

The provision of a culturally sensitive home-like environment in residential aged care: experiences from Melbourne's West

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Abstract

As people are living longer, residential living has become a fact of life for those who need extensive care and are no longer able to live in the community. Care facilities, bound by legislative requirements, follow strict government guidelines and, unless identified specifically as ethno-specific, accept all 'cultures and creeds'. The quality of life for people residing in facilities has been a focal point for some years, and the requirement to provide a home-like atmosphere emphasised. However, a home-like environment is difficult to define because of its subjective interpretation.

This thesis reports on a small study of residents, family/friends and staff connected with three residential aged-care facilities in Melbourne's western suburbs. Their experiences and opinions have been gathered to establish their definitions of a culturally sensitive home-like environment, the ways they experience their own facilities, and what they regard as the positive and negative qualities of their facilities.

This study contributes to the wider body of knowledge relevant to the provision of culturally sensitive home-like environment provided in residential aged-care facilities. The definition of what comprises a culturally sensitive home-like environment is explored, and whilst the study broadly correlates with findings in existing literature, it highlights the variations of interpretation that are given to the acceptable provision of such an environment.

Because of the impact that residential care services have, not only on residents, but also on the wider community, this area of research is important to social work. It contributes to understandings of what a culturally sensitive home-like environment might mean from diverse perspectives, and is relevant to service delivery and service development.

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I am also very thankful to my family and friends who have shared my many difficulties and joys during this course.

Dedication

This thesis is dedicated to the memory of my father Arthur, and my sisters Helen and Anne, all of whom never grew old.

I also include my mother Patricia and the rest of my family that I hope will have happy, healthy and long lives.

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Chapter 1: Introduction

The current provision of residential aged care services has evolved from decades of traditional institutionalised residential care to a more contemporary model that espouses the rights of the individual. Historical developments provide an important context in which contemporary changes to traditional practices have been implemented.

Since World War II there has been international mobility and relocation of the world's population to different countries, on an unprecedented scale. Accompanying this is the phenomenon, long recognised by social demographers, of human longevity on a scale that is similarly unprecedented.

Against this back-drop, the demand for long term care for ageing people has grown accordingly. The numbers of people in residential aged care in Australia has steadily risen from 139,917 as at 30 June 1998 to 159,532 as at 30 June 2005 (Australian Institute of Health and Welfare 2006, p. 7). Population projections estimate that by the year 2051, about 5 million people, or more than 20% of the population, will be aged 65 and over (Department of Health and Aged Care 2001, p. 298).

Australia, in common with many other nations, is affected by the ageing phenomenon. This is clearly reflected in the increasing numbers of older persons, no longer able to live independently in the community, moving into residential care facilities. The demand for the provision of services in response to increased needs has put pressure on the public purse.

In Victoria during the 1970s and 80s, significant changes in government philosophy resulted in policies that embraced the process of de-institutionalisation, across a wide range of residential care services. This trend seemed to have a common thread in the western world, with old established large institutions closing down in preference for smaller units, many of which were to be privately owned and run, although still government funded. Melbourne, for example, witnessed the closure of large institutions, such as Caloola in Sunbury (a satellite suburb, about 45 kilometres north-west – now a Victoria University Campus) and changes to the provision of services in places such as the Mount Royal Hospital in Parkville (an inner suburb).

One of the drivers for these changes was underpinned by the philosophical notion that a sprinkling of smaller units would enable residents to be cared for in their immediate neighbourhood, thus facilitating family access and visits, and therefore the continuation of family ties. Additionally, the smaller units could be seen in a more positive light by users, a perceptual move away from the large impersonal institution to a less austere, more 'user-

friendly' facility that could both blend into and take on the particular flavour of the neighbourhood.

The shift towards smaller units was coupled with a new focus of seeing clients¹ as customers and therefore issues of residents' rights and quality of care became prominent - so much so that some of these are embedded in current government policy through mandated funding requirements. The Federal Government, acknowledging its obligation to respond to Australia's ageing population, enacted specific legislation to create a structure informing the provision and management of care, including residential care.

For over two decades I have worked in Melbourne's Western suburbs, as a Registered Nurse Division 2, with people who are elderly and/or have disabilities. Throughout this time, I have grown more aware of the special needs (in addition to the immediate and obvious physical care needs) and concerns, particular to these people.

Whilst fulfilling my nursing role, I observed that a range of historical, social and economic constraints continued to influence care provision. These often translated into models of care that were prescriptive and task-oriented, with emphasis on addressing immediate physical needs over less tangible emotional and psychological needs. Practices in some areas of residential care, for example, medical procedures and basic life needs, such as personal care, food and lodging, are well established and clearly defined. Other areas though, such as the process and provision of client care, in an environment that is experienced by residents as culturally responsive and 'home-like' (Department of Health & Ageing 2002), are not so easily defined or readily measured.

I desired to understand how the combined influences of traditional care practices and current legislative obligations and social expectations have impacted upon the environment in long-term residential care settings. I also wondered how people within the western suburbs community who reside in local long-term care facilities, and also their family/friends and the staff who provide care, experience and interpret that care environment.

Western Melbourne's rich multi-cultural population mix presents a challenge to its residential care facilities, to provide essential care that complies with relevant regulations and legislation, in an environment that is responsive to the residents' cultural diversity, and experienced by those within as home-like.

¹ In this thesis the following words are used interchangeably: client and resident; carer and family/friends.

A description defining a home-like environment is complex, because of the many variables that are involved in its provision. One explanation, reflecting more tangible aspects, states (Aged and Community Care Division 1998, p. 88)

The environment in which residents live must be safe, comfortable and consistent with their care needs. Management of the service should actively encourage resident to personalise their individual space and communal living areas should be aesthetically pleasing.

The Commonwealth Department of Health and Ageing, actively responding to this, has published a Charter of Rights and Responsibilities for care services. This charter outlines several relevant obligations accompanying the provision of a home-like environment (Department of Health & Ageing 2002, p. 1):

- *to be treated with dignity and respect, and to live without exploitation, abuse or neglect*
- *to live without discrimination or victimisation. The resident is not obliged to feel grateful to those providing his or her care and accommodation*
- *to live in a safe, secure and home like environment, and to move freely both within and outside the nursing home without undue restriction*
- *to be treated and accepted as an individual. Each resident's individual preferences are to be taken into account and treated with respect*
- *to continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination*

My interest is in the interpretation of a culturally sensitive, home-like environment, and its ongoing implementation, coupled with an exploration of the influences affecting the ongoing provision of such an environment.

My Honours research, conducted within Victoria University's Bachelor of Social Work program, investigated how a selected sample of residential care facilities in Melbourne's Western suburbs practically translated the concepts of culturally sensitive and home-like in their environment. Residents, family/friends and staff were invited to participate in semi-structured interviews and a brief written survey, to contribute their views and opinions.

The thesis explores how the provisions of a home-like environment in long term residential aged care are interpreted from the perspectives of residents, family/friends and staff.

Chapter 2: Literature Review and Theoretical Framework

In reviewing the literature on the provision of a culturally sensitive home-like environment in residential care in Australia, I noted a scarcity of published literature specifically addressing this topic. Much of the information found was in government policies, regulations and procedures that are related to the mechanics of application and funding, such as the *Charter of Resident's Rights and Responsibilities* (Department of Health & Ageing 2002) and the *Standards and Guidelines for Residential Aged Care Services Manual* (1998) (Aged and Community Care Division 1998). These documents reflect an expectation that staff and facilities will provide culturally sensitive home-like environments, in line with legislated obligations, but details of how this might be achieved are limited because of the task oriented approach regulators take. A recurring theme emerging from the literature reviewed was that although care providers exhibit a genuine desire to see a culturally sensitive home-like environment blossom in residential care facilities, qualitative aspects in the generation of such an environment are supplanted by quantified tasks and routines that have emerged from the traditional and dominant medical model (Baragwanath 1993).

This review firstly provides commentary on cultural and ethnic differences, and the challenges of providing a culturally sensitive home-like environment against a backdrop of different philosophies and interpretations. An outline of the basic requirements of aged care needs common throughout the western world, and what the provision of a good quality of care entails, follows. Finally, it highlights the emerging challenges faced by organisations in implementing the provision of culturally sensitive home-like environments.

There is much literature on the issue of culture, although the definition of culture has many variations. Diller (2004) attempts to explain culture, and acknowledges that it is a difficult concept to grasp. In discussing culture, he observes that each explanation has a cultural basis, and official definitions are those ascribed by dominant cultures. He notes two anthropologically recognised approaches to working cross-culturally. They are emic, or regarding and responding to a culture through concepts and theories that are indigenous to that culture, and etic, meaning that a culture is viewed through 'glasses' that are external to it. Diller (2004) advocates the adoption by helping professions of an emic approach, indicating that cultural sensitivity is spoken out in the ways a service reflects its acceptance of the wisdom and values of other than the dominant culture. Services modelled in response to the

dominant culture may well be inappropriate when working with clients from diverse cultures, and may in fact constitute a form of institutionalised racism.

