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THE UNIVERSITY OF ALBERTA

NURSING HOME PLACEMENT CONSIDERATION

By

CHERYL L. KNIGHT

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF NURSING.

FACULTY OF NURSING

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Nursing Home Placement Consideration

submitted by **Cheryl L. Knight**

in partial fulfilment of the requirements for the degree of **Master of Nursing**

Marion Allen
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Date: April 6, 1989

Abstract

Placement, the movement of an elderly person from the community into an institution, has been called "the last step", one to be avoided as long as possible and, once taken, irreversible. The health care literature includes the work of researchers examining the reasons for placement and the effects of institutionalization. Less emphasis has been placed on the lived experience. The purpose of this research was to provide an emic perspective of the experience of considering nursing home placement. Interviews of fourteen purposely selected informants were completed. The content of each interview was analysed using a grounded theory method of constant comparison. The analysis revealed a basic social process describing informants' ability to take care of themselves as they managed changes accompanying their aging process. Changes that interfered with the successful completion of normal tasks of daily living to such an extent that independent living was no longer feasible constituted a crisis and led to consideration of nursing home placement. Eight types of informant responses to the consideration of placement emerged. The researcher concludes that recognition of events prior to relocation and the individual's perception of the impact and meaning of those events will enable community and institutional nurses to assist in the positive adjustment to nursing home placement.

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Chapter I: Introduction

In the last century, major medical advances have controlled or eliminated many life-threatening diseases. However, medicine has had less success in checking the debilities of chronic illness and old age. As a result, more individuals are living longer, although Brody (1985) notes that few people reach the end of life without some period of dependency.

The older Canadian population is increasing more rapidly than any other age cohort. By the year 2006, the projected number of individuals over the age of 65 will swell from 10% to almost 20%, an increase of 130 thousand persons. Of these, 16.3 thousand people will be over 85 years of age, an increase of 114% (Engleman, 1987). In light of increased longevity, increasing numbers, and the potential for increased periods of chronic illness, the care of the dependent elderly has become a major concern of Canadian society. In recognition of the need for care, a spectrum of long-term care services has been developed, including institutionalization.

Forbes, Jackson and Krause (1987) note that in the context of care for the elderly, institutional care usually refers to long-term care. The definition of long-term care adopted by the Alberta Hospital Association states: "... a hospital or institution which provides primarily for the continuing treatment of patients with long-term illnesses or with low potential for recovery and who require regular medical assessment and continuing nursing care" (Canadian Hospital Association, 1981, p. 6-7). "Such facilities provide twenty-four-hour accommodation, food services, and various degrees of care and treatment" (Forbes, Jackson and Kraus, 1987, p. 1).

The movement of elderly persons from the community into a long-term care institution has been society's traditional response to the elderly's problems of poverty, feebleness and illness (Forbes, Jackson and Kraus, 1987). Prior to World War II, institutions provided custodial care. Little attention was paid to individual needs and there were few attempts at rehabilitation. The expansion of long-term institutional care after 1940 accompanied the implementation of governmental cost-sharing agreements for health care and insurance. Today, 8 per cent of Canada's elderly live in institutional settings, one of the highest percentages in the world (Melanson and Meagher, 1985).

In Alberta, the average age of persons entering a nursing home is 79. The average age of individuals entering the more intensive environment of auxiliary care is 73 (Engleman, 1987). These figures suggest that while large numbers of elderly persons are moving into an institution from the community, this "placement" takes place late in life.

The inference of delaying placement is supported in the literature. Many researchers refer to institutionalization as a "last resort". Smallegan (1985) summarizes the reasons for placement in her statement: "A decision to enter a nursing home is always the result of inadequacy -- in finances, health, social supports, emotional strength, or other ability to cope" (Smallegan, 1985, p. 364).

The stress of a placement event is also alluded to in the literature. Rosen (1981) found that "the very act of making application to the nursing home may exacerbate family tensions and cause open conflict" (p. 238). It would seem that despite the many positive changes in long-term care over the last forty years, placement is still considered to be a last resort, to be avoided as long as possible, and once in place, irreversible. If such negative connotations exist, then how does the elderly individual ever reach the point of considering placement? If the consideration of institutionalization is such a traumatic event, then how does placement ever come about?

Statement of the Problem

The reasons for and the manner in which individuals consider placement has implications for both community and institutional care of the elderly and their families. Some researchers have stated that the experience of considering placement influences the elderly person's subsequent adjustment to the new environment (Beaver, 1979; Burnette, 1986; Chenitz, 1985; Smallegan, 1985). However, aside from an acknowledgement of its importance, the elderly individuals' experience of considering placement has not been described.

In order to be eligible for nursing home placement, an individual must be dependent in activities of daily living. It is assumed that dependency has not been a life long experience for most elderly individuals entering a nursing home and that the individual was once independent in the community. The events between independence and dependence and the elderly person's perspective of the change have not been documented.

Further, the researcher assumes that placement occurs over time. The researcher has witnessed three stages in the placement process including contacting an agency responsible for screening nursing home applicants, waiting for a bed to come available and moving into the facility. These stages are not referred to in the literature.

Many researchers have examined the factors influencing placement and the effects of relocation. What is less known are the reasons why two individuals sharing the same attributes may experience two different living arrangements, one in the community and the other in an institution. Elderly persons' responses to risk factors, their activities to meet their own needs and their feelings about the consideration of placement have not been documented.

Purpose of the Research

The purpose of the research was to provide a description of the placement experience from the emic perspective. Further, the research aims to:

1. describe the elderly persons' experiences of considering placement;
2. describe the elderly persons' involvement in the process;
3. describe the factors influential to the elderly persons' considerations, and,
4. describe the meaning of the experience from the elderly persons' perspective.

Definitions of Terms

Placement: the movement of older persons from their residence into a nursing home.

Nursing Home: an institution that provides personal care on a 24 hour basis, under the supervision of nursing personnel, as directed by a physician, or, an institution that provides supervision and assistance with activities of daily living and the administration of medications (Government of Canada, 1985, p. 5).

Elderly: an individual over the age of 65.

Chapter II: Review of the Literature

A review of the literature examining placement as relocation into an institution is presented in this chapter. For the purposes of this review, the terms placement and institutionalization are used interchangeably. Institutionalization has been investigated and reported in the literature from three perspectives: (a) the characteristics of the population considered "at risk" for placement, (b) the provision of community alternatives, and (c) the effect of relocation. Throughout this body of literature the two themes of "choice" and "adjustment" are consistently repeated.

Characteristics of the At Risk Population

Many researchers have examined the types of individuals likely to experience institutional placement. These studies involve the comparison of institutionalized elderly persons to individuals remaining in the community. The results of the studies indicate that the care-giving options available to an elderly person are dependent upon the individual's personal, family and social resources (Barney, 1977; Smallegan, 1985).

Personal Resources. The epidemiological research into personal factors placing elderly persons at risk for institutionalization is summarized in Table 1. As can be seen in this table, North American researchers describe the individual most at risk for placement to be older, female, single (either through widowhood or having never married), childless or having few children, in poor health and of low economic status.

Table 1

Individual At Risk Factors

Factors	Researchers					
Stuart	Branch and Jette (1982) Massachusetts	Dechant (1975) Alberta	Kraus et al. (1976) Ontario	Raasok (1979) Alberta	Spooner (1980) Alberta	Branch and (1980) Massachusetts
Age	x	x	x	x	x	x
Female			x	x	x	
Single (widowed or unmarried)	x	x	x	x	x	x
Limited Family Support	x	x	x	x	x	
Frail or Poor Health	x	x	x	x	x	x
Low Economic Status	x		x	x	x	x
Social Policy				x		

Health status has been specifically examined as a predisposing indicator of risk for placement by some researchers. As summarized in Table 2, the general health problems found to be associated with institutionalization included: limitations in mobility requiring the use of a walker or wheelchair, confinement to bed, and the inability to carry out activities of daily living. Diseases affecting mental acuity or behaviour, such as dementia, depression and cerebral vascular deficiency were found to stretch elderly persons' support systems beyond their tolerance. The occurrence of frequent falls or the problem of eliminary incontinence were most often cited as the critical event precipitating placement (Kovar, 1977; Krauss, Spasoff, Beattie, et al., 1976; Smallegan, 1985).

Table 2

Individual, Health-related At Risk Factors

Specific Health Indicators	Researchers						
	Cohen et al.	Johnson and Werner	Knight and	Pearlman and Walker	Smallegan Ryan-Dyke	Kovar	Kraus, Spasoff,
		et al.					
	(1986)	(1986)	(1985)	(1986)	(1985)	(1977)	(1976)
Mobility Limitations	x	x	x	x	x	x	x
Difficulty with ADL	x	x	x	x	x	x	x
Decreased Mental Function		x	x		x		x
Behaviour Problems			x				x
Incontinence					x		x
Frequent Falling	x	x		x	x	x	x
Cardio-vascular Disease					x		x

Knight and Walker (1985) condensed their criteria of at risk to one major factor. They stated that although all of the above attributes influenced the elderly person's institutionalization, the actuality of placement was dependent upon his or her behaviour. If their behaviour was considered inappropriate or unmanageable by their family or the society in which they lived, then Knight and Walker believed society's response was to have them placed.

Family Resources. The presence of a care-giving support system has been noted to delay or prevent placement in spite of severe declines in the individual's health status (Barney, 1977; Brody, Poulshock and Masciocchi, 1978). Placement was sought only after the resources of family and individual were depleted (Branch and Stuart, 1984; Brody, 1985; Brody, Pulshock and Masciocchi, 1978; Ekberg, Griffith and Foxall, 1986; Knight and Walker, 1985; Koran and Rossman, 1985; Kraus, Spasoff, Beattie, et al., 1976; McCauley and Blieszner, 1985; Rakowski and Clarke, 1985).

Social Resources. The influence of the availability of community-based formal care services is not clear in the literature. Raasok (1979) reported that the availability of services outside of the home influenced the options under consideration for the care of the elderly. On the other hand, Kane and Kane (1980) and Johnson and Werner (1986) found that community services, although available, were not always utilized by families in need. The reasons behind this lack of utilization were not investigated by these research groups. One possible reason was cited by Bowers (1987). She found that some families did not use services because they did not want their relative to know they were dependent. Whether or not community services are involved, many researchers agree that relocation to an institution remains a "last resort" sought only after all other options have been ruled out (Brand and Smith, 1984; Brody, 1985; Brody, Poulshock and Moasciocchi, 1978; Ekberg, Griffith and Foxall, 1986; Knight and Walker, 1985; Koran and Rossman, 1985; McCauley and Blieszner, 1985; Rokowski and Clarke, 1985).

Other Factors. Some researchers identified other risk factors that influenced placement decisions. These factors included living in a cold climate, increasing isolation, high neighbourhood crime rates and the redevelopment of older urban communities (Beland, 1984; Branch and Stuart, 1984; Cohen, Tell and Wallack, 1986; Kraus, Spasoff, Beattie, et al., 1976; Melanson and Meagher, 1986; Pearlman and Ryan-Dyke, 1986; Raasok, 1979).

The above descriptive research provides a clear indication of who should be considered at risk for placement based on the individual's personal, family and social resources and other related factors. However, a description of the elderly person's placement experience, in light of these indicators, remains beyond the scope of the questions these researchers addressed.

Community versus Institutional Care

A second group of researchers examining institutionalization have focused on the pros and cons of community versus institutional services. The availability of formal care services outside of the institution is based on social policy and reflective of social attitudes toward long-term care. The argument pivots around what type of support services will provide the most benefit to the individual, yet acknowledge economic realities. As well there exist few mechanisms for clearly measuring the cost-effectiveness of home care programs.

There is ambivalence in the recognition of the need and desire for institutional resources. While on one hand, Canada is known to have one of the world's highest rates of institutionalized elderly populations, there is social reluctance to consider the institution as an appropriate resource for the care of the elderly (Schwenger, 1983). Gallagher (1985) states that ". . . institutionalization of the elderly is equated with failure, by the older consumer, by family members of the older person and by a large portion of society . . ." (p. 19). Although the researcher acknowledges that the availability of alternatives for elder-care outside of the institution influences placement decisions, the ongoing debate between advocates of community versus institutional services is beyond the scope of this review.

Effects of Relocation

One important factor fuelling the debate regarding community or institutional services is the effect of relocation on the elderly individual. As perceptions of institutional life greatly influence the consideration of placement, this body of research has been reviewed in depth and is summarized in Appendix 1.

While it is recognized by researchers that nursing homes, extended care facilities and auxiliary hospitals exist as social supports for the increasing numbers of dependent elderly persons, the impact of relocation on the individual is still debated. Borup (1982) summarized "even after 20 years of research, little is known of the effects of involuntary relocation" (p. 409). Discrepancies between research results may be related to design differences, the date of the research, the setting of the research and the theoretical perspective of the researcher.

Design Differences. Relocation is a social phenomena not lending itself to controlled, experimental designs. Blenkner (1967) points out that the ultimate study would examine the same individual first in the community until death and then in the institution until death. Of course this is not possible. Further, Blenkner states that no one can say what events may have occurred should a relocated individual have remained in the community.

Another design difference between studies is the use of different outcome indicators. Many researchers based their conclusions on the incidence of mortality following relocation. Leiberman (1974), however, criticized the use of this indicator because he believed that concentration on such a negative outcome blinded researchers to positive effects that may occur with institutionalization.

The choice of subjects has also contributed to conclusion discrepancies. The majority of researchers sampled only those individuals who were cognitively and physically able to be interviewed. These results cannot be compared with those of researchers who sampled very frail subjects. In studies where researchers sampled subjects with various levels of health, they found that individuals in poor health or with cognitive impairment experience more negative effects following relocation (Grant, 1985; Gutman and Stark, 1986).

Longitudinal and cross-sectional designs to study relocation effects. Longitudinal designs have been hampered by cost, loss of subjects and changes over time that cannot be attributed to environmental change alone. Cross-sectional designs assume homogeneity of all factors except the one under observation. Leiberman (1974) states that researchers must match control and experimental groups in physical, psychological and social spheres. Where researchers have succeeded in such matching, results measuring the effects of relocation are still mixed (Beaver, 1979; Blenkner, 1967; Borup, 1981; 1982; Brand and Smith, 1974; Huclika, 1975; Leiberman, 1968; Leiberman, Prock and Tobin, 1969; Wolk and Telleen, 1976).

Date of Research. Researchers have examined relocation over a period of 40 years. Over that period of time the facilities themselves have undergone change. For example, smaller facilities with private and semi-private rooms have been built to replace the large dormitory-like complexes. The date of the research is therefore important when comparing studies. With the exception of one North American study (Bourestrom and Tars, 1974), all studies after 1970 have yielded neutral or positive relocation effects on variables such as health state, attitudes and mortality. This may indicate that the policy changes in the 1970's have had a positive impact and contributed to the differences in results between studies.

Differences in Settings. Admission policies, type of care and institutional labels differ from place to place. Researchers' omissions of clear definitions of common terms such as "nursing home" make it difficult to compare results across settings.

Theoretical Perspective. Discrepancies in research results may also reflect differences in researcher perspective. Relocation effects have been attributed to one or more of three sources: 1) the individual, 2) the manner in which the move took place, and 3) the institutional environment itself. Assumptions of cause for relocation effects directed researchers to investigate different paths of inquiry and different results.

Some researchers attributed relocation effects to personal attributes of the individuals experiencing placement. They based this perspective on multiple biologic, psychologic and social theories of aging that concluded that the older person is less able to adapt to stressors because of the natural changes inherent in growing older (Ebersole and Hess, 1985). The difference between institutionalized elderly and their community cohorts was the presence of unmet needs.

Other researchers state that community and institutional populations differ in the kinds of stressors they experience. One such stressor is the meaning attached to relocation. Although Leiberman (1974) found meaning to be an unimportant variable, Chenitz (1986) disagreed. She found that the meaning attached to relocation influenced how the individuals perceived their placement and ultimately, their post-relocation adjustment. Patient expectations of relocation stress have also been found to contribute to an initial short-term decline in physical and psychological wellbeing immediately following relocation (Harel and Noelker, 1982). Engle (1985) claimed that patient perception of placement as being short-term in contrast to permanent had a positive influence on wellbeing indicators. However, she did not sample individuals who were experiencing permanent placement.

The manner in which the studied relocation experience took place also contributed to discrepancies between research studies. Such factors as whether the move was voluntary or involuntary and whether placement occurred because of a crisis or after planning, are cited in the literature as having an impact on the effect of relocation.

