residents continued to use the CCF confidently as one of the means of reporting problems and concerns as they occurred. The number of complaints rose from 18 in the first five-year period to 60 in the second and to 87 for the last five years (2008 – 2012). From the Food and the Environment & Maintenance categories it can be seen that many residents (37 and 22 respectively) made complaints. Voicing complaints clearly was not the sole preserve of a small number of disgruntled residents. In the Food category, just under 60% of residents made a complaint. Once the 11 residents in the Dementia Unit were eliminated from the calculation, the proportion of residents who made a complaint about food rose to 72.5%.

Greentrees was built in the late 1990s and it is understandable that the number of environmental and maintenance issues increased as the building aged from six in the first five years to 24 in the last. It was during the first five-year period that the number of residents rose from the initial 20 or so to the full complement of 65 as the five wings of *Greentrees* were built.

Residents were encouraged to use the maintenance books provided in every wing to note any maintenance issues. As these are read and attended to daily by the handyman, many minor maintenance issues would not appear on the CCFs.

The second and perhaps most important component of the CCF system was the actions generated as a result of complaints or suggestions. These reflected an

organisation listening to and acting on the voice of the residents. The actions taken in response to the complaints above appear in Table 7.29.

Table 7.29 CCF – actions undertaken

Complaint or suggestion	**Action taken**
Food	
Pork too tough.	Referred to the kitchen and the catering company. Letter sent to resident.
Plum sauce didn't taste like plum sauce.	Referred to the kitchen and the catering company. Letter sent to resident
Beetroot juice leaking through salads.	Kitchen staff instructed to drain the beetroot well. Letter sent to resident.
Why do we not have boiled eggs for breakfast?	Kitchen staff to organise extra egg for this resident. Verbal response to resident.
Dinner was cold.	Letter sent to residents explaining problems with food heating machine. Referred to Property Manager.
The evening meal is being served prior to the agreed time.	Manager wrote in communication book. Notice prepared for kitchen staff. Communication with resident.
Environment & Maintenance	
Trees rubbing on windows.	Trees checked by gardener, no fault found. Manager spoke to resident.
Garden bed needs weeding outside dining room.	Garden to be weeded by volunteer. Note sent to resident.
Lighting outside Room 5 needs fixing.	Handyman changed bulb. Resident informed verbally.
Wing heating not working.	Report sent to Regional Property Coordinator. Contractor notified.
Quality of Care	
Chemist very expensive	Letter sent to resident. Referred to Chemist.
Complaint – no cuppa offered when ill	Discussed with kitchen and care staff. Note sent to resident.
Staff did not respond to her needs appropriately – son upset	Discussed with care staff and RN. Note of apology to son and resident.
Complaint re buzzer not being answered	Staff to check buzzers at beginning of each shift. Note to resident.
Health and Safety	
Residents using tea towels to wipe their hands in wing kitchen	Manager asked handyman to purchase and install paper towel dispenser.
Resident drinking from milk bottle	Resident moved to area with more supervision.
Do the heaters need vacuuming? Heavy build-up of dust.	Cleaners instructed to vacuum heaters.
Staff	
Disturbance at night due to staff talking in Nurses' Station	Notice sent to staff. Communication with resident re outcome.
Staff entering resident's room without permission	Manager communicated with Nurse Educator. Notice to staff reminding them of policy about entering rooms. Staff training.
Problems between residents	
Respite lady upsetting other residents	Resident sent letter. Son advised of difficulties with his Mother.
Resident hassling her	Manager met with resident to discuss.

I observed that while actions were initiated, there was no mechanism for long-term follow-up of how well any action remained effective, beyond noting further similar complaints. However, with the exception of ongoing problems with the temperature and quality of the food, were very few repeat complaints, once they the initial issue had been resolved. Thus, the CCFs provided a readily accessible system for residents and others to voice their opinion and remedy situations in the home.

The importance of the CCFs is that most items reported would only be noticed by residents. Without this mechanism in place, it seems unlikely that improvements in some areas could be made. For example, with regard to the quality of the food, staff are not permitted to eat the food provided for residents, so its taste and consistency remain a mystery to them. The usual reasons given for this rule are firstly that, as on board an aircraft, if there were an outbreak of gastroenteritis originating from the food, the situation would escalate from serious to disastrous if the staff also succumbed to it. The second reason is that allowing staff to eat food supplied for the residents may induce some staff members to put aside for themselves food that should be served to residents.

It may be asked why residents do not comment at the time of the meal. While some residents are outspoken, others are shy and do not like to create a scene during mealtime. In addition, in some cases, for example *beetroot juice leaking through the salads*, the person serving the food is not necessarily the one who makes the salads. The residents are aware of this and would hesitate to complain to the wrong person. Another factor is that making a written submission is a more reliable way of ensuring the message gets through both to the person responsible and to the manager of the home.

The CCFs highlight the key areas of concern to residents: food, environment and maintenance, quality of care, health and safety, staff, and problems between residents. These concerns are addressed by management in the context of a Continuous Improvement meeting and a response in writing to the complainant if they have signed the form, as shown in Table 7.29.

The following table (Table 7.30) shows the top five subjects raised in each of three forums, CS, CCF and Resident Interviews.

Table 7.30 Comparison of data relating to top five issues

Client Survey (CS) Arranged from greatest to least dissatisfaction 2012	**Comments and Complaints Forms (CCF)** Arranged from most to fewest complaints	**Resident Interviews** From greatest number of sources to least
Activities	Food	Activities
Meals (Food)	Environment & Maintenance	Staff
Spiritual Life	Quality of Care	Food
Care	Health and Safety	Environment
Welcome	Staff	Quality of Care

Two themes – food and care – appear in every forum. Activities, environment and staff appear in two forums. All five of these subjects are addressed in more detail later in this section.

There are two aspects to food in this research. The first is the consideration of food as a source of nutrition, a means of preserving life. Intuitively it would seem that most people like to have a role in the selection of their food, especially in the western world where food is plentiful. Mostly *good* food is the desirable choice. People generally do not like having to eat food they do not like, and after the age of about 12 years, people's preferences are generally taken into account. Certainly most people like to have hot food served hot and cold food served cold. Thus, from the point of view of food as nourishment, in any but a subsistence society or a society in famine, reasonable quality, a good choice and attractive presentation are givens. Food is fundamental, a basic biological and physiological requirement, in Maslow's Hierarchy of Needs. There are parallels between these situations described in the Personal Reflection below and the aged care environment.

> ***Personal Reflection:*** *I have been subjected to 'institutional' food on a number of occasions in situations in which there has been no choice of food as well as situations in which there has been a limited choice, namely, while living in the Nurses' Home as a trainee Registered Nurse when 'living in' was compulsory, as a patient in hospital and as an amateur researcher attached to a group of palaeontologists in outback Australia where both food and water were in limited supply. In each of these situations over a period of a few days or weeks, food became a focus and an important topic*

of conversation. Although the food offered was basic and nourishing, there was a very limited choice and presentation was unimpressive. People became disenchanted with the food supplied. Thinking back to observations made when working as a nurse in a public hospital, the choice of food and its variety and quality become very important to patients after the first day or two, if they are well enough to care. They look forward to their meals – the service of meals breaks up the day, provides a different person to talk to briefly (the person who takes their order and delivers the food), provides a talking-point with their visitors and other patients.

The second very important aspect of food which emerged from this research as a way of expressing oneself and providing a feeling of power by influencing the choice of ingredients, types of dishes produced and their presentation. Again, most people have had some degree of power over the food they have eaten from the age of 12 and when as older people they enter aged care establishments this power is usually taken from them. Aged care organisations have claimed and continue to claim that this is due to budgetary considerations. This research has established that food is very important to the aged care residents in the organisation studied. It is consistently complained about and commented on. This was seen from the Comments and Complaints forms and Client Surveys, both of which showed high levels of input about food from the day the home opened until the close of the data collection for this research.

Another consideration is that most aged care organisations use a nutritionist or dietician to design meals that are adequately nourishing, cover the five food groups and contain the necessary vitamins. While this is commendable, sufficient nourishment is only obtained by residents when they eat all the food they are offered. Few people want to eat food they do not like and while it is difficult to please everyone, a choice of menu should be given.

At the beginning of the research I imagined that residents' views in homes from three geographical areas (suburban, urban fringe and rural New South Wales) would be different and provide a contrast of experiences. Although such differences were not evinced, due to the fairly homogenous aged care population and their experience of the one aged care organisation, data were uncovered that allowed a comparison of

their satisfaction or otherwise with food in homes with and without an on-site chef. It was found that residents whose facilities had a chef were far less disenchanted about the food quality than those whose facilities offered little choice. However, the issue of improving the food remains a very high priority for residents, irrespective of whether their aged care homes have a chef or not.

Minutes of residents' meetings

Residents' meetings were held monthly in the *Greentrees* chapel and conducted by the chairman in a formal style. A meeting agenda template appears in Appendix 1. There are usually around 20 residents of a possible 64 in attendance. Eleven of the 64 residents live in a closed ward (the dementia unit) and about five others would be too frail (bedridden) to attend. As a result, approximately half the resident population attends.

Each meeting moved from a welcome, to proposing and seconding the minutes from the previous month's meeting, matters arising out of those minutes, new business and reports from management. The floor was then open to anyone to ask questions or make comments.

The minutes of the residents' meetings were taken by a resident, or in his/her absence, a member of staff. The minutes were transcribed and made available to the residents via their monthly in-house magazine, which was prepared by the receptionist of *Greentrees* and included articles contributed by the manager, the lifestyle coordinator, the chairman of the residents' meeting, the chaplain and anyone else who wished to contribute. The magazine provided a way of disseminating news and the activities timetable and was distributed by hand to each resident. The minutes of resident meetings were also saved permanently on FaithCare's intranet site.

There were very few complaints tabled at the meetings. The meetings were most importantly a forum for presentation of reports and upcoming events by the manager, lifestyle coordinator and continuous improvement officer, who also dealt with work, health and safety issues.

The manager used this forum to comment on operational issues that affected the smooth day-to-day running of the home and the residents' understanding of background issues:

Please be aware that the RN knows you have to have your dressing done, but you will need to be patient. They may have up to 15 dressings to do. - M1

Residents have only submitted 5 pink forms [Comments and Complaints Forms] while I have been away. – RN1
We don't get replies. – R8 It takes a few weeks for the reply to reach you. – RN1

Occasionally the manager had a complaint about the residents:

Some staff have reported that some residents speak to them sharply. Staff are not your slaves or servants. Please be mindful to offer a 'please' and 'thank you'. If you have an issue with staff please come and see me or address the issue via a pink slip [Comments and Complaints Form]. Staff are here to help you with your care needs and they are doing the very best they can. – M1

Typically, complaints that are tabled are issues requiring clarification by management or indicate that residents are seeking information:

The laundry detergent isn't very good. – R13
The dryer in [our wing] is not working properly. – R65
Can we have set days for activities please? – R66
We sometimes don't get an announcement over the loudspeaker. – R8
Could there be more staff? – R5
People leave lint in the dryer. – R14

In many cases, problems raised are addressed immediately:

Why is it hard to get the DVD player going? – R8 It was just unplugged. – M1

I'm concerned about the doors being closed especially when my visitors come. – R56 Staff were worried that the stairs present a risk to some of our frailer residents so we've activated the security doors. Please buzz from your room for a staff member to release the doors. – RN1

I don't have a neck pendant. – R56 The neck pendants are for residents who can't get out of their chair. – RN1

I'm worried about getting out if there's a fire. – R39 In a fire, all door locks are de-activated. – RN1

Sometimes we wait up to half an hour for our lunch in [my dining room] - it doesn't arrive until nearly 12.30. – R8 [Your dining room's] lunch time is 12.30. – RN1

None of the meeting minutes, from the very beginning 15 years previously, had evidence in 'matters arising from the minutes of the last meeting' that concerns raised the previous month had been answered. In this regard, there was a shortfall in communication with the residents. In most cases, as can be seen from the examples above, the manager or RN acting as the continuous improvement officer, was able to give an answer as soon as the concern was raised. However, in some cases when a question was asked or a matter raised, and no immediate answer was given, further information should be given at the following meeting, but is not. For example:

The laundry detergent isn't very good. – R13

This comment was acknowledged but there was no follow-up at the next meeting.

These meetings provided a forum for residents to ask questions and raise concerns in a very supportive atmosphere, but the follow-up at subsequent meetings was lacking. This was a failure of communication from management to residents and demonstrated that, although there was a well-run and well-attended forum for management to hear the voice of residents, what was heard may indeed be acted upon but the communication loop was not closed, so residents had no way of knowing about any action taken.

Observation of residents' meetings

I observed nine residents' meetings, plus a special *food* meeting in February 2013, to increase the depth of data, gauge power relationships and ensure that residents were encouraged to speak up and did not feel intimidated. Chapter 5 showed that focused observation emphasises observation supported by interviews. This was a valuable way of observing the behaviour of residents and hearing their opinions first hand, rather than depending only on the minutes, which may or may not have been correctly interpreted by the minute-taker. Hansen (2007) makes the point that observation is 'also useful for building rapport and "getting to know" research participants' (p. 69).

It was hoped that observation of the residents' monthly meetings would provide further insight into how well the residents' voices were heard and responded to.

Features of the residents' meetings were:

- Meetings were convened monthly, at the conclusion of which the next meeting's date was decided. Meetings were usually held on the first Wednesday of the month but the date was occasionally changed to fit in with other activities or special events.
- All residents were reminded of the meeting time on the day of the meeting, first by a staff member at lunch time and then 15 minutes before its commencement, over the public address system. A notice was also posted on the door of the chapel.
- Attendees were the chairman (a nominated resident), the manager of the home, the lifestyle coordinator, the continuous improvement /work, health and safety RN, someone designated by the manager to take the minutes of the meeting (either a resident or a staff member), residents who wished to attend and occasionally a visitor.
- All staff attendees could elect to send a delegate if they wished. This occurred quite regularly as staff were often called away on other matters. Although this appeared to indicate that the Residents' Meeting was not a top priority for staff, it had been decided by the manager that the meetings should go ahead no matter what, unless there were exceptional circumstances. The priority was for meetings to proceed even if staff who would normally attend had to send a proxy.
- The chairman was a resident-appointed role until he or she resigned or a move was made to replace him/her.
- The chairman, manager, lifestyle coordinator, continuous improvement officer and minute-taker sat at a table and faced the residents who sat in rows in front of them.
- Minutes of the meetings attended for this research were recorded by hand by a staff member.
- An agenda for each meeting was developed by the chairman before the start of the meeting in accordance with a pre-determined template. The majority of the meeting consisted of staff members providing reports and residents asking

questions or seeking clarification of issues. Residents were free to offer items for the agenda throughout the month between meetings; these items were submitted to the chairman.

- I sought verbal informed consent from the manager to attend the meetings. This was confirmed at a residents' meeting prior to my first attendance, when the residents agreed to allow me to attend and observe their meetings for as long as necessary. Thereafter at the commencement of each meeting, implied consent was obtained when I was welcomed by the chairman.
- Notes of the content of each meeting were taken by me in writing.
- These notes were analysed by me after the meeting's conclusion and compared to the minutes of the previous meeting published on the intranet in order for me to:
    - confirm alignment between the discussion at the meetings and the minutes recorded;
    - identify whether interactions between residents at the meeting allowed all attendees to voice their views on business being discussed;
    - ascertain whether items of concern identified during the previous month were dealt with between meetings and reported on at the following meeting; and
    - identify issues affecting residents

Findings from observation of residents' meetings

- A total of nine meetings were convened out of a possible 11 (two were cancelled by the manager) during my 13-month observation period.
- Meetings were held on the first Wednesday of each month.
- I attended all nine meetings.
- Resident attendance at meetings ranged from 12 to 22 participants, usually closer to 22 than 12. The special *food* meeting drew 24 residents.
- Staff were in attendance at all meetings. The manager attended four of nine, and provided a proxy for the other five. Meetings were between 30 and 60 minutes in duration.
- Meetings were held in the *Greentrees* chapel.