Introducing his study on the provision of high-quality residential care, commissioned in 1972 by the Brotherhood of St Lawrence, Dargaville (1972) quotes Tucker (1956), who noted that the building of a home for elderly people is only the beginning. This observation indicates insight to the complexities of caring for people and an understanding that it is more than just the basic provision of bricks and mortar.

Older people occupy an unenviable position in modern western social hierarchy according to Thompson (2000) who notes that, despite the growth of this segment of the population, they constitute a minority group. Thompson (2000) claims that older people experience discrimination, which manifests at structural, cultural and personal levels. He extrapolates that belonging to a minority; in this case a cultural minority, increases the experience of discrimination and oppression.

Perhaps some of the problems experienced by the ageing population may be due to the various ways ageing is understood. Lymbery (2005, p.13) notes that the distinctive quality of ageism 'the unwarranted application of stereotypes to older people', at least in western society, is that older people are systematically disadvantaged by the place they occupy in society. He points out that, whilst the bulk of a social service department's budget is spent on the care of older people, the per capita outlay is the smallest of all the main service user groups. He explains that much of the day-to-day care in residential aged care is carried out by staff with no professional qualifications. Often paid on an hourly basis, they are under intense pressure to complete tasks within a defined period. This environment makes staff susceptible to adopting stereotypes and demeaning impressions of older people, and that negatively impacts on individuals and environments.

Marshall and Eaton (1980), too, recognise the special needs that exist among the elderly, and note that failure to provide appropriate care has meant many 'have been denied the right to live quietly and at peace, sharing a homely domestic life with compatible companions'. They believe society has an obligation to uphold peoples' rights and provide those who require it, with residential care in a home environment with friendly, compatible people. These sentiments are echoed and extended by Faison and Mintzer (2005) who argue that the field of health care will only move forward when it is inclusive to the growing, ethnically diverse elderly population.

The challenges experienced in Australia, in the provision of culturally sensitive care in a home-like environment, are not dissimilar to those experienced in other western world

countries. For example, evidence of special concerns in the ethnic minority elderly population was recognised before 1971 in the USA, according to Wright and Mindel (1993). In 1971, the White House Conference on Ageing put forward 153 specific recommendations to deal with these concerns. Recommendations included making available health services that were more culturally accessible, employing staff from the various cultures represented amongst the resident population, and the continuation of socially important community links. Wright and Mindel (1993) quote Aguilar (1972) and Vontress (1976) who described the importance of a climate of trust that needs to develop between practitioners, clients and their families, as families frequently serve as facilitators, linking the elderly to the 'system'. In the context of cultural competence and ability to respond to diverse needs, as noted by Mui, Choi and Monk (1998), individual and community perceptions about residential care are important.

The imperative to provide care that is culturally sensitive is driven by basic universal principles that particularly apply to the Australian context because of the diverse ethnic population mix. Translation of these principles has been the subject of ongoing government enquiry. A Victorian Government report of 1988 noted that older people, including ethnically diverse older people, have a right to services. The needs and expectations of older people, which include language, religious and dietary needs, are similar, regardless of their ethnicity. All older people have a right to appropriate services, and where culturally relevant generic services cannot be provided, ethno-specific services are required. To provide services that are appropriately responsive to the people requiring them, the report advised, service providers should recognise the importance of family and community networks and liaise with ethnic community organisations

A report released in 1989 by Ronalds – *Residents' Rights in Nursing Homes and Hostels*, outlined the findings of a study undertaken by the Commonwealth Government. The study revealed that the majority of people in long-term residential care felt disempowered and isolated from their loved ones, and ignorant of and unable to protect their rights due to lost independence, individuality and self-esteem. These people also felt financially insecure, unimportant, bored with the monotony and regimentation of their daily lives and afraid to speak out about even minor concerns. This report provided guidelines that aimed for the development of a partnership between residents and front-line staff for the way care happened, rather than a surveillance and regulatory model imposed by management and professionals.

Whilst the goals advocated in the report are honourable, according to Correll (1998), quantifying client focused service and measurable improvements are difficult tasks in

practice. Correll notes that in the quest to improve long-term residential care services, the participation of older people in the process is token, and standards required to achieve accreditation are externally imposed rather than internally driven.

In a 1993 report on Aged Care in Victoria, Baragwanath, the State of Victoria Auditor-General, comments that nursing home care is still provided along the lines of the medical model, rather than the more home-like facilities in community settings or in people's own homes. Baragwanath asserts that the inability of the Department of Health and Community Services to respond to the changing requirements for effective aged care resulted in many residents experiencing problems, including restricted social independence and limited freedom, as well as inadequate respect for privacy and dignity. The report found that the emotional and psychological well-being of some residents was not addressed in the delivery of aged care services, and some residents appeared to be culturally and emotionally isolated.

Therefore, to realise the goal of culturally sensitive gerontological care, a shift from the institutional focus inherent in traditional care practice is required. Lee (2004) reflects upon a model of care which recognises that older people need to be acknowledged as individuals who have distinct life histories and make choices within socioculturally determined norms and boundaries. She acknowledges that while culture shapes an individual's values and beliefs, great diversity exists within culture. Lee (2004) argues that our (Western) model of care has been influenced and shaped by our own cultural setting, that is, research and writing from the Western world, consequently, the goal of culturally sensitive care is rendered a somewhat distant ideal.

Gibson (1986), however, points out that catering for individual differences is well nigh impossible for any institution. Individual responses to the same stimuli may be quite idiosyncratic; therefore it would be over-optimistic to expect a residential home to be able to provide a micro solution for each client. This is not to say the quality of care or style of life offered by the home is irrelevant or unimportant, rather it is a matter of 'fit', or compatibility. To illustrate the complexities involved in providing a quality of care that parallels ideal, Gibson quotes Peace et al (1982), who report that, whilst no universally acceptable home exists, there are many kinds of 'good homes' that provide positive role models in their provision of quality care, in relation to flexibility, sensitivity and consideration of the individual.

A residential care organisation has been likened by Hartz and Splain (1997) to a family, with members having ways of treating and communicating with each other. They identify the patterns of these interactions as processes. Where such processes are destructive, they can

erode the most conscientious efforts of individuals and teams. Hartz and Splain (1997) also note the emotional and social vacuums experienced by residents in long-term care. They present guidelines for the physical layout of a facility, which they see as enhancing the quality of life for residents. Hartz and Splain (1997) refer to a particular experiment conducted in the late 1970s, in which Clifford Bennet, a nursing-home administrator, posed as an alcoholic. Bennet was admitted into residential care for medical intervention. He was quickly able to observe, first-hand, a variety of negative aspects of client care; although he also recognised that some nursing staff provided care that was sensitive and nurturing.

Dixon (1991) points out that structural problems in large institutions are evidenced through organisational policies and procedures that impose specific behaviours and routines on staff, and translate into institutionalised care practices. He argues, however, notwithstanding the necessity for prescribed routines, care provision can be conducted with a degree of human warmth. Negative perceptions of institutions, as places that are 'impersonal and lacking in warmth', are recognised elsewhere, too.

A research report from the National Council on Ageing and Older People in Ireland (2000), recommends strategies that long-stay facilities might employ, to reduce the institutional feel currently found in many aged care settings. The report states that whilst good physical care is a must, not enough attention has been paid by policy makers and regulators to quality of life issues. It highlights four main quality of life areas for people in long-term residential care:

- independence and autonomy
- ability to maintain personal identity and sense of self
- ability to maintain connectedness, social relationships and networks within and outside the care setting, and
- engagement in meaningful activities.

The improvement of quality of life in the context of culturally sensitive residential care and a home-like environment must therefore stem from organisational changes. According to Cross, Bazron, Dennis and Isaacs (1989), for an organisation to claim cultural competence, there will be evidence of five essential elements:

- valuing diversity
- the capacity for cultural self assessment
- consciousness of the dynamics inherent when cultures interact
- institutionalised cultural knowledge, and

- a service delivery model, adapted to reflect understanding of cultural diversity.

According to the authors, these elements must be present at every level, and should be reflected in the organisation's attitudes, structures, policies and services.

WestCASA is an example of an organisation providing a culturally sensitive and inclusive workplace and practice that (Buchanan, L & Webster, K 2000):

- does not demean, diminish or disempower people from differing cultures
- is attuned to difference and to working with difference and
- encourages staff to explore their own beliefs and attitudes, and challenge cultural myths and prejudices they may hold.