Lieberman (1969) believed that researchers' use of voluntary or involuntary relocation to measure the individual's amount of control is a poor discriminator as most relocations occur without choice. He claimed that a better descriptor would be the amount of control the individual had over the move. Agreeing with Leiberman, Borup (1981) substituted willingness to move as the contributing variable, in an effort to recognize patient resignation with a decision that lacked choice.

Schultz and Brenner (1977) described relocation as a stressful life change. They assumed by virtue of its operation, the institution needed to exert control over the individual. They also assumed that this control was greater than the control exerted by other forces outside of the institution. Based on Avril's theory of personal control, they predicted that those environments that allowed personal control would be less stressful than those with controlling environments. That is, the amount of control in the environment was presumed to be inversely related to the individual's subjective wellbeing.

Choice or control over placement decisions has been studied by other researchers. Beaver (1979) found that "adjusters" to a new senior citizen's high rise were more likely to have been involved in the decision to relocate than "non-adjusters". Chenitz (1986) also found that involvement in the decision to move had an impact on the individual's adjustment to a nursing home. Harel and Noelker (1982) found that the individual's perceptions of choice influenced his or her subjective measure of wellbeing, even when their physical states had given them no choice but to relocate.

Along with the amount of control over the placement decision, the relocation effect experienced by a placed elderly person has also been attributed to the amount of predictability inherent in the new environment (Schultz and Brenner, 1977). Predictability is inversely related to the degree of change between environments and directly related to the amount of preparation a person receives. One group of researchers hypothesized that preparation would familiarize the individual to the institution and offset the negative effects of relocation (Bourestom and Tars, 1974; Brody, Kleban and Moss, 1974; Gutman and Herbert, 1976). Pino (1978) compared four groups of individuals receiving varying types of relocation preparation and experiencing varying degrees of change. He found that planning fostered the individual's subsequent adjustment to the new environment.

With the exception of Pino (1978) none of the above researchers were able to randomly assign individuals to groups. As well, subjects receiving pre-relocation preparation also experienced relocation to an improved setting. It is therefore difficult to state whether the noted patient outcomes can be attributed to the programs or to improvements in living conditions.

Brody, Kleban and Moss (1974) described the individual's adjustment to relocation as a function of time. Familiarity with the new environment increases over time and exposure. They found that the initial negative reaction to a strange environment had dissipated in three months time.

Grant (1984) and Borup (1981) supported this finding with different institutionalized populations.

Researchers have painted a bleak picture of institutional life. Lack of privacy and socialization, restrictive conditions and isolation from the outside world have been cited as contributing to a gradual loss of "personhood" and increased mortality and morbidity (Goffman, 1961; Baum, 1977). Few researchers have repeated Baum and Goffman's studies in light of the changes in institutional policy in the late 1970's. However, those that have, also document negative environmental features (Melanson and Meagher, 1986; Sigman,1986).

Melanson and Meagher (1986) used a grounded theory approach to determine the elderly person's perceptions of the institution. Following analysis of nine informant interviews, they determined four categories of self-perceptions including, seeing self as being tamed, as a prisoner, as a survivor or as an outsider. Their title "Out of the Jungle and Into the Zoo" captures the overall negative connotation.

Sigman (1986), using the ethnographic method, described one nursing home setting. His reports provide descriptions of staff-resident interactions and conversational behaviour. He found that the attitude and behaviour of staff had a great impact on the quality of life experienced by residents. Staff labels for residents influenced the manner in which residents socialized with each other and how they permitted new members into their ranks. He concluded that resident interactions and administrative decisions were equally significant in determining both who would enter the nursing home and how that individual would be accepted.

Stannard (1978) also provides insight into how staff attitudes influence the nursing home environment. In his ethnography of one nursing home, he found that staff attitudes of their role in caring for residents and their perceptions of patient rights were molded by their working conditions. In one particularly disturbing conclusion he states that the communication patterns between levels of staff allowed the continual existence of an environment conducive to patient abuse.

Other researchers have substantiated the influence of staff attitudes regarding the value of patients and the legitimacy of patient needs on the level of care provided (Bagshaw and Adams, 1986; Chandler, 1986; Fielding, 1979; Gottesman and Bourestom, 1975). The attitude of physicians toward the elderly has been found to influence institutionalized elderly persons' access to medical care (Mitchell and Hewes, 1986). The health care team's perception of institutionalized persons' rights to make decisions concerning the cessation of treatment has been shown to influence patient life and death choice opportunity (Steinberg, 1986).

Before attributing relocation effects to the new environment, Leiberman (1969) cautions that it is important to know of both the pre- and post-relocation living arrangements. Few researchers have provided this information. Pincus (1968) has developed an evaluation tool for such a comparison, but this researcher could find no evidence of its use by other researchers. It may be said that the relocation effects of a move from a positive environment to a negative one will be different from a relocation from a negative environment to a positive environment. One group of researchers determined that the designation of negative and positive varies with the individual (Harel, 1981; Turner, Tobin and Leiberman, 1972). The more important factor, they believe is "congruence", that is, the match between the individual's personal characteristics and those of the environment. Where a match exists, adverse effects are reduced.

From this discussion, it can be seen that the relocation event and the effects of relocation are complex. Personal, situational and environmental circumstances influence the outcome of any given individual's adjustment to the institutional environment. It may be that these factors also influence the consideration of placement, but few researchers have addressed this aspect of relocation.

The Consideration of Placement

The events leading up to and including the consideration of placement have not been directly addressed in the literature. However, two aspects of placement consideration have been discussed tangentially, that of the availability of institutional resources and the involvement of the individual in the placement decision (Brody, 1977; Chenitz, 1986; Gutman and Stark, 1986; Kahana, 1987; Linn and Gurel, 1972; Mirotznik and Ruskin, 1984; Smallegan, 1985; Stein, et al., 1985).

The availability of institutional resources was inferred by one researcher to influence the elderly's relocation into an institution. In a longitudinal study examining mortality rates of individuals receiving different levels of care, Gutman and Stark (1986) found that 37% of their sampled population died receiving the level of care initially assessed to meet their needs, even though their health status had changed. More individuals in urban settings, where long-term care facilities were available, died after relocation to these facilities. In rural areas, where long-term care facilities were not readily available, individuals were more likely to die in the community. The researchers inferred that, where institutional resources are available, the elderly will experience placement more readily than where institutional resources do not exist.

Four researchers have referred to the impact of the placement decision-making process on the subsequent adjustment to living within the institution. Brody (1977) believed that the elderly person's degree of involvement in decisions about their placement is hindered by the medical crisis that generally precipitates such a decision. She stated: "The decision-making process usually operates in absence of order or careful consideration" (p. 46). Linn and Gurel (1972) support this belief. They stated that the medical crisis surrounding relocation causes "the once intra-family decision to give way to a process of negotiation between family and hospital staff" (p. 222).

Smallegan (1985) and Chenitz (1986) have acknowledged the importance of the elderly person's placement experience on his or her subsequent adjustment to the new environment. Smallegan was able to identify the specific problems leading up to her subjects' consideration of placement but she did not indicate the influence of these risk factors on their placement experience. Chenitz described the process of adjustment to relocation. Her grounded theory analysis revealed that the elderly individual's involvement in the decision allowed him or her to "legitimize" the move into a nursing home. She did not report how individual variables influenced the individual's involvement. In addition, as her focus was experience following placement, the data explaining pre-relocation events were retrospective. Smallegan and Chenitz concluded that health professionals lack information about elderly persons' experience prior to nursing home admission.

Summary

From this review of the literature, it may been seen that researchers have examined various aspects of relocation. Researchers agree that the context surrounding the consideration of placement influences the individual's subsequent adjustment to institutionalization. Further, adjustment to institutionalization has an impact on mortality and morbidity following relocation. Although researchers have alluded to the importance of pre-relocation events, they have not examined the elderly person's descriptions of placement consideration as they have experienced it. In recognition of the importance of events leading to nursing home placement and the apparent lack of research in this area, the purpose of this research is to investigate and describe the older person's experience of considering placement.

Chapter III: Method

Introduction

The purpose of this research project was to describe the elderly persons' experiences of nursing home placement consideration. In order to understand the phenomenon of placement, one must understand the "lived" experience. Thus a qualitative method was chosen for this research. Informants' descriptions of their placement experiences provided the researcher with data to develop an understanding of their experiences. This chapter describes the method used to conduct this research.

Grounded Theory Method

The researcher began the project with the assumption that nursing home placement consideration was bound in social context, that placement evolved over time and involved a change in status. The researcher also assumed that the best source of information about this experience was the elderly themselves. The goal of the researcher was to describe the elderly informants' experiences in order to generate an explanation of their behaviour. To attain this goal, the researcher chose to utilize the data collection and analysis method of grounded theory (Glaser and Strauss, 1967).

Grounded theory is defined by Glaser and Strauss (1967) as "the discovery of theory from data systematically obtained from social research" (p. 2). This highly systematic approach to the collection and analysis of data was chosen to describe the elderly informants' experience and generate an explanation that would enhance understanding of the consideration of placement. Informants and their experiences are selectively chosen, in that the goal of explaining the phenomenon guides researcher choices rather than pre-determined attributes or variables.

Data is collected through observation or informant interviews. The substance of the information is coded for its content. Through ongoing constant comparison, the substantive codes of one informant or experience is compared with codes of other informants. Data collection, analysis and coding is an ongoing, back and forth process of comparison of similarities and identification and exploration of discrepancies. The identification of similarities and differences guides the researcher's progress in the discovery of an explanation for the studied phenomenon.

Similar codes, reflecting similar descriptions or experiences are grouped together and labeled as categories. Categories change or merge as constant comparison of new data proceeds. The relationships between categories are hypothesized, tested, verified or rejected with informants. The researcher constantly strives to identify the informant or situation that does not fit with the hypothesized relationships. Identification of the "negative case" provides direction for modifying hypotheses. When no new information is being collected, data collection ceases. A pattern among relationships is developed to provide an explanation for the variety of informant experiences of the phenomenon under study. The core category is the best explanation of how the informants processed their identified problem. Through this process the explanation of the phenomenon is derived from the data itself, grounded in the data, without direct influence of established theory.

Selection of Informants

The sampling technique used in this study was theoretical sampling (Glaser and Strauss, 1967). Theoretical sampling involves the deliberate selection of informants who have specific characteristics or experiences which will add to, support or refute the theory, thus enhancing the researcher's knowledge of the setting (Field and Morse, 1985). By selecting such knowledgeable individuals, the researcher decreases the amount of insignificant information. Selection begins with sampling of individuals assumed to be experiencing the phenomenon. Theoretical sampling is guided by data analysis to capture the full range and variance of categories. By consciously seeking individuals whose experience of the same event differs from others, the researcher can enhance representativeness (Chenitz and Swanson, 1986).

For the purposes of this research, ten elderly individuals currently experiencing or anticipating placement consideration were chosen to describe their experiences. Four informant relatives were chosen to provide supplemental information. Informant biographical information is presented in Tables 3 and 4.

Eight informants had been assessed by a placement agency and cosidered eligible for nursing home admission. The other two elderly informants had not yet considered placement as a personal possibility and had not approached the placement agency for assessment. All informants were over 65 years of age and were experiencing varying degrees of physical limitations to their activities of daily living. All

Table 3

Demographic Data of Sample: Informants

Age	Sex	Marital Status	Has Been Assessed	Placement has Occurred	Living Arrangements	Perception of Health Status	Caregiver Arrangements
71	F	Married	No	No	Own home	"Poor"	Cares for Self
78	M	Separated	Yes	Yes	Nursing Home (relocated from daughter's home)	"Good for age"	Cares for Self with minimal assistance
66	F	Separated	Yes	Yes	Nursing Home (relocated from apartment)	"Not bad"	Assistance with ADL by N. H. staff
75	F	Widow	No	No	Own home shared with daughter	"Very good"	Cares for Self
83	F	Married	Yes	No	Rented Home shared with husband	"Alright"	Cares for Self
90	M	Married	Yes	No	Rented Home shared with wife	"Alright"	Cares for Self with minimal assistance from wife
74	F	Widow	Yes	No	Lodge	"Poor"	Cares for Self with support from lodge staff, home care
92	F	Widow	Yes	No	Own Home	"Not so good"	Cares for Self
78	F	Widow	Yes	No	Lodge	"Rapidly declining"	Cares for Self with personal care aide assistance, some care and support from lodge staff
80	F	Widow	Yes	No	Own Home	"Frail"	Cares for Self
92	F	Widow	Yes	No	Lodge	"Weak"	Cares for Self with support from lodge staff

informants were considered cognitively intact by placement nurses and the researcher.

Only one couple were married; the rest were single through separation or through death of a spouse. One informant lived with her daughter at the time of the research, but three informants had done so in the past. Although their children did not live close by, all informants involved children or grandchildren in their placement consideration.

Table 4

Demographic Data of Sample: Informants' Relatives

Age	Sex	Marital Status	Relationship to Informant
34	F	Married	Granddaughter
50	F	Widow	Daughter
54	M	Married	Son
43	F	Married	Daughter

Selection Criteria. Initial criteria for informant selection included individuals over 60 years of age who were considered eligible for nursing home placement and who were willing and able to articulate their experience. The researcher emphasized that the outcome of the placement decision did not have to be immediate nursing home admission. By not restricting selection of informants to individuals who were actually placed, the researcher had the opportunity to explore differences between informants' situations.

Late in the process of data analysis the researcher realized that one potential informant group was not sampled. The chosen selection criteria inadvertently eliminated those individuals who had considered placement but were not eligible for placement. Further elaboration of the impact of this omission is included in the discussion section of this report.

Gaining Access. Following ethical approval and under the direction of the researcher, seven informants were selected by the field nurses of the Central Assessment and Placement Service of the local Nursing Home District. The other three elderly informants were referred to the researcher by acquaintances familiar with the study. The advantage of obtaining informants through the Central Assessment and Placement Office was that it allowed the researcher indirect access to a large variety of elderly persons known to be experiencing placement consideration. At the same time, it allowed the individuals to remain anonymous to the researcher until such time that they agreed to participate in the research.

The disadvantage of using the assistance of a third party to access informants was that it required the researcher to provide constant, direct and clear communication of expectations to a group of people not involved with the design or conduct of the study. General acceptance and interest in the research on the part of the field nurses helped reduce this disadvantage. Further, the field nurses provided the researcher with the opportunity to explore the findings of the study and discuss ideas for direction.

The field nurses were provided with an explanatory letter of introduction to give to potential informants (see Appendix 2). Potential informants verbally consented to provide the researcher with their name and telephone number. They were then contacted by the researcher using the Telephone Contact Guide (see Appendix 3). Given that the individual agreed to participate, the researcher obtained their address and arranged for an interview visit. The initial interview progressed after the study was re-explained to the informant and the consent form was read, reviewed and signed (see Appendix 4).

Only one individual referred to the researcher by the placement nurses refused to participate in the study. He denied the fact that his placement was being considered and therefore did not believe he could be of assistance. Unable to determine the reasons behind the incongruity of information, the researcher chose not to pursue his involvement.

As the researcher became aware of the concept of change in informant definition of self from "able" to "unable", other informants were sought. These individuals had not yet considered placement. The intent of their selection was to enable the researcher to capture the beginnings of the placement process rather than rely solely on informants' retrospective data.

The later stages of the placement process were captured through the selection of informants newly admitted to a nursing home. As well, the researcher was able to follow two informants from the time of their initial contact with Central Placement through to their eventual admission into an institution. In such a manner, informant selection enhanced the collection of cross-sectional and longitudinal data of the informants' experiences.

Informants' relatives were interviewed to provide verification of events leading to placement. Elderly informants provided the researcher with permission to approach someone close to them and involved in considering nursing home placement. Although relationship was not specified by the researcher, all informants provided the name of a family member.

Four relatives were available to be interviewed. Other relatives cited the lack of available time as the factor interfering with their participation.

The Research Technique: Interviewing

The data collection tool utilized in this research was informant interview. Each primary informant was interviewed one to four times according to the quality of the resultant data and the stage of the research. Interview questions focussed on the events leading up to the consideration of placement, the placement decision itself and the feelings that accompanied the process.

The interviews took place at the informants' convenience. Although five informants were interviewed in their present residences, two informants were interviewed in nursing homes following placement, and three in a geriatric rehabilitation hospital, immediately prior to their placement. Privacy was achieved in all but one setting. The influence of the presence of a second person during the initial interview was taken into account in the analysis of that interview. The content of the first interview was verified in private at the time of the second interview.

All interviews were audiotaped. Mechanical failure caused the partial loss of one interview and the complete loss of a second. Once recognized, the researcher reviewed the questions with those informants a second time.

Initial interview questions were unstructured directives asking informants to describe the events leading up to their present situation. The more specific questions of later interviews were based on informants' initial interviews and insights of previous informants. Interviewing ended when informants confirmed previous data and no new information was elicited.