- The structure of the meetings was formal, both in agenda and physical layout of the room.

Alignment between the meetings and the minutes

My observations revealed that the minutes of meetings were a true reflection of the discussion at the meetings and the ensuing discussion and responses from management; nothing controversial or unfavourable was excluded.

The opportunity to have a voice

The manager of *Greentrees* (M1) or her representative ensured that the information or news to impart to residents was heard and understood by all. Information not heard by those with hearing difficulties was repeated until heard and understood.

Adequate time was allowed for residents to ask questions or seek clarification of points made, both throughout the meeting and at the end. Every problem or comment raised by any resident was patiently and adequately dealt with by management, in some cases until the topic was beyond the point of exhaustion.

I concentrated on the interactions between residents, and between residents and management. Two residents, R8 and R66, tended to be argumentative and very forceful. In the case of R8, his hearing loss affected his ability to realise that he has been responded to adequately. In addition, because of his loss of hearing, he talked over other people because he could not hear them speaking. Once R8 was heard and had received a reply he could hear, he expressed gratitude and was subdued. R66, on the other hand, remained argumentative throughout. This behaviour was handled with patience and politeness by the chairman and manager. Other residents were, on the whole, calm and polite.

On one occasion a very frail resident (R56) arrived in the company of a member of staff (RN8) who acted as her advocate, making sure she was able to get to the meeting and reminding her of the points she wanted to make, which were written down in the resident's handwriting. The staff member was able to make sure the resident was listened to and appropriately responded to. On five occasions shy residents were encouraged by friends to speak, or another resident spoke for them.

During the more than one year of observations, the chairman was R2, a tall man of some authority in the resident community who was experienced in chairing meetings. He followed formal meeting protocol. R2 had a remarkable gift of smoothing troubled waters and when the residents were agitated about something, would wait until they had finished, quietly put the problem into perspective and try to offer some background information. He was also able to diffuse volatile situations with a quiet word, never making anyone feel unimportant. He was a very valuable buffer between management and the residents. He often concluded the meeting with a short reminder about the difficult work the carers were doing and the importance of understanding and patience from the residents. Because he was a resident, these words of advice were more readily accepted than if they had come from management.

From these observations, it was clear to me that every resident who had something to say was given the opportunity to speak and was responded to at the residents' meetings.

Follow-through from one meeting to the next

It was not apparent from the content of the meetings whether items of concern identified during the previous month's meeting had been dealt with between meetings. Although the heading or subject 'matters arising' was always read out from the agenda, no matters were ever referred to from the previous month or months. This highlights again the same failure of communication that came to light during the analysis of the meeting minutes.

During the time of observation very few complaints were made at the meetings. The following issues are typical of those raised:

Food

'McDonalds outing the other day – I have a complaint about the food.' – R8

Environment

'What is the holdup with the new DVD player?' - R8
'When is the new TV coming?' – R8
'Lights near one [wing] are set wrong and need to be adjusted.' – R9
'Could we have our outdoor setting re-stained?' – R14

'I don't approve of having to have sprinklers when our fire safety equipment is so good.' – R8 'This is the law now.' – S5
'The spring on top of my door is broken.' - R8 'The company has been to inspect and we're waiting for quotes to fix all problem doors.' – S5

Communication

'When action isn't taken on complaints, people ask me to speak on their behalf and then everyone thinks that I'm the troublemaker.' – R66

Activities

'We are not happy with the children being here (for playgroup).' – R66

Staffing

'Why are so few new staff members able to give out medications?' – R66 'All new staff are being trained at present.' – S5
'This morning when we were getting ready to go shopping, some of us worried that we wouldn't receive our medications.' – R66 'In future I'll make a note in the Communication Book indicating to the staff which residents are going on the bus so you can get your medications early.' – S1
'Re the eye drops - may I NOT get them in the middle of a meal.' – R8

It can be seen from the examples above that many concerns were addressed immediately. However, some, for example R14's question *Could we have our outdoor setting re-stained?,* which, aside from it being noted, could not be addressed immediately, could be brought up at the next meeting and R14 and the other residents should have been informed of progress on that issue.

The following chapter defines baby boomers, describes the particular attitudes and perspectives they will bring to aged care and provides a snapshot of what the boomers think will be important to them in the context of aged care.

Chapter 8

THE BABY BOOMERS' VIEW

'I was a conscientious objector when I was young …
I could create trouble.' – BN6

This chapter describes baby boomers, the next demographic wave to enter aged care and explores a third category of important issues, this time from the point of view of those future residents identified as the baby boomers.

The baby boomers are defined usually as the people born in the post-World War II period between 1946 and 1964. By the time most of the boomers enter aged care, whether in residential aged care or home care, they will double the size of the aged population (Knickman & Snell 2002).

The baby boomers are set to enter the aged care market in the near future. 'During the next two decades there will be, on average, 250 000 Australian baby boomers having their 60th birthday each year' (Humpel et al. 2010, p. 8). 'As the population ages there are increasing numbers of older people in need of secure and appropriate housing' (Bartolomei 2000, p. 49). Indeed, the Boomers are already having an effect on aged care as they act as informal advocates for their parents.

Baroness Greengross, retiring head of the Counsel and Care charity in the UK, said:

> Older people are not going to be as compliant or easily satisfied as in the past… They are no longer a hand-me-down generation, willing to accept what has been given to them … We've bred a new generation of older people who are more educated and self-reliant, more ready to question authority, assert their rights and make their legitimate demands on society … All aspects of society … will have to change to meet older people's demands and respond to their growing political and consumer power (Brindle 2000).

The baby boomers will bring new attitudes to old age. Some writers claim that Boomers reject the label of 'old age' and are 'frozen at middle age'. Osenton (2009) writes that 'terms such as *seniors* and *golden years* are rapidly losing relevance, as

more and more Boomers move into their sixties' (p.148). Even boomers over the age of 60 view their parents as seniors, but not themselves.

Baby boomers bring new perspectives to old age. They see themselves quite differently to how their parents viewed themselves. 'This generation does not intend to go quietly and probably not anytime soon. And they certainly don't intend to live the same sedentary lifestyle that their parents did after reaching the age of 62' (Osenton 2009, p. 121).

The current residents of aged care facilities weathered the Great Depression and World War II. They are generally grateful to be taken care of, complain very little and accept their lot. They are survivors.

Baby boomers, as an overall group, are vocal and demanding, indulged and wealthy (Cravit 2008; Mackay 1997). The boomers have been instrumental in the rise of consumerism and since the 1960s have been consumers with a voice, a loud voice, that has been heard and responded to by suppliers of goods and services. There is every reason to believe that they will expect to have a high level of input into all aspects of this new phase of their lives. Indeed, without strong, meaningful leadership, the boomers have the potential to trample ineffectual leaders and systems. Strong inclusive leadership allowing participation by the boomers, who over the past 50 years have been shown to make far better allies than adversaries, would seem to be a prerequisite for Faith-based aged care facilities to run smoothly. It seems unlikely that the baby boomers will be anything but feisty and difficult when they enter the aged care sector. Their cooperation will be far easier to achieve if they have a voice that is heard.

Baby boomers will expect a high standard of service. Many have travelled widely, enjoy dining out and are part of the 'coffee culture'. They are used to being entertained. They barely remember life without television. They have embraced the computer revolution. Unlike the present residents in aged care, baby boomers are more attuned to the consumer society. They therefore present a demographic challenge, not only because of their increased numbers but also because their expectations of aged care will be high.

Fortunately, service providers are beginning to realise that an increasingly larger section of the economy of the future will be built on service, not on products.

Selecting Baby Boomers

A sample of baby boomers was interviewed to ascertain their view of aged care. The baby boomers selected for this research were divided into two broad categories – knowledgeable and naïve. Knowledgeable baby boomers were the relatives or close friends of aged care residents whom they had visited regularly over a period of at least six months and had developed a feel for the good and bad points of residential care.

Naïve baby boomers had either never been to an aged care facility or have done so only peripherally or many years previously:

> *I haven't been in an aged care place for some years. When I was at school we used to go and sing to them at Christmas time. – BN1*

The baby boomer interviewees were coded similarly to the residents – for example, BN1 is a boomer, naïve and number one. BK2 is a boomer, knowledgeable and number two.

Twelve baby boomers were interviewed, six men and six women, three of each in the naïve and knowledgeable categories. Six boomers were interviewed by phone and six face-to-face.

Some knowledgeable boomers were chosen in consultation with the manager and senior care staff at their resident/relative's care home, or were suggested by their relative during a resident interview. The manager and/or senior care staff were asked to recommend boomers with potentially different viewpoints. Other knowledgeable boomers were chosen from among my acquaintances and were selected for their diverse opinions and backgrounds.

The naïve boomers were identified among my acquaintances and those of my supervisor. All were purposively chosen to reflect a range of potentially different opinions and backgrounds so that rich data would emerge.

Of the 12 boomers, seven were married, three were unmarried, two were bi-sexual and two were born and spent their formative years overseas. All were chosen to reflect as closely as possible the socio-economic group currently living in the aged care homes used in this research, that is, *middle Australia*.

The boomer interviews were expected to give a glimpse of the future of aged care. I hoped to learn what they thought would be important to them if they entered care in the future, and whether there were any new issues that may have to be addressed by organisations in the future. Convergent interviewing was again used for the knowledgeable boomers.

Baby boomer interviews - knowledgeable

Each selected knowledgeable boomer was invited to participate via a written invitation that also included an information sheet, consent form and stamped addressed envelope. If necessary, one reminder call was made. If there was no response, it was assumed that the boomer did not wish to participate. Those who wished to participate, phoned me. Interviews were conducted in a variety of places: coffee shops, the aged care home itself, or by telephone. When the interview was conducted in person, and following ethics requirements for my safety, a third party was made aware of my whereabouts.

After I gave a brief introduction and answered any questions, I requested that a consent form be read and signed. This happened in all cases without incident. When the interview was to be conducted by telephone, I arranged the interview only after I had received a completed consent form by mail. The first few minutes of in-person and telephone interviews were spent chatting to gain rapport. I then asked the participant if they were ready to begin, reminded them that I would be recording the interview and started each interview with the same broad opening question (see text box below). For in-person interviews the boomer was encouraged by the use of eye contact, nodding and interested vocalisations to keep them talking for as long as possible. For telephone interviews interested vocalisations were used. This time there was no limit to the duration of the interview but generally the interviews were kept to 60 minutes as that was considered to be long enough for both parties to remain enthusiastic. After 40 minutes, or if the boomer was wandering off-topic, I began to

introduce prompts if relevant points had not been covered. The questions for 'knowledgeable baby boomers' appear in the following text box.

Questions for Knowledgeable Baby Boomers

Open question:

- I understand that you are a frequent visitor to an aged care centre. In the future when you are very old, you may need to go into an aged care home. Imagine there are lots of aged care homes in your area. What would you look for in an aged care home that would make you choose one over another? What features of the home do you think would have the greatest impact on your quality of life?

Possible prompts or focus questions:

- Would the residents have input into all decisions, e.g., food, activities, entertainment, visitors, communication, facilities, choice of staff, accommodation.

At the end of each interview the boomer was thanked and asked whether they had any questions. The third party was contacted by phone to report that all was well.

I transcribed the interviews as soon as practicable and entered them into NVivo9 ready for coding. Some of the comments below appear in more than one category, for example *Space in the rooms is very valuable – BK5,* appears under the headings Facilities and Space.

Table 8.1 Code numbers and demographics of BKs

Boomer Code	Gender		Approximate age
BK1	Female		Late 50s
BK2	Male		Early 60s
BK3	Female		Early 60s
BK4	Female		Mid 60s
BK5	Male		Mid 60s
BK6	Male		Early 60s

Table 8.2 shows the results of open coding these interviews. Knowledgeable boomers spoke most about activities, power and the facilities provided.

Table 8.2 Themes – knowledgeable Baby Boomers

Themes	Number of sources	Number of references
Activities	6	24
Power	6	22
Facilities provided	6	21
Care	5	14
Food	5	13
Comparison of NFP-FP-Government	5	11
Involvement in running the aged care home	5	10
Other themes:		
Future of aged care	4	11
Staff	4	8
Space	4	3
Religion	2	6
Pets	2	6
Choice	2	3
Couples/de facto/same-sex	1	1

The seven top themes are discussed below. These were mentioned by most residents many times. This is followed by a shorter discussion of the remaining seven themes which were mentioned by fewer residents and less frequently.

Activities

The knowledgeable boomers (hereafter BKs) were most interested in expressing their requirement for the number and variety of activities they will require. All six BKs made comments, totalling 24 and covering four nodes.

Table 8.3 Activities

Nodes	Responses
Good activities they have observed in aged care	*When there's a birthday they have a special lunch. – BK3* *They have an outing at least once a week. There's a walking group who walk to the railway bridge and back every morning. – BK3* *They do a bus trip every week but Mum doesn't go. She needs so much encouragement to go to anything. There are two things she goes to – the monthly church service, and the woman who does the aromatherapy does 'swimming' – swimming actions in the chair – she'll go to those. – BK3* *At Mum's place they do exercises every week and a physio too. – BK4* *They provide outings. DVDs shown into each room. Entertainers are provided. – BK4* *They have bus trips. I do know that some of the people from there walk every morning. – BK4* *I know my Mother enjoyed the holidays that she had away in the earlier stages. – BK5*
Deficiencies in activities observed now	*Even there I had to be there constantly to make sure she was gotten up and was walked, that she was included in day-care programs because she would say 'no I don't want to go' but once you get her there she*

	enjoyed it. – BK1
Desired future activities	*I wouldn't want to spend every day in the facility. Somewhere with beautiful views, go to the theatre, concerts. – BK2* *I don't know if they have shopping sprees – I think mostly that's done by the families. – BK4* *… having facilities for having hobbies like painting. – BK5* *… being able to go out. – BK5* *Sitting in the sun to watch activities, they don't have to be far away, but that would be important. – BK5* *Just going to the shops, doing a bit of shopping. – BK5* *Just opportunities to get out. I'm not one so much for group activities like games and bingo and things like that, but I know a lot of people would be. – BK5* *I suppose I'd like to treat it more like a half-way house where you were independent and could leave the premises and could walk to the village. – BK6* *Excursions to Canberra, to the National Gallery, sporting events, to the cinema, probably things that I don't do now as much as I should do. – BK6* *It would be nice if they organised dinners for small groups of inmates. – BK6* *Perhaps people could go to different restaurants. It could be lunch. – BK6*
Fear of doing nothing	*I know a lot of people who sit in their rooms and do nothing all day – I can't see how they do it – I would be bored stiff. – BK4* *Maybe we won't have quite the same sort of ability to participate in the same range of activities that we might like to. – BK5* *It seems a pity if people are confined to the place and don't have a lot of opportunities to get out. – BK5*

It was important to the BKs to imagine that they could leave the home regularly for a change of scene and be offered a variety of activities. They hoped to be kept engaged to avoid boredom.