The WestCASA service ideals are further supported by qualities identified in a research report for Diversitat (Anglem, J & Maidment, J 2004, pp. 11-2), as important in the provision of care for older people. These attributes are:

- listening
- acceptance
- tolerance
- patience
- honesty, and
- compassion

The report, although not focused on residential care and the provision of a home-like environment, discusses relevant issues in relation to the provision of care for older people who are culturally and linguistically diverse.

Given that the purpose of residential care is to provide an alternative home for those no longer able to cope in their own home, Prime (1991) argues that the quality of environment and care a residential home provides should make it a better place for the residents than any other. She also believes that first impressions have great impact on any would-be or newly admitted resident. In identifying components that contribute to a congenial atmosphere, Prime (1991) notes as desirable the inclusion, and presence, especially at times such as admission, of people amongst the staff, who are from the same ethnic backgrounds as clients. She highlights the importance of staff taking on a role of advocacy for residents. Additionally, she is of the view that menu choices and leisure activities offered within a facility, and décor and accessories need to reflect the multicultural composition of the resident cohort, and personal items such as pictures, knick-knacks and furnishings should feature in residents' rooms.

According to Trim (1991), cultural diversity exists even among those of similar racial groups. She identifies four components of care when working in a multicultural situation as:

- skilful, sensitive questioning and sharing of information
- listening, in a way that reassures the speaker they have been heard, and what they said respected
- genuine appropriate verbal and non-verbal responses, and
- the ability to work effectively with interpreters.

Trim (1991) is convinced that the existence of genuine opportunities to express themselves facilitates a confidence in residents about their environment, and a growth in their self-confidence.

The Eden Alternative is a model of care that recognises older adults have values which exist regardless of whether they reside in the community or in long-term care. This model strives to decrease loneliness, helplessness and boredom by developing healthy habitats in a home-like environment, and regards three key components; children, plants, and companion animals, as providing variety and spontaneity in life. Tavormina (1999) proposes that this model embraces the notion of a culturally sensitive home-like environment.

The literature reviewed highlights the complex tangible and intangible components necessary to provide a culturally sensitive home-like environment in residential aged-care facilities. The major questions posed through this thesis are:

- how do residential aged-care facilities in Melbourne's western suburbs provide a culturally sensitive, home-like environment, and
- how do residents, family/friends and staff connected to the environment perceive the environment?

To address these questions, research, through semi-structured interviews and a brief written survey, was conducted, to seek the views of residents, family/friends and staff. The subsequent report is an account, based on participants' responses, of how selected facilities in Melbourne's Western suburbs interpret the provision of quality of life in the context of a culturally sensitive home-like environment.

Chapter 3: Research Design

3.1 Research Aims

The aim of this project is to gain an insight into how those directly connected to a residential facility - the residents and those close to them, and the personal care staff - experience their facility's environment. Project participants were able to reflect upon and describe their experiences, from their personal perspective.

The two principal aims of this study were to:

- investigate and describe the provision of a culturally sensitive home-like environment in selected aged care residential facilities in Melbourne's western suburbs, and
- explore, in the context of this research, what residents, their family/friends, and staff in long term residential care facilities understand by a home-like environment.

3.2 Research Design

This project uses an approach that combines interpretive and critical research. Interpretive theorists believe that reality, rather than being 'out there', is in the minds of people and based upon the definitions people attach to it (Sarantakos, 2005). Interpretive research involves a partnering with participants, who become empowered in the research process (Marlow, 2001). It openly acknowledges the researcher's biases and values, and it assumes that reality is socially constructed, mutually shaped and ever-evolving. Interpretive research employs observation and considers the particulars of a phenomenon. This leads to the development of generalisations describing or explaining relationships amongst the particulars. Such process of finding patterns common to separate phenomena is known as induction (Marlow, 2001).

The methods employed by critical research enable the researcher to get below the surface, to expose real relations and disclose myths and realities and help people to understand and change social reality. Critical research methodology uses a conceptual framework that:

- accepts the necessity of interpretive categories in social sciences
- understands that many actions people perform are constructed through social conditions and by social processes that objectify and limit their agency. It works to

uncover systems of social relationships including the unanticipated, though not accidental, consequences of these actions

- explicitly recognises interconnections between social theory and practice (Sarantakos, 2005).

Critical research can provide important insights and understandings of society and impetus for social and political change (Sarantakos, 2005).

Over years of employment as a direct-care worker in residential aged-care in Melbourne's west, the researcher noted that the norm for facilities was the co-habitation of people from many different cultures under one roof, with high needs for care the common thread. It was recognised that such diversity may constitute considerable challenge when organising and undertaking service provision and routines in ways that are culturally sensitive and contribute to the 'feel' of a home-like environment. This research was developed in order to further explore these observations. It was designed to provide an opportunity to those directly related to residential aged-care to reflect upon what a culturally sensitive home-like environment is. Participation gave them an opportunity to express their thoughts, view-points and suggestions about residential environments, and it is envisaged that this will result in a useful residential aged-care resource.

Concurrent to formulating the proposal for this project, the researcher participated in informal discussions of ideas around the planning and implementation of the research and its potential value, with unit managers and other staff, as well as some residents and family members. These discussions resulted in the identification of three different groups of people who could provide valuable insights into the research topic. The groups included facility residents, family/friends, and care staff. Three homes, considered fairly representative of aged-care facilities in Melbourne's western suburbs, were then chosen. The researcher approached management at each organisation and secured in-principle agreement, subject to obtaining Victoria University Ethics approval, to conduct the research on their premises.

3.3 Sample and Recruitment

Participants from were recruited from three facilities in Melbourne's western suburbs. Eighteen people, all of whom were above 18 years of age, took part in this study. A purposive sample (Kumar 2005, p. 179) was constructed, whereby the researcher used discretionary judgement in choosing participants because individuals chosen were regarded by the researcher as most likely to have, and be willing and able to share, the information required

for this study. Other factors included the availability to participate, and illness of residents' inasmuch as this possibly impaired ability to communicate (e.g. dementia). In constructing participant groups, the researcher ensured an ethnic mix so that diversity was represented. Participants chosen were:

- six residents
- six family/friends of residents
- six staff members.

It was considered that involving people with individually different connections to the facility ought to provide perceptions from differing perspectives regarding the provision of a culturally sensitive home-like environment, and also highlight differences in the prioritisation of factors that lead to the holistic provision of such care.

A colour flyer, advertising the research and inviting voluntary participation, was developed (see Appendix 1). The flyer was prominently placed in each facility, on main noticeboards. The promotional information specifically sought two each of residents, family/friends and staff, from each facility. When individuals made contact with the researcher, a suitable appointment time for an interview, to be held at the facility, was arranged. Once all participant places in the research project were filled, the flyers were removed from the noticeboards. Volunteers in excess of project requirements, who contacted the researcher, were thanked and placed on a 'reserve' list in case some participants withdrew from participation at any later stage. The researcher mailed participant information and consent forms (see Appendix 2), together with details of the agreed appointment time. At the appointed time, the researcher went over the information, answered any questions, and ensured that the consent form was signed and witnessed before proceeding with the interview.

Even though the research sample included people from non-English speaking backgrounds, the flyer in English was not expected to be a limiting factor in recruiting participants, as language assistance was readily available (if required) through the family/carers and/or staff of each facility. It is acknowledged though, that where family/friends or staff were used as interpreters, there was a risk that the responses given could potentially have been influenced by the interpreter's own biases and agendas.

3.4 Research Methods

In this study, the information-gathering tools and the collection methods aim to facilitate the voices of people who are often unheard, and separate out individuals who are often lumped together as a group. Human diversity is taken into account. The research tools enable sustained focus on the participants' experiences in relation to their residential environment and can accommodate all contributions. To ensure the inclusion of different viewpoints and perspectives, participants were selected from a cross-section of cultures. According to Marlow (2001), this is an appropriate way of counterbalancing potential bias and a recognition that the research findings are likely to impact on 'diverse populations'.

To gather information on the research topic from participants for this thesis, a two-stage method was employed. Firstly, participants contributed specific demographic data (see Appendix 3). The purpose of this, as well as enabling the efficient collection of factual data from each participant, such as place of birth and length of residency in Australia, was to preface the second step, a semi-structured, or guided, interview (see Appendix 4).