Interview Plan for Each Informant. The initial interview of all informants was used to introduce the purpose of the study and to allow the informant and researcher to become comfortable with each other. Consent forms were signed prior to the interview, and demographic information was gathered following the first visit. The second interview allowed the researcher to clarify data, explore significant points in depth and to explore the impact of events occurring between interviews. Permission to approach informant relatives was re-affirmed at the end of the second interview. A third, and in one instance a fourth, interview was carried out with informants who were particularly informative or if their experience was so variable it required further exploration.

Interviews of the informants' relatives took place following the primary informants' second interviews. These informants' relative interviews took place at a time and place convenient to the relatives once they agreed to be interviewed. Informants' relatives were interviewed once.

Interview Scheduling of Informants. Interviewing of informants took place in three groupings, according to informant availability and outside influences on the course of the research. The first three informants were interviewed alternately. Analysis of their interview data directed choice of the next four informants and the focus of their interviews. The final three informants were interviewed with the intent of confirming previous informant data and the emerging processes.

Data Analysis

Data analysis and data collection were ongoing. Each interview transcript was analyzed prior to the next interview. The analysis of initial interviews provided guidance for later questions. As a pattern of events emerged, each informant was asked the same or similar questions in an attempt to verify the process and to discover variance between their experiences.

Each transcript was reviewed with the interview tape to verify its accuracy. Transcripts were then read for key words or phrases that described the placement experience. The key points were noted in the margin and underlined. The researcher wrote notations expressing ideas about the content of the interview as they arose. These notations were kept for reference in the later stages of developing the two processes. The key points of later interviews were compared with former interviews to discover similarities and differences.

Following each interview, the researcher diagrammed the events in the informant's placement experience. The diagrams were revised following subsequent interviews if new information was gathered. Each informant's diagram was compared to the other informants' experience.

The researcher then separated the key words and phrases from each interview into the stages outlined on the diagrams. Later interviews and analysis verified the stages of the "Considering Placement" process and provided the informants' terms for them.

The researcher focussed on the identification of the elderly informants' nursing home placement consideration experiences in all interviews. However, as the research evolved, it became apparent that the nursing home placement consideration process evolved from a larger process of caring for self in that the steps taken in placement consideration mirrored the steps taken to make other self care changes throughout their lives. Thus the researcher concluded that the data held two processes, one arising from the other. The transition from the process of Taking Care of Self to Considering Placement reflected a basic social process involving a change in definition of self from *being able* to *being unable*. A basic social process is defined as a process having two or more stages and evolving over time (Glaser and Strauss, 1978).

The emergent processes and informant responses to placement consideration were validated by one informant. The literature was reviewed to compare the model with existing theory. Nursing peers involved in geriatric care were consulted throughout the research. The processes and responses were supported by those reviewing them. In such a manner the researcher provided initial validation of the emerging theory.

Reliability and Validity

The strength of qualitative research is said to be in its validity

(LeCompte and Goetz, 1982). Several methods were used to enhance the credibility of this study. The fact that the theory is *grounded* in the verbatim interview data ties the results directly to its sources. As the researcher carried out interviews and observations in the natural setting, the resultant data were assumed to reflect the reality of the setting. The researcher has no reason to believe that the experiences shared by informants were not true to their perspective of their experience.

LeCompte and Goetz (1982) identify ways that qualitative researchers address issues of reliability and validity. They state that "researchers enhance the external reliability of their research by recognizing and handling five major problems: researcher status position, informant choices, social situations and conditions, analytic constructs and premises, and methods of data collection and analysis" (p. 37). The manner in which these factors were addressed by the researcher are outlined below.

The researcher was introduced to informants by the placement nurses or by mutual acquaintances as a nurse undertaking research as partial requirement for the completion of a Masters degree. Only one informant was known to the researcher prior to the study. At the time of the initial interview it was made clear to informants that the researcher had no influence on the placement decision, nor would their participation in the research project change their placement outcome. Informants generally welcomed the researcher as a guest in their home.

Informants were made aware of the researcher's background and past experience with placement events through the explanation of her interest in their placement experience. The advantage of informants knowing the researcher's background was that they expressed appreciation of having the opportunity to share their experience with someone who was interested and who could understand. The disadvantage was that informants asked the researcher for advice or opinions about their experience. When this occurred, the researcher asked informants to make their requests known to the placement nurses. If the informant pressed for an answer, then the researcher asked that the informant wait until the interview was completed. In most instances, informants sought information on how to gain access to community services or an explanation of the nursing home referral procedure. Their questions acted as reinforcement for various stages of the processes and were incorporated into data analysis. Answers to informants' questions were also analyzed for their influence on the informants' placement experience.

In one instance, the researcher interfered with events because she believed that the informant's situation placed him in jeopardy and required immediate action. With the informant's permission, the researcher contacted the placement nurse on the informant's behalf, requesting that the nurse make a re-assessment visit. The influence of the researcher's intervention may have sped up the placement process, but did not influence the informant's response to the process. The informant reported that the researcher's action did not change his feelings or response to placement.

The selective sampling of informants for this study served to provide the researcher with individuals who were knowledgeable about the nursing home placement experience. Initially the researcher asked the placement nurses to refer any individual assessed to be eligible for placement and willing and able to articulate their experience. As the research progressed, the researcher became more specific in the types of individuals she wished to interview. Selection of informants was based on where the informants were in the placement experience, informant response to placement and specific personal or environmental factors cited in the literature as influencing the decision for placement.

All informants were willing to be interviewed and audiotape-recorded. They answered questions willingly and completely. All interviews were scheduled at informants' convenience. Six informants and three informant relatives were interviewed in their own homes. The private and informal atmosphere of these settings was conducive to the sharing of information.

One informant was considering placement in conjunction with his wife. He did not wish to be interviewed alone. At the time of the first interview, his wife was not eligible for placement, but was being considered by the authorities as a candidate for compassionate admission. Over the course of the research, the wife's health declined, thus changing her status. As their experiences were intrinsically bound, the researcher added both husband and wife to the sample. Their information was collected in joint interviews.

Four informants and one relative were interviewed in hospital or nursing home environments. The researcher attempted to ensure privacy by asking the nursing personnel to allow the interview to take place in a quiet place without interruptions. For the most part, this was achieved. However, in one interview, an informant's roommate would not leave the room. As the informant was comfortable with his presence the researcher did not stress the point. Comparison of this data with information gathered in private at the next interview indicated no differences in content.

Interviewing most informants more than once allowed the researcher to clarify and verify her understanding of their comments and the points raised by others. It also allowed the researcher to witness different stages of the processes within the context of one person's experience.

Data included actual informant quotes. The audiotape-recorded interviews were transcribed and the transcriptions were checked for accuracy against the tape recordings. Where possible, stages of the processes were named according to informant labels. Direct quotes from informants are provided in the results to substantiate categories.

While admitting to informants that the researcher had experienced the placement process as a health professional, she also stressed her ignorance of *their* experience. With this in mind, the researcher verified the stages of the emergent processes with later informants. They were able to recognize their position in the process. The response types were also reviewed. One informant stated he could identify which category he fit in and could recognize acquaintances as members of other groups.

The results of the study were also reviewed by other professionals involved in gerontology. Ongoing peer review assisted the researcher to identify areas that required further investigation. The placement nurses were particularly helpful in directing the researcher and confirming the final processes and responses as valid from their experience with a larger population of individuals undergoing nursing home placement.

Risks and Benefits

Informants agreed to participate in the research and signed a consent form indicating their understanding of the study. It was made clear from the onset that their participation would not influence their nursing home placement. All interviews were informal and informants were assured that they could discontinue their participation at any time, or refuse to answer any question. Informants gave no outward indication of discomfort with questioning although it is possible that they felt anxious about expressing negative opinions for fear of retribution from their relations or placement authorities.

There were no tangible benefits to informants for their participation. However, informants expressed their appreciation of having the opportunity to talk about their experiences and welcomed the researcher back for subsequent interviews.

Ethical Considerations

The research proposal received ethical approval from the Faculty of Nursing, University of Alberta. Permission to approach informants was also received from the nursing home district authorities and the placement nurses' supervisor.

Several measures were taken to ensure confidentiality. The audiotapes were kept in a locked, unmarked drawer in the researcher's home or office and erased at the completion of the study. Transcripts were coded by colour and number and kept in a locked drawer. Names of individuals or facilities were replaced with initials. In the final report, names have been changed and specific facilities have been replaced with a general statement.

Chapter IV: Findings: Processes and Response Types

The findings generated from the grounded theory analysis of informant interviews are presented in this chapter. The direction of the research changed as the project progressed. Initially, the researcher intended to examine the manner in which elderly individuals considered nursing home placement. Discussion with informants started with the question "Why have you been assessed for placement?".

The individual's self-assessment of his or her ability to manage the "normal" activities of everyday living affected every aspect of placement consideration. Initially the researcher concentrated solely on the informants' perceptions as they pertained to the nursing home placement situation. However, as analysis of interview data progressed, it became apparent that informant perceptions of self as able or unable had also influenced their actions throughout their lifetime.

As the researcher explored informant responses in the past and compared them with their responses to the consideration of nursing home placement, three differences emerged: (a) their definition of self, (b) the intensity of the reason for a change in self-definition, and (c) the individual's perception of available options to assist them in performing everyday activity. In spite of the presence of these differences, the pattern of adjusting to a change in ability remained the same. That is, informants' definitions of self constituted the impetus for transition between seeing self as *able*, *not as able* or *unable*. The movement from one perception to another emerged as the basic social process described this study.

To explain the evolution of change in definition of self, the researcher has divided the research findings into three sections: (a) the "Taking Care of Self" process, (b) the "Considering Placement" process, and (c) informant responses to placement consideration. As "Considering Placement" emerged from the process of "Taking Care of Self", the latter will be presented first.

The Process of "Taking Care of Self"

Case Study

The following example was developed by the researcher to depict informants' common experience. No one informant is cited in the example, rather the researcher utilized information from all informants' experiences. It serves to detail the process of "Taking Care of Self" as a lifelong experience of adjustment to change.

> *Mary and Jack had been married for 40 years before Jack had a heart attack and died. Mary was left alone in their small-town home of twenty years. Their children had married and moved away, Jack Junior to B.C. and Marilyn to Calgary. For a time, Mary continued with the activities she had enjoyed all her life. She kept busy with her community work, sewing and season tickets to the theatre.*
>
> *Mary was surprised when she suddenly became ill. The disease progressed quickly. At first, she kept up with her usual activities, but finally she reached a point where she couldn't manage the yard work. She decided that she would sell her house and invest the money. Mary decided to stay close to her friends and move into a local apartment. She found it difficult to sell the house and part with things she had collected over the course of a good marriage.*
>
> *Once in the apartment, things were easier for a time. Mary was relieved to be free of the responsibilities of a home, but as the disease progressed, Mary began to worry again. Making meals became more difficult. She often resorted to frozen dinners or tea,*

> *soup and toast. She had to give up driving her car because she was no longer safe behind the wheel. Losing her car meant that she couldn't get her own groceries, go to the theatre, get to bridge or serve as a voluntary board member.*
>
> *As managing became more difficult, Mary decided she needed help. Marilyn wanted her to move to Calgary, but Mary didn't know anyone there and her children worked during the day. She had a little money, so instead of moving she hired a housekeeper. The woman worked out well for a while, but eventually, Mary felt that her authority and privacy were being eroded. Mary had to let her go. It was impossible to find anyone else. By this time, Mary was finding it hard to move around. She couldn't get out of bed and was finding it difficult to get to the toilet. At Christmas her daughter was appalled at how much help she needed. Her family suggested that Mary move again to get further assistance.*
>
> *Mary looked for accommodations that would provide her with help, yet not rob her of privacy. She started to worry about the future. Although she wasn't ready to go to a nursing home, she feared things might amount to this. She contacted the authorities and arranged for placement on the waiting list of a "good" nursing home. In the meantime, she decided to go into a seniors' lodge. This lodge provided a small amount of assistance with personal care. Mary gave up many more of her possessions in order to fit into one room. The room was expensive, but Mary preferred to spend her money for this type of arrangement rather than immediately moving to a nursing home while she still had all her faculties. She intended to delay her nursing home admission as long as possible.*
>
> *For now, Mary is holding on. She requires assistance with most personal-care activities. Although she has extra assistance from the local visiting nurses, this program cannot meet all of her needs. The lodge's resident aide program is rapidly draining her monetary resources. Mary is considering nursing home placement because she believes that she has run out of alternatives. She believes that she has no other choice.*

The "Taking Care of Self" process (see Figure 1) is composed of six elements: (a) a pre-change state of *being able*, (b) a change event, (c) "facing" the change, (d) "dealing" with the change, (e) response to the change, and (f) the work of implementing the alternative. Every stage or element of the process is influenced by several interacting factors.

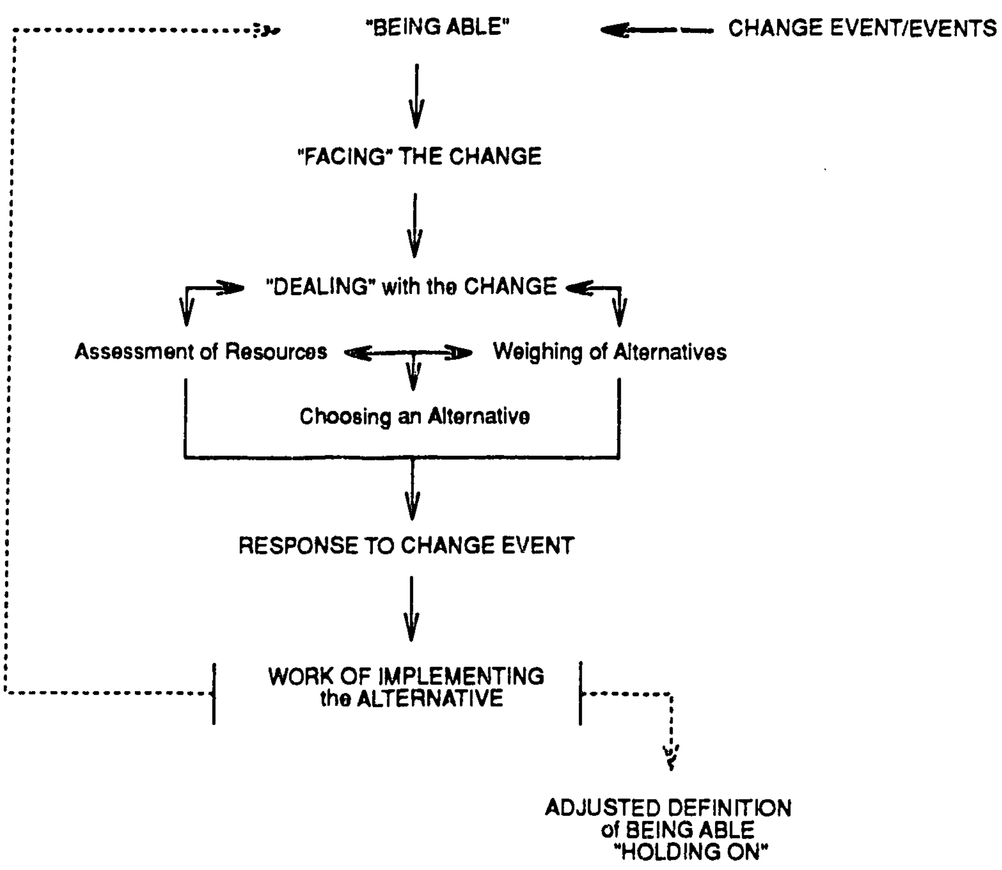

Figure 1. Process of "Taking Care of Self"

Although the number and intensity of the factors varied in each individual's experience, all informants experienced the same elements. This process was found to be generic in that it was applicable to many different life experiences, including the consideration of nursing home placement.

The identification of a beginning and an ending to the "Taking Care of Self" process and the isolation of its discrete steps was necessary to articulate the elderly individuals' experiences. It must be understood, however, that such a delineation is artificial and solely for the purpose of explanation. Although the process is depicted as a linear progression, the informants often vacillated between the elements. There is no intent to imply that the process is always descending. Informants accommodated to positive or negative changes in the same manner.

The goal of the "Taking Care of Self" process is to sustain an optimal level of managing. When an optimal level of managing was achieved, informants believed they were *able*. The informants believed their ability to manage the usual activities of daily living became more difficult as they experienced changes related to illness or aging. Although they strove to continue to be *able*, they found that this was not always possible. Numerous "Taking Care of Self" cycles, undertaken in response to their experience of growing older, might be depicted as a downward spiral, each successive state lower than the one preceding it. The six elements of the "Taking Care of Self" process are outlined below.