Power

All six BKs made comments (totalling 22) about personal power in the aged care situation. These comments were around three nodes.

Table 8.4 Power

Nodes	Responses
The future	*I think we're going to be more demanding and more enquiring because we have more information. – BK1* *We have the right to question. – BK1* *I would like to get involved, I tend to get involved wherever I am. I would like to be on a residents' committee and involved in decisions. I just know that on bodies corporate and my orchestra I get involved. – BK2* *I don't think we'll have the ability to say anything. At 90 odd I don't think I'll worry about any of it. – BK4* *People would like to think they have a meaningful say in their meals. – BK5* *I know it's an objective in all aged care facilities to feel that they're not*

	patronised, respected as an elder of the community. – BK5 *I'd like to treat it more like a half-way house where you were independent and could leave the premises and could walk to the village. – BK6*
Advocacy	*People who are directly involved in aged care as I am at the moment because of visiting John and Mum. I am their advocate. – BK1* *We have relatives' meetings about once a quarter. We get to meet the lifestyle coordinator … and chat about local issues. – BK3*
Level of power they observe in aged care now	*Even in independent care there's a level that enables that person, that individual, to access that care if needs be but a lot of them don't because they don't want to be bothersome, they don't want to be questioning, they don't have the feeling that they have that authority to ask. – BK1* *When you get to the next level, the hostel level of care, you've got people who are dealing with a loss of independence, which sets up a level of resentment. I guess they don't want to be dictated to but don't feel that they have the right to say anything for fear that they might be displaced. – BK1* *… you come up against the obstructions of a system. – BK1* *… she was grieving the loss of life as she'd known it. No one offered any care to that side of her. She was a non-person. – BK1* *Also the way they do the menu selection was explained. – BK3* *She has her own furniture and pictures. We swapped the chair with one she had at home. – BK4* *There can be a tendency for people to feel that they've made a suggestion and it was well received, but has anything happened about it? – BK5*

BKs noted the importance to them of a feeling of personal power, they mentioned advocacy and discussed their observations about limitations on power of the present residents. Limitations on power were couched in terms of not having the authority to question, fear of 'displacement' from the home, the obstructions of the system and having suggestions apparently listened to but not acted upon.

Facilities provided

All six BKs made comments (totalling 21) about the facilities provided. These formed two nodes, facilities now and facilities in the future.

Table 8.5 Facilities

Nodes	Responses
Aged care facilities now	*I don't think she liked the closeness, the communal dining. – BK1* *Here they seem to have a slightly stale smell and be like a modified hospital. – BK2* *If there was ever a way of having a bed as wide as the one at home, a double, so she can starfish. She says the bed is too narrow. – BK3* *In the low care they [could] have a sitting room as well as a bedroom, and probably a little balcony. – BK3* *We can book a private dining room – we're doing that when a friend comes up from Melbourne next week - $12.50 for a meal, $8.50 for sandwiches. It's quite a substantial meal. – BK3*
Aged care facilities in the future	*You could use internet broadband as long as reception was decent, good TV reception, the ability to download movies. – BK2* *… people in another 20 years won't be reading books, they'll be reading*

	it on tablets. – BK5 *Opportunities for visitors to come in and to have contact with friends and family. – BK5* *A lounge that people could use that wasn't normally used by residents and has facilities for preparing tea and refreshments. That would be good. – BK5* *Being able to have internet connection to their room would be essential. – BK5* *The way facilities are developed to have good sun access to rooms and nice light rooms and space. – BK5* *I wouldn't want to be in a ward. – BK6* *I'd have to have a sound system – that's one of the most important things in my life. – BK6* *I'd like to think that I'd like to paint and draw. – BK6* *And a telly and Foxtel because watching the football is very important to me. – BK6*

The BKs wanted up-to-date technology when they enter aged care. They wanted space for their possessions and privacy, especially when their visitors come. They wanted a pleasant environment with plenty of light.

Care

Five BKs made 14 comments about care. They commented about the care they had observed in aged care now, and what they would like in the future.

Table 8.6 Care

Nodes	Responses
The care now	*Care is very constrained by way of budget and also resources that are actually put out there for aged care. - BK1* *The person who was in charge said they only last six months after a break at this age. The six month lifespan they gave her has lasted five years. She still asks when is she going to get better. – BK1* *The biggest issue we have now is getting a quality care program which is based on individual need up and running. – BK1* *A lot of high-care places, doctors work on a rotational basis and people are allocated a doctor and they can't have their own doctor. Getting a doctor who will do more than just sign his sheet. – BK1* *The hairdresser visits and the physio and the podiatrist, the GPs. Mum's podiatrist comes monthly now. – BK3* *When my Mother was in, one of the things that really upset me was that the doctors burdened her down with terribly strong medications. – BK6*
The care in the future	*Intervention within the framework of aged care, i.e. the therapy services are not a priority, and they should be a priority. So that is something that is very very important. – BK1* *I think it's essential that the nursing staff take people for a walk, keep their bodies moving, whatever they can do every day. – BK4* *The way things seems to be going, people in aged care need a lot more attention, a lot more help. – BK5* *I think sometimes the profit motive would intrude on the quality of care that you'd get. – BK5*

BKs thought there was insufficient care for acutely ill frail aged people. They noted the difficulty of achieving person-centred care, medical staff who were not proactive and a generally defeatist attitude from staff. There was an acknowledgement that quality care was achieved through adequate funding.

Food

Five BKs made 13 comments about food, as it is now in aged care, and the ideal diet in the future.

Table 8.7 Food

Nodes	Responses
The food now	*When there's a birthday they have a special lunch. – BK3* *We can book a private dining room – we're doing that when a friend comes up from Melbourne next week - $12.50 for a meal, $8.50 for sandwiches. It's quite a substantial meal. – BK3* *Our parents have a constitution and immune system that are used to plain food. Mother always says how wonderful the soups are. It's always well-presented on a tray in her room. I don't blame her not wanting to go to the dining room – they don't talk to each other. – BK4* *It's kind of English nursery food. I remember lots of mince, mashed potatoes and peas. I wouldn't mind that once a week. Food seems to be so much more important to people. – BK6*
The future ideal diet	*A varied and complex diet is important. – BK1* *If one menu fits all, I don't think that would satisfy people in the future. – BK5* *People would like to think they have a meaningful say in their meals and have quite a bit of variety in what they get. – BK5* *I would think I'd like some variety, and my input, perhaps one day a week the residents could pitch in and make it. They could make their favourite recipes, perhaps make a cookbook. – BK6* *Once a week there'd be a choice – three entrees and three mains. – BK6* *If you expected something like that it would cost you more. – BK6* *Perhaps people could go to different restaurants. It could be lunch. – BK6*

The boomers noted that the residents they observed today were more used to plain food than they were. They said that choice and variety would be important for them in the future and realised that there would be an element of increased cost.

Comparison of NFP-FP-Government

Five BKs made 11 comments about the comparison between not-for-profit, for-profit and government-run aged care organisations. They commented about what they had observed now and the type of organisation they would prefer in the future.

Table 8.8 Comparison of NFP-FP-Government

Nodes	Responses
The now	*Government place in Canberra. She ended up with her own room there which she was quite happy with. It was quite old and they were closing it down. – BK2* *She's in for-profit. When we made an appointment we were asked to come when we could meet the director of nursing, and a few others. At the church one it was unprofessional – not organised. They couldn't find anyone to speak to us. – BK3* *There are some other Christian organisations who struggle to get accreditation because of old facilities or whatever even though their heart is in the right place. – BK5*
Their preference in the future	*In theory I'd prefer church-run. – BK3* *I think that as long as it's a really well-run place, no matter what the organisation behind it is, or whether it's the people behind a for-profit place, it doesn't matter as long as they do their utmost and keep to the rules set out by the aged care government agency. – BK4* *I certainly would rather be in a not-for-profit place because all the extra help is so readily available. – BK5* *I think sometimes the profit motive would intrude on the quality of care that you'd get. – BK5* *Faith-based as opposed to others, Christian organisations have high values. My father-in-law is in an RSL place in Queensland – he has good care there. – BK5* *Regarding Christian organisations, I would expect the values would be high and a lot of my friends would think the same. Although we may not be affiliated to a church, we still expect high values. – BK5* *If it's run by the church, you'd hope the care would be sensitive and sympathetic and well-run. – BK6* *I think the for-profit, corners could be cut to make as much profit as possible. – BK6*

In summary, BKs raised concerns about the profit motive in a for-profit organisation; they acknowledged that there should be high values attached to a church-run establishment, and, even if not religious or Christian themselves, they would appreciate the sensitivity and good care they perceived existed in the not-for-profit sector.

Involvement in running the aged care home

Five BKs made 10 comments about being involved in the running of the home. They talked about having involvement in aged care today, and what they would like in the future.

Table 8.9 Involvement in running the aged care home

Nodes	Responses
Involvement today	*I think we have to be political and have a voice. Advocacy within this framework must be important. – BK1* *I would like to get involved, I tend to get involved wherever I am. – BK2* *We have relatives meetings about once a quarter. – BK3* *There can be a tendency for people to feel that they've made a suggestion and it was well received, but has anything happened about it? – BK5*
Involvement in the future	*I've involved myself in the nursing home – I chair a meeting monthly for residents and carers. – BK1* *I don't think we'll have the ability to say anything. At 90 odd, I don't think I'll worry about any of it. – BK4* *People would like to think they have a meaningful say in their meals. BK5* *Certainly I think people will want to feel they have a meaningful say in the way the place is run. – BK5* *Feeling that the suggestions are acted on. – BK5*

BKs saw themselves as being involved in certain aspects of the running of the aged care home, based on their involvement in the organisation of their lives nowadays. They talk about being political and having a voice, a meaningful say.

Future of aged care

Four BKs made 11 comments about the future of aged care. They covered three nodes.

Table 8.10 Future of aged care

Nodes	Responses
Stumbling blocks in the future	*I think we're going to be more demanding and more enquiring because we have more information. – BK1* *I put her name down but vacancies never come up. Aged care up here is quite critical. – BK1* *I don't think Mother likes being amongst strangers. – BK4*
Needs in the future	*The last year we visited our friend's Mother in Holland. It's a quite upmarket place. She has a two room apartment, a bedroom and a nice living room. – BK2* *She goes down to a dining room for dinner and there's excellent food. You can take guests there, and we were her guests and it was*

	terrific. It can be done. I had never seen anything like it in Australia. – BK2 *The best thing is to keep yourself as healthy as possible. – BK2* *The way things seem to be going, people in aged care need a lot more attention, a lot more help. – BK5* *With the change in the population, people coming to Australia who are other religions, they would not be looking for Christian organisations. – BK5*
Fear of the future	*I could tolerate a hostel but I find nursing homes totally depressing. I shudder at the thought of that. – BK2* *The whole environment would make me want to curl up and die. – BK2*

The BKs saw many changes ahead, including a reduction in the number of beds available, a greater diversity of residents from overseas and the more demanding nature of the better-informed boomers. One boomer mentioned the better facilities provided overseas. They feared going into a nursing home.

Staff

Four BKs made eight comments about staff which fell into two nodes.

Table 8.11 Staff

Nodes	Responses
The importance of good staff – observations about aged care now	*She walks so much better with the male nurse. – BK3* *There are lots of Nepalese carers. An Irish RN is our favourite - there's an Irish, Scottish, 3 Koreans, a Chinese RN. – BK3* *There are lots of Nepalese – they are some of the most charming people. They have always revered the elderly. We have to do that. – BK4* *She had a Chinese male nurse who she liked and I think she thought she was back in China with the servants. – BK6*
Hopes for the future	*Consistency with the staff. – BK3* *If there was enough staff time to take people for a little walk every day. - BK3* *I think it's essential that the nursing staff take people for a walk, keep their bodies moving, whatever they can do every day. – BK4* *I think that's terribly important, that the attitude of the staff to the residents is the same anywhere. – BK5*

The level of staffing and the residents' positive relationship with the staff were concerns for the BKs.

Space

Four BKs made three comments about space.

Table 8.12 Space

Node	Responses
Space	*Mum had bugger all because of limited space. – BK2* *In the low care they have a sitting room as well as a bedroom, and probably a little balcony. – BK3* *It'd be a relief to get rid of my stuff – there's too much stuff. The amount of books, music, DVDs and on top of that there's art everywhere. You've been on this earth for 62 years, you collect a bit. – BK6*

Opinion was divided about the amount of space required, with one boomer lamenting the lack of space for his mother's possessions, one noting that they had seen a facility with plenty of space and the last looking forward to divesting himself of his accumulated possessions.

Religion

Only two BKs commented about religion.

Table 8.13 Religion

Node	Responses
Religion	*They've got to try their utmost to be kind, some patients are trying and some staff can be trying. It works both ways. – BK4* *I think they're important to keep everyone in the organisation focused. – BK5* *Faith-based as opposed to others, Christian organisations have high values. – BK5* *Regarding Christian organisations, I would expect the values would be high and a lot of my friends would think the same. – BK5* *Although we may not be affiliated to a church, we still expect high values. – BK5* *With the change in the population, people coming to Australia who are other religions, they would not be looking for Christian organisations. – BK5*

Kindness and high values were tied in with religion for the BKs.

Pets

Only two BKs mentioned pets. They made six comments on the topic, covering problems advantages.

Table 8.14 Pets

Nodes	Responses
Problems with pets	*They can actually be a hazard or a nuisance. – BK5* *I know I have friends who would object to having pets around the place. – BK5* *If you've got them running around the place they can actually be a trip hazard. – BK5*
The advantage of pets	*I'm not a pet person myself but I could see that other people could get a lot of benefit from them. – BK5* *There was a village dog, and that was good for some people but then someone has to manage them. – BK5* *I think there should be a pet in the place that everyone can take care of and take for walks and pat. – BK6*

In summary, pets were viewed in a balanced way as an advantage to many people, but as a source of problems in their management.

Choice

Two BKs made three comments about the importance of having a choice.

Table 8.15 Choice

Node	Responses
The importance of choice	*If one menu fits all, I don't think that would satisfy people in the future. – BK5* *When my Mother was in, one of the things that really upset me was that the doctors burdened her down with terribly strong medications. – BK6* *They let us bring champagne and a bottle of whiskey in the drawer. – BK6*

They wanted a choice of food, medication management and perhaps their choice of vices!

Couples/de facto/same-sex

Only one BK made a comment about couples/de facto/same-sex.

Table 8.16 Couples/de facto/same-sex

Node	Response
Couples/de facto/same-sex	*It makes no difference – when couples have been together for years and years, they should stay together. – BK6*

This BK hoped that all couples could be accommodated together.

Baby boomer interviews – naïve

The process for interviewing naive baby boomers was exactly the same as for knowledgeable baby boomers, including initial contact, response and agreement to participation, consent, method and arrangements for the interview. For the first few minutes of in-person and telephone interviews, we chatted to gain rapport. The boomer was then asked if they were ready to begin, reminded that I was going to record the interview and each interview began with the same broad opening question (see text box below). For face-to-face interviews, the boomer was encouraged to keep talking for as long as possible by the use of eye contact, nodding, and interested vocalisations. For telephone interviews, interested vocalisations were used. There was again no limit to the duration of the interview but generally the interviews were kept to 60 minutes as I considered that was long enough for both parties to remain enthusiastic. After 40 minutes, or if the boomer was wandering off-topic, prompts were introduced if those points had not been covered.