Whilst there are several types of interviews commonly used in social science research (Sarantakos, 2005; Kumar, 2005; Alston & Bowles, 2003; Dudley, 2005; Marlow 2001), the researcher believed the best approach for this study was the guided or semi-structured interview. This type of interview typically uses a questionnaire, but the researcher is allowed more flexibility in the order the questions may be asked, and additional questions can be added as considered appropriate during the course of the interview. This approach allowed the interviewer 'more freedom to pursue the hunches and [the interviewer] can improvise questions' (Marlow 2001, p. 158). Given this research was exploratory by its nature, 'the flexibility built into semi-structured interviews makes them a useful tool for exploratory studies' (Dudley, 2005, p. 164) – this type of interview was appropriate to use. Because of the flexibility of this method 'the interviewer is allowed more initiative and has more ability to respond to the perceptions and the priorities of the respondent' (Alston & Bowles, 2003, p. 116). This was a particularly important consideration, given that the focus of the research was to gather participants' opinions about **their** perceptions, on topics that they may be sensitive about. The researcher, to encourage participants to focus on the research topic, in a way that facilitated continuance of their story sharing, therefore needed the flexibility of the semi-structured interview.

Each interview was expected to occupy one hour. Audio-recorded interviews were transcribed by the researcher immediately after, in order to clearly reflect upon and capture

important aspects of each participant's contribution. The demographic data, followed by participants' responses and analysis grouped by themes is provided in Chapter 4.

3.5 Data Analysis

The researcher listened to, and transcribed the information from the audio-taped interviews. This information was reduced, coded and analysed. Data reduction was based on the objectives of the research and its theoretical framework. The coding was based on recurrent themes and concepts that were expressed through key words and phrases. A matrix was developed to group information around certain themes and points. This information was more specifically categorised to present results in a clear form (Sarantakos 2005).

The process of analysis identified certain patterns and regularities in the groups of residents, family/friends and staff interviewed. Additionally, similarities and differences among the three groups were explored, enabling the development of answers to the research questions.

3.6 Ethical Issues

3.6.1 Confidentiality and Privacy

A right to, and the maintenance of confidentiality is an important issue for all in the intimate environment of residential care. It was therefore important to clearly explain to participants that any information gathered would be kept confidential, and no identifying details would be disclosed in any public output. Pseudonyms replace all names in this thesis, and the researcher and the supervisor are the only people with access to the research data. The privacy and confidentiality of all notes and associated information was consistent with the Australian Association of Social Workers Code of Ethics (AASW 2000).

3.6.2 Informed Consent

The researcher was contactable by telephone, as per the details provided on the flyer advertising the research study, and available on a daily basis to answer any queries about the research. Prior to the interview, participants were informed about the reason for the research and the structure of the interviews. During first contact with participants, they were given a copy of the Information to Participants Form and Consent Form – copies of these documents are in Appendix 2. After potential participants were assured that any disclosures shared with the researcher would not incur judgement or affect their relationship with the researcher, and

advised they were under no obligation to answer all the questions, and could withdraw at any time, they signed the Consent Form.

3.6.3 Limitations and Strengths

One of the limitations of this research was its narrow scope due to the small number of participants. However, this study provided a voice for the participants, enabling them to express their own ideas and opinions in relation to the research undertaken, in ways that they may have not otherwise been able to. The researcher's prior working experience in the field of aged care enabled her to forge positive relationships with participants, as she could empathise with their situations. Because this created potential for the researcher to introduce bias in the process, it could also be seen as a negative point, Participants were able to share their experiences and strategies in this research, bringing the participants closer together. This study captured individual responses that may prove valuable insights to those designing and developing future services.

Chapter 4: Analysis and Discussion

4.1 Background

Three long-term residential aged care facilities in Melbourne's western suburbs hosted this exploratory study. The voluntary participation of residents, family members and staff from these facilities enabled the following insights regarding the translation and provision of care in a multicultural communal environment. All names have been replaced with pseudonyms to protect the identities of facilities and participants.

Burnley Villa, established in one of the west's most affluent suburbs thirty years ago, is home to about forty people, and has (limited) accommodation for people in the community who require short-term, respite care. It is one of relatively few public aged care facilities left in Melbourne. High level care provided by qualified nurses is a feature that Burnley Villa prides itself on.

A remarkable feature of Camdon Lodge - situated on Melbourne's inner western perimeter and owned by a private not-for-profit organisation, is the diversity of cultures represented amongst the staff. This home for forty residents, established about twenty-five years ago, underwent major renovations and extensions two years ago to add bedrooms, enlarge communal spaces and improve its internal and external appearance.

Willington House, also established over twenty years ago, is another privately owned forty bed facility. The facility recently acquired a new name when it was sold. Much to the disappointment of all connected with the facility, a bus, previously available for resident outings, was not purchased by the new owners.

From the facilities, two residents, two family/friends and two staff representing the diversity of cultures, ages and circumstances, major features of this area's population, were sought. Each group was interviewed, and general demographic data, summarised in tables 4.1, 4.2 and 4.3, and observations, coupled with historical and current information, provided. Analysis and discussion of findings from the semi-structured interviews follows this.

4.2 Demographic Data

4.2.1 Residents

A summary of demographic data for residents is shown in table 4.1.

Table 4.1 Demographic data: residents

Residents	Bert	Anna	Flo	Wendy	Sam	Rosa
Age	59	96	87	48	56	78
Gender	Male	Female	Female	Female	Male	Female
Country of birth	England	Poland	Australia	Australia	Italy	Croatia
Year of arrival in Australia	1965	1950	N/A	N/A	1956	1970
Period of residence in facility	3.5 years	2 years	1 year	1 year	20 years	3 years
Previous address	St Kilda	Williamstown/ Sunshine	Footscray /Sunshine	Coburg	Yarraville/ West Footscray	St Albans

The ages of participating residents range from forty-eight to ninety-six, and include two in their fifties, and one each in their seventies, and eighties. That half of the participants are under sixty reflects the fact that significant numbers of residents in aged care facilities are aged well below the average age of the residential population. The gender ratio of participants, four women and two men, reflects the overall pattern of Australia's older age population, which features greater numbers of females.

Australia's population is culturally diverse and, because of the influx of migrants from Europe post World War II, it is predominantly broadly western, particularly amongst those over sixty. With four participants born overseas and two in Australia, this study reflects the typical picture of mixed origins and cultures that make up Australia's population. Two residents migrated to Australia in the 1950's, one in the 1960's and the other in the 1970's. Prior to moving to the facilities, one resident lived in St Kilda, one in Coburg, and the others around the western suburbs of St Albans, Sunshine, Footscray, Yarraville and Williamstown. The majority of participants have a previous living association with the western suburbs. Whilst one resident has been in the same facility for twenty years – an unusually long period - the length of stay for the other five residents is between one and three and a half years.

4.2.2 Family/Friends

A summary of demographic data for family/friends is shown in table 4.2.

Table 4.2 Demographic data: family/friends

Family/Friends	Michelle	Pauline	Gina	Joan	Marg	Christina
Age	56	74	48	49	55	54
Gender	Female	Female	Female	Female	Female	Female
Country of birth	Australia	France	Australia	Australia	Malta	Croatia
Year of arrival in Australia	N/A	1950	N/A	N/A	1965	1970
Relationship to resident	Wife	Daughter	Daughter	Daughter	Daughter	Daughter

The ages of family/friends interviewed range between forty-eight and seventy-four, with two in their forties, three in their fifties and one who is seventy-four. Three of the family/friends were born in Australia, and the others in Malta, Croatia and France. Those who came from Europe - one in 1950, one in 1965 and the other in 1970 - were part of the wave of migration to Australia that followed World War II.

Family/friends interviewed included one wife and five daughters of residents. Due to a range of contributing factors that include defined gender roles, family circumstances, economic ability, and personal and emotional interests, women have traditionally taken on the caring role. Whilst the translation and enacting of a carer role are influenced by personal relationships and family circumstances, I noted the influence of traditional social gender (female) roles in family care arrangements.

4.2.3 Staff

A summary of data for staff is shown in table 4.3.

Table 4.3 Demographic data: staff

Staff	Teresa	Pip	Wilma	Sally	Mary	Saria
Age	53	47	43	32	42	48
Gender	Female	Female	Female	Female	Female	Female
Discipline	Div 2 Nurse	Div 2 Nurse	Div 2 Nurse	Div 2 Nurse	Personal Care Attendant	Laundress
Weekly working hours	15 to 20	35	28	35	18 +	37.5
At current employment	5 years	8 years	4 months	3 years	12 months	12 years
Country of birth	Australia	New Zealand	Fiji	Kenya	Australia	Venezuela
Arrival to Australia	N/A	1978	1987	2002	N/A	1962
Identification of ethnic mix of residents in facility	Australian Maltese Italian Yugoslav Polish Finnish Scottish English	Australian Maltese Italian Yugoslav Polish Finnish Scottish English	Italian Australian Yugoslav Mauritian Vietnamese Greek English	Italian Australian Mauritian Maltese German Greek Vietnamese Chinese	Italian Yugoslav Croatian Greek English Scottish Vietnamese Turkish Polish Australian	Australian Italian Vietnamese Polish Croatian Greek

Staff interviewed are all female – reflecting the bias of female employment in nursing and allied care. The ages range from thirty-two and fifty-three, with four in their forties. Three staff (two nurses and the laundress) work full-time and the other three (two nurses and the personal care attendant) work part-time. The laundress has worked twelve years, three of the nurses, eight years, five years and three years, and the personal care attendant and another of the nurses, fewer than twelve months in their current employment. Whilst two staff - a nurse and the personal care attendant - were born in Australia, another migrated from Kenya in 2002, and others from Venezuela, New Zealand and Fiji, and each have been in Australia for at least twenty years.