Being Able

The beginning step of the "Taking Care of Self" process was the informants' self-assessment of *being able*. They defined *being able* as independently managing their usual tasks of everyday living.

> *We can get around and take care of ourselves, bathe ourselves and do whatever we've got to do. We can even go shopping by ourselves.* (4)[2]

> *I can do the things that I used to do. Vicki will worry about me going to get my groceries by myself when she can't go with me, but I'm perfectly able to . . . I can go over town on my own still, and do things I have to do. My banking and things like that . . . I had my hips done and they don't bother me. I don't even know that I had them. Other than I can't run. But then when I get to my age, what do I have to run for anyway? There's another bus coming.* (7)

The work of *being able* involved three sets of tasks, intimate tasks such as bathing, supportive tasks such as cooking and housework, and outside tasks such grocery shopping, transportation and recreation activities. Thus, informants judged their state of *being able* by their ability to manage the work within each of the three task areas.

Self-assessment as *being able* was threatened when debilities of illness or old age interfered with informants' successful management of any or all of the three task areas. Individuals responded to the occurrence of debilities by attempting to regain *being able*. Resolution could be achieved if changes were made in managing behaviour, if the debilities could be eliminated, or if *being able* could continue in the absence of task completion.

Self-assessment as *being able* could also be retained if individuals modified their judgment criteria. The researcher found that informants recognized different degrees of *being able*. "I can manage as well as I ever did" was at the apex, followed by "I manage, but not as well", "I manage with help" and finally, "I can't manage". With the exception of "I can't manage", informants continued to describe themselves as *being able* but *not as able*.

> *Yes, I was managing. Oh, a little help with cleaning and things like that, but I was getting my own groceries and taking myself to the hairdresser or anywhere I wanted to go.* (6)

It was acceptable for informants to modify their definition of *being able* when they received assistance with supportive and outside tasks. However, informants were less likely to continue to define themselves as *being able* when assistance was needed to carry out intimate tasks. The difference between intimate tasks and the other task sets lay in perceived level of importance. Completion of intimate tasks was considered essential in that the inability to manage this type of work threatened one's quality of life, if not life itself.

The unanimous goal of all informants was to continue their usual existence as long as possible. As time went on, the informants found this task to be more difficult. Instead of *being able*, they labelled their managing state with terms such as "holding on", "hanging in" or "holding out". This change in definition marked the transition between *being able* and *being not as able.*

> *So I'm holding on here as long as I can.* (6)
>
> *I don't look at it (moving from home) with stark fear. I look at it that I'll hang in as long as possible.* (9)

A self-assessment of holding on or hanging in was an indication that informants recognized a deterioration in their abilities. Informants identified that both cognitive and physical abilities were necessary to continue *being able.* They believed they needed to be aware of their own needs, to have an idea of how to meet them and the energy to make changes to continue to *be able.* The absence of any one of these three factors led the informants to define themselves as *being not as able* or *being unable.* Defining oneself as *unable* became the precursor for consideration of placement and will be more fully discussed under that process.

There were many reasons informants had difficulty in retaining a state of *being able.* The impetus altering informants' self-assessments is called the "change event".

The Change Event

Change events caused alterations in the individuals' manner of accomplishing the work of *being able.* Changes were internal or external and involved individuals' health or environment. When a change event occurred, the individual examined alternative ways to manage *being able* tasks.

Change events could be positive or negative. Positive changes in health status, or the addition of alternative forms of assistance not previously available, were positive change events. For example, one informant was accepted into a home support pilot project that provided her with extra hours of personal care assistance. The initiation of the pilot project was a positive change event that altered her manner of carrying out the tasks of *being able.*

Informants most often referred to a change event as an interference in their ability to maintain *being able.* Negative health changes included the abrupt or insidious onset of disease or the gradual, generalized, slowing down informants attributed to the aging process. Therefore the term "change event" includes discrete experiences or the accumulation of many experiences over time.

> *There was a definite change when I was 65. But, mind you, I got sick when I was 65, too.* (9)
>
> *Well, like, I was 75 in May. Now at one time, it -- I could go and go and go, but I'm just finding that you just get a little bit slower all the time, when you get a little bit older. You just don't have that extra oomph.*(7)

Environmental changes included events such as the loss of supportive family, or neighbourhood changes.

> *We were very close, you know. But she (daughter) has a husband now, and I realize she doesn't need me. Not to the extent that she did. . . . she can't (help me) because she's up there. She would do more if we were closer. And now she is expecting.* (5)

> *I don't think it's right for a woman to be living alone in a house either. Crime . . . . . . we lived in a neighbourhood where there are quite a few men and my granddaughters would come and I hated the way the men would watch the children.* (4)

Informants stated that they anticipated, yet did not anticipate, the change events that would interfere with their *being able*. For example, death was a change event expected by all informants. They spoke of having prepared by making out their wills and organizing their funerals. Some had bought their burial plots and most had discussed their plans with family members. While informants shared their expectations of death, the change events occurring between the now and then were less expected.

Informants were aware that deficit health changes could accompany the aging process. All informants spoke of witnessing the aging experience of parents, siblings and friends. However, personal experience of such change events came as a surprise.

> *Up until the time that I was old, I knew how I was going to handle it. What an ass! What sheer stupidity! Who in the hell did I think I was that I was going to handle it different than all of them?* (9).

> *You don't expect that (the inability). It just comes.* (1)

> *I've always said, "I'll never do things like that. I'll never have to wear a pad because I can't control my bladder." And here I am. You never think of yourself as having to do that.* (6)

Informants shared the expectation that their *being able* would continue until death.

> *I hoped to keep up with my choir. I hoped to keep active. I hoped to be independent. That was going to continue.* (6)

> *I felt that -- I've had the disease for a long time, and I have fought it for that long. And I somehow feel I've -- that I've gone this far, so why couldn't I go further? And the belief that I could.* (10)

Changes in ability were unexpected by informants for many reasons. Older informants were surprised to have lived so long. They had expected to die at a younger age because their parents had died in their sixties or seventies. Informants stated that reaching the age of eighty-five or ninety had been unheard of when they were growing up and therefore not expected as a personal experience.

> *But I didn't expect to be living now by 15 years, because my parents and all my relatives were short-lived. Very, very few of my people ever got to 70. Now, me and my family, my children, my brothers and sisters, we're getting to -- just about all of us are in our 80s.* (4).

Some informants experienced very few changes in health or environment. While they shared their co-informants' surprise at living longer and healthier lives than the generations before them, they were also surprised when changes in this status did occur.

> *(Son speaking) He was 86 -- 87, and shovelling his own snow. He worked until he was 85 years old.* (4)

> *And I never thought about being in -- as an older person. In fact, I guess I was quite young until after 65. Near 70 I started slowing down a bit. I used to joke about it-- they used to ask me whether I was a senior when I went to the bank, or someplace like that because I was quite active and independent.* (6)

Informants expressed surprise that change events occurred to interfere with their ability to manage. The need to take steps to regain *being able* was also unexpected and therefore unplanned. The first step in informants' return to managing was termed "facing the change".

Facing the Change

Facing the change involved the informants' cognitive appraisal of the effect of the change event.

> *. . . I was at the stage, I just was home from the hospital a short while, facing the fact that I was not getting any better. I was getting worse, and I had to face the fact that I had Parkinson's. I wouldn't believe it at first.* (6)

Informants' assessment of impact influenced their responses to the event. Their assessment of impact included the weighing of three interacting factors: the intensity and timing of the change event and the individuals' expectations of lifestyle quality (see Figure 2).

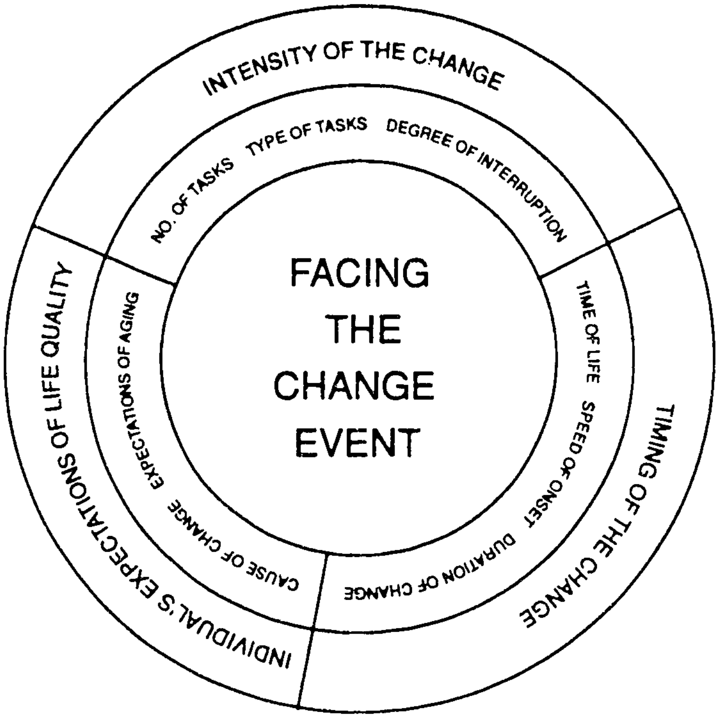

Figure 2. Facing the Change Event

The Intensity of the Change Event. The intensity of the change event was influenced by the number of *being able* activities interrupted by the change and the degree of the interruption. Change events causing a minimal disruption of a small number of activities were faced without difficulty and generally required little behavioural adjustments. As one informant stated:

> *Well, I get up and take off my bathrobe, or something like that, and I find that I don't just get up and take off right now, I have to stand there for a minute or so, and do it easy-like.* (7)

The type of *being able* task affected also influenced the intensity of the change event. Informants found it easier to adjust to change events affecting supportive and environmental tasks than those affecting intimate tasks. The inability to complete intimate tasks was often considered a crisis, requiring an immediate response. For example, one informant explained that when it became difficult to manage the supportive task of meal-making, she hired someone to assist her. However, when she required assistance with the intimate tasks of toiletting and moving from one position to another, she was unable to find help outside of an institution.

Another informant pointed out that the intensity of the change event influenced her energy levels. In turn, her energy levels determined the focus of her attention.

> *If the pain level's extremely high, I've a tendency then just to think of today. I know -- when -- this disease has this habit of becoming acute -- blowing it's top, and at such times -- today seems like a never-ending time. So even trying to live for today -- just to do that, is all I can cope with. But as I begin to improve -- and this is one way now I recognize improvement, by how I think -- and I do begin to think of the future when I'm feeling better.*

> *And so that this is almost like a weather-vane as to how things are going inside, as to where I'm at in my stage of thinking.* (10)

The Timing of the Change Event. The impact of change events were further influenced by timing. Timing took three forms: time in terms of "time of life", speed of onset and duration of the effects.

Informants' perceptions of what to expect at this time in their lives influenced their acceptance of change events. Some informants accepted deficit changes as the inevitable result of growing old.

> *. . . at this age, you can look forward to a gradual deterioration as you get older, and you'll finally end it all. But that's life.* (7)

Other informants believed that one's age had nothing to do with changes in *being able*. Instead, they attributed difficulty with managing the tasks of *being able* to illness rather than age.

> *. . . my problem, I don't feel, has anything to do with age. It's a disease. And no matter what age I -- it has -- it would be at this stage, it would be a problem. And -- but I think now because it comes along with age, you have a greater sense that it's being tagged as something that's -- you get when you're old.* (10)

The speed of change event onset also influenced informants' ability to face the change event. Change events occurred abruptly or gradually. Abrupt change events were more likely to be attributed to illness and to be addressed immediately.

> *I attribute my sickness to the day the gas well blew. I was sick and I couldn't seem to get my face out from behind this mask of fumes. . . . . I watched myself lose weight and I was powerless. . . . And it happened -- the illness happened so fast that it did feel like bombarding. It was coming at me from all directions.* (9)

Gradual changes were accommodated to over time and often only retrospectively identified by informants or their relatives. They attributed gradual changes to the aging process.

> (Daughter speaking) *There was nothing special. Just old age, I guess. . . . She was slowing down. Her eyesight's poorer, her hearing is very, very poor.* (2)

> (Son speaking) *The stages he went through? We finally convinced him to give up his driving because he had a couple of minor accidents. He didn't see the other car. And he finally gave that up, but his customers kept coming to the house, taking him over and bringing him back. Well, it's -- there was a stage when the driving was given up and then he worked for several more years. I don't know if it was eight or ten, with people coming to get him.*
>
> *And I think the next stage was, you know, he slowly gave up. You know, "Well Mrs. So and So, I can't do it anymore." And he narrowed down and down and down. And the summer he was 85, and he was coming home, he hopped on the bus at the end of the day and home. Get off, just walk, just gliding. Just played right out. Couldn't even eat when he got home. He'd have to lie down and sleep for awhile after. And then it got to where he just worked at home, the last couple of years. Kept the garden going and cut the grass, shovelled his walks.*
>
> *Then last year, they didn't put a garden in, except for maybe a row of potatoes. This year they put in two rows. They have some strawberries. And he ended up in the hospital this year. He's very weak.* (4)

Finally, the duration of the change event or its effects influenced how informants faced change. If informants perceived the change event to be temporary, then it was often tolerated without a corresponding adjustment in behaviour. This "putting up with it" response was particularly apparent with those informants who spoke of good days and bad days.

> (Son speaking) *There were good days and bad days. When they're feeling badly, they'll phone up: "Yeah, I guess we better sell what we have and do something." And then okay, I'll say, "Fine, just let me know what arrangements you want me to do." And then they'll -- they'll feel a little better when you go over the next day and, "No, we'll stay here for awhile."* (4)

Expectations of Quality in Lifestyle. The informants' expectations of quality of life affected how they faced change events. If the informants believed quality was not affected by the event, then they did not change their manner of managing. Although some change events could be put up with without a change in behaviour, when their quality of life became intolerable they felt forced to seek other ways to manage.

> (Granddaughter speaking) *I think she came to a realization that she could not keep up her house, feed herself and take care of herself the way she wanted. It was the quality rather than a sudden decision that she couldn't because I'm sure if she set her mind to it she'd still be doing it. . . . I think she was tired. . . . . Suddenly she said, "I don't want to cook for myself anymore. I'd like to have somebody take care of me. I want to go to a lodge." That was the first step.* (3)

Facing the change event involved the admission that the event had occurred and the acceptance of the need for response. If the change in self went unrecognized, then the informants did not change their definition of self and therefore had no perceived need to continue the process. The change event may have been ignored or acknowledged by informants, depending upon the intensity of the event, its timing and the individuals' expectations of quality of life. Acknowledgement. if it occurred, occurred reluctantly, over time.

> (Husband)*Just know that I can't go ahead and do something else. I know when I've got to get help. I have to get help. You just make up your mind. You have to.*
> (Wife) *At first he didn't want to make up his mind. But he has now.* (4)
>
> *The doctor laughed at me one day and he said, "Don't worry, when you drop the first cup of tea you'll know you have Parkinson's." I said, "Oh, don't tell me that. I don't want to drop the first cup of tea." But you do. You get to the stage where you're -- you can't move things or carry things, and you find yourself becoming more and more dependent.* (6)

"Dealing" with the Change Event

Once informants faced a change event they next considered how to respond to that change. Informants separated their activities into three groups, those they could continue to manage independently, those that required assistance and those they could do without. Dealing with the change event involved two interacting elements: (a) assessing the available resources for management change, and (b) weighing the effect of the alternatives on their preferred lifestyle (see Figure 3). Although the activities appear to be progressive and logical for the purposes of examination, it must be recognized that the decision-making process was not linear and informants moved back and forth between assessment and weighing of resources in a random and sporadic manner.