The questions for naïve baby boomers appear in the following text box.

Questions for naïve baby boomers

Open question:

- In the future when you are very old, you may need to go into an aged care home. Imagine there are lots of aged care homes in your area. What would you look for in an aged care home that would make you choose one over another? What features of the home do you think would have the greatest impact on your quality of life

Possible prompts or focus questions:

- Would the residents have input into all decisions about things like food, activities, entertainment, visitors, communication, facilities, staff, accommodation?

At the end of each interview the participant was thanked and asked whether they had any questions. The third party was contacted by phone to report that all was well. I transcribed the interviews as soon as practicable and entered into NVivo 9 ready for coding. Some comments were coded in more than one theme, for example *I guess*

when you're older and you don't have many activities, food would be an activity or interest. It would be disappointing to have sub-standard gruel. – BN2 appears under the themes Activities and Food.

Table 8.17 Code numbers and demographics of BNs

Boomer Code	Gender	Approximate age
BN1	Female	Mid 50s
BN2	Female	Mid 50s
BN3	Male	Late 50s
BN4	Female	Early 60s
BN5	Male	Early 50s
BN6	Male	Mid 60s

Table 8.18 Themes – naïve baby boomers

Node	Number of sources	Number of references
Activities	6	46
Power	6	30
Comparison of NFP-FP-Government	6	23
Food	6	22
Facilities	5	35
Future of aged care	5	17
Religion	5	11
Involvement in running the aged care home	4	11
Staff	4	10
Space	4	9
Couples/de facto/same-sex	4	8
Care	3	15
Pets	3	7
Choice	3	7

Activities

Six BNs made a total of 46 comments about activities; these covered three nodes.

Table 8.19 Activities

Nodes	Responses
Importance of technology	*Perhaps something with computers by the time I'm there. – BN2* *I'd want to play Scrabble by computer. – BN2* *I wouldn't be interested in carpet bowls and those types of recreational activities. I would want activities for the mind – a room full of computers. – BN3* *Entertainment is something – to get movies. The internet is the way to go, you don't have to be in a communal area, and can watch at any time of the day. – BN5* *I look at my study at the moment, that's probably what I would like to have, computer, music system. – BN6*

	I like to watch sports and I would keep myself busy watching TV. *Books, some books, but I'm getting used to reading books on Kindle and my son has just bought me an iPad, so I'm trying to get to the stage where I don't have to have a bookshelf full of books. – BN6* *Electronic reading – I'm not sure when I become frail whether I can still read in the electronic format. Or I could do what Alan does which is to convert the thing into voice and listen to it. – BN6* *Internet connection would be necessary for me because I'd like to search and read newspapers and make connections. I suppose I would use more Facebook connections when I grow old because I might not have the social relationships I have at the moment at work. – BN6*
Suggested activities	*Even if it was a big enough facility, then to have a camera club in-house, or have someone come in and teach the ladies knitting. – BN1* *Lots of activities. – BN1* *We have far more available to us and therefore our expectations are higher. I would expect them to take me out and about, but I'd be selective of the places I went. – BN3* *Knitting, crocheting, crafty things. Being able to learn new things. Computers, cameras, all sorts of things. You can't cater to everybody's tastes. – BN1* *To make you feel worthwhile in the community. You could crochet squares to make rugs to send to poor children, so you feel you're contributing. – BN1* *Shopping – they could take you in the morning and you'd have the run of the place for the day. – BN1* *There may be a nice concert that some of us want to go to, so the bus could take us there all together, if we weren't too decrepit. – BN1* *Would the bus go to only one shopping centre every week? Would there be outings to concerts or day-trips, go to the mountains to see the scenery. – BN1* *I think they really need recreational, like yoga, stretching classes, physical jerks class. It's a social outing as well. Once you move into that sort of environment, it would be very easy to slip into just sitting on your lounge chair all day. A pool, or a paddling pool, aquarobics. Sudoku, Bingo, crossword puzzles or anything so they use their brain and their body. – BN1* *I guess when you're older and you don't have many activities, food would be an activity or interest. It would be disappointing to have sub-standard gruel. – BN2* *Outings - I'd like bus outings, to get out of my room when I want to escape. I don't have to get off the bus. I'd just like to look at the scenery from the bus. – BN2* *It could be cricket which would be nice, to discuss about the various stories of cricket. I'm not particular about being surrounded by Indians because since we left India we haven't actually chosen to live in any communities where there are predominantly Indians. – BN6* *I think exercises would be good, like meditation, yoga, tai chi, Pilates – those types of exercises that you are capable of doing at any age. – BN6* *I don't think I could play cricket or tennis, although I would love to. – BN6* *… a board game. I used to play chess, and I play a lot of scrabble, I suppose those kind of games I would enjoy. – BN6* *I play card games. – BN6* *I like to relax with games. Maybe if I didn't do meaningful work that would become my intellectual exercise. – BN6* *I would love to go to the movies, I would love that. I'm not sure I would go to an opera or a play. – BN6*

	I certainly want to go to watch a test match or an AFL game and the tennis. – BN6 *So I suppose I would love people to develop technology usable by older people rather that we go and use technology that has been developed for young people. I hope somebody will realise there's a big market for this. I'm expecting something like that will happen. – BN6* *Perhaps get out and get a cup of tea. – BN2* *For shopping it would be nice to have a little courtesy bus that would take you to the shops, you wander around the aisles and get what you want and they take it home for you. – BN2* *If someone came in to do art classes or pottery, I'd enjoy something like that. Camera club, educational activities. – BN2* *I read all sorts of things from novels to serious, so good library facilities. And as you grow older, that's the company you have, especially if you're alone. – BN4* *Music is very important to me. – BN4* *To keep busy and to feel productive and useful. It's also a group activity, while you are knitting together. – BN4* *I'm not good at handicrafts but I could learn. – BN4* *For people like me with words perhaps I could help with proofreading. – BN4* *I would like to go with my family and friends, but I would also like to go out on the bus for a picnic outside or to visit an art gallery, all things I do now, if I was able to do it, even at a scaled down version, once a month. – BN4*
Things to be avoided	*I don't think of myself as a great mixer. I wouldn't like to be expected or coerced into group activities like bingo or whatever they do. – BN2* *I guess if they had activities I'd join in sometimes, but I wouldn't want to be made to take part. – BN2* *I would like to be taken to places, even shopping centres, and be on my own or with company, whatever suited me at the time. – BN3* *I was at a shopping centre recently and a minibus pulled up and some aged care residents got out and they were told in no uncertain terms to stay together. – BN3* *If every activity was preceded by prayer, BBs may not like that because we're not great church-goers. – BN3* *Loneliness and boredom. – BN5*

The naïve boomers could think of many activities they felt will be suitable for them in their final years. Most importantly they wanted to keep up-to-date with the technology they were used to. They did not wish to be forced to join in and mentioned many activities they would not want to take part in.

Power

All six BNs made a total of 30 comments on power.

Table 8.20 Power

Nodes	Responses
Independence, usefulness and making your own decisions	*Knowing that I had my independence but knowing that there were people there if I needed them, a vital call or a button or something, if I fell and hurt myself I could call for help. – BN1* *I suppose it's a fine balance between having your independence and not being alone. – BN1* *Even if I'm very, very frail as much as possible I'd like to do my own washing. – BN2* *I would expect them to take me out and about, but I'd be selective of the places I went. – BN3* *I think it's important to have one or more residents on a planning or steering committee. BN3* *They should be involved in those things that affect the day-to-day running of the facility. They shouldn't be permitted to know the financial operation of the facility. – BN3* *I found a lady a couple of years ago at Collaroy in winter, we were sitting on the beach and a lady was swimming around in the ocean. I thought she had a funny sort of wetsuit on. A few minutes later she came out of the water, crawled up the beach, stood up and just fell over backwards. So I ran down and helped her a bit. She was from the really nice nursing home across the road and she was very concerned that we would tell anyone. She was allowed to go for a walk but a small wave hit her and she fell in and it sucked her out. She was actually in a tracksuit. She didn't want to go back wet and we took her back to where I was living and dried her off and took her back. She was really concerned that the people didn't notice it because it felt like it was really claustrophobic, with everyone knowing everyone else's business so I don't know how much you can protect yourself from that because I think that would really do your head in. She was concerned that that would be reported and she would not have any freedom, they'd lock her in. I don't know to what extent they can control your behaviour. That would be a major issue for me. She was quite fearful of someone reporting her. – BN5* *I think that element of how much you have to interact with other people would be something I'd be a bit … I think who lives there makes a big difference and how they manage that. – BN5* *People in there in general, they should be able to, whether it's a sexual relationship or have a friend over for the night … a pull-out sofabed. You can still have control of your own environment. – BN5* *To have control over your own medication. To what extent they can zonk you out to keep you harmless, keep everyone whacked out. – BN5* *I may not demand things but I may create some trouble for the organisers because I could work with the other residents and voice an opinion. – BN6* *I have always been on committees, I am the president of my Rotary Club this year and I've been the president of a professional society, so I have always taken that sort of role. I was a conscientious objector when I was young, against imposing Hindi on South Indians. I could create trouble. – BN6* *I used to work in an organisation where the vision was always given by top management – I was looking after an operation and I insisted that our operation should have a shared vision. – BN6* *I would like to be taken to places, even shopping centres, and be on my own or with company, whatever suited me at the time. – BN3*

	How do they feel about me drinking? – BN2
Being part of the management of the home and making decisions about your room	*Depending on the level of mental capacity of the residents, if everyone's got their full marbles, I wouldn't be averse to having a body corporate. – BN1* *I think having representation on behalf of the residents, they themselves or their relative or nominated carer. Some might not be interested. – BN1* *At the end of the day it's usually top-down leadership and unfortunately the little people get swept away a bit in that scenario. It would be good for them to have a voice. – BN1* *If you want red walls in every room, it should be your prerogative. – BN1* *I don't see any reason why you couldn't decorate. For me, the whole point of moving to somewhere like that, and it would be the most difficult transition in anyone's life, would be the make it feel as homely as possible. – BN1* *Having your own things, in your own space, your own curtains, pillows and bedspread. – BN1* *If I was going to be the resident in that room I would like to be able to do what I want to it within reason. I wouldn't like to have to ask permission to put hooks on the walls, and I'd like to paint it if I wanted, and take down the curtains and put up blinds. That would be good. – BN2*
Being treated respectfully	*I was at a shopping centre recently and a minibus pulled up and some aged care residents got out and they were told in no uncertain terms to stay together. – BN3* *They were walking along with their walking frames in twos like kindergarten children. – BN3* *I would like a place where the nurse or the doctor, whoever's looking after you, doesn't treat you like a child, but tells you. – BN4* *I mean they might not have the time to have long chats with every resident but I would like information, and honest information. – BN4* *You probably wouldn't want to go to the dining room all the time depending who's there. – BN5* *I do realise that it could happen to me and so I need to be prepared for it. And I think I'm prepared for it, if I have to go, the best choice is a place for me, then I will go. – BN6*

A feeling of power for the boomers derived from being as independent as possible, being involved and useful, making their own decisions and being treated respectfully.

Comparison of NFP-FP-Government

Six BNs made 23 comments about the comparison between not-for-profit, for-profit and government-run aged care organisations.

Table 8.21 Comparison of NFP-FP-Government

Nodes	Responses
The perceived differences between the three	*Obviously if people can afford a higher quality of accommodation they may stay in a more luxurious place overlooking the sea. – BN1* *If there are going to be values and mission statements, they should be the same for everyone, government, church or private.- BN1* *The food, it could be varying quality depending on how much money you've got or if it's a public or a private place. – BN2* *It's the model of care, what is their philosophy, what are their values, that would be more important rather than the type of organisation. – BN6* *I probably would have qualms about government organisations, non-profit I do have some experience of non-profit organisations and people in not-for-profit have values. So my choice would be between for-profit or not-for-profit. I used to work for a firm that had good values. – BN6* *Probably some organisations have values given to them by the board or CEO or senior management. In some organisations where it is more democratic, they can actually have more bottom-up values. Having a shared vision. – BN6* *I see all three as being different. – BN3*
Not-for-profit aged care organisations	*I haven't had any experience of it but I don't mind it being run by a religious body as long as they don't worry that I'm a heathen. I would feel they are less for profit and more for looking after people. – BN2* *Church-run – they would probably be the best. – BN3* *I think I would go for a non-profit. – BN4* *I'm not religious so even if it's church-based or faith-based, I wouldn't want the faith to be imposed on me and I don't know whether the faith-based organisations would only take people who are of that faith. – BN4* *I think mostly the non-profit people would choose to go there because they have the values. – BN4* *I guess the church ones are better on the whole. They're a big organisation, they can't afford the bad publicity. – BN5*
For profit aged care organisations	*As far as the running goes, it should be someone who's a professional and have a medical or nursing background – I don't think that business people should run it because I don't think their motives are necessarily as true as someone who's got a nursing background and knows the compassionate side of nursing, because that's the danger – that old people are just a means to an end in some of those places. – BN1* *The people who live there are just there to feather the nests of those who own them. Then the quality of care could suffer as a result. – BN1* *There probably should be a minimum ratio of staff to patients wherever you are across the board, and if you have more money, there'd be more staff. I guess if you're very wealthy, you'd be nursed at home. – BN1* *The private place might be plush, you would get all your add-ons but it would be very expensive. There is a sense that there might not be oversight there as well, more chance for corruption. – BN4* *The for-profit ones are going to be more … they're pitching it at the market so you'd get better services. Although there's a hierarchy of affordability. I grew up in a restaurant business and nursing home owners would come in and they skited about how little they could spend on food. – BN5*
Government-run aged care organisations	*People who are not so well off may have to go into a government funded place which is smaller, but the quality of the care shouldn't suffer because of any factor whatsoever. – BN1* *Government run would be watching the pennies but the staff wouldn't care – they've got their public service job. – BN3*

	A government run place would be basic, badly run because it would be bureaucratic, the luck of the draw – you might get a good carer or not, and people who can afford it wouldn't want to work there unless they're really dedicated. – BN4

They clearly distinguish between the three types of organisations. They see the not-for-profit or church-run as the best, the for-profit as bottom line-oriented and the government as less expensive and less well run.

Food

Six BNs made 22 comments about food. These fell into three nodes.