The origin of residents, as identified by staff, varies from one facility to another. According to the information shared, European cultures predominate.

4.3 Interview Responses and Analysis

4.3.1 Introduction to the Participants

4.3.1.1 Residents

Bert, sixty, and Anna, almost ninety-seven, both live at Burnley Villa; Flo, in her early eighties and Wendy, forty-eight, live at Camdon Lodge; and Sam, fifty-three, and Rosa, in her mid-seventies, live at Willingtun House.

Bert migrated from the United Kingdom in the early sixties with his parents and sister. Although never married, he has a daughter; however, they are not in contact. Bert lived mainly with his parents in Melbourne's inner bay-side suburbs until his early thirties, then in various rental arrangements in the same area. He worked as a semi-skilled tradesperson in factories, building industrial equipment. Over three years ago, when he was no longer able to care for himself due to exacerbation of chronic illness, Bert moved into Burnley Villa. In describing his experience of the environment, he said the atmosphere was home-like, warm and satisfying. He conveyed that one of his life's pleasures is regular phone contact with his elderly but independent mother from regional Victoria. Throughout our association I noted Bert's genuine consideration for other residents at Burnley Villa, and also for staff.

Anna migrated in 1950 from the Ukraine, with her two children. Anna described her family's suffering in their home-land; how she was forced to work for little money on farms and in homes of well-to-do people, and penalised by employers for having children. It grieved Anna that her children, from a very early age, were forced to work and were denied educational opportunities. Anna said that throughout her life she has been independent, and never envisaged becoming so dependent, and feels that under the circumstances she is in, her long life is a punishment. Quietly spoken and quite deaf, frail and virtually bed-ridden, Anna does not want to burden or bother anyone, and wishes she could do more for herself. She related that often her care needs and requirements are either slow to be addressed or not met, and shared that she did not feel part of Burnley Villa in any way, other than simply existing there until she dies. The bright spots in Anna's life are the almost daily visits from her daughter and son, and occasional visits from other family and friends.

Flo, of Australian origin, has lived and worked in Melbourne's Western suburbs all her life, in various workshop foreperson and assembly-line positions. After being widowed in 1991, she lived alone in her Footscray home, but worsening emphysema made independent life harder, so three years ago, following medical advice, and with encouragement from her supportive family, she moved to Camdon Lodge. Flo shared that relinquishing her

independence, accepting the need for a high level of assistance, and leaving her home and neighbours of many years to live in a communal setting with people she didn't know was a big move. Flo noted that Camdon Lodge staff were personal and caring in their attention to her, and described the environment as home-like.

About six months before this survey, Wendy, of Australian origin, was admitted to hospital and diagnosed with a disabling and debilitating illness, which progressed rapidly to the point where she could no longer look after herself. Well aware of the dramatic changes in her situation, she followed advice and sought residential care, and was granted residence at Camdon Lodge. Formerly a secondary school History and Art teacher, Wendy proudly displays her impressive art-work, University degree and other academic achievements, with the aim of making her room 'home-like' and comfortable. However, lonely amongst a group of much older people, and missing those things that would facilitate continuance of her interests, especially art, Wendy is not comfortable and does not feel Camdon Lodge to be home-like.

When Sam migrated from Italy with his family, he was six years old. Sam attended school in Footscray where the family settled. After completing his education at Footscray High School, he began work as a labourer, and within six years bought a house and moved into it. In his late twenties, Sam, unfortunate victim of a random, violent attack, was left with permanent brain damage. Following eight months in hospital, Sam was discharged to the family home. Soon afterwards, he desired to live independently, and enquired about accommodation at Willington House, a new local facility. He was offered residence, and has lived there for over twenty years. Sam, at fifty-three, the facility's youngest resident, says he is comfortable, happy and looked after at Willington House, and helped with the things he is unable to do for himself, such as getting meals and attending to his personal hygiene.

Rosa, through her daughter Christina, explained that she migrated from Yugoslavia with her two teenagers after being widowed in 1970. She raised her children single-handedly, and Christina described Rosa as a mother and grandmother who was active and supportive, and worked as an assembly-line worker, then a cleaner, until recent times. Three years ago, Rosa's declining health, including diabetes and depression, led to admission at Willington House. Rosa described the atmosphere of this home as warm and home-like, and identified staff as helpful, understanding and sensitive, particularly when she felt 'down'.

4.3.1.2 Family/Friends

Whilst each person in this group was a family member of a resident, there is not necessarily a connection between participating family/friends and participating residents.

The responses to the interview questions of this group reflect their understandings of the challenges and constraints inherent in providing a home-like environment that is culturally sensitive, in a communal facility catering for people of diverse origins, who have different health issues and personal requirements.

Michelle is a sixty year old Australian (Ukrainian background) who visits Burnley Villa almost daily to see her Australian husband, Jim, admitted there a year ago as his dementia worsened. Jim's daughter, parents, and other family and friends also visit regularly. Michelle described Burnley Villa as having a warm and welcoming atmosphere, and she has confidence in the staff, and peace of mind regarding Jim's care.

Pauline was fifteen when she migrated from Poland with her mother and brother. Now in her mid-seventies, this independent extroverted lady visits her mother, Anna, for a few hours every day, except Sunday, when no public transport is available. During visits, Pauline and Anna chat, and Pauline arranges Anna's area and organises the wardrobe, or sits beside Anna when she dozes off. Pauline, whilst happy to participate in this survey, phrased her responses carefully. She expressed feeling culturally and linguistically misunderstood at Burnley Villa and uncomfortable about the way she fits in there.

Once or twice a week, Gina visits her mother Tina, who has advanced dementia, at Camdon Lodge. Gina is kept busy working full-time, looking after her husband and two teenage children, and her elderly father, who visits Tina daily. Gina spoke positively about Camdon Lodge.

Joan visits her mother Alba, at Camdon Lodge, practically every day. Alba has dementia and is totally dependant on care. Joan, who never married, has no children or siblings, and no longer works, is one of a regular group of daily visitors to Camdon Lodge, and the visits are an important part of her life. Very much 'at home' at Camdon Lodge, Joan enjoys interacting with residents and visitors. Her comfortable familiarity with others there was evident to me.

Marg, who visits her mother Joyce, at Willington House once or twice a week, would prefer to visit more frequently, but working part-time and caring for a family leave her with little time. Marg is pleased Joyce has developed friendships among the residents, and recognises that her mother's relocation close to the family home means that Joyce's old neighbours continue to visit her.

Christina lives in an adjoining suburb and visits her mother, Rosa, about four times a week. Christina, mother of three teenage children, works from home, running a family business with her husband. Christina recounted how Rosa's busy life slowed down only a few months before her admission to Willingtán House. She was glad her mother's friendships included staff that were long-time family friends. Throughout time spent with Christina and Rosa, I became aware of the strong Christian faith that influenced their lives.

4.3.1.3 Staff

All staff participants, with the exception of Wilma, have worked at their facilities for lengthy periods, and their responses reflect an understanding that they play a role in the provision of a culturally sensitive and home-like environment.

Teresa and Pip, Registered Nurses, Division 2, work at Burnley Villa. Teresa works four five-hour morning shifts per week and Pip works full-time, mornings and afternoons. Teresa and Pip are happy to be working in a public health network, and are proud of the care provided at Burnley Villa, feeling it superior to care at private facilities.

Wilma is a recently qualified Division 2 Nurse who has worked at Camdon Lodge for four months, twenty-eight hours a week. She regards staff as committed and experiences the facility's atmosphere as friendly. Sally, from Kenya, a Division 2 nurse who has worked at Camdon Lodge for three years, spoke positively about the activities, staff and physical presentation of the facility, which she regards as superior to others.

Mary has worked as a personal care worker at Willingtán House for eighteen months. Although contracted to work eighteen hours, she averages thirty to forty weekly. Mary's temporary stint as Activity Worker increased her appreciation of the individuality of each resident. Mary also saw the difficulties busy direct care staff sometimes had to meet residents' needs. Saria has been the laundress at Willingtán House for twelve years, and works thirty-seven and a half hours per week. Saria, proud of her multicultural workplace, understood the challenges in the environment, and has opinions regarding their address.