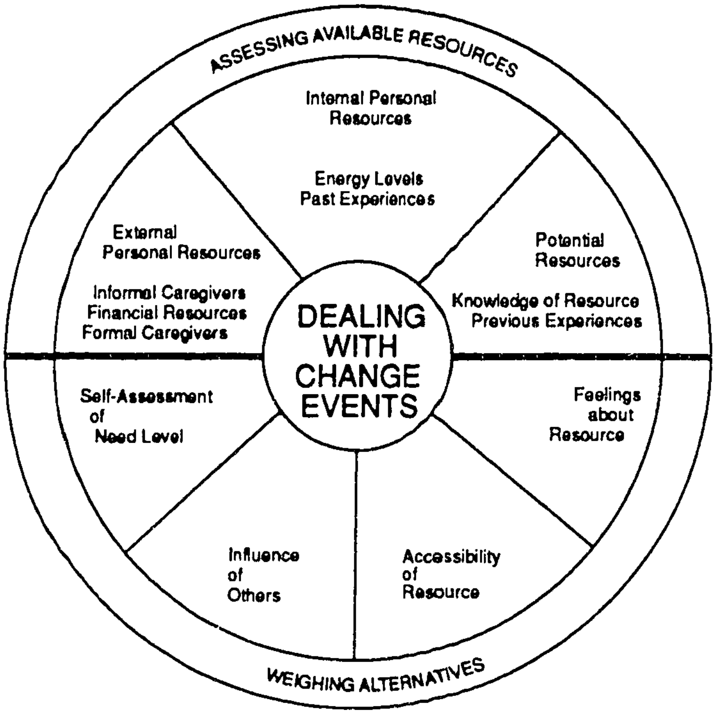

Figure 3. Dealing with the Change Event

Assessment of Available Resources. Assessment of available resources started with an assessment of internal and external personal resources. Two internal personal resources included personal energy and past experiences.

The availability of personal energy was identified as informants' most important internal personal resource. If the energy required to respond to a change event was depleted, then informants sought outside help, the activity was given up or the effects of the change event was endured without a responsive change in behaviour. Informants expressed their lack of this internal resource with phrases such as: "I didn't have the energy" or "I was too tired to continue".

The second type of internal personal resource was the informants' experience with change in the past. Informants repeated behaviours that had previously proved successful.

> *I can adapt to almost anything. I've done it all my life. I've had to. And it's been good for me -- broadened my outlook on life.* (2)

> *And looking in the lodge didn't scare me a bit. I thought it's just a case of getting along with different people, and I'd always done a good job of that.* (8)

Most informants perceived current change events to be permanent. This perspective influenced the manner in which they dealt with change events. They stated that they managed because they saw no other alternative. The answer to "How did you deal with the change event?" was: "I had to. I had no choice but to manage. What else could I do?". Informants could offer no other explanation or description of the intricacies involved in "having to".

Besides the personal resources of energy and past experiences, informants also assessed their available external personal resources. These resources included the availability of family or friends, financial resources and informants' use of the formal care services.

Roles of family and friends varied between informants. Few informants lived with their children. Most had rejected this arrangement. Either they or their families believed co-habitation would interfere with their parent-child relationship and personal independence.

> *. . . my daughter was a widow and she wanted me to come and live with her and I didn't think that was fair -- to her. I have seen daughters burdened with their mothers and it isn't -- to my way of thinking -- it isn't right.* (2)

Family and friends took on many other roles besides that of providing living accommodations. Primarily, significant others supplemented informants' efforts in the tasks of *being able*. Supplemental assistance included carrying out activities on the informants' behalf and organizing or procuring formal services upon request. Family and friends acted as advocates and consultants, providing encouragement, love and support. In general, they looked out for informants' wellbeing and attempted to ensure their safety.

Although all the informants had family or friends actively assisting them in the tasks of *being able*, only three of the ten informants had family members making their decisions for them. Of these three, none felt their families were imposing opinions on them without their input.

Informants were acutely aware of invisible limits to assistance. The limit was determined by the informants' assessment of their relationship with the helper. To expect help beyond the invisible limits was considered improper.

> (Son speaking) *They say, "Oh, the neighbours will look after us." I said, "Well, the neighbours looked after you while either one of you were in the hospital. Your neighbours, one still comes to cut the grass. But you know, that stops after awhile." The neighbours are only going to do it for awhile. . . . It's fine to ask the neighbours to do that but don't count on it after a month or so.* (4)
>
> *And I found once or twice, I panicked a little bit -- called on friends. Well, you can't do that. It just doesn't -- it isn't right. I had a friend in the apartments, and she'd come any time. But she needed her sleep, and she'd get quite frightened when she'd see me panic even a little bit.* (6)

Beyond the personal resource of available family or friends, financial considerations played an important part in informants' ability to respond to a change event. When the change event required an outlay of money to continue *being able* even those informants who believed themselves to be "well off" were stressed. Their feelings of stress were related to uncertainty. They could not know what the future would bring. As they could not know how long their savings had to last, they were reluctant to spend what they had.

> *. . . would have a private room, and all the rest of it. And of course, also, money can obtain that for you. But then, you know, if one knew how long they were going to live, you would know whether or not you would dare spend that money. And so you hold back on spending it.* (10).

Another reason finances influenced informants' manner of dealing with change was identified by an informant's son. He stated that his parents found it difficult to spend money on anything. He attributed their reluctance to their experiences during the Depression and a lifetime of minimal financial security. Regardless of the relative cost of the alternatives, for this couple any alternative was too costly for them to consider.

Formal care services often supplemented those *being able* tasks that could not be managed by, or were considered inappropriate for, family or friends. A variety of formal community care services were utilized by most informants at one time or another. Services included homemakers, personal care aides, meals on wheels, and a daily telephone contact service. Formal services had been contacted in response to informants' previous identification of their inability to carry out tasks of *being able*.

Initial response to a change event included the assessment of internal and external personal resources. If the event could be managed within available personal resources, then such resources were called upon. If, however, informants perceived their personal resources were inadequate, then informants examined their potential resources.

Assessment of Potential Resources. Potential resources included any person or service not currently utilized by informants. Informants assessed potential resources in terms of the type of care provided, their feelings about the care, and the availability of the service. All known alternatives were identified, including options previously dismissed. Judgment of service appropriateness depended upon informants' knowledge of the service, the input of others and their previous experience with the person or agency. Deciding which alternative to choose involved "weighing" alternatives.

Weighing of Alternatives. Once informants identified actual and potential sources of assistance, they then weighed these alternatives to determine which option would best enable them to regain *being able*. Alternatives were weighed against one another and against the option of not making any behavioural changes. Factors that influenced weighing of alternatives included assessment of their own needs, their feelings about the potential alternatives, the influence of involved others, and the accessibility of the resource (see Figure 3).

Informants attempted to find an alternative that would give them the most assistance while costing the least. If the informants believed that an alternative was too costly, they would settle for a solution that cost less, even though it may not have completely met their needs. Considerations of cost extended beyond that of financial burden to include personal costs such as the loss of privacy and routine.

> (Son speaking) *Home Care Services came out to see them. Mother was slightly bad and they were saying -- offering housekeeping services, and my mother said, "I don't want them in the house." Then they offered Meals on Wheels, and Mother said, "Well Dad won't eat it anyway." And he said, "Try me." But they didn't want that, and when they offered the nurse coming over every once in awhile -- every week or so -- Mother said, "Why do we want to do that when we can go to the doctor?"*(4)
>
> *I hired a housekeeper. But after a while, she began to take over. It was her house, not mine. She was answering the phone and answering questions about me, which she shouldn't have done. And she -- her husband wasn't working, and he'd come over and see her in the evening and they'd sit around and want to drink a few bottles of beer which I objected to very strongly. And I don't remember just exactly what I was paying her, but everyone said I was paying her well. But I had to let her go. I couldn't be myself.* (6)

The influence of the opinions of others on informant consideration of alternatives cannot be understated. Almost all informants included their family in the weighing of the various alternatives. The extent of the relatives' involvement varied. In most instances, family acted as sounding boards. Their opinions were sought, but the final decision rested with the informant themselves.

> (Daughter speaking) *So we went down the next day to look at one of the lady's rooms that was fixed up so nicely. And I thought, "Oh boy! This looks good." And I didn't say a word -- let her make her own decision.* (2)
>
> ... *This friend, she was awful good to me, and she said, "Jo, you're too sick." She said, "You shouldn't be here."* (5)

In other instances, family, friends or health professionals attempted to direct the individual in making an alternative choice.

> (Son speaking) *I think I have to keep -- I pressure them every time I see them. I keep after them with that ... ... what I've been intending to do was cultivate a bit -- to get them thinking along that line ... ... I always refer to those incidents (the falls). I say, "Look, you know, if Dad falls down again you know, and you're weaker now, you can't help him up. It's time to be where there's other people around."... ... I think it's -- it's my prodding of them steadily that's slowly getting them to this point.* (4)

Some informants became upset when caregivers' assessments of what should be expected differed from their own.

> ... *it just seemed to me that every one of them would get to the point where I would get this line, 'What else do you expect? At your age you can expect this.'... ... Which is another way of saying, 'Learn to live with it, my dear.' Another way of saying, 'There's not much quality left. We'll do what we can for the quantity, but the quality has to suffer.'* (9)

Although the informants varied in their reactions to the direction of others, the opinion of their significant person always entered into the weighing of alternatives. Informants considered the effect of their choices on the continuation of their important relationships. While some informants passively bowed to the choices of others, other informants resisted outside pressure. In two instances, informants found that choosing an alternative their families did not agree with caused friction in their personal relationships.

> *I've had a psychologist that initially helped me get -- have the guts to move out of Dee's. Which sounds stupid, but very true, that I could not screw up enough courage to pull out of there. And then they -- then when, as I said, I finally did, it caused so much trouble that Dee wouldn't talk to me.* (10)
>
> *They said I was just being stubborn and -- we've pretty near gone on the outs.* (4)

Availability of resources had to be taken into consideration in the weighing of alternatives. Although an alternative may have been preferred, it may not have been available. This forced informants to consider other options.

Choosing the Alternative. Informants' desires could be summed up in the statement: ". . . as long as I could, I wanted to stay independent and in my house". After examining the impact of the change event on their lifestyle, the resources in place and the resource alternatives available, informants decided which care alternative would assist them to manage following the change event.

Each option was judged for its value in achieving the informants' desires. If an option did not allow them to meet their desires, then it was rejected for another. Once an option to assist them to remain in their own home was found, then the search ended, even if other options were available.

Response to Change Event

The opportunity and ability to choose an option was very important to informants. Even in situations where the "best" choice was not available and the individual had to settle for "second best", second best could be tolerated because it was a personal choice rather than imposed upon them by others.

Informants responded to change events in many different ways. They put up with the change event without a corresponding change in managing, gave up an activity, put contingency plans into place or took on a new way of completing the affected *being able* task.

"Putting Up With" Response. Some informants put up with the consequences of a change event without making a corresponding change in lifestyle because the events were so gradual they went unnoticed.

> *We didn't know* (we were starving), *because I was eating all I wanted to eat. We didn't ration ourselves on anything. If we wanted it, we ate it. But we didn't want anything.* (4)

Other informants put up with the negative effects of change events because they did not know what to do.

> *I was sick enough that instead of taking the bull by the horns and say, "Look, somebody, help," I kind of just let it -- I guess I was trapped.* (9)

"Giving Up" Response. More often, informants responded to a change in their abilities by giving up activities rather than searching for alternatives to manage them. Giving up activities changed the quality of their lives.

> *I gave up my symphony tickets, because I no longer -- I was the driver -- seems as though I was a driver for most things. We had a little book club, and I drove to it -- in town. I had to give it up. And my theatre seats, I gave up because I thought, "I just can't get in."* (6)
>
> *Up 'til then, she was doing her own cleaning but not that much. It was just getting -- deteriorating . . . even in the lodge she wasn't eating breakfast. Breakfast was at 8:30 and there was no way that*

> *she could get to breakfast by 8:30. It takes her an hour and a half to get dressed. . . . That's fine. It was just too early.* (2)

> *I don't know. I guess -- I had to manage just the same. . . . . . . I couldn't do the things as much as I wanted to. Like sewing. It was getting harder, but the things I did remained the same.* (1)

Contingency Plans. Some informants perceived the change event to be a warning of things to come and a reason to initiate actions that would prevent a future crisis.

> *If you're managing, then you're on top of things. You're able to do things. You stay on top -- almost to the point of wanting to get things done a little ahead.* (9)

Anticipation of future change events motivated these informants to put contingency plans into place. They described their reasons as "Just in case".

Implementing the Alternative

Once an alternative was chosen, the work of implementing the decision began (see Figure 4).

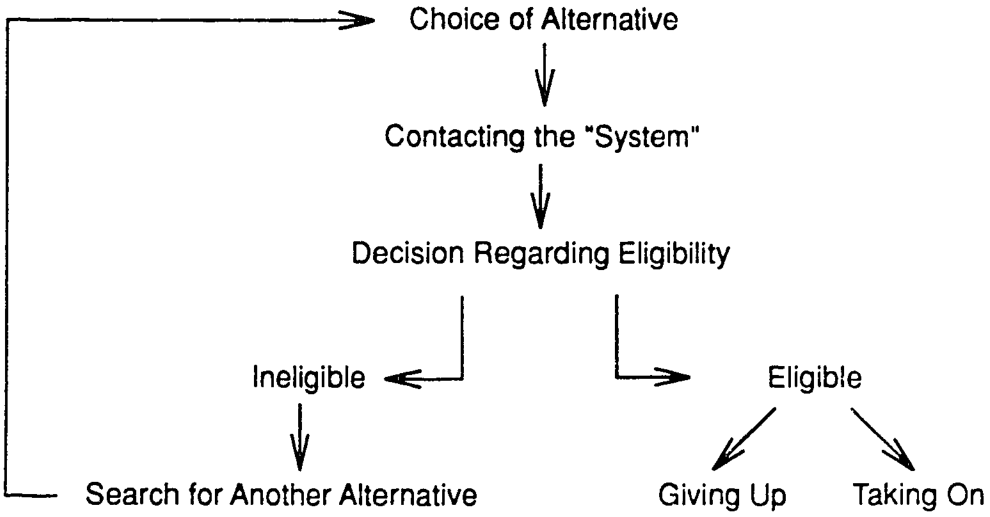

Figure 4. Implementing the Alternative

The individual had to take steps to make the chosen resource aware of their need. In the case of formal service agencies, informants spoke of "contacting the system". Contacting the system involved two activities, making a referral and learning the eligibility rules.

Making a referral required knowledge of how to access the service agency. In some instances health professionals known to the informants were involved. In other instances, the informant and family initiated contact on the advice of an experienced friend. Informants were generally unaware of available information/referral agencies and therefore did not use them.

The activities of "contacting the system" were repeated when informal resources such as family and friends were called upon to provide assistance. Helpers had to be contacted, and be available and willing to be involved.

Making contact did not guarantee initiation of service. Informants' eligibility for formal or informal assistance depended upon the rules. The rules determined the informants' responsibility to the service agency or to the significant other providing the assistance. Once the rules were determined, the individual had to decide if the rules were acceptable. If they could live with the rules, the informants then began the work required to receive assistance.

> (Son speaking) *I told them that, if they want to stay there, we can come over once a week -- that's not -- not likely any more than that unless there's an emergency.* (4)
>
> *At first we were thinking about the lodge. But they don't take me, because of the medical report.* (3)

Implementing a change in care management required that informants give up and take on activities. As many of the change events involved deficit changes, alternatives often involved giving up possessions or routines. Examples included loss of a house for an apartment or an apartment for a room in the lodge. Relocation choices were accompanied by giving up belongings such as furniture, cooking utensils, and china. The most difficult loss cited by informants was the loss of the ability to drive.

> *It was harder to part with my car than it was my house, in a way. 'Cause that meant my independence.* (6)

Besides material and activity losses, informants also experienced intrinsic losses. This included such things as the loss of privacy, independence, the dependency of others, and being oneself in one's own daily routine.

> *. . . almost everybody at that point was saying, "Isn't it marvelous to think your daughter would take you in and --" but you know, I had her family, that -- my son-in-law wanted to run my life for me.* (10)

Accompanying the work of giving up was the work of taking on. While giving up their independent activities, informants were taking on dependence. Informants' examples included getting used to someone else driving, having someone in the house, having a stranger provide personal care, finding new friends, learning to use new equipment or relearning old skills previously taken for granted.

Informants experienced the work of giving up and taking on in response to every change event. Once informants had chosen the manner in which they would respond to the change event, and implemented that choice, they regained a state of *being able*. As has been previously noted, the achieved state may or may not have been *as able* as their pre-change state. As long as they believed they were managing, informants defined themselves as holding on. When they could no longer define themselves as *being able*, the process of "Taking Care of Self" involved nursing home placement consideration.

In summary, the "Taking Care of Self" process explains how informants sought care alternatives that would assist them to remain *being able* following a change event. As deficit changes accompanied the aging process, each informant attempted to hold on to as much normality in their lives as possible. When a response to a change event was necessary, alternative ways of managing were assessed and weighed. Options were chosen according to the benefits they provided, their costs and availability. Informants implemented their choices and if necessary, modified their definition of *being able* to incorporate the help of others.

Institutional placement, the initial focus of this research, was perceived to be necessary when holding on or *being not as able* became impossible. *Being able* or *not as able* became *being unable*. The process of "Taking Care of Self" then included consideration of nursing home placement as a possible alternative.