Table 8.22 Food

Nodes	Responses
The quality of the food	*I'd go to a dining room for my main meals. The quality of the food would be important. I'd hate to be somewhere where they served hospital food, crap really. – BN1* *The quality of the food would be the first thing that springs to mind because I've heard people say that the quality of the food is really bad. – BN1* *The food, it could be varying quality depending on how much money you've got or if it's a public or a private place. – BN2* *What I wouldn't like is hospital food – steamed vegies. – BN4* *That traditional catering, a lot of those places contract the catering out – it would be pretty awful. That would be an issue. – BN5*
The variety of food	*It would be nice to have some variety with some spicy things sometimes because I think you'd lose your tastebuds as you get older so sometimes I'd like to have something spicy. – BN2* *I'm used to variety so I'd like to continue with lots of variety. – BN2* *If I still had teeth, I'd like roast dinner, a spaghetti bolognaise, a Thai curry, just to set the different styles, quiches. – BN2* *I'm very flexible but I like a variety. I'd like cereals, porridge, toast and marmalade. I guess when you're older and you don't have many activities, food would be an activity or interest. It would be disappointing to have sub-standard, gruel. – BN2* *I think it's similar to bowling club food – mass-produced pap. They need to somehow lift their game as far as different cuisines go. – BN3* *We no longer want to eat meat and three veg, we want pasta and Chinese. Whenever I've been in an aged care place [he used to visit briefly for work as a maintenance person] there never seems to be any fruit. – BN3* *Now everybody is used to eating so many cuisines. – BN4* *You'd want a range of food. – BN5* *Ideally if it's located close where you can walk to a coffee shop or somewhere to sit out that's nice. – BN5* *We have started eating a lot more vegetarian food because we grew up as vegetarians. So I suppose I'll still have a lot of vegetarian food. – BN6*
Trying to cater for everyone	*I've never liked cooking so I'd be happy for them to do the cooking for me. Would I have to eat it with other people or could I eat by myself? – BN2*

	Maybe a choice between two meals would be good, like on planes. You can't possibly cater to everybody's taste. – BN4 *What could be done is to get a list of what people like and offer it sometime during the week, so at least once you get the dish you like. – BN4* *Some frozen meals are very good, like TV dinners. – BN4* *I would probably want to have some self-cooking just for minimum stuff. I presume the meals would be provided. I'd like to make a cup of tea or have a snack. – BN5* *When we lived in Tweed Heads, on our campus there was no canteen, so we used to go to the bowling club and they had a cheap lunch for us and we were members. It was Australian food. We got used to it because it was the only thing we could eat at that time. – BN6*

The quality and variety of food are very important to the boomers. This reflects the dining preferences of the boomers now.

Facilities

Five BNs made 35 comments about the facilities they expected to be provided. Their comments covered facilities they would like in the future and maintaining independence and feeling at home.

Table 8.23 Facilities

Nodes	Responses
Facilities they would like in the future	*Built-in wardrobes and I suppose just the comforts that you're used to at home like a little microwave. – BN1* *I'd go to a dining room for my main meals. – BN1* *And being able to have visitors. Overnight visitors would be lovely. If my grandson wanted to come and visit, I could have a pull-out couch or a sofabed. – BN1* *Obviously if people can afford a higher quality of accommodation they may stay in a more luxurious place overlooking the sea. – BN1* *If you've got a room with your own tellie and VCR, DVD player. – BN1* *I guess hand rails would already be there in the bathroom. – BN1* *I wouldn't have to share with anybody. – BN2* *I've never liked cooking so I'd be happy for them to do the cooking for me. – BN2* *I'd like the room or the place to be well-lit with natural light. The lighting would be important to my mood. – BN2* *It would be nice to have enough room in my room to entertain. – BN2* *To have a guest area where we could sit where other people wouldn't be listening to us. – BN2* *I would like my own [computer], so we'd need wifi throughout the building. I expect by the time we're doing it, it would be more normal. – BN2* *If there were a suggestion box where, if we had an idea about an activity, or something we wanted to let management know about, a non-blame system where you could make comments or suggestions. – BN2* *Do they have physios who come and help you strengthen your ankles? – BN2*

	What I would look for personally would be library facilities, would be important to me, and a wide choice of material, not just popular books and prize winners. – BN4 *I would want to be able to listen to music. – BN4* *… have a bit of a garden, greenery. – BN4* *I would like friends to be able to visit and I would like to be able to go out on occasion. – BN4* *I would want the internet, so that would be a key thing and that would have to be very high speed. – BN5* *In 10 years' time you already watch movies on YouTube. – BN5* *They'd have to have bar services. I wouldn't want any restrictions on what to drink or how much to drink. – BN5* *Ideally if it's located close where you can walk to a coffee shop or somewhere to sit out that's nice. – BN5* *I look at my study at the moment, that's probably what I would like to have, computer, music system. – BN6* *I would not mind staying in different retirement homes, I would probably stay close to my home because I would like to come out and see the city and the traffic even though living in a mountain or seashore may be better for me. – BN6*
Maintaining independence and feeling at home	*A little kitchen like a serviced apartment. – BN1* *Knowing that I had my independence but knowing that there were people there if I needed them, a vital call or a button or something, if I fell and hurt myself I could call for help. – BN1* *For me, the whole point of moving to somewhere like that, and it would be the most difficult transition in anyone's life, would be the make it feel as homely as possible. – BN1* *Having your own things, in your own space, your own curtains, pillows and bedspread. – BN1* *I'd like to have my privacy, having my own room and not having to share with somebody who may be slightly more demented than myself would be nice. – BN2* *If there were little washing machines it would be good. In my room I'd like to be able to make a cup of tea if I was safe with the kettle. You can get those one cup ones that just boil and squirt it into a cup. I could have a little minibar fridge. – BN2* *I would prefer to have a separate bedroom to having a big bedroom with a bit of a lounge area. I would probably want to have some self-cooking just for minimum stuff. I presume the meals would be provided. – BN5* *I'd find it really difficult not to have an outdoor area outside that's private. Without that it's just not the same. Ideally you could put a table so you could read a newspaper and have a barbeque. You'd be self-sufficient then. – BN5* *People in there in general, they should be able to, whether it's a sexual relationship or have a friend over for the night … a pull-out sofabed. You can still have control of your own environment. – BN5*

The boomers were clear about the facilities they would like in the future, ranging from physiotherapy, personal kitchenette, a sofabed for overnight visitors to bar services. These would help them to retain their independence and the feeling of being at home.

Future of aged care

Five BNs made 17 comments about the future of aged care.

Table 8.24 Future of aged care

Nodes	Responses
The future of aged care	*I have a friend who's found it very difficult to get them accommodation for the two of them together. Together in the one apartment. – BN1* *I think there'll be an ever-increasing demand for aged care of all types. – BN3* *We have far more available to us and therefore our expectations are higher. – BN3* *Nobody wants to go into aged care but sometimes you can't help it, especially as you grow older. – BN4* *It would be nice to be with people with similar interests, but that's asking for too much I guess. – BN4* *I guess if you had a pet you could have a grandchild [to stay]. – BN4* *I don't have grandchildren yet but I think the nicer thing would be for you to visit the grandchild rather than the grandchild come to you - it's not a very nice environment for young children is it? – BN4* *And I think life is beautiful because it's short. If everybody lived forever it would be hell I think. – BN4* *What's the cost to the government if someone's got dementia? – BN5* *I see it as an export industry myself. I've got friends over in Asia, the food's great, it's low cost, healthcare is as good if not better than here. I see that they've got a lot of … probably a large part of it is relatively low-skilled work and on a pension over there you can live like a king. Vietnam, Thailand. I think you could set up a whole series of them in different places. You could be a year there and then go to another one for a year. The family could come and visit for almost nothing, have a month with them. … Labour is so cheap there. – BN5* *I don't think many people keep themselves engaged, but over there you could serve a purpose over there and be useful to the local community. – BN5* *If you look at countries that need aid and employment. They'd get good training. It's labour intensive. Nice environments. It's warm. – BN5* *In every other place we have been we have had multicultural friends. – BN6* *I don't know how technology will change. There'll be other kinds of technology. I think technology is taking more time these days. I always used to play around with technology but I'm getting frustrated now because I can't adapt to technology as fast as I could. So I suppose I would love people to develop technology usable by older people rather that we go and use technology that has been developed for young people. I hope somebody will realise there's a big market for this. I'm expecting something like that will happen. – BN6*

They saw an exciting future, including aged care homes being established in countries overseas where the Australian dollar was needed and where it bought more for the

resident. These opportunities of course already exist. They also saw a future with specially-adapted technology for older people.

Religion

Five BNs made 11 comments about religion. Two nodes were evident.

Table 8.25 Religion

Nodes	Responses
Christian values	*I suppose you can have all the mission statements in the world but if you don't adhere to them, it's no good. I'd hate to think that someone was running an institution based on church values and not adhering to those values. – BN1* *If there are going to be values and mission statements, they should be the same for everyone, government, church or private. – BN1* *I haven't had any experience of it but I don't mind it being run by a religious body as long as they don't worry that I'm a heathen. – BN2* *I think respect and respecting people for the life they've led. Not treating them like children even though they're behaving like children. Being kind to people is rare and very nice when they are. Compassion and honesty. – BN2* *That's the kind of philosophy I would like in a place, not just treat me as if I've come to die but to help me to improve myself and do preventive measures and educate you on the latest technology. – BN4* *I can see that some organisations have values from their own faith but I suppose that in the day-to-day running of the facility, the residents could have a voice if they are given the opportunity to do so. – BN6*
The acceptance of different values or views	*It depends on the level of commitment to the church that the residents were expected to provide. If every activity was preceded by prayer, Baby boomers may not like that because we're not great church-goers. – BN3* *Baby boomers would appreciate that it exists but wouldn't want it shoved down our necks every minute of the day. – BN3* *I believe in euthanasia. – BN4* *I feel strongly about organ donation too. – BN4* *I'm not religious so even if it's church-based or faith-based, I wouldn't want the faith to be imposed on me and I don't know whether the faith-based organisations would only take people who are of that faith. – BN4*

The naïve boomers, although not always religious themselves, appreciated what Christianity had to offer in their twilight years. They were very accepting of different values or views.

Involvement in running the aged care home

Four BNs made 11 comments about involvement in running the home.

Table 8.26 Involvement in running the aged care home

Node	Responses
Involvement in running the home	*Depending on the level of mental capacity of the residents, if everyone's got their full marbles, I wouldn't be averse to having a body*

	corporate. – BN1 *If they're not in a position to have that, there's no reason why my family couldn't represent me on a board. – BN1* *A residents' morning tea where they could have an informal chat with management every couple of months, they could say how they're going. – BN2* *They could have a newsletter, every couple of months, with residents sharing what they've been up to, or if anything new is going to happen with the facility, e.g., a diving board in the pool, suggestions about recipes etc. – BN2* *I think it's important to have one or more residents on a planning or steering committee. They should be involved in those things that affect the day-to-day running of the facility. They shouldn't be permitted to know the financial operation of the facility. – BN3* *I may create some trouble for the organisers because I could work with the other residents and voice an opinion. – BN6* *I can see that some organisations have values from their own faith but I suppose that in the day-to-day running of the facility, the residents could have a voice if they are given the opportunity to do so. – BN6* *So I think there would be operational values versus the organisational values. [So the residents would be more inclined towards the operational side?] Yes. – BN6* *How to behave to each other, not disturbing others, not throwing rubbish around, those things could be developed by the residents. – BN6*

They saw themselves as taking part, sitting on committees and making decisions about some aspects of life in the home. All reflected enthusiasm about taking part.

Staff

Four BNs made 10 comments about staff. Two nodes emerged.

Table 8.27 Staff

Nodes	Responses
Expectation that standards would be high in the future	*The number of staff would affect the level of care, but not the quality of care. – BN1* *I would hope that when I'm old, nurses would be kind. I worry about some of the carers you hear about who aren't as kind to old people as they could be. – BN2* *If you get the same people looking after you day after day, you'd form a bond with them, if you liked them that would be lovely, like a new friend and I think you would hopefully feel comfortable telling them anything. – BN2* *When there's a new member of staff, they bring them round to meet you, have a little morning tea or something. – BN2* *It's important to make everybody feel part of the family, the staff and the residents. – BN2* *I would like a place where the nurse or the doctor, whoever's looking after you, doesn't treat you like a child, but tells you. – BN4* *I think mostly the non-profit people would choose to go there because they have the values. – BN4*
Concerns about	*What do I do if I don't like a member of staff, can I say I don't want*

staff	*them near me. – BN2* *I would expect all the people running it to be empathetic. There's no place for vicious nurses. – BN3* *I worry that the next generation (of nurses) are not so caring. – BN2*

The boomers envisaged becoming close to staff members and being involved in their care on a level with the staff. They acknowledged that there were problems around not getting on with staff.

Space

Four BNs made nine comments about the space they would need.

Table 8.28 Space

Node	Responses
Space	*How much space I'd have for my stuff and also just to live in. I'd hate to be in something like a motel unit with the bed in the living room. I think a separate bedroom with an ensuite is very important. – BN1* *Built-in wardrobes and I suppose just the comforts that you're used to at home, like a little microwave. – BN1* *A little kitchen like a serviced apartment, so I could make a cup of tea. But not a full oven. A bit like a serviced apartment. – BN1* *It would be nice to have enough room in my room to entertain. – BN2* *To have a guest area where we could sit where other people wouldn't be listening to us. – BN2* *I think as you get old you value your privacy more. – BN2* *In terms of my physical accommodation there I would prefer to have a separate bedroom to having a big bedroom with a bit of a lounge area. – BN5* *I live in a 3-bedroom townhouse now and if I go to a place I may have only one room. – BN6* *I like to watch sports and I would keep myself busy watching TV. Books, some books, but I'm getting used to reading books on Kindle and my son has just bought me an iPad, so I'm trying to get to the stage where I don't have to have a bookshelf full of books. – BN6*

They talked about space and privacy and having enough room for their possessions.

Couples/de facto/same-sex

Four BNs made eight comments about the issue of accommodating married, de facto and same-sex couples.

Table 8.29 Couples/de facto/same-sex

Node	Responses
Couples/de facto/same-sex	*It'd be nice to have somewhere we could be together. – BN1* *Same-sex couples should be in a normal place. In our generation it's*

	much more acceptable for same-sex couples to be together. In my parent's generation, no, but my generation, as we get older and generations to follow, it'll almost be the norm. Or not seen as abnormal. – BN1 *Anyone who's been in any sort of long-term relationship, irrespective of sexuality or marital status. – BN1* *What if I had a boyfriend? Some friends of ours, a gay male couple, one of them had to go into a hostel in his own room. His friend couldn't be with him. And there's another one I know whose partner was a lot older and needed some support and they had to move to the Central Coast. – BN2* *Will they do rooms with two people or side-by-side rooms? – BN2* *So it wouldn't offend the philosophy of a religious place, if you weren't married, or were gay? – BN2* *It shouldn't make a difference if you're a de facto or same-sex couple. Now, it's not accepted by the age group currently there. By the time the baby boomers get there it will be accepted. – BN3* *People in there in general, they should be able to, whether it's a sexual relationship or have a friend over for the night … a pull-out sofabed. You can still have control of your own environment. – BN5*

These comments pointed to the importance of maintaining relationships of whatever variety, and being accepted.

Care

Three BNs made 15 comments about care. Comments were divided between being secure and yet knowing that help was near, and maintaining quality of care.

Table 8.30 Care

Nodes	Responses
Security, having help at hand	*Knowing that I had my independence but knowing that there were people there if I needed them, a vital call or a button or something, if I fell and hurt myself I could call for help. – BN1* *Having someone you'd check on you if they hadn't heard from you for, say, 12 hours. – BN1* *Security I'd be very mindful of. The security of patients who can't fend for themselves. – BN1* *Would a nurse pop in, or only if I'm unwell? – BN2*
Maintaining quality of care	*Being able to have a bath is still nice. If you couldn't have a bath in your ensuite, then having somewhere like a plunge pool or spa room. – BN1* *The quality of the care should be as high as it can possibly be and it shouldn't be restricted because of religion or government or money or whatever. BN1* *People who are not so well off may have to go into a government-funded place which is smaller, but the quality of the care shouldn't suffer because of any factor whatsoever. – BN1* *That's down to the professionalism of the staff. – BN1* *The people who live there are just there to feather the nests of those who own them. Then the quality of care could suffer as a result. –*

	BN1 *The number of staff would affect the level of care, but not the quality of care. – BN1* *I wouldn't have to share with anybody. – BN2* *I don't want my washing mixed up with someone else's. – BN2* *I think respect and respecting people for the life they've led. Not treating them like children even though they're behaving like children. Being kind to people is rare and very nice when they are. Compassion and honesty. – BN2* *It's the model of care, what is their philosophy, what are their values. That would be more important rather than the type of organisation. – BN6*

Quality of care and security were very important to the boomers. They mentioned the number of staff influencing the quality of care and the professionalism of the staff being important including kindness, compassion and honesty.