4.3.2 Participants' Responses

4.3.2.1 The Facility's Environment

When considering what the attributes of a culturally sensitive, home-like environment would be, and the ways their facilities could be made more home-like, participants highly valued intangible qualities, such as an atmosphere infused with implicit tolerance, and inclusive practices that showed recognition and acceptance of each person who belonged to

the environment. These qualities and care practices are identified by Maidment, Egan and Wexler (2005) as also important to culturally and linguistically diverse older people and family caregivers in the wider community.

For one resident and some of the family members, equal treatment of individuals regardless of their reason for needing care, recognition and acceptance of differences, openness and honesty among all, and staff who share residents' cultures are hallmarks of such an environment. Sam was content to be at Willington House:

A culturally sensitive home-like environment would be like this. It's pretty good here and that's the reason I've stayed.

Michelle appreciated feeling completely at home when she visited Burnley Villa, and echoed the observations of Marshall and Eaton (1980), and Faison and Minter (2005) that a culturally sensitive, home-like environment is welcoming, and staffed by trustworthy people.

Teresa used the words 'loving, calm, relaxed and clean, and considerate of the individual' to describe such an environment. For Wilma this meant:

Relaxed, safe and comfortable and able to feel this is my home and people around me feel part of my family. From first thing in the morning – it's the way you get up, have breakfast and all the things you do as you plan for the day.

Sally and Pip noted that residents had a sense of belonging, and Mary and Saria agreed that a smooth transition from home to residential care and the right to, and respect of, privacy were important.

Anna, who shared that her needs were sometimes neglected, and care often lacked warmth or response, said she would feel her facility more home-like if she experienced sensitivity, consideration, warmth and connection.

Rosa regarded sharing a room with people of her culture as opportunity for connection and the development of satisfying friendships, and a chance to speak her own language; special needs recognised by Marshall and Eaton (1980). In contrast, Flo considered the environment at Camdon Lodge would be more culturally sensitive and home-like if all people spoke English, because:

When they gabble away in their own lingo together, it does not worry me, but some others are very sensitive about it.

Wendy said she would like more of her things around her, and Camdon Lodge would feel more home-like if there was an area where she could paint. Hartz and Splain (1997) noted

residents in long-term care experienced such emotional and social vacuums as Wendy, a young person in an old people's home expressed, and they believed medically informed processes in care settings thwarted the potential for care that was more responsive.

Michelle considered that literally being able to view the world through the windows kept people 'in and part of' the happenings in the neighbourhood, and she felt limited space and lack of access to window views disadvantaged residents at Burnley Villa, and expressed the common view that to make more it home-like, the facility needed renovation. Marg noted garden space, and Gina and Joan, attractive facility layout and presentation, as components of a home-like environment - observations that tie in with the recognition of Hartz and Splain (2005) that the physical layout is one of the factors that enhance the quality of life for residents.

For Mary, entertainment, activities, music and décor at Willington House did not reflect resident diversity, and therefore some residents are 'missing out'. Outings were enjoyed by most residents, and whilst Burnley Villa and Camdon Lodge each had a bus, Willington House no longer did, and the loss was regarded as a minus for the residents. Indeed, activities and events are seen by Prime (1991) as integral components of quality residential care.

When residents, family-members and staff at Camdon Lodge gathered and interacted during meal-times, Gina experienced a sense of community 'like a family'. Mary noted a similar atmosphere at Willington House when one family brings and shares home-cooked food with residents. Flo said simply being offered a cup of tea with meals would add to the home-like feel of Camdon Lodge.

In identifying the attributes of a culturally-sensitive environment, all participants accepted Sally's description:

A culturally-sensitive, home like environment is considerate of the individuality of residents and accepts their differences.

4.3.2.2 A Culturally Sensitive Home-Like Environment – Participants' Perspectives

When considering what components combined to make a culturally sensitive, home-like environment, and the ways their facilities could be made more home-like, participants highly valued intangible qualities, such as atmosphere infused with implicit tolerance, and inclusive practices that showed recognition and acceptance of each person belonging to the environment. These qualities and care practices are identified by Maidment, Egan and Wexler

(2005) as also important to culturally and linguistically diverse older people and family caregivers in the wider community.

For one resident and some of the family members, equal treatment of individuals regardless of their reason for needing care, recognition and acceptance of differences, openness and honesty among all, and staff who share residents' cultures are the positive hallmarks of such an environment. Sam was content to be at Willington House:

A culturally sensitive home-like environment would be like this. It's pretty good here and that's the reason I've stayed.

Michelle appreciated feeling completely at home when she visited Burnley Villa, and her description echoed the observations of Marshall and Eaton (1980), and Faison and Minter (2005), that a culturally sensitive, home-like environment is welcoming and staffed by trustworthy people.

Teresa used the words 'loving, calm, relaxed and clean, and considerate of the individual' to describe such an environment. For Wilma this meant:

Relaxed, safe and comfortable and able to feel this is my home and people around me feel part of my family. From first thing in the morning – it's the way you get up, have breakfast and all the things you do as you plan for the day.

Sally and Pip noted that residents had a sense of belonging, and Mary and Saria agreed that a smooth transition from home to residential care and the right to, and respect of, privacy were important.

Anna, who shared that her needs were sometimes neglected, and care often lacked warmth or response, said she would feel her facility more home-like if she experienced sensitivity, consideration, warmth and connection.

Rosa regarded sharing a room with people of her culture as opportunity for connection and the development of satisfying friendships, and a chance to speak her own language, special needs recognised by Marshall and Eaton (1980). In contrast, Flo considered the environment at Camdon Lodge would be more culturally sensitive and home-like if all people spoke English, because:

When they gabble away in their own lingo together, it does not worry me, but some others are very sensitive about it.

Wendy said she would like more of her things around her, and Camdon Lodge would feel more home-like if there was an area where she could paint. Hartz and Splain (1997) noted

residents in long-term care experienced such emotional and social vacuums as Wendy, a young person in an old people's home expressed, and believed medically informed processes in care settings thwarted the potential for care that was more responsive.

Michelle considered that the ability to see out of the windows kept people 'in and part of' the happenings in the neighbourhood, and felt limited space and lack of access to window views disadvantaged residents at Burnley Villa. She expressed the common view that to make more it home-like, the facility needed renovation. Gina and Joan noted attractive facility layout and presentation, and Marg, garden space, as components of a home-like environment. The importance of the physical layout as a factor in enhancing the quality of life for residents is similarly recognised by Hartz and Splain (2005).

For Mary, the consequence of entertainment, activities, music and décor not reflecting resident diversity was that they were 'missing out'. Outings were enjoyed by most residents, and whilst Burnley Villa and Camdon Lodge both have a bus, Willington House no longer does, and the loss was regarded as a minus for the residents. Indeed, activities and events, according to Prime (1991) are integral components of quality residential care.

When people gathered and interacted 'like a family' during meal-times at Camdon Lodge, Gina experienced a sense of community, and Mary described a similar home-like feel at Willington House when one family brings and shares home-cooked food with residents. Flo said simply being offered a cup of tea with meals would add to the home-like feel of Camdon Lodge for her.

All participants expressed similar attributes, which Sally defined:

A culturally-sensitive, home like environment is considerate of the individuality of residents and accepts their differences.

4.3.2.3 Recognising Cultural Differences: Challenges for a Multicultural Facility

Because great diversity exists within each culture, and each residential facility is home to multiple representatives of numerous nationalities, there are challenges to being able to recognise the differences of individuals in the way a facility catering exclusively for one culture could. In answer to questions that ask whether this, or that, is the right way, Buchanan and Webster (2000) highlight guiding principles for working effectively with cultural diversity. Participants were asked to consider how their facility honoured the cultural importance of various aspects of life that tend to be interpreted differently according to the cultural lens they are viewed through. They were also asked to describe what they saw as the biggest challenges for staff in a multicultural facility.

Long-time resident Sam liked the relatively recent increase in the cultural diversity of residents and staff at Willington House, and regarded the staff as often well equipped to make sense of the 'hard-to-understand'. Gina's belief that employing staff who were ethnically similar to residents was a positive contribution to care concurred with Prime's (1991) observations noting that including staff with the same ethnic backgrounds as residents contributes to a congenial atmosphere. Wilma regarded Camdon Lodge's multi-cultural staff as very comfortable working with the cultural mix of residents, picking up words from various languages to assist communication with residents, and learning what their personal preferences were, in order to accommodate where practical.