The Process of "Considering Placement"

As the research project progressed, it became evident that informants had considered nursing home placement in the same manner that they had considered other alternatives in the "Taking Care of Self" process. The impetus for both considerations was change. The steps taken by informants to adjust to change included the same elements (see Figure 5).

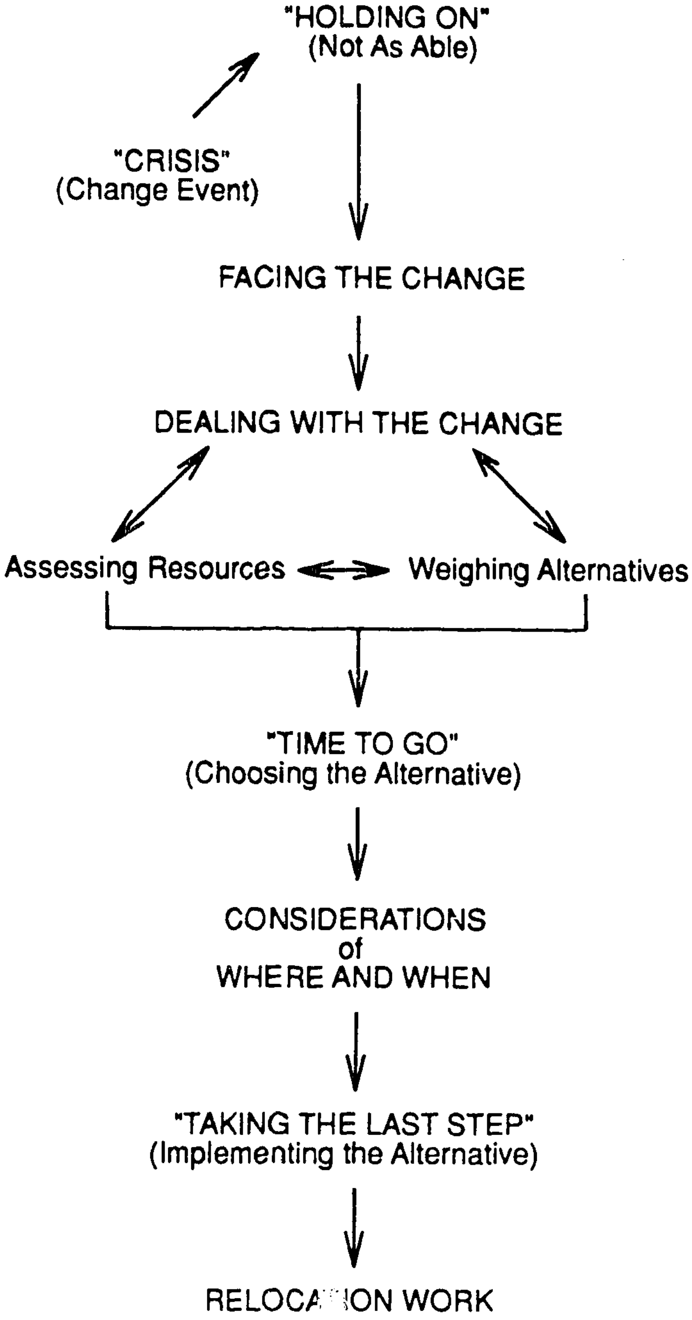

Figure 5. The Process of Considering Placement

Although the pattern was the same, the researcher identified three differences that made the process of "Considering Placement" a unique example of the "Taking Care of Self" process: a) informants' definition of self remained as *being unable* as opposed to regaining *being able*, b) increased acuity of the change event, and c) rejection or lack of other alternatives. The process of "Considering Placement" will be presented in this section.

"Holding On" Becomes Being Unable

Within the "Taking Care of Self" process, *being able* represented informants' ability to independently carry out the work of intimate tasks, supportive tasks and outside tasks. As their independent capabilities diminished, informants modified their definition of *being able* to include the assistance of others. They described *being not as able* as "holding on". When informants believed that they could not maintain an independent management state even with the assistance of others, they assessed themselves as *being unable.*

Being unable meant that informants could no longer carry out the intimate, supportive or outside work of *being able* capably and safely. The informants described themselves as useless and needing the total care an institution could provide.

> *We've got to accept the fact -- that we're no good anymore.* (4)
>
> *I think when you go into a nursing home you feel you're just about as low as you can go.* (6)

The circumstances that caused the transition in informants' self-assessment of *being able* to *being unable* was the change event.

The Change Event

The change events that brought about informants' placement consideration consisted of complex combinations of abrupt and gradual alterations in individuals' health or supportive environment. The difference between change events within the "Considering Placement" process and the process of "Taking Care of Self", was that the former was described as a crisis. "Crisis" was defined as an insurmountable change in self or circumstances that demanded a change in self-definition from *being able*, or *being not as able*, to *being unable*.

A crisis prevented informants from continuing to manage independently, even with the help of others. Abrupt changes in health status was the primary reason for four informants' considerations of placement. Two informants experienced falls, one couple had unknowingly starved themselves, and one informant experienced heart problems. Independently, these acute events may have been managed, but in combination with other gradual changes including loss of energy, feelings of lost security and stretching of current resources, informants believed that they could not return to a state of *being able*.

> *Many years ago, when I cut my lawn or did some gardening, I was wondering, "Should I be in a nursing home already?" And I always said, "As long as I feel I can stay in my house, I like to stay.". . . Before Christmas I didn't feel too well, and later on I fell and broke my leg, my wrist, the shoulder and the nose . . . then I said to myself, "Now, no more in the house."* (3)

> *It (the fall) just happened very suddenly. But I must have been low in blood count. I wasn't watching my food close enough, I guess, and I was not feeding myself properly.* (2)

> *I was struck too with this -- the added problem of the disease having affected my heart. As long as it was my legs -- that was*

> *pain I had to work with. And I felt that I could handle the pain situation. But this was a different kettle of fish. This was my heart involved, and I got tired very quickly, and I just found life much more difficult.* (10)

For other informants, health state was a contributing factor rather than the direct impetus for placement. These informants experienced a combination of health and support problems. They believed that the gradual deficit changes in their health status contributed to their loss of support systems. Their care needs had extended beyond the services provided by the lodges where they lived. The limitations of the lodge environment forced these informants to look for alternative living arrangements.

> *. . . they've (the lodge) said that they can't -- I can call the nurse and pay for it, but she can only come so many times, because she's the only person here. And she's got another 150 people to think about.* (6)

The remaining two informants experienced a loss of their support system. They did not believe that their health was a contributing factor. Instead, they attributed their placement to the abrupt loss of their supportive environments. While neither of them could live independently, these two individuals managed within a supportive environment. One informant had entered an acute care facility for rehabilitation. A nurses' strike closed the hospital and led to her abrupt admission to a nursing home. The other informant was admitted to the nursing home because his family went on a vacation. In both instances, the informants believed that their admission was temporary, pending restoration of their former supportive environments.

> *Well, I couldn't (care for myself) -- I was throwing up and I had the diarrhea so bad. My arthritis was getting worse and I, my doctor said, "Just go to the hospital. They'll get you a bed there." So that's what I did. . . . Then the strike came along, then they moved me over here, to this place.* (1)

> *They figured I shouldn't stay alone, because I was at the age where anything could happen. The idea was for me to stay here for the time my daughter was on holidays.*(8)

The inability to manage the intimate tasks of *being able* constituted a crisis. To adjust to the crisis, informants had to first admit that a change event or combination of change events had occurred and that the event affected their ability to continue *being able*. Changing their self-assessment from *being able* to *being unable* constituted facing the change.

Facing the Change

Informants could not take steps to adjust to a change event until they had cognitively acknowledged the event had occurred. Generally the change events that brought about considerations of placement were of such magnitude that although they might be tolerated for a short time, they could not be ignored.

> (Granddaughter speaking) *She put the brakes on. She decided that she wouldn't move until spring. Then she fell again and broke everything. For awhile, nothing was said about it, and I of course wasn't going to bring up the topic, but at one point she said, "Well, I guess this means I really do have to go into a nursing home." And I guess that's what it means.* (3)

Facing a change event varied according to the intensity of the change, the timing of the event and informants' personal expectations (see Figure 6).

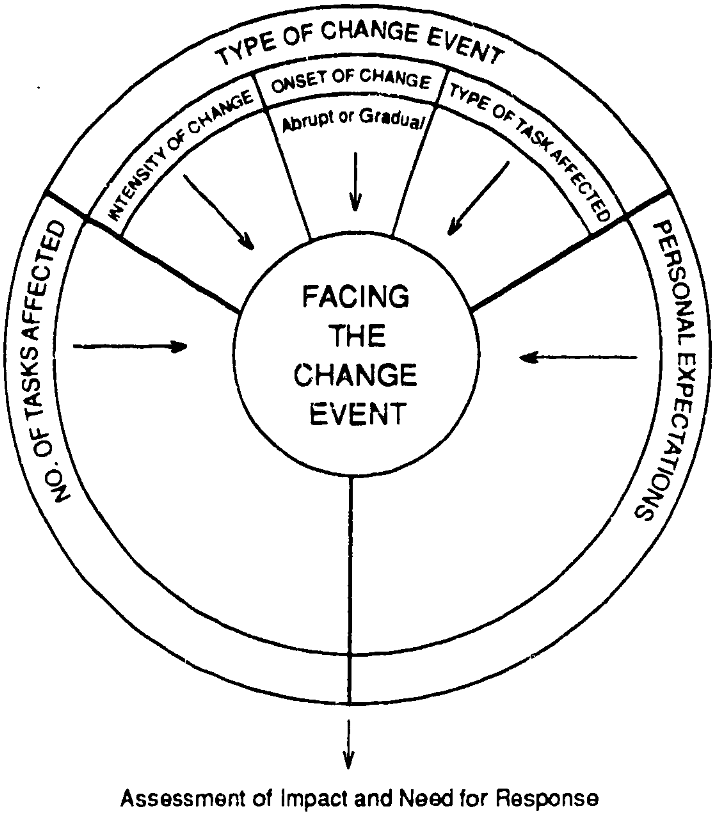

Figure 6. Facing the Change Event

Intensity of the Change. The intensity of the crisis was reflected in the type and number of tasks affected and the degree of the effect. When changes in personal health or environmental supports prevented the individual from managing intimate tasks such as getting dressed, getting to the toilet or moving freely then placement was considered.

> *I did the wrong move and it was hard overnight to get up and to go to the toilet, and so on.* (3)
>
> *I'm no good. I'm so weak it's as though my legs are filled with water. I am thinking about the nursing home. I can't carry on. . . . I have to hang on to the door jamb. . . . can't get out of the bathtub anymore. By myself -- in the last two weeks.*(4)
>
> *You see, I couldn't dress myself. I had the shoulder -- what I*

> *need to put on a stocking -- taking on and taking off -- and then I had the long handle to pick up everything and then I had a cleaning lady, she came twice in a week, but then I went downstairs to wash and if I iron and I felt, I fear I cannot do it too long anymore. And so I talked to my granddaughter, "It's time for a nursing home."* (3)

Informants' responses to change events were also influenced by the number of *being able* tasks affected by the change and the number of change events experienced. The greater the number of tasks interrupted by the change event, the less likely that the change event could be tolerated.

As informants experienced problems with their health, their energy levels were also affected.

> (Granddaughter speaking) *She hadn't felt that well through the summer. I think her colostomy was bothering -- her stomach was bothering her. And she was -- she didn't have as much energy as she usually had. She seemed kind of slow and tired.* (3)
>
> *He is getting -- you see, he is getting thinner. He doesn't want to eat. And when I cook the meal and he comes to the table, he said he wishes he could eat, but he eats because he has to. That's not very good. And it's not good for me to try to make the meal . . . and it seems like he likes to lie down and sleep, or sit there, and he hates that because he always was active. But he can't do anything about it.* (4)

A lack of energy interfered with their ability to carry out the tasks of *being able* including their ability to think, plan or take responsibility for their future.

> *You see, I'm at the stage now, physically where I cannot do things for myself so I must have -- have help, you see. When you're physically unable to do things -- it changes the picture. I'm mentally, but I'm not physically equal to it, you see. I'm not -- I haven't got the strength in my body that I should have.* (2)

Informants spoke of needing both physical and cognitive ability to manage the tasks of every day living. All informants hypothesized that should a change event occur that interfered with their mental ability to recognize their own needs, it would constitute a valid reason for seeking nursing home placement. They stated that when they became unaware, they would become *unable.*

> *When I become so I'm not aware of my surroundings or what I'd like to do, well then that's (the nursing home) the best place for me.* (5)

Timing of Change Events. The timing of change events in relation to one another and in terms of speed of onset also influenced informant responses. As change events occurred in rapid succession, it became more and more difficult to achieve complete recovery.

> (Granddaughter speaking) *I think maybe the thought started after the first time she broke her hip. "Oh boy, you know. Here I am stuck again." At that time I didn't know whether or not she'd be able to walk again. So she's just always pulled herself back together. She's doing it this time again. I think it has been harder each time. She has lower energy levels. Maybe her health hasn't been quite so great as it could be.* (3)

> *Too much has happened in too short a time. That's why -- that it has been so hard for me . . . I don't know how much longer it's going to be, because, as I say, my -- I'm so dizzy right now, the dizziness has become very, very much more pronounced. Some days it's a little better, but it's never good. . . . . . . I'm very, very dizzy. Like, balance is gone. And this thing (colostomy) is really acting up. I'd like to cut it off my stomach. It just gags me. So, I never know when this is going to materialize in the -- if I get too bad then it brings on an attack.* (5)

Change events may have been gradual or abrupt. The progressive changes accompanying chronic illnesses such as Parkinson's Disease, arthritis, and diabetes created the need for gradual changes in self-care management. Informants stated that they hardly noticed these changes, as responsive adjustments were easily incorporated into their everyday lifestyle. However, as their gradually declining levels of health affected their energy levels to the point that accommodation became more demanding, some informants believed that their safety was placed in jeopardy.

> (Daughter speaking) *But with her Parkinson's Disease, gradually she's been able to do less and less for herself. And she'd got to the point where -- it's dangerous really for her to be living by herself, because she would get into certain situations where she couldn't move.* (6)

They were afraid to live alone because "something might happen". There was a shared fear of not being discovered if they were to fall or become severely ill. Their concerns of "No one would know" extended to a fear of dying alone. With these thoughts in mind, some informants based their need to consider placement on gradual changes alone.

> *I am afraid of falling, yes. And to be -- not to be able to do what I like to do -- and the main reason was to be alone in the house, because I am old and nobody knows what can happen.* (3)

All informants believed that the gradual deficit changes in their state of health had stretched their resources to such a point that they were at risk for nursing home placement when an abrupt crisis occurred. Abrupt changes in the informants' ability to manage generally resulted in admissions into an acute care hospital. Informants did not expect an abrupt change event nor had they prepared for the possibility of *being unable*. Although particulars of individual experiences differed, change events constituted an abrupt change in individuals' health status and/or existing support systems.

Personal Expectations. In the first stages of facing the change event, informants assessed the impact of the event in terms of their ability to continue to manage independently. They could not believe that they had become *unable*. Facing this fact was difficult. Informants spoke of the grief they felt over their losses.

> *It's terrible (the loss of independence). It's just terrible. You just fight it. And it makes a person quite depressed.* (6)
>
> (Granddaughter speaking) *I think the first decision is the decision that a person cannot be totally independent. Although we never are totally independent, it (nursing home living) requires a greater degree of dependence than what we're used to and giving that up is giving up a lot.* (3)

Informants perceived the change event that introduced the personal experience of placement as an "unexpected-expected" event.

> (Researcher) *Did you expect to fall -- were you getting progressively weaker?*
> (Informant) *No, not at all -- just happened very suddenly. . . .*
> (Researcher) *Did you expect to have to face this?*
> (Informant) *No. I was rather hoping that I would go quickly, because I don't like this long drawn out stuff at all.*(2)
>
> (Daughter speaking) *I think it is, I guess, quite a change. It's, I suppose, even a shock.*(2)

The prevailing attitude expressed by informants was "I know nursing homes are there for old and sick people, I just never dreamed that that would include me".

> *And we laughingly said at the time, "Oh well, when we're in our 80's maybe we'll come here."* (6)

While nursing home placement was expected for the elderly as a group, it was generally unexpected as a personal experience.

> *Even though you knew damn well that as year 63 or 64, when you're 65 it's* (placement)*going to happen darn quick, but yet it's like the ostrich when he's sticking his head in the sand so the other guy won't hurt him.* (8)
>
> *Well in my case, it never occurred to me that I would have to go to a nursing home. I just figured that I would live in my apartment, and one day I'd be gone.* (5)

> *It was a surprise, you know. If you had asked me three or four months ago I'd say, "I don't know, I'm home now."* (1)

Some informants admitted that their placement in a nursing home was possible, but not right now. While they could see themselves in a facility that would provide for their needs, they could not believe that the time had come.