Pets

Three BNs made seven comments about pets.

Table 8.31 Pets

Node	Responses
Pets	*The first thing would be that I could keep my little dog with me because I've got a little dog. And if I didn't have her, then a companion pet of some like, a dog or cat or a fish or whatever. – BN1* *I really, really think it's so important, that if someone's long-term they should have their pet, unless it's a Rottweiler or a Great Dane. So many people are heart-broken when they go in and they have to lose their pet. They become your whole life, like your children. People don't appreciate how much animals can improve your life. Even if the centre has a pet. You can't loll in bed all day if you know you have to take it for a walk. – BN1* *I don't plan on having a pet myself because I feel it's a huge responsibility but I would love to have a place where animals are there, like a resident cat or dog. That would be great. – BN4* *I know that they bring a lot of joy to you especially when you are upset, an animal gives you love unquestioningly. If you had a dog you would be forced to exercise so it's nice to have a resident cat or dog, or a few, so when you feel like it you have the facility. – BN4* *I don't think I would be able to look after a pet. – BN6* *It's something I would like to have but I don't really think I could have one. [Could there be a pet to share?] Yes that would be good – a cat or a dog. Cats are probably easier, although dogs, you can walk them. – BN6*

The naïve boomers had only positive comments about keeping pets.

Choice

Three BNs made seven comments about choice. They would like to be able to decide what to do for themselves.

Table 8.32 Choice

Node	Responses
Choice	*What I worry about is being trapped with someone I don't like who talks a lot. I talk a lot, so I don't want any competition [smiles]. – BN2* *I don't like it too regimented, for example always sitting next to Mrs Jones at dinner. – BN2* *You probably wouldn't want to go to the dining room all the time depending who's there. – BN5* *I think quality of life at that stage … I wouldn't be going in there by choice for the sake of it. It would be an absolute last resort. – BN5* *I think if you get to that stage … I wouldn't want to go there until I was at that stage. – BN5*

The boomers would like to be in charge of their own destiny as much as possible.

This chapter provides a snapshot of what baby boomers, both knowledgeable and naïve, think about aged care including what they would like from aged care if they go into a home.

The following chapter contains the discussion of all data collected.

Chapter 9

ABOUT SUCCESSFUL PRESENCE

'One cannot think well, love well, sleep well, if one has not dined well.'
Virginia Woolf, 1929

This chapter draws together the findings arising from the research into my six research questions. It places the resident, the 'third-party stakeholder', within Russell and Morse's (2002) Servant Leadership Model. Finally, I develop the idea of residents' 'Successful Presence', in which they are potentially able to achieve a feeling of quiet satisfaction and peace within their community.

The research problem and research questions

The research problem

My work as a Registered Nurse and within a not-for-profit Faith-based aged care organisation, and my connection with the ARC linkage research grant on leadership capability development in the Faith-based not-for-profit sector formed the catalyst for this research. I wanted to investigate the care recipients' experience of the leadership model adopted by the organisation studied, FaithCare. The residents are the most important group in residential aged care for two main reasons:

- without them there would be no aged care organisation; and
- because of their age and frailty they are the most vulnerable of the groups within and connected to the organisation, that is, management, staff, contractors, volunteers, relatives and friends.

Their vulnerability stems from these factors:

- the aged care home in which they live is in most cases the last residence they will inhabit;
- they live at the home full time;
- they have little chance of escape back to their family home because their home may have been sold to finance their entry into aged care;

- they may be too frail and ill to live alone again;
- they have little chance of living with a relative or friend because that option has almost always been considered before their arrival at the home; and
- we, the people who care for our residents, are in the best position to affect their wellbeing and happiness, positively or negatively.

The residents' happiness is dependent to a large extent on the culture and leadership model adopted by the organisation that determines how care is delivered and managed. These interconnected features form the background or atmosphere within which everyone at the aged care home operates. They provide structure and guidance for staff and others, and inform their behaviour towards the residents and each other.

The research questions

I decided to investigate the leadership of FaithCare and the residents in its care by addressing these questions:

- (RQ1) How was the leadership model of FaithCare chosen?
- (RQ2) How are the culture and the chosen leadership model transmitted throughout FaithCare?
- (RQ3) Does the wider business community acknowledge that 'third-party stakeholders' should have a say in any key aspects of organisations?
- (RQ4) What is important to today's residents?
- (RQ5) Do today's residents have a meaningful say in decisions affecting them in their aged care home?
- (RQ6) What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?

The information in the following table brings together the main findings uncovered during the research.

Table 9.1 Summary of main research findings

Research Method and Chapter	Data source and Participants	Major findings
RQ1 How was the leadership model of FaithCare chosen?		
QUAL **Chapter 6**	Manager interviews **Managers**	Managers are taught Servant Leadership. This is complementary to the culture which has evolved within FaithCare since it was founded.
RQ2 How are the culture and the chosen leadership model transmitted throughout FaithCare?		
QUAL **Chapter 6**	Focus Group **Staff**	Communication is the most important factor in dealing with the residents. Staff understand their own importance in the transmission of the culture to the residents. When discussing their dealings with the residents, staff talk in terms of 'us and them'.
QUAN **Chapter 6**	OCAI **Staff**	The culture of FaithCare is predominantly a Clan Culture, which sits well with Servant Leadership and becomes a proxy for the leadership model.
QUAN **Chapter 6**	Staff Surveys **Staff**	Staff are aware of the culture and vision and values of FaithCare, and of Servant Leadership. Staff do not feel themselves involved in the decision-making aspects of the organisation.
RQ3 Does the wider business community acknowledge that 'third-party stakeholders' should have a say in any key aspects of organisations?		
QUAN **Chapter 7**	Aged and Consumer Care Leadership Survey **Managers**	The client- or resident-stakeholder has a role to play in aspects of management decision-making around strategic planning and the mission of the organisation.
QUAL **Chapter 7**	IBM CEO interviews **CEOs**	The client-stakeholder has a role to play is aspects of decision-making.
RQ4 What is important to today's residents?		
QUAL **Chapter 7**	Resident interviews **Residents**	Residents want to have a say in things that affect them. They are not consulted about things that affect them. They lack the power to change things that are important to them, for example food and activities. They want better communication. They want to remain as independent as possible.
QUAN **Chapter 7**	Client surveys **Residents**	There is no long-term follow-up of problems identified by residents. Residents are more dissatisfied with food and activities than with other aspects of aged care life. Satisfaction with the activities provided has

		declined.
QUAN **Chapter 7**	Comments and Complaints forms **Residents**	Residents are most dissatisfied with food. Actions are initiated but there is no long-term follow-up.
QUAL **Chapter 7**	Observation of Residents' Meetings **Residents**	All residents have an opportunity to have their say at meetings. Follow-up of problems during a later meeting does not occur. The residents' meeting minutes are a true reflection of what occurs during the meetings.
QUAL **Chapter 7**	Minutes of Residents' Meetings **Residents**	Follow-up of complaints or concerns from one meeting to the next does not occur. The residents' meeting minutes are a true reflection of what occurs during the meetings.
RQ5 Do today's residents have a meaningful say in decisions affecting them in their aged care home?		
QUAL **Chapter 7**	Resident interviews **Residents**	Residents want to have a say in things that affect them. They are not consulted about things that affect them. They lack the power to change things that are important to them, for example food and activities. They want better communication. They want to remain as independent as possible.
QUAN **Chapter 7**	Client surveys **Residents**	There is no long-term follow-up of problems identified by residents. Residents are more dissatisfied with food and activities than with other aspects of aged care life. Satisfaction with the activities provided has declined.
QUAN **Chapter 7**	Comments and Complaints forms **Residents**	Residents are most dissatisfied with food. Actions are initiated but there is no long-term follow-up.
QUAL **Chapter 7**	Observation of Residents' Meetings **Residents**	All residents have an opportunity to have their say at meetings. Follow-up of problems during a later meeting does not occur. The residents' meeting minutes are a true reflection of what occurs during the meetings.
QUAL **Chapter 7**	Minutes of Residents Meetings **Residents**	Follow-up of complaints or concerns from one meeting to the next does not occur. The residents' meeting minutes are a true reflection of what occurs during the meetings.
RQ6 What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?		
QUAL **Chapter 8**	Interviews **Knowledgeable**	A feeling of personal power is important to boomers.

	Baby Boomers	They want to be kept engaged to avoid boredom. They want up-to-date technology. They want good, varied food and a choice of food. They want to be involved in the running of the aged care home. They have little understanding of how frail and unwell they may be in their 80s and 90s.
QUAL **Chapter 8**	Interviews **Naïve Baby Boomers**	The naïve baby boomers want lots of activities and up-to-date technology. They do not want to have to join in activities in which they are not interested. They want to be involved in the running of the home. The quality and variety of food is important to them. They want space and privacy. They have little understanding of how frail and unwell they may be in their 80s and 90s.

Servant Leadership

Servant Leadership was the model deliberately chosen by FaithCare to reflect and reinforce its culture. One senior manager stated during the manager interviews that there was a secondary reason for selecting Servant Leadership.

> *… we wanted people to have the chance to explore different types of leadership and what the advantages were if you could build a relational focus to how you manage your team rather than just being authoritarian. – M5*

This was to flatten the structure of the organisation from the very hierarchical management structure typical of nursing and health organisations. Whether the latter had or had not occurred was not studied here.

'Servant-leadership holds that the primary purpose of business should be to create a positive impact on its employees and community' (Spears & Lawrence 2002, p. 9). In the leadership literature since the 1960s the emphasis has been mainly on the leader and the followers. As discussed in Chapter 2, there has been little mention of the 'third-party stakeholder', or as Greenleaf says, the community. Sometimes the 'third-

party stakeholder' is referred to as the 'external stakeholder' (Harrison & St. John 1996). I have not used this terminology because I am concentrating on the inclusion of the resident in the leadership model and to refer to the resident as an external stakeholder would be contrary to the thrust of my argument. Indeed, in aged care, the residents *are* our community.

The residents are thus part of the Servant Leadership model from Greenleaf's perspective. Also, as mentioned in Chapter 1, the residents are in the building 24 hours a day, so may be thought of as physically within the model, if one considers the model a living, transforming entity, one that accommodates the needs of the people occupying it.

Two of the nine functional attributes of Servant Leadership are service and empowerment, and three of the accompanying attributes are communication, listening and encouragement (Russell & Stone 2002). These five attributes are very relevant to FaithCare's residents and from the findings presented here, are the areas that residents have said are of particular importance to them. Service, listening and encouragement are very much part of the culture of FaithCare. From the research findings we see, however, that empowerment and communication could be improved.

The culture of FaithCare was found to be clan culture (Cameron & Quinn 2011). Among the hallmarks of clan culture are shared values and goals, cohesion, participativeness, individuality, and a sense of we-ness. This is said to be typical of Servant Leadership. Cameron and Quinn were writing about the effect of the culture on employees, but as I found during the staff focus group, the transmission of the culture from management to staff to residents in this organisation was dynamic. Staff demonstrated a strong understanding of their importance in transmitting the culture of FaithCare to residents. Communication was the key component, scoring over 50% in the OCAI, more than the next aspect, nurturing.

In Chapter 2 I reproduced Russell and Stone's (2002) Servant Leadership model diagram (see Figure 9.1 below).

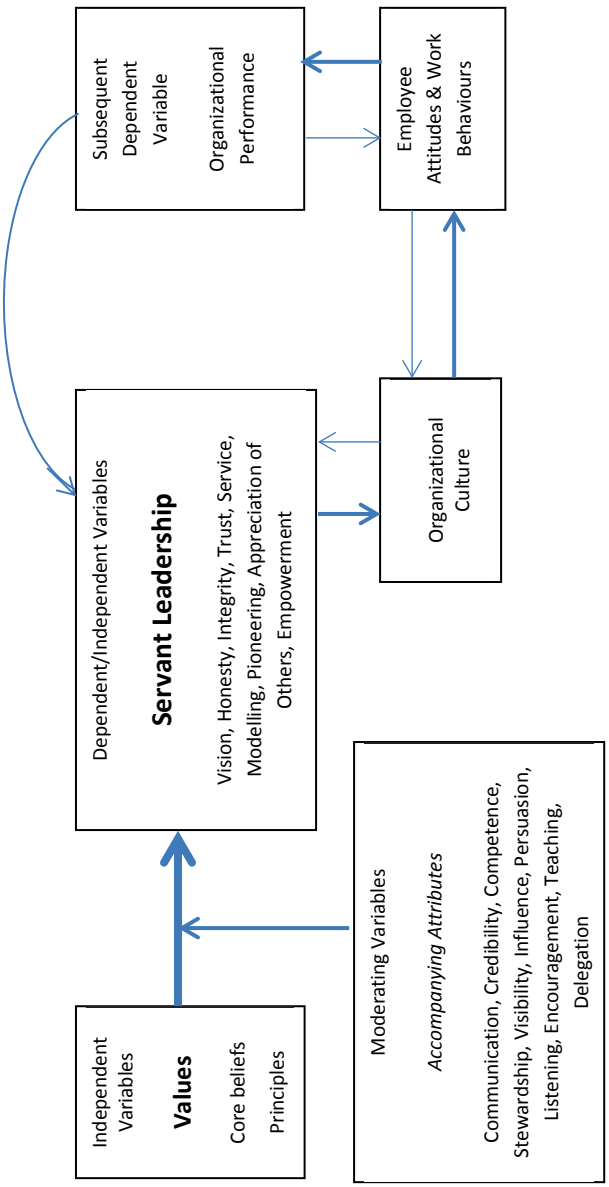

Figure 9.1 Servant Leadership model 2
Source: Russell and Stone (2002, p. 154)

I would like to add the residents into this diagram as my contribution from this study. I have done so in red to differentiate my additions from Russell and Stone's original diagram. The boldness of my arrows reflects the strength of the connection or flow and a fuller explanation of my red arrows follows Figure 9.2.