Bert regarded diverse presentations of illness as more apparent than cultural variations, and explained that because dementia has robbed many residents of their skills and cognition, there are few he can converse with. Unaware of policies regarding cultural matters, and noting minimal cultural differences amongst Burnley Villa residents, Bert explained that people have to 'just get on with it' (their life). Marg noted the communication frustrations for people who have reverted to their mother tongue and no longer speak the language that has kept them connected with others, and for Teresa, residents' loss of verbal expression was added reason for staff to maintain communication with families about their loved one in care. Teresa's responsive attitude exemplified some of the attributes of care identified by Maidment, Egan and Wexler (2005).

Other than Flo, who considered everybody should speak English, participants acknowledged the difficulties experienced by residents with poor English skills. For Sally,

Communication is one of the main ones [challenges]. Different customs and cultural habits and behaviours and variations in beliefs and expressions of religions are others. Also the way the staff are heard by residents can be a challenge for both.

Pip and Saria agreed, and Pip added that while picture and language boards, assistance of staff who understands the resident's language or a phone call to a family member were all seen as practical and acceptable ways to understand what was being said, they were no substitute for common language. Pip further drew attention to the prolonged and time-consuming process to access interpreter services.

Each family member observed that residents with poor English experienced isolation, and Gina and Joan recognised the high level of frustration experienced between people who were endeavouring to communicate, but lacked a common language. Christina, Rosa's daughter, expressed relief that her mother had enough English skills to ensure comfortable

communication with others; however Rosa described herself as struggling with English, and happy to communicate with some staff in Croatian.

Music was appreciated by all participants, regardless of culture. Marg noted it as an enjoyment to be had, regardless of what country you came from, and the rest of the surveyed family members generally agreed that, whether it be classical, traditional folk or popular sing-along, music gave pleasure and was a vital part of the atmosphere.

Gina considered that

It is important that people, especially those who don't speak English, hear music they are familiar with. It makes them feel welcome and like they are at home.

Sam, Flo and Wendy regarded music as important, but did not elaborate on the types of music they preferred or thought others would enjoy. Similarly, entertainment and activities, with no culture-specific imperatives, were seen as desirable. Bert regarded entertainment as significant, but preferred the idea of being taken for a walk in the neighbourhood, as he had little interest in the offerings at Burnley Villa. Bert's comments illustrate Gibson's (1986) assertion that any institution may find it impossible to cater for individual differences, and the quality of care, or style of life, is a matter of 'fit'.

Craft and small group activities, and communal entertainment, according to Teresa, were important for the residents, because their dynamics create social definition and provide pleasure to all at the facility. Outings, with journey more important than destination, were a favourite small group activity, regarded by all as a chance for residents to enjoy time away from their facility. Pauline expressed sadness that her mother's care needs precluded her from outings. Perhaps work-load pressures on staff, a fact discussed by Limbery (2005), meant there was little opportunity to organise or undertake pleasurable alternatives with Anna.

In relation to the cultural fit of festivities and religion, Gina summed up the group's response:

Christmas and Easter are well recognised, as is St Patrick's Day and the Australian ladies love that, but beyond that I'm not sure how, for instance, Muslim occasions are recognised.

Religion had personal and cultural importance, especially, according to Bert, for some older residents, and all participants indicated open-to-all Christian services were regularly held at their facilities. As participants thought about religion and all residents, I observed a general dawning of awareness that only main-stream Christian religions recognise. The failure to be all-inclusive of other cultures, according to Diller (2004), leads to non-dominant

cultures not being recognised and responded to; consequently they feel diminished and isolated.

Sam said he had no interest in ornaments or photos, he saw them as more what 'ladies go for'. These, indeed, were important to all the ladies; they beautified and personalised areas and rooms, and were reminders of home and family. Rosa thought it sad that some residents' areas lacked them. Family regarded such personal things as adding a 'home-like' feel and giving staff more insight into their loved one as a member of a family and a person with an identity, and staff felt they got a bigger picture of the residents through their photos. In addition to encouraging personal expression through photos and décor, Pip believed that honouring choice of attire, and recognition and facilitation of radio station, television channel and music choices showed respect and acceptance of the preferences and rights of residents.

Food was seen as integral to an environment, and its cultural importance was recognised. Willington House caters in-house, and although Mary and Saria did not see the menu as representative of the tastes and preferences of their residents' cultures, residents expressed their liking of food provided. Burnley Villa's meals are delivered in bulk, pre-cooked, however, to cater for individual preferences, the kitchen stocks a variety of extra foods.

Saria and Marg observed that some residents only ate food their families brought them. Pauline felt meals offered to her mother lacked variety and bore little resemblance to food her mother was used to. To compensate, she and her brother regularly brought home-cooked food to Anna, as Pauline considered:

For people to be able to enjoy the taste of food they grew up with is a comfort to them.

When Michelle saw her husband given blended food, she ensured his meals were reverted to the textured food she knew he enjoyed. Bert considered food as important and complimented the food offered at Burnley Villa. Flo and Wendy echoed similar comments about their facilities too; but Wendy expressed understanding that people of different cultures may be unused to, or not enjoy the food at the facility, and that may be a difficulty for them. Once again, the issue of 'fit' between resident and facility, as identified by Gibson (1986) can be seen, and a challenge for facilities is to conform to government guidelines that recommend a dietary regime that is culturally sensitive.

When asked what the biggest challenges for staff working in a multicultural residential facility would be, Bert and Sam saw the challenges of behaviours as a consequence of dementia, with staff having to remain patient whilst dealing with residents wandering in and out of other people's rooms and the aggravation this caused other residents.

Flo saw the big challenge for staff as a lack of human resources to effectively respond to resident's differing needs, however, Wendy didn't think staff working in a multicultural setting had many challenges.

At Burnley Villa, Michelle observed the biggest staff challenges were recognition and understanding of the cultural differences, and interpreting the expressions and body language of residents suffering advanced dementia. In sharing Michelle's concerns, Pauline said:

It would be difficult because a lot [of staff] have never been out of this country, but they are looking after people from all different countries. They don't really understand other cultures. The different languages would make it difficult too. It's a lot of little things.

Mary summed it up as:

Responding to residents from a different culture imposes an additional layer of adaptation.

4.3.2.4 Influences on the Provision of Services

Facilities each have an official process to deal with suggestions, compliments or complaints. The facility's manager responds to the communication, usually documented on an Opportunity for Improvement form, and advises the initiator of outcomes. Staff and family were aware of the communication process, however residents were not, and whilst they knew they could express verbal opinions, were unsure they would be heard. Reduced access to even simple processes is an issue highlighted by Thompson (2000), who recognises the marginalisation and discrimination of minority groups, such as aged people, in modern western social hierarchy. Flo provides a good example:

Yes, we all had a chance to have our say. We all went down to the dining room and I told them we haven't got enough staff. One of the big wigs here said I'd even talk under water. That hurt me a bit and then I decided not to let it worry me. If there were enough staff there'd be nothing to complain about.

Wendy was unaware of processes and relied on the advocacy of her family:

There is not a residents' committee [there actually is one at the facility]. My family is able to speak on my behalf and there are opportunities for that to happen.

Michelle appreciated the open communication channels that enabled her to influence her husband's dietary preferences. Pauline with the same opportunities, feared misinterpretation

and believed her strong opinions placed her in a situational bind, resulting in her reluctance to speak freely and feeling unable to influence the care given in the facility.

Gina and Joan identified that Camdon Lodge staff were available and approachable. Whenever Gina needed to discuss anything, her requests were heard and heeded, and Joan said whilst she hasn't needed to, she would feel comfortable to speak to management on changes to her mother's care needs.

Neither Marg nor Christina attended the Willington House family and friends meetings, but both felt relaxed in talking to nursing staff about any concerns they may have, and Christina found the charge nurse particularly easy to talk to.

Burnley Villa, according to Teresa and Pip, recognises, welcomes and values input, especially from those connected with the facility. Staff at every facility said suggestions were always followed up. Staff appreciated the open communication lines with the manager at Camdon Lodge - similar sentiments were expressed by staff in other facilities.

Staff meetings and discussions provided comfortable opportunities for input into the provision of services at Willington House, according to Saria. Mary claimed to have a fuller appreciation of the resident as an individual, as a result of her temporary role as activities co-ordinator and working with different staff, and felt empowered to offer suggestions and take up suggestions of others.

Staffing issues were identified as a major hurdle throughout the interviews and Pauline and others recognised the negative effects of the heavy work-load carried by staff

Maybe if they would have more staff there would be more time [for the residents]. They only have time to do the work and nothing more.

This resulted in a less than ideal environment, because there was little, if any, opportunity for staff to dedicate time to one-on-one care, a matter that Dixon (1991) points out as being a result of organisational structures that impose specific behaviours and routines on staff resulting in 'institutionalised' care. Staff shortages were dealt with by short term solutions, such as agency employees. However this 'solution' created its own problems. Gina commented that high usage of agency staff, unfamiliar with residents, meant individual personal touches were often neglected. As Lymbery (2005) points out, the tightly controlled aged care budget influences the structure and organisation of the care industry, and imposes challenges and pressures on staff and others who are part of the environment.

Interviewees shared the same challenges on this issue, and agreed that solutions were beyond their control, with facilities requiring additional government funding to provide the desired resources to enhance service provision.

4.4 Conclusion

One of the most important, yet difficult to define aspects of residential care is the provision of an atmosphere that translates into the feel of a home-like environment for residents. Because home-like is a subjective notion that has different meanings influenced by the culture of individuals, it is largely intangible and challenging to provide, particularly where ethnic mixes exist. The main reasons for undertaking this research were to gather opinions directly from residents, family/friends and staff to further define what home-like means in a culturally diverse facility, and how care provided reflects such an environment.

The findings highlight a number of issues that arose in relation to the provision of a home-like environment in culturally diverse aged care residential facilities, including:

- The existence of individual differences, even among people who share the same culture. For example, Flo expects everyone to speak only English, but Wendy does not.
- Language as fundamental to communications, with staff demonstrating a willingness to overcome these barriers through the use of other people with appropriate language skills, as well as picture boards and interpreter services.
- Family/friends continuing to assume responsibility for their loved ones to maximise their quality of life. Family/friends became part of the care team with staff as advocates for residents.
- The creation of identity for residents, through personal items, with particular emphasis on photographs.
- General appreciation of the availability of open-to-all religious services and dawning recognition that the emphasis was on catering for the dominant belief, which is Christian.
- Activities, such as outings, designed to approximate 'normal' living. These were regarded as 'a break' from residential care, with the journey more important than the destination.
- The provision of food. This was regarded as an essential quality of life component by many family/friends, who appeared keen to ensure their loved ones had an

opportunity to continue to have their traditional food. As residents in the main reported general satisfaction with the food provided at facilities, perhaps the family/friends efforts in supplying favourite food was hinged on the relationship they wanted to enjoy with their loved ones in care, which encompassed more than just the taste of the food.

- The physical layout of facilities. This appeared to be an accepted factor, with family/friends in particular resigned to the fact that there was no choice in the design, but they focused on the positives.
- Staff workload. This was regarded as excessive by some residents and family/friends. Staff were open in their comments, lamenting the lack of opportunity to provide more individualised care to residents.

Previous research highlighted the importance of understanding culture as it ‘is a difficult concept to grasp’ (Diller 2004, p. 58), yet ‘verbal expressiveness’ (Diller 2004, p. 70) is a basic means of communication, and ‘until we acknowledge the different socio-cultural values that shape interactions and relationships ... we will neither recognise nor accommodate successfully the cultural differences that inevitably exist’ (Lee 2004, p. 351), therefore there must be ‘an awareness of similarities and differences between residents’ (Gibson 1986, p. 107). The challenges associated with pleasing all are discussed by Gibson (1986) who supports the assertion that whilst there is no such thing as a universally acceptable home, there are many kinds of good homes that are flexible, sensitive and considerate of the individual.

In addition to these factors, my research found that what was important for residents were very personal considerations, such as a cup of tea with a meal, an area to paint in, more multi-lingual resources, and sharing a room with people of the same culture. For family/friends the important aspects included feeling welcomed and included, and maintenance of connections with the wider community by the residents, through activities such as outings and celebration of festivities. For staff it was important to claim they recognised individual differences and rights, and maintained relationships with family/friends.

This study has contributed to the existing knowledge by providing ‘front-line’ insight into the interpretation of a culturally sensitive home-like environment in residential care through the ‘lenses’ of people who share a direct involvement in the provision of such care. These insights have the potential to enrich service delivery and design in the future.

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Appendix 1: Flyer Advertising Research Project

Cultural Sensitivity and The Provision of a Home-like Environment

Research Project *Participants Needed*

Marie Farvis, a final year Social Work student at Victoria University, is conducting research on this topic. Residents, carers and staff at this facility are invited to participate.

If you would like to give one hour of your time to take part in this study, please contact

Marie by email
Marie.Farvis@students.vu.edu.au

Or call Marie on
0422 691 970



Appendix 2: Information to Participants and Consent Form

BACHELOR OF SOCIAL WORK (HONOURS) THESIS BY MARIE FARVIS

INFORMATION TO PARTICIPANTS:

I would like to invite you to participate in my research that I am undertaking, as a final year student, in order to complete the thesis requirement in the Honours component of the Bachelor of Social Work program at Victoria University.

My research focuses on your opinion in relation to the provision of a culturally sensitive home-like environment in your residential care setting.

What you are asked to do

If you agree to be involved in this project, you will take part in an interview with me and complete a small survey. I expect that the interview and the survey will be completed within one hour. In order to accurately capture information, I would like to record the interview, as this will help me in writing the final thesis.

I would like to ask you about your thoughts and ideas in relation to the provision of a home-like environment, including how you define a home-like environment. I will ask you where you see things working well and where you see room for improvement.

During the interview I will not pressure you into speaking about issues that may cause you discomfort and you are under no obligation to answer any questions that you do not wish to answer. You may withdraw from the research at any time without having to explain your decision to do so. You may also withdraw information previously given at any time without having to explain why you have decided to do so.

You should note that I am bound by the requirements of mandatory reporting so any information that is divulged to me by you may be subject to these requirements that will require me to act accordingly.

Confidentiality

The University has strict rules about confidentiality and I am conducting my research under these rules. I am able to interview you because my research has been approved by Victoria University's Social Work Unit Human Research Ethics Committee and the management of the facility have also given their consent to maintain confidentiality of participants and their contribution.

Any information gathered as part of the research will be accessed by the researcher and the supervisor only.

In any public output, data will not identify individuals or facilities. The results will be published in aggregate form only to ensure the confidentiality of participants and facilities is maintained.

If you would like to take part in this project, and share your thoughts, ideas and experiences with me, I would be very grateful. If you wish to discuss any aspect of this research with me, you can contact me on 0422 691 970, or my University supervisor, Dr Marty Grace, on 99192920.

Thank you

Victoria University
Consent Form for Research Participants

CERTIFICATION BY PARTICIPANT

I,
of

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study entitled:

The provision of a home-like environment: an investigation of culturally sensitive practices in residential care facilities in Melbourne's western suburbs.

Being conducted at Victoria University by:

Marie Farvis

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Marie Farvis

And that I freely consent to participation involving the use on me of these procedures.

Procedures:

Personal Interview

Completion of a written survey

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed.....

Date:

Witness other than the researcher:.....

Date:

Any queries about your participation in this project may be directed to the researcher (Ms Marie Farvis, ph. 0422 691 970). If you have any queries or complaints about the way you have been treated, you may contact the Honours Coordinator, Social Work Unit, Victoria University of Technology, PO Box 14428, Melbourne, 8001 (telephone no: 03-9919 2920).

[*Please note: where the participant/s age is under 18, separate parental consent is required; where the participant is unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]

Appendix 3: Participants' Demographic Data Forms: residents, family/friends and staff

Demographic Data Form

Questions for the survey – Residents

1. What is your age? _____

2. Are you male or female? _____

3. Where were you born? _____

If born overseas, in which year did you come to Australia? _____

4. How long have you resided in this facility? _____

5. Where did you live previously? _____

Demographic Data Form

Questions for the survey – Family/Friends

1. What is your age? _____

2. Are you male or female? _____

3. Where were you born? _____

If born overseas, in which year did you come to Australia? _____

5. What is your relationship to the person you visit in this facility?

Demographic Data Form

Questions for the survey – staff

1. What is your age? _____

2. Are you male or female? _____

3. What is your job at this facility? _____

4. How many hours per week do you work here? _____

5. How long have you worked here? _____

6. Where were you born? _____

If born overseas, in which year did you come to Australia? _____

7. What is the ethnic mix of clients in this facility?

Appendix 4: Interview Questions

Semi-structured Interview Schedule

Questions for the personal interview (all categories)

1. In what ways does this facility feel home-like to you?
2. In what ways could this facility be made more home-like?
3. Can you tell me some of the things, for example language, food entertainment, music, objects, or religion that you think are culturally important to residents?
4. What would a culturally sensitive home-like environment be like from your perspective?
5. In your experience how are the cultural differences of residents regarded and recognised?
Can you provide examples?
6. What opportunities have you had for input into the provision of services from the facility?
7. What do you consider the biggest challenges for staff working with a multicultural clientele?