> (Researcher) *Is going to a nursing home something that you expect when you get older?*
> (Informant) *Well, we do, yes.*
> (Wife) *When we get helpless.*
> (Informant) *We expect likely there will be a day when we'll just have to go where we'll be taken care of. . . . It's still -- we're able to get around, and so we'd like to keep on getting around. . . . I don't think we're ready for a nursing home.* (4)

The duality of nursing home placement as an expected event accompanying aging but an unexpected personal experience was reinforced by the healthy informants. They were surprised to be asked if they had ever considered placement. Although both could see that they may eventually need the intensive assistance provided by an institution, thoughts of placement had been fleeting. They had never contemplated placement because they were not presently in, nor had they ever pictured themselves as being in a situation warranting such a drastic change in lifestyle. When asked what they would perceive as being an impetus to placement, these informants answered, "Physical or mental inability to maintain personal care."

> *But if I were to see -- if I were alone, or if Jacob were alone, I would hope that if we were to see -- that we simply couldn't handle keeping clean -- I want to have the wisdom at that time to say, "OK, the time has come."* (9)

> *Say if you got a stroke, or you get a heart condition or something like that, that you cannot take care of yourself, then the nursing*

> *home -- you have to go.* (7)

Having acknowledged the actuality of the change event, informants moved on to deal with the event.

Dealing with the Change Event

Admission that the change event had occurred also involved admitting the permanency of the change and the implications for the future. Informants moved back and forth between the consideration of placement and believing they could continue to manage in some other manner.

Some informants attempted to change the behaviour they believed attributed to the change event. For example, when one couple found out that they had been starving themselves, they refused to believe it.

> *It was a surprise to us. . . . We didn't believe them. We just went on -- ate a little bit more.* (4)

Good days and bad days became important indicators of their condition. When bad days outnumbered good, informants were forced to admit they were not managing. Although they acknowledged a change event had occurred, they may or may not have faced the implications of this event. The possibility of nursing home placement was not contemplated until all other alternative solutions had been considered and rejected. The activity of examining all possibilities was called "dealing" with the change event (see Figure 7).

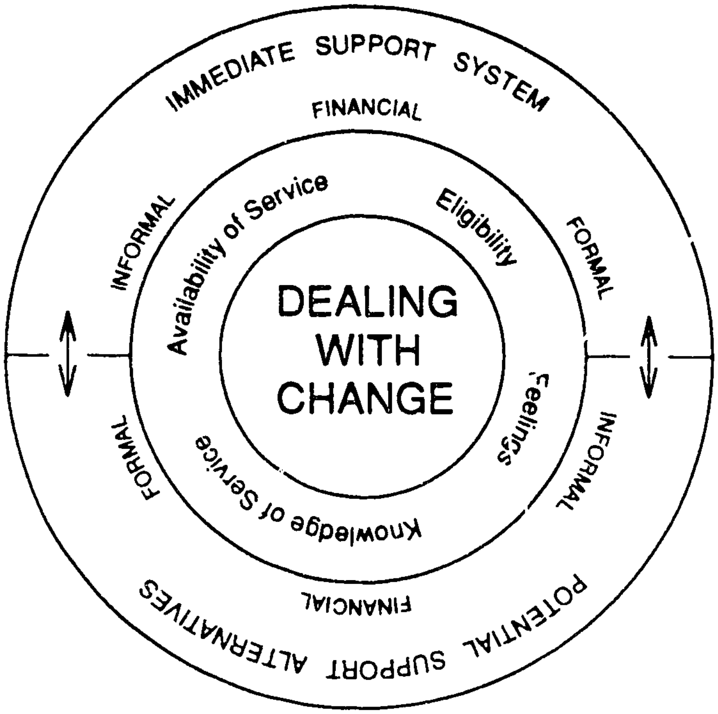

Figure 7. Dealing with the Change Event

Assessment and Weighing of Current Resources. The impact of the change event amounted to a crisis in self-care. The type of support they now required involved assistance with intimate tasks on a twenty-four hour basis.

> *I realize that if I get worse -- much worse -- that I need more attention -- like, not just for three hours at night-time, but all night. . . .* (6)

Informants first asked themselves, "Can I manage the change event without changing my behaviour? Can I hold on?" Most often the answer was "No!" The reasons for this negative response were that the level of care required was not only beyond their personal ability and energy resources, but also necessary for their survival.

> (Daughter speaking) *She just can't do the things -- she can't look after herself. She can't dress, she can't, you know, wash herself, she can't brush her teeth... and she feels so bad when she can't look after herself properly. Because she's always been, you know, very careful with her grooming and so on. So, basically, at the moment, she's holding her own, but it's kind of nip and tuck with it. Often she can't get out of bed. She needs help to get out of bed. She needs help to go to the bathroom.... She's just at the point where she's needing a bit more help. So I think she knows that a nursing home is, you know a good possibility soon.* (6)

If the informants felt they lacked the ability or energy to "hold on", then they believed they had no choice but to give up self-care and seek assistance.

> *I disagreed with it. I disagreed inside. I gave in, because I was tired, because I still didn't have what it took to really manage.... I felt very inadequate when all these decisions were being made for me. I felt crushed. I felt no longer like myself. I felt that -- well, I guess perhaps, you know, one might also say I gave in. And I stopped fighting.* (10)

When informants admitted that they could no longer independently manage the tasks of *being able*, they looked first to their immediate support systems. As in the "Taking Care of Self" process, there was still a general reluctance to receive support by moving in with family. Some informants stated that their families had their own lives to live and that they did not wish to be in the way. On the other hand, some families did not feel that they could manage if their parents moved in.

> *I have seen daughters burdened with their mothers and it isn't -- to my way of thinking it isn't right.... I figure we should leave our daughters free.*(2)

> (Son speaking) *And one other time I said, "Well, what would you really like?" And she said, "Well, we would really like to move in with you. Well you know that's impossible." And I said, "Yes,*

> *that's impossible." I'm cruel, I guess. Well, that's selfish, but that's what it amounts to, and you know we're not set up for it. We would have to move down into the basement.... We should do more for them and yet we have our own lives.... They wouldn't be any better off here than they are where they are, because we're just not around enough.* (4)

Other informants spoke of their children's inability to be of assistance because of their own limitations in health or living arrangements.

> *My daughter lives in an apartment and she has MS. And my granddaughter is working. They like to be alone too. It's not good together.* (3)
> *I had to come because my daughter-in-law, they got two little kids, so they, you know, they're both working. And my other son is working, so I can't have anybody to look after me.* (1)
>
> *I couldn't even get her into my apartment. I'd have to hire somebody to help carry her up the stairs to put her in. You see, I've got twenty-six stairs with no elevator. It's a two-story condominium. I have a little kitchen and a living room, and the bedrooms and the bathroom are upstairs.* (2)

In other instances, informants believed that the cost of moving in with family would not be worth the benefits. One informant felt that she would lose contact with her friends:

> *... my daughter said, "Well, Mom I'm here. You're welcome to come here. We can't offer you a place like this, and you haven't any friends there, but we'll be there." And I said, "No." I thought I'd better just stay close to home, where I had made so many friends over the last ten years. Better to stay here.* (6)

Others felt their relationships with family members would be placed at risk.

> *...I said I really felt that two women, mother and daughter, often had a hard time. That trying to live together would spoil the relationship, and that I didn't want to risk that.* (10)

Again, the kinds of assistance informants received from family members varied. In some instances, family supplemented those activities that the individual could no longer manage themselves. Families provided assistance with supportive and environmental tasks such as offering transportation, running outside errands, preparing food packages, and giving housekeeping assistance. However, none of the informants spoke of their family as providing assistance with intimate tasks. The one interviewed couple provided stand-by bathing assistance to each other, but as their health declined, they stopped using the bathtub and sponged rather than call on other family members.

For those informants that lived in their own home, families were also depended upon to provide assistance in the event of an emergency.

> *I fell off the ladder -- crawled in the house and called my daughter. And this side, a broken hip.* (3)

> *I took Dad into emergency, oh, two or three times. Mother would phone me, usually on a Friday afternoon, for some reason or another. I'd go over and take him to the hospital.* (4)

These informants' awareness of their vulnerability heightened when their family went away. Their fears for their safety and of being alone prompted two informants to discuss placement when their families returned.

If family resources were stretched to capacity or unavailable, informants looked to community services for assistance in the tasks of *being able*. In the examination of these resources, informants' financial situations had an impact on their ability to engage an alternative source of care and prevented nursing home placement. Consequently, when the required care exceeded the informants' financial ability to sustain it, placement had to be considered.

> *I'm gradually needing more care, which I'm not going to be able to get here, unless I have a companion. And I can't afford a companion.* (6)

Even when financial concerns were not an issue, the availability of caregivers or the limitations of community services forced informants to consider alternative care arrangements.

> *I was facing the prospect of getting someone in -- almost day and night I needed help. And it's just impossible to find someone.* (6)

> *. . . I'd like to have somebody come in . . . and tidy up my drawers and do odds and ends. I'd be willing to pay for it. But do you think you can? No, it's an impossibility. They don't -- it's just like they shut a door on us. You can't seem to find anyone.* (5)

This limitation of services was particularly apparent in situations where informants were currently residing in a lodge environment. When informants' care needs reached a point where they required ongoing personal care assistance, or if they experienced difficulty in mobility, then they were unable to continue to live there.

> *Because I'm getting these spells. And when you break out in perspiration and you're literally so weak . . . . They're good at the lodge but they can't -- they're not supposed to look after me.* (5)

They perceived their relocation choices as limited.

> (Daughter speaking) *She would have liked to have gone back to the lodge, but she made the decision herself that she couldn't possibly because you have to be mobile on your own.* (2)

Assessment and Weighing Potential Sources of Help. If informants assessed their care needs to surpass the personal resources at their disposal, they examined other available resources. As in the "Taking Care of Self" process, informants' assessment of potential resources was based on their knowledge of the existence of resources, the availability of the service and their feelings about receiving that type of assistance. Four factors were important to weighing potential resources: informants' perceptions of their needs, their feelings of priority, the feelings and opinions of others and the availability of the resource. Again, as in the "Taking Care of Self" process, this was a random and sporadic activity rather than a logical sequence of events.

Informants judged their needs on the number and type of tasks with which they required assistance. They then rated fulfilment of these needs against those activities they would have to give up in order to acquire assistance. If the need took priority, then they would give up a great deal to have it met.

Informants' considerations of potential alternatives were strongly influenced by the people around them. Family members played an important role. Their advice was actively sought by all informants before any move was taken.

Health professionals were also important to the weighing of alternatives. Most of the informants' knowledge of available services was provided by health professionals. Although most informants believed that they had a choice in the consideration of alternatives, health professionals influenced informants' considerations by the types of alternatives they presented. For example, one informant became very angry as she related her experiences with a health care team:

> *The doctor said that a conference was coming up and the issue would be brought up. And when this conference did come, I was told, then, that I would have to either go to my daughter's home to live, or I'd have to go to a nursing home.* (10)

The informant's anger stemmed from the fact that her choice, to live in her own home with paid help, was ignored by the health care team and not presented or considered as an option for discussion.

> *So this doctor came in and said I was going to have to go to a nursing home. And my daughter said, "But mother doesn't want to go to a nursing home." And so he turned to me and he said, "I'm sorry. You're old and you have no right of making decisions for yourself." . . . I said, "My daughter's right." And I said, "You know, I do not want to go to a nursing home. I will look up alternatives." And so, "Well," he said, "you know, you're old and old people just do not have this right." So I argued the point with him, but I didn't get anywhere.* (10)

The availability of resource alternatives was a major consideration when informants considered choices for care. If the resource was not available, then it could not be considered as an alternative. Health care professionals were very involved in this consideration as well. They both determined the criteria for eligibility and completed the admission assessments. Their decisions determined if informants met admission criteria and would be allowed to receive the service. If informants did not meet the criteria set down by the service agency, then the service would not be provided even if it was desired.

> *He's been trying to get us into a nursing home, and they won't take us because we're too active, they say. And we're too feeble to go to the lodge. So where does that leave us?* (4)

The Nursing Home as an Alternative. Informants expressed a general reluctance to choose nursing home admission as a solution to *being unable*. They perceived nursing home placement as a negative experience and one that should be avoided as long as possible.

> Respondent: *I think when you think about going into a nursing home you feel you're just about as low as you can go.* (6)

> Interviewer: *You told me that the nursing home was to be your last step and you wanted to delay this as long as you could. Is this true?*
> Respondent: *Yes. I don't want to give in and think I have to go there.* (6)

Some informants attributed their negative feelings to the position the nursing home occupied in their conception of the life cycle. They described this position as being "the last step" toward the "end", meaning their death.

> *I think the feeling is -- well this has been my feeling over the years, and I've noticed it in people who are in there, that somehow it's the last step. . . . I'm taking a step that is leading to the end. And you feel when you go into that nursing home, "This is the end" in many ways. And this will be your home until you die.* (6)

> (Son speaking) *They know they have to, it's just Dad keeps saying, "Well, you know, that's the end of the line, when we get there."* (4)

Along with the belief that nursing home admission was the last step before death, some informants expected to have to put up with negative experiences in a nursing home.

> *I've gone to some of the nursing homes and talked to the patients, the residents. I haven't liked what I've seen. I was in one where I felt that people -- people were everywhere, as though you're almost being smothered by too many people in too small a space.* (10)

Some informants anticipated that they would be placed with individuals who were cognitively impaired and that these people would bother them. One informant believed that "wanderers" would take her things and come into her room uninvited. Even though she realized they couldn't help it, she did not look forward to having to put up with these people in a nursing home.

> *Even when I was in the hospital, at one point one of the visits I had there, there were five Alzheimer patients on the floor. These people took everything that I had, so that you can't have any of*

> *your own possessions there with any sense of security. In the middle of the night one of the Alzheimer patients tried almost every night to crawl into bed with me. Of course you feel sorry for these people. My heart breaks for them. But, nevertheless, I resent their intrusion. . . . They're in the nursing homes, and the patients are expected -- all the patients are expected to put up with this. . . . You have it on a twenty-four hour basis, and it's terrible.* (10)

Informants felt that once in a nursing home, they would have no one to socialize with, they would lose their present friends and have no opportunities to make new ones.

> *And also the knowledge that you get into these places and people -- you don't mean to forget. They say they'll visit, but I can think of a dozen people who said they'd visit me, and in three years they haven't come . . . . It gets to be a chore for a lot of people to go to nursing homes or places where people are -- I know it hurts them when they come and see me.* (6)

Informants expected that moving to a nursing home meant sharing a room with a stranger. They could not see themselves getting used to this idea because they had been alone for so long. They worried that they would lose their privacy and independence.

> *And suddenly it occurred to me that I was going to have to give up a lot of that (independence). But I never really faced the fact that it might be a nursing home, I don't think.* (6)

> *And anyhow, the powers that be seem to think that older people do much better if they're in with somebody else. Well, you know, I don't know what most patients want, and maybe there are some patients who would like to be with someone else, but I don't want to. I've been alone ever since my husband died and I would like it to be that way.* (10)

Moving to a nursing home meant losing their present residence and possessions. While some informants had already given away many of their things in previous moves, others had to dispose of a lifetime of possessions.

> *Do you know what the other thing is in moving from here? It's moving to a nursing home where I can take only a very few things from here. That's parting again. You know -- when these things have been part of your life for 60 years almost.* (6)

Finally, some informants felt that moving into a nursing home placed them at risk for receiving poor care. They believed that although nursing staff may express concern, they were not allowed enough time to carry out their duties and therefore the personal quality of "tender loving care" would be absent.

> *. . . some of the nurses do really care about their patients, and I've heard some lovely, wonderful stories about some of the staff. But, the shortage of time that they're allowed to give to patients is one of the things that some of the nurses complain about -- rather bitterly. They have too large a case-load in order to really give adequate care, and I'm a very human sort of person, and I like communicating with other people, and if I was stuck in a room with somebody who couldn't communicate, then I would hope the staff could do this. But, from what I've picked up, the staff are so over-used that they never have time.* (10)

While informants acknowledged their need for assistance in the intimate tasks of *being able* and that such assistance was available in the nursing home, they wanted to go somewhere where they could receive such care outside of a nursing home environment.

> *When I came here I didn't feel I was coming to a nursing home. It was a retirement home. And I can get care there, without, you know, feeling that I was in a nursing home.*(6)

For some informants, the thought of living in a nursing home was so repugnant that if they had to live in such an environment then they would prefer to be cognitively disabled.

Informants' perceptions of the limited availability of "good" nursing home beds prompted them to take action to ensure themselves placement of their choice. Belief in the necessity of "getting on the nursing home waiting list" sparked "insurance-type" activities prior to a crisis event.

> *I put my name down then for the nursing home. . . . my daughter feels that I need that as a bit of an insurance plan. . . . It's a two year wait anyhow.* (10)

Informants would allow their name to rise to the top of the preferred nursing home's waiting list. If their name came up before they were ready to go, they would refuse placement and ask to be put to the bottom of the list. This activity would help them retain more control over when and where they would be placed should the necessity for placement arise.

> *I was worrying about it. Felt I needed to have something that I knew where I could go. And of course there's such a waiting list, just -- there on the nursing homes -- especially the better ones.* (6)

> *We'd like to have our name in there so that if we decide to give it up, we'd have a chance to get in -- when the next opportunity comes.* (4)

The right to refuse placement was appreciated. However, informants perceived this right to have a negative side. They felt that if they got on the waiting list too soon and refused to accept placement too often, then "the system" would resent their refusals and be reluctant to assist them when the time to go to a nursing home actually came.

> *And it's been more or less said to me that if I were to sign myself out or to get myself out of the system that I would be placing myself in jeopardy. In jeopardy for any future care. Any future help . . . by not accepting their advice and what they have to offer.* (10)

How soon to initiate contact with the system became a dilemma, as informants had difficulty clearly predicting their care needs of the future. Further, some informants expressed a reluctance to contact the system for fear of losing control over their own destiny.

> *. . . the doctor said that if I didn't recover fast enough that I would have to go to a nursing home. This reminded me of that gentleman that I had heard speaking, who said that it was dangerous letting yourself become part of the system. And I realized that I was actually now part of their system, and it was very, very frightening because I was losing control. The control of my life, which I resented. Decisions were being made for you . . . perhaps there aren't any alternatives.* (10)

Time to Go

Informants held on for as long as they could but eventually their inability to independently carry out the work of *being able* forced them to consider placement as a real, albeit regrettable, alternative.

> *And when you're so sick and so weak, you just think, "Oh, what the heck's the use?"* (5)

Having eliminated all other care possibilities, informants perceived themselves to have no choice but to seek nursing home placement. This was a difficult conclusion.

> *I think the feeling is . . . that somehow it's the last step. And taking that last step is not easy . . . . I'm taking a step that is leading to the end. And you feel when you go into that nursing home, "This is the end" in many ways. And this will be your home until you die.* (6)
>
> (Wife speaking) *It's the hardest (point in life).*
> (Husband speaking) *Well, if there's one thing you know, always all your life, you get sick, well you're going to get well again, but here, moving here, that's one step down you'll never step back up again.* (4)

Informants spoke of accepting the decision because "they had to".

> *-- it's come to the point where I have to like it, or else. I can't keep changing from one place to another. It's too hard on me.* (5)
>
> *Yes, it's hard for me. But I have to tell myself, "It must be."* (3)

Acceptance of the no choice situation of nursing home placement occurred over time, if at all. The tone of the decision is best described as one of resignation.

> (Informant) *You wake up in the morning, you think, "Well, I've got to get up and do that." And you gotta think, "No, you're gonna fool around and do nothing." It bothers.*
> (Wife) *It bothered very much awhile ago. He's kind of getting used to it.* (4)

Once acceptance of nursing home placement was reached, informants spoke of "time to go".

> *I had a feeling -- the time is here. It is hard for me to leave the house, but I thought it must be.* (3)

In those instances where informants had a part in the discussion, but did not agree with the decision, they believed that their placement was not the result of time to go, but rather was imposed by others.

> *Well, what else can I -- I got to make out, because that's the only place I am. So what you going to do? I got to make out.* (1)

"When and Where" Considerations

Once placement was chosen as the only alternative, informants turned their attention to issues of when and where. Most informants expressed frustration that once they had decided to go, a nursing home bed was not available. They found that "when" and "where" were not within their control but rather up to the "authorities".

Even though they could not always fulfill their wishes, informants expressed a variety of desires regarding their preferences in accommodation. These secondary considerations included the nursing home's proximity to friends and relatives, religious preference, a satisfactory physical environment, such as access to a window, the wish for a single room, a "nice roommate" and available social activities. Secondary considerations also reflected the desires of family or friends.

> *He would like me to be in that nursing home. He didn't think it was the best, because he went with me, but the other one is farther for him, and he's at the stage where he's losing his eye-sight so another year he might not have his driver's license.* (6)

If the crisis event did not leave informants totally dependent, then they attempted to hold on until a nursing home bed reflecting their secondary considerations became available.

> *Now my desire, if I do get on that waiting list, it would be a two-year wait. And then can I stay on my own for that length of time? If I can then that is something that I will strive to reach, and so that at least maybe at that point then I can have what I would like.* (10)
>
> (Wife speaking) *He says, "No", he's not going to go there and let me stay here. So's that's that.*
> (Husband speaking) *It kind of soured us on the nursing home. They said they only take one at a time. And they're insisting on taking me alone. Well I'm not going to do that . . . . We are not really ready for that.*
>
> (Two beds became available, that met their requirements)
>
> (Husband speaking) *It just happened -- they said once in a million years that two people would move out together. Two girls that was here, and they moved out at once. And that left a hole for us to crawl in. And we crawled in.* (4)

However, if the crisis placed them in a totally dependent state, then the first available bed was taken or imposed upon them. When a bed in the facility of their choice became available, they would relocate a second time.

> *. . . this other one seemed so over-crowded . . . That is the one where when people first go in a nursing home and go on an emergency basis, that is one where they're always sent. I thought, "Well, what one would have to do would be to survive an emergency period and then you would have a chance of going to a place that you would choose, rather than where you'd have to go."* (10)
>
> (Daughter speaking) *. . . at the hospital they decided that she had to give up her bed. Someone else needed it. She had to go to a*

> *nursing home somewhere. I said it would be nice if I could get her into the west end somewhere . . . but you just wait until there's an empty bed somewhere -- just go where there's a first vacancy.* (2)

In a crisis admission, the initial nursing home was perceived by informants as a holding place to be tolerated until something better came along rather than their permanent home.

Taking the Last Step

Moving into a nursing home was not only emotionally difficult for informants, but also posed organizational problems. In order to take a vacant bed, relocation had to occur over a short period of time. If the individual was not ready to relocate, the bed might be given to someone else.

> *All at once they phoned on a Thursday -- we want you in here by eleven o'clock. Both of you. We had to be in there by Friday. Well, then Ben got on the phone and he talked them into waiting until the first of the week. And they did that. And we came on Sunday.* (4)

> (Daughter speaking) *On Friday, she said, "Oh, there's a vacancy now." And I said, "That's lovely. When should she come?" She said, "She's got to be there on Monday, or someone else will take it." So of course this was very fast, from Friday to Monday.* (2)

This perceived short response time presented problems for informants and their families in pre-planning.

> (Daughter speaking) *I had to contact the special bus and so on, and -- I phoned on Friday, actually, to book it for Monday. "Oh no, we can't book that far ahead." I thought, "What! The farther ahead the better." No. You gotta phone either Saturday or Sunday. I said, "I'm not even going to be at home." So I thought "Well, I've got to work this in somehow." So I phoned Saturday.* (2)

Informants experienced a dilemma in knowing how to time arrangements. Someone had to be available to assist with the move.

Family schedules had to remain flexible. Timing the dispersment of their possessions also posed problems. They could not give away possessions that were needed if the move was not going to take place immediately, neither could they give up their apartment if they were staying.

> *We was going to have a garage sale, and we don't know whether to have it or not because seems we need to use it if we're going to stay.* (4)

Apart from organizational problems of knowing when and where the move was to occur, informants spoke of other preparation tasks involved in placement. These tasks have been labeled "relocation work".

Relocation Work

Once the decision for placement was made, informants became involved in the work of relocation. This work started prior to relocation and was often continued after the physical move took place. Relocation work can be grouped into sets of tasks named "giving up" and "taking on". Examples of relocation work included disposing of possessions, obtaining new possessions, and preparing a strategy for managing in the nursing home.

Managing Possessions. Managing their possessions was very important. Informants were concerned about which possessions to take into the limited space of their new environment, which to give away and which to sell.

> *I had to give up a lot. I lost all my things. Naturally, I miss my stuff. . . . I can't bring much and they're gonna storage my stuff in their basement.* (1)

Many informants had already experienced one or two moves in the past. These individuals were not as concerned with giving up possessions as much as those who had been living in one place for a long time. Informants' families were actively involved in the decision of where things should go as well as in organizing and moving.

> *He's (son) pretty busy right now, getting rid of all our junk. It's funny how much stuff you've got when you're disposing of it . . . Him and his wife have painted the whole house inside.* (4)

> (Researcher) *You were the one that had to do all the physical moving and the arrangements.*
> (Daughter) *Oh yes. She can't do anything at all like that herself.* (2)

Informants who owned their own home were able to continue deciding on where their possessions should go after their move into a nursing home. Informants who were living in rented accommodation often had difficulty dispersing their possessions because of time constraints. They had to organize their things quickly, pay extra rent or store them until decisions could be made.

> *My daughter-in-law has given notice. They're going to have a garage sale. . . . There's no use my paying for both places.* (1)

One couple also stated that they were involved in gaining possessions. They viewed the nursing home as a public place, where their belongings would be seen by strangers. Therefore they prepared for their move by purchasing a pair of comfortable chairs and quilts they felt would be suitable to be seen in public.

Organizing the Move. Organizing the actual move took place over very short time periods and required the assistance of family. All informants in this study had family or friends available. Organizing activities included making and carrying out the arrangements for transportation, moving possessions and contacting involved professionals. Where secondary considerations involved further moves, family members continued in this role.

Changing Expectations of Self. The informants spoke of taking on a new identification of "self-as-dependent" while giving up independent activities. This was difficult for them to articulate. Most informants spoke of feeling sad but accepting of their limitations.

> *And after that, it was this feeling of, "Well, it's the end of the road." You've got to give up so much to get that care.* (6)

Planning Strategies for Coping in the Nursing Home. Regardless of how they felt about placement, all informants had thought about how they would cope once they were in the nursing home environment. They talked of the anticipated losses and benefits of relocation. Their perceived losses included the loss of privacy, friends, dignity, and independence in daily routines. They attributed the losses to the nursing home environment rather than the deficits that had placed them there.

Informants tempered their thoughts of losses with thoughts of what was to be gained. They expected to receive extra help in personal care and in meal preparation as well as an enhanced sense of security because there would be always be someone available.

> *We're going to cooperate and be happy with it. Realizing that it's the best thing -- the best thing that happened to us.* (4)
>
> *I'll take it as it comes. Step by step . . . I don't think one needs to make a fuss about it. I've known some women who've gone into nursing homes and they're very dissatisfied. I know some of them are nicer than others, and you're put with people, undesirables, and so on and so forth, but these are the things in life we've got to put up with.* (2)

All informants in this study considered themselves to be cognitively intact. Their greatest fear was to have to manage living with individuals who were not. Their strategies to deal with this anticipated problem included plans to isolate themselves in their rooms to avoid contact or simply putting up with the mentally impaired because they had no choice.

Most informants expressed doubt that mentally alert individuals such as themselves would be available for socialization. They tentatively put forward the hope that nursing home staff would fill this need but at the same time believed that staff would be limited in the amount of time available "just for talking". They feared that the resultant social isolation would have to be tolerated.

The one informant who looked forward to her nursing home placement possessed an attitude unique among the interviewed informants. She believed that she was still alive because she had things left to learn. With that purpose in mind, she was determined to go to the nursing home to find out what it was she could learn there.

> *I'm not looking for it to be difficult, dear. I'm looking for it to be easy. I think so often we build up things a lot. No, I can -- even if I get in with a woman that is nasty, remarks and so on, one can learn to shut their mouths. As I say, we are always learning.* (2)

The majority of informants believed that nursing home placement was something that they had to endure, day by day, until they could die.

Summary

The "Considering Placement" process is an example of the generic process, "Taking Care of Self". Like the process of "Taking Care of Self", the "Considering Placement" process is the result of change. The difference between the two processes is reflected in the magnitude of the change. While on one hand, informants expect the change events because of age and physical condition, it is unexpected as a personal experience. Informants weighed care alternatives and eliminated all other possibilities before considering nursing home placement. Informants who were placed before they had the opportunity to eliminate other resources believed their placement was premature.

All informants considered placement as their last choice and believed they had no choice but to be placed. The belief that they had no choice dictated the timing and site of relocation because of the perceived availability of "good" nursing home beds. Once acknowledging that it was time to go, informants contacted the formal care system in order to be placed on the nursing home waiting list. Having been accepted as eligible for placement, the work of relocation began. Relocation work included organizing the move, distributing their possessions, obtaining new possessions, changing their self-perceptions and planning strategies to help them cope with the new environment of the nursing home.

For the most part, although the process of "Considering Placement" was one of the most difficult challenges of their lives, informants accomplished the process tasks and expected to adjust to nursing home life. Sufficient time and opportunity to participate in the process was considered necessary by informants for a positive experience.

> *If I were to make the choice, if the situation changed sufficiently that I recognize the fact I absolutely had no more alternatives, and I couldn't manage, then I think I would probably accept more easily.* (10)

Informant Response Types

Informants' responses to "time to go" in the "Considering Placement" process varied between individuals. Although all informants (with the exception of two) had been assessed by placement nurses as eligible for nursing home admission, not all informants *experienced* placement in the course of the research. Informants also differed in their acceptance of placement and with the degree of participation they had in the decision-making process. A matrix (see Table 5) illustrates the eight possible combinations of these three factors.

Table 5

Time To Go: Informant Response Types Matrix

Informant Agreement with Assessment	Informant Placement Experience	
	Experienced	Not Experienced
Agreed		
With Participation	Positive Anticipation	Delaying
Without Participation	Active Abdication	Placement Not Yet Considered or Active Abdication
Disagreed		
With Participation	Positive Abdication	Avoiding
Without Participation	Placement Imposed	Considered not eligible

As can be seen in Table 5, the researcher identified eight types of informant responses to the consideration of placement: a) positive anticipation, b) passive abdication, c) active abdication, d) imposed placement, e) delay response, f) responses where placement was not experienced because of ineligibility, g) avoidance, or h) placement considerations were inappropriate. All informant response types were captured directly or indirectly in the research sample.

There was evidence of informant movement between response types over the six months of data collection and analysis. For example, none of the informants began the process of "Considering Placement" positively anticipating their relocation. However, three individuals moved to that position from other points on the matrix. Informant movement between response types depended upon changes in circumstances and the time available to them for completing the "Considering Placement" process. The following is an explanation of the informant response types including a comparison table of common characteristics and a schematic presentation of the "Considering Placement" process illustrating the various responses.

Response Type Characteristics

Informant responses to the "Considering Placement" process were influenced by the actuality of placement, informant agreement with placement as the alternative of choice, and informant participation in the decision-making process. Three other factors also impacted upon informant response, including informants' self-assessment of *being able*, their feelings about nursing homes and informants' beliefs regarding satisfactory elimination of other assistance alternatives. Discussion about each response type follows.

Positive Anticipation Response. Informants who exhibited a positive anticipating response expressed the desire for or resignation to the reality of nursing home placement. These individuals were placed, agreed with the decision, and participated in the process.

Although informants may not have been happy that their circumstances brought them to the position of requiring placement, they were content that all other alternatives had been considered and eliminated. They believed that their placement was necessary and would help them meet their needs.

> *It's the right thing to do. That's what I feel about it. It seems to be, it seems to be the right thing to do. . . . I'm not looking for it to be difficult, Dear. I'm looking for it to be easy . . . it's learning for me all the time. I haven't ceased learning and I hope I can keep on learning.* (2)

> *I feel the nursing home is the right place for me, because I cannot live alone.* (3)

Having accepted the need for placement, positive anticipators actively sought the "right" nursing home that would meet their secondary considerations.

Abdicating Responses. Abdication referred to informants' acceptance of others' assessment over their own. Abdication was active or passive. Active abdication was expressed as acceptance with the decisions of others because others "know better".

> (Informant) *I'll go anywhere. . . .I'll just let them put me where they can, you know. . . . . .I think it had gotten to the stage where I can't -- it's out of my hands entirely. It's up to the authorities.*
> (Researcher) *You didn't expect to be part of this process* (making

> the decision for placement)?
> (Informant) *No, not at all. . . .I'm perfectly content to let things happen. . . .I cooperate as best I can. I don