Figure 9.2 shows in red where the residents can sit in Russell and Stone's diagram. They benefit from the attributes of Servant Leadership via the organisational culture

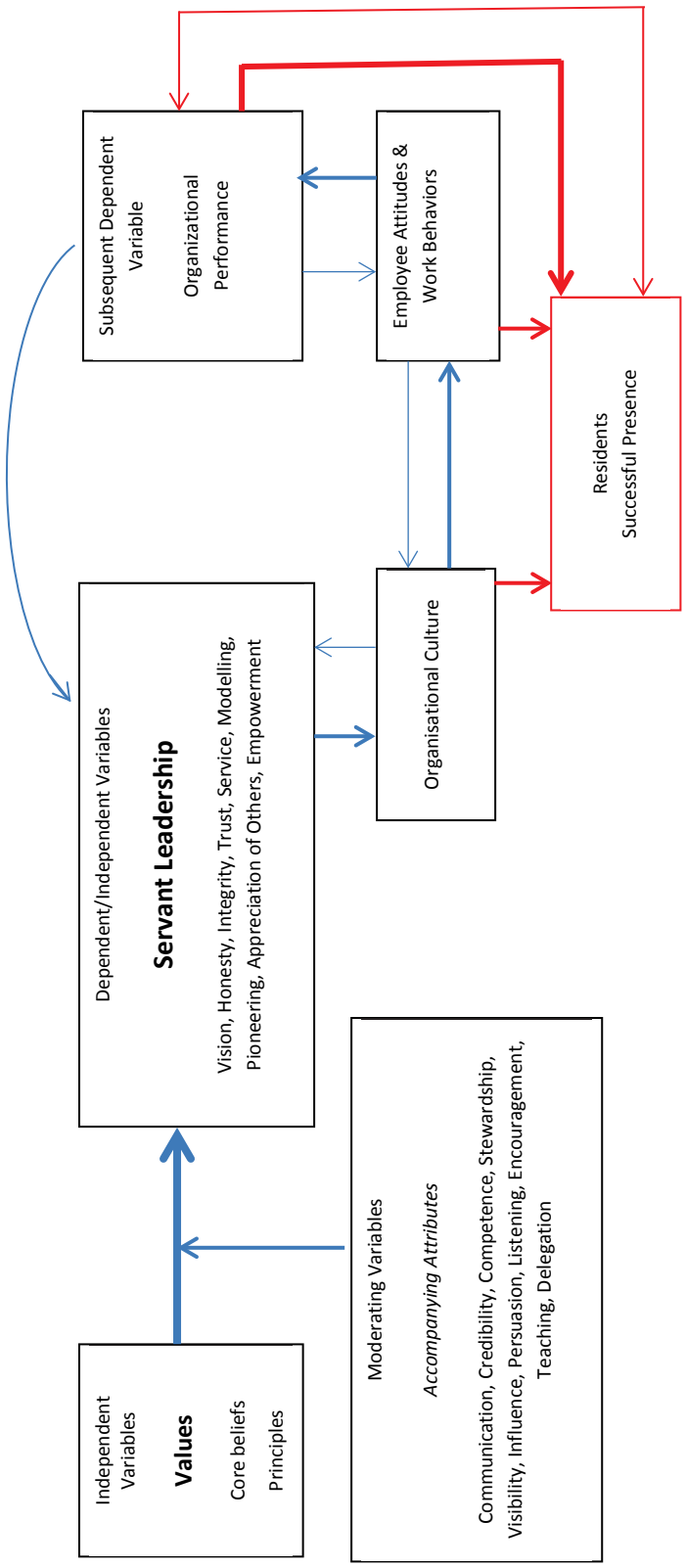

Figure 9.2 Servant Leadership model 2 incorporating the resident
Source: Russell and Stone (2002, p. 154)

and also via the staff attitudes and behaviours. These are two different but complementary avenues in FaithCare.

As mentioned previously, organisational culture acts as a proxy for leadership, especially among the staff rather than the managers. Indeed, in an organisation of this age (more than 60 years), the leadership model and the culture are virtually interchangeable. The culture is conveyed to the residents, as described previously, via literature and posters around the aged care home, but also via the staff, especially the carers, who are intimately aware of their obligation to act towards the residents and each other in a manner that is in accord with the culture they learn at orientation and beyond.

Looking back to Table 9.1, both residents and future residents (baby boomers) value communication and self-determination (empowerment). The residents' issue with food since *Greentrees* was commissioned is a good example of the way in which they are encouraged to comment on and/or complain about what is important to them; the organisation appears to listen and respond but frequently no long-term resolution is found. The two-way connection (red arrow in the figure) illustrates this complaint/response mechanism when it is in place and that it can operate very successfully between the residents and the organizational (*sic*) performance.

Organisational performance in this sense refers not only to the ongoing financial viability of the organisation but also to FaithCare's preparedness to embrace Servant Leadership as an empowering force. The flow of information from resident to organisation is sought by FaithCare, and the organisation responds by undertaking an action to address the problem and communicating the action to the resident. Examples of the actions undertaken appeared in Tables 7.25 and 7.29.

It was found from the client survey data and the comments and complaints forms data that, although actions were initiated by FaithCare and the action was communicated to the resident, the long-term staying power of the action was not followed up. Thus, the same complaints appeared year after year about, for example, the food.

Therefore, I have added another bold connection between the organisational performance area and the resident. This red one-way arrow represents the most important part of the resident's existence in the model, and addresses the greatest

difference between what the residents want to happen and the way they are responded to at present. It provides a potential formalised avenue for longer-term checking of whether the initiated action has remained in place. This avenue could be in the form of a further written communication to the resident.

As mentioned above, communication and empowerment are the attributes of Servant Leadership that were most often described by residents as being absent or in short supply. By placing the resident within the Servant Leadership model, both would be improved to a level acceptable to residents.

Can Servant Leadership sustain this shift in thinking? In his 1979 lecture on Politics and Reason (1988), Foucault outlined the origin of the pastoral modality of power. This concerned the relationship between the shepherd and his flock, a metaphor that was used in ancient Oriental societies (Egypt, Assyria and Judaea) and developed further in Hebraic texts. The shepherd's role in these ancient times, he said, was characterised by individualised kindness and devotedness to each member of the flock through which each member of the flock is fed and saved. McNay (1994, p. 120) writes that 'the relation between shepherd and flock is transformed, in Christian conception, from one of obedience to one of absolute individual dependence'. Clegg, Kornberger and Pitsis (2011, p. 217) take this a step further, suggesting that in the area of business culture, the contemporary manager 'tends an organizational arena wherein the employees may be vicariously treated as a crop'. It would seem in the view of these two writers that the dependence of the flock on the shepherd as part of modern Christian leadership does not provide members of the flock with power. Dependence implies less power than obedience does.

This lack of empowerment is evident in the language used by staff about residents. As mentioned before, the language is of *us and them*. Is Servant Leadership simply a one-way street of care and compassion? Is Servant Leadership translated by this organisation into a way of lavishing care on residents but not empowering them? Empowering people who are frail is not easy. It will require more attention and empathy from the staff.

Although residents said in their interviews that they would like to be consulted about things that affected them, for example the choice of curtain material in the aged care

home, they did not expect to be involved in the management of FaithCare or the administration of the home. Baby boomers imagined that they would like to be involved in the running of the home at a higher level than today's residents, but seemed to be unaware of the limitations they may face at an older age. I learned from the baby boomer interviews that the boomers are quite similar to today's residents, but want more say and were unlikely to accept being ignored.

Residents expected good communication in the aged care home. Several residents mentioned in their interviews a lack of communication, especially concerning how their fellow residents were doing if they are unwell or in hospital.

By placing the residents within the Servant Leadership model, their position is strengthened and formalised. They would thereby have an opportunity to impact the Servant Leadership model itself via communication. This would begin to change the position of Faith-based organisations from that of shepherd, enforcing their well-meant efforts to nurture, care and help, to that of true servant-leader, on a more equal footing with their residents.

Successful Presence

It will be remembered that the philosophical basis of this thesis is pragmatism. I want to introduce the idea of Successful Presence into this work. The aim of Successful Presence is to have respected, happy residents. Successful Presence will be even more important when the boomers arrive in aged care.

Successful Presence is a gentle notion. It is not formulaic and clinical, like person-centred care. It is not even a framework. The use of frameworks to promote person-centredness has been criticised by some writers as being too technical, forcing the older person and even the nursing staff to fit the framework (Dewing 2004).

Caputo and Yount (1993) wrote that power is not one thing, but multiple and multiplied, scattered and disseminated. Power relations are embedded in the very heart of human relationships (p. 5). There is evidence that humans do better when they derive power through having a voice that is heard and acted upon. The aged care residents of today are not seeking power *per se*. They are seeking a successful

presence in which the few problems they have are taken seriously, a way of occupying some space within the Servant Leadership model of their chosen home.

The research findings (restated in Table 9.2 below) have not indicated that residents want to run the show. They do not complain without reason. Their wants are few, and mirror those of people in the general population. They want food that they enjoy eating. They want to be kept busy doing whatever they can, up to their capacity. They want a pleasant environment and people who care about them. They want to be kept informed about what is important, for example the welfare of their fellow residents who are unwell. Most importantly, when they have a problem with any of their issues of importance, they want some action taken that improves the situation long-term.

Table 9.2 Comparison of data relating to top five issues

Client Survey (CS) Arranged from greatest to least dissatisfaction 2012	**Comments and Complaints Forms (CCF)** Arrange from most to fewest complaints	**Resident interviews** From greatest number to sources to least
Activities	Food	Activities
Meals (Food)	Environment & Maintenance	Staff
Spiritual Life	Quality of Care	Food
Assessing and delivering care	Health and Safety	Environment
Welcome	Staff	Quality of Care

There are benefits to be had for the organisation from adopting Successful Presence. FaithCare strives to give excellent care to residents. When given the chance to comment on their experience of living at the aged care home, residents said the failure to close the information loop was the underlying cause of much dissatisfaction.

If the concept of Successful Presence were developed and implemented, FaithCare's already excellent reputation would be enhanced. This would assist in attracting good committed staff and attracting new residents. The current residents and their families are surely the greatest advocates for the home.

I believe there would also be a saving in time and therefore money by proactively creating a happy atmosphere for residents and their families instead of reactively trying to shore up unhappy residents and families.

Chapter 10

THE CONCLUSION

'A leader is best when people barely know he exists, when his work is done,
his aim fulfilled, they will say: we did it ourselves.'
Lao Tzu, 6th-5th Century BC

Restatement of the research problem

Through my work as a Nurse Educator in an aged care organisation, I was offered the opportunity to join the ARC linkage research on leadership capability development in the Faith-based not-for-profit sector. After reading the leadership literature, it became apparent that there was no discussion of the residents' view of leadership or how they were touched by it. There are reforms underway in the aged care sector and so an exploration of leadership in aged care from the residents' point of view is important.

The future care of older Australians has become increasingly problematic recently as the reality of the financial and practical considerations of caring for the imminent influx of ageing baby boomers into the aged care market has become apparent. By the 2060s, spending on dementia is set to outstrip that of any other health condition: $83 billion (in 2006-07 dollars), representing 11% of the entire health and residential aged care sector spending (Alzheimer's Australia 2015). Both the federal government and independent aged care providers have researched and discussed the issues over the past few years and recommendations have begun to be implemented (Productivity Commission 2011). The main issues are the way the government funds aged care, the greater age, frailty and poorer health of people coming into residential care than previously, the imminent influx of baby boomers and consequent staffing shortages, and leadership in crisis.

This research has concentrated on how the leadership model chosen by one not-for-profit Faith-based residential aged care provider, FaithCare, impacts current residents and whether it is an appropriately dynamic and flexible model to cope with the future baby boomer residents.

It is acknowledged that the Australian government is encouraging and enabling a move away from residential care of older Australians towards home care but it is argued that there will remain plenty of scope for the care of the aged in residential homes in the future for reasons outlined in previous chapters. These include:

- Failing physical health requiring around-the-clock nursing care. This level of care in the home is beyond the financial capacity of most people.
- Falls. Not only do older people suffer more falls than younger people, but these falls frequently result in serious injury necessitating hospitalisation. Many older people are unable to get up after a fall. Older people fear falling and fear not being found relatively soon after a fall.
- Dementia. This is characterised by impairment of brain functions, including memory, understanding and reasoning (Australian Institute of Health and Welfare 2012). As people live longer, more have dementia. At the other end of the spectrum, younger people are developing dementia as a result of drug and alcohol abuse.
- Incontinence. This is a problem of the older age group in both men and women. It can prevent easy access to the outside world and takes planning and concentration to follow the regimens put in place by continence advisors. When combined with dementia, it leaves people living in unpleasant circumstances, fearful of venturing into the outside world.
- Chronic disease and co-morbidities. The most basic problem associated with chronic disease and co-morbidities is taking prescribed medications correctly. Another problem is simply living well and maintaining good nutrition and hydration when feeling unwell.
- Older peoples' children who live far away and are unable to help with transportation to appointments, bill-paying and daily reminders. This is more common now than it was in the past.
- Loneliness and fear of being alone. This often drives people into residential care.
- Lack of professional care staff to visit people in their homes. As the number of older baby boomers increases and the government makes residential care more expensive, more people will opt to stay in the family home. Many more professional carers will be required to care for people at home.

Additionally, it is very difficult for many family carers to deal with the less attractive aspects of people who are unable to care for themselves, however much they love their parent or other aged dependant. Crossing the fine line between being *the daughter or son* and *the carer or nurse* can be a cause of acute embarrassment for both parties. Not everyone is a *natural nurse*.

The research problem was therefore to investigate the experience of the most important group in residential aged care, the care recipients. I decided to investigate the suitability of the chosen leadership model of an organisation in addressing the concerns of the residents.

Restatement of the research questions

- (RQ1) How was the leadership model of the organisation chosen?
- (RQ2) How are the culture and the chosen leadership model transmitted throughout the organisation?
- (RQ3) Does the wider business community acknowledge that 'third party stakeholders' should have a say in any key aspects of organisations?
- (RQ4) What is important to today's residents?
- (RQ5) Do today's residents have a meaningful say in decisions affecting them in their aged care home?
- (RQ6) What do future residents, the baby boomers, envisage will be important to them and will they want a say in decisions affecting them?

There were two purposes to this research. The first and primary purpose was to understand how residents' concerns may be heard and acted upon more effectively by managers and leaders in a way that is ongoing and meaningful to the residents. The research aimed to look at which issues residents were passionate about.

The second or subordinate purpose was to explore how the process of acting upon residents' concerns will flow on positively to the baby boomers, who will bring a slightly different perspective to residential aged care.

The impact of Servant Leadership on residents

Chapter 6 described the results of extant and new data gathered. This evidence outlined the leadership style that FaithCare had put in place to reflect its Christian theology and the culture that was already in place. It described how this was taught to managers and transmitted to staff via the culture of the organisation, and how this was in turn passed to residents in care.

Chapter 7 outlined research about the things that mattered to residents. All avenues by which residents usually offered their opinion and expressed their needs were analysed, and interviews were conducted with residents about what it was like to live in the care home.

Are residents' concerns listened to and acted upon? An analysis was conducted of residents' meeting minutes, of observation of the meetings, and the outcome of complaints submitted to find whether any change took place as a result of residents voicing their concerns.

As explained in Chapter 8, the requirements discussed by future residents, the baby boomers, were not dissimilar to those of the current residents. However, the boomers had extra requirements, particularly in the areas of food, space and technology. The boomers also expressed an unrealistically optimistic view of their health and energy as their reach their older years. They had a limited appreciation of frailty.

Several issues emerged from the data collected from residents and these were outlined in Chapter 7. Out of these, four issues or themes that really mattered to present aged care residents stood out. The four issues that really mattered, drawn from Table 7.2, were Activities, Food, the Environment at the home and Care.

Residents were quite obviously provided with ample opportunity and encouragement to voice their opinion about any issue. The issues that really mattered were mentioned in the client surveys, the comments and complaints forms, at the monthly residents' meetings and during the researcher's individual interviews with residents. Apart from the individual interviews, information from these sources was analysed, recorded and fed back to the manager of the home and to others in the organisation at corporate level.

The leadership model of the organisation today is Servant Leadership. Chapters 3 and 4 outlined the history of the organisation's adoption of this leadership model as one that provides a good fit with the theology of the organisation and the existing culture. The application of the OCAI (Organisational Culture Assessment Instrument) to a group of staff members demonstrated a strong leaning towards clan culture. The clan organisational culture category is exemplified by features such as being a pleasant place to work; the workplace is regarded as an extended family where people share personal information. Leaders in a clan-culture organisation act as mentors, facilitators and team builders and the value drivers are communication, commitment and development. Effectiveness is achieved by human development and participation. A clan culture's quality strategies include empowerment, team building, employee involvement, human resource development and open communication.

Clan culture would seem to be a good fit with Servant Leadership and was viewed in this work as a proxy for leadership. The focus group demonstrated that staff valued good communication most highly, followed by nurturing, respect and compassionate end-of-life care. These were the ways in which they demonstrated FaithCare's culture to the residents.

The leadership style adopted by FaithCare was a good fit with the pre-existing organisational culture, developed during the life of FaithCare. Servant Leadership afforded everyone in the organisation the opportunity to nurture, help and serve each other. The question, however, was whether Servant Leadership was a style that suited the residents. This was particularly important for the baby-boomer residents of the future, for whom empowerment was a very important issue, high up on the agenda during their interviews. The research conducted here revealed that the issues that really mattered to residents remain issues for them 13 years after the care home was established. The residents cared very much about the quality of the food they were offered. Complaints about food had not decreased over the years and the areas of concern had not changed. This indicates that empowerment of the resident/client/stakeholder is not a feature of Servant Leadership or Clan Culture.

Key contributions from the research based on the evidence

The leadership style introduced by FaithCare did indeed mirror the Christian philosophy and culture of the organisation and enhanced the practice of the managers who undertook the leadership development programs offered by the organisation. The leadership style was passed from management to staff successfully and supported by and became embedded in the pre-existing culture. The staff transmitted and exhibited the culture to the residents through their daily practice. They were well versed in how to transmit the culture in this way. Therefore the adopted leadership model reached the residents via the culture of the organisation.

Residents were encouraged to express the things that matter most to them via different forums – resident meetings, comments and complaints forms and client surveys. Residents' concerns were listened to and acted upon in the short term, but the actions taken did not stick. This was most evident in the case of the food served at the home. The residents were not happy with it. There was no choice and it was often not very palatable, nor served in an attractive manner. Despite many complaints over a period of 13 years, very few long-term changes were implemented.

There are some differences between what is important to today's residents and what future residents, the baby boomers, think will be important to them when they are in residential care. On is in the area of political influence. Overall, the boomers are quite similar to today's residents but may pose some additional challenges. Boomers say they will require good food drawn from the many cuisines they enjoy now, more space for the possessions they have gathered through their lives and access to technology.

Table 10.1 Summary of research contributions

Research issue	Status of research issue in the existing literature	Contributions of this research
To investigate how Servant Leadership is experienced by the most important people in aged care, the care recipients.	The literature revealed little about how leadership in any field flowed on past its followers to the third party stakeholders. The literature sometimes mentioned third party stakeholders, usually customers, in the context of how well the business serves them and thereby retains their custom.	Care recipients in residential aged care are uniquely placed. Care recipients are not followers and are not customers in the usual sense. They are unable to walk away easily. However they experience leadership's flow-on effect via organisational culture because of their proximity.
The suitability of the chosen leadership model in FaithCare.	The literature suggests that the Servant Leadership model does not include the third party stakeholder.	This research has placed care recipients within the Servant Leadership model and has made them part of the leadership dynamic.
To investigate whether the concerns of the residents in care are listened to and acted upon. Residents' concerns are listened to but the actions taken are short-term and are not followed through, but allowed to reoccur.	The importance of having one's voice listened to and acted upon is not prominent in the aged care literature. Residents were clear that they value being listened to but, as importantly, they expect ongoing changes to be made as a result of their concerns being voiced when appropriate.	Development of the idea of Successful Presence in which residents are listened to and their issues are addressed in a meaningful and respectful way.
To give the resident a special place within aged care.	The literature does not afford the care recipient their own special place in the aged care community.	

Implications for practice

This research will help organisations providing aged care in Australia to respond well to the voice of the resident/customer by giving them a formal, dynamic place within their leadership model, whether it be Servant Leadership or another, and pursuing the idea of Successful Presence, whereby the resident's voice is heard and acted upon meaningfully.

Implications for policy

Interviews with the baby boomers revealed that they may well enter care in greater numbers than currently forecast. Many boomers are not as averse to entering residential aged care as some government publications would lead us to believe.

The boomers have an unrealistic idea of the limitations that older age brings to day-to-day life.

Many baby boomers are caring for their parents; but one question not asked in this research was whether Gen X will care for their baby-boomer parents.

Implications for methodology

The philosophical foundation of this research is pragmatism. I was hoping to find a practical solution to what I had experienced while working in aged care and what I found when I conducted my research. This was a mixed-methods study, incorporating elements of grounded theory. Mixed methods provided an opportunity to incorporate every available source of data, qualitative and quantitative. This research contributes to the literature on mixed methods in its application to aged care as well as the not-for-profit sector.

Limitations

This is a single case study, in the sense that the research was conducted using only one organisation. Therefore it can be generalised only broadly to other not-for-profit Faith-based organisations. It explored only one model of leadership (Servant Leadership) used in the organisation investigated. Other organisations may use different leadership models.

Residents with dementia were not interviewed for this research.

The limitations and disadvantages of mixed methods research have been debated at length in the literature, especially the difficulties of effectively integrating studies with different methodological paradigms (Cagle & Wells 2008). However Cameron (2010, p. 27) writes:

> Mixed methods research designs are said to add value through providing a more comprehensive and richer understanding of the research problem being investigated. This is because the approach explores the problem through the different lenses and perspectives of qualitative and quantitative research techniques.

Areas for further research

There is room to conduct multiple case studies with a diverse variety of organisations providing aged care in Australia to examine a variety of leadership models.

Such a study could examine models of care used by different aged care organisations to determine policy implications at government level to support different models of care that are both cost-effective and lead to customer satisfaction.

There is scope for further research by scholars studying organisational performance to look at the relationship with 'third-party stakeholders'.

This research has examined the model of care in which older people are moved to aged care homes as they age. Recently the Australian Government has promoted community or home care as an alternative to residential aged care. The model of care and the leadership capabilities of new organisations that develop to fill this need is another area of investigation for the future.

It is hoped that aged care organisations using the Servant Leadership model will formally place residents within the model and instigate the second communication string, enabling residents, present and future, to be assured that their concerns are taken seriously and long-term solutions in the form of action are taken by the organisation and most importantly, communicated to their residents.

It is also hoped that organisations using a different model of leadership examine their own models and apply some of the findings from this research to improve their model of care.

This will lead automatically to the growth of Successful Presence, the notion that residents are present within their community in a gently successful, acknowledged way.

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APPENDIX 1

DE-IDENTIFIED COPY OF ORGANISATION ETHICS CONSENT

Barb Vindin Illingworth
UTS Room 559
720 Harris Street
ULTIMO, NSW, 2007

12TH October, 2011

Dear Barb,

Investigating Consumers' Expectations of Service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a Leadership and Organisational Culture Perspective

Thank you for your application to the Human Research Ethics Committee (HREC Code: EC00432) for the above titled project. I am pleased to inform you that the Ethics Committee has approved your application for the project.

In order to comply with the Ethics Committee Requirements, I wish to confirm that:

- The Ethics Committee is notified as soon as possible of any changes to the project scope and methodology;
- Any untoward events occurring during the approval period are notified to the committee in writing immediately;
- A progress report is submitted to the Ethics Committee at the 6 month point from the approval date of this letter; and
- A final report on the attached file is submitted at the end of the approval period.

The Ethics Committee's approval is valid for one year from the date of this letter. Should you require an extension to this time a written application should be made to the committee three months prior to the termination date.

Please feel free to contact me on 9xxx xxxx or s……k@xxxxxxxxxxxxx should you require any further information or clarification regarding the above.

Yours sincerely,

Sarah M…..k
Secretary
Ethics Committee

From: Ethics Secretariat <Research.Ethics@uts.edu.au>
Subject: Eth: HREC Clearance Letter - UTS HREC 2011-333A
To: "A/Prof Sivarama (Shankar) Sankaran" <Shankar.Sankaran@uts.edu.au>
Cc: "Ms Barbara Illingworth" <[redacted]>, "Ethics Secretariat" <Research.Ethics@uts.edu.au>
Received: Thursday, 13 October, 2011, 11:00 AM

Dear Sivarama (Shankar) and Barbara,

Re: "Investigating Consumers' Expectations of service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a leadership and Organisational Culture Perspective"

Thank you for your response to my email dated (insert date). Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics clearance is now granted.

Your clearance number is UTS HREC REF NO. 2011-333A

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9772.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee

C/- Research & Innovation Office
University of Technology, Sydney
Level 14, Tower Building
Broadway NSW 2007

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INFORMATION LETTER - Resident

Investigating Consumers' Expectations of Service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a Leadership and Organisational Culture Perspective

Dear …….

My name is Barb Vindin-Illingworth and I am a student at the University of Technology, Sydney.

I am conducting research into how organisations can adapt to the change in service requirements expected when the Baby Boomers enter aged care and would welcome your assistance. The research will involve being interviewed by me and should take no more than 45 minutes of your time. I have asked you to participate because you have been a resident of Morven Gardens for more than six months.

This research has been funded by the Australian Research Council.

If you are interested in participating, I would be glad if you would write your name, phone number and room number on the slip on the next page and hand it in at the downstairs office, or ask a staff member to hand it in for you. I will then contact you to make a convenient time to see you.

You are under no obligation to participate in this research. You may withdraw from the research at any time without giving a reason.

Yours sincerely,

Barb Vindin
Room 559
Level 5, Building 6
University of Technology
Sydney
Telephone: 9514 8994
Email address:
[redacted]

My Supervisor's details are:
A/Prof Shankar Sankaran
Level 5, Building 6
University of Technology
Sydney
Telephone: 9514 8882
Email address:
Shankar.sankaran@uts.edu.au

Research Project – slip to be filled in
My name ……
My phone number …… My room number …….

PRINTED ON UTS LETTERHEAD

INFORMATION LETTER – Baby Boomers

Investigating Consumers' Expectations of Service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a Leadership and Organisational Culture Perspective

Dear ……..

My name is Barb Vindin-Illingworth and I am a student at the University of Technology, Sydney.

I am conducting research into how organisations can adapt to the change in service requirements expected when the Baby Boomers enter aged care and would welcome your assistance. Baby Boomers are those of us who were born between 1946 and 1964.

The research will involve an interview followed by possible participation in a focus group and should take no more than 45 minutes of your time for each activity. I have asked you to participate because I believe you are a Baby Boomer and I am interested in what you think about Aged Care.

This research has been funded by the Australian Research Council.

If you are interested in participating, I would be glad if you would contact me on .

You are under no obligation to participate in this research. You may withdraw from this research at any time without giving a reason.

Yours sincerely,

Barb Vindin
Room 559
Level 5
Building 6
University of Technology Sydney
Telephone: 9514 8994
Email address:

My Supervisor's details are:
A/Prof Shankar Sankaran
Level 5, Building 6
University of Technology Sydney
Telephone: 9514 8882
Email address:
Shankar.sankaran@uts.edu.au

PRINTED ON UTS LETTERHEAD

INFORMATION LETTER – Baby Boomers

Investigating Consumers' Expectations of Service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a Leadership and Organisational Culture Perspective

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Barb Vindin
Room 559
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My Supervisor's details are:
A/Prof Shankar Sankaran
Level 5, Building 6
University of Technology Sydney
Telephone: 9514 8882
Email address:
Shankar.sankaran@uts.edu.au

PRINTED ON UTS LETTERHEAD

CONSENT FORM – Residents

I, ……., agree to participate in the research project **'Investigating Consumers' Expectations of Service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a Leadership and Organisational Culture Perspective'**, being conducted by Barb Vindin-Illingworth (UTS, Level 5, 720 Harris Street, Ultimo 2007, telephone 9514 8994). Funding for this research has been provided by the Australian Research Council.

I understand that the purpose of this study is to help residential aged care organisations adapt to the change in service requirements expected when the Baby Boomers (born between 1946 and 1964) enter aged care in the future.

I understand that my participation in this research will involve being interviewed for about 45 minutes at the BCS facility where I live. I will be interviewed in my room or in an office, in which case the interviewer will walk with me from my room to the office and take me back to my room afterwards. I understand that if I feel tired, unwell, uneasy or emotional, I may ask for the interview to be terminated or postponed immediately with no repercussions.

I understand that I can ask for the interview to be rescheduled for any reason, even during the interview.

I am aware that I can contact Barb Vindin-Illingworth if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. My withdrawal will be treated confidentially and will have no impact on my future care.

I agree that Barb Vindin-Illingworth has answered all my questions fully and clearly.

I understand that I may contact the researcher's Supervisor if I have further questions. His details are A/Prof Shankar Sankaran, UTS, Level 5, 720 Harris Street, Ultimo 2007, telephone 9514 8882, email Shankar.sankaran@uts.edu.au.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ _____ ___/___/___

Signature (participant) Signature (researcher)

NOTE

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

PRINTED ON UTS LETTERHEAD

CONSENT FORM – Baby Boomers

I, ……., agree to participate in the research project **'Investigating Consumers' Expectations of Service in Not-for-Profit Faith-based Residential Aged Care from the 2020s: a Leadership and Organisational Culture Perspective'**, being conducted by Barb Vindin-Illingworth (UTS, Level 5, 720 Harris Street, Ultimo 2007, telephone 9514 8994). Funding for this research has been provided by the Australian Research Council.

I understand that the purpose of this study is to help residential aged care organisations adapt to the change in service requirements expected when the Baby Boomers (born between 1946 and 1964) enter aged care in the future.

I understand that my participation in this research will involve being interviewed or participating in a focus group for about 45 minutes at a place convenient to me and to the researcher.

I am aware that I can contact Barb Vindin-Illingworth if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. My withdrawal will be treated confidentially.

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I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ _____ ___/___/___

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Comments and Complaints Form

Residents, Staff, Families, Visitors, Volunteers….everyone!!

Our aim is to continuously improve the standard of our service at the home – to achieve this we need and greatly appreciate your help.

Please assist by recording your

Comments and Complaints and Suggestions!

(All comments will remain confidential.)

Date: ……

Please add your name so that we may reply to your comments personally:

Name ……

Address……

Telephone No:……

……
……
……
……
……
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……
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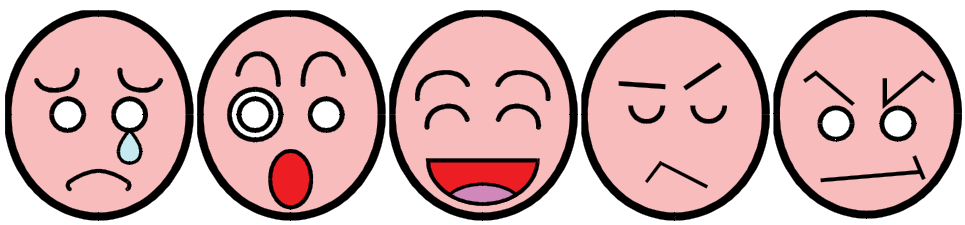

OFFICE USE ONLY

Letter of Acknowledgement sent: Date:

Follow-up Letter sent: Date:

File No: Type of Comment: Phone/verbal/written/other

Referred to:	Report due by:

Recommendation:

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Outcome:

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……

Was the person satisfied with outcome? Yes ☐ No ☐

File closed: Yes ☐ No ☐

Executive Care Manager

……

APPENDIX 2

De-Identified report

Organizational Culture Assessment Instrument

October 15, 2012


OCAI online

Table Of Contents

[Production Note:

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www.ocai-online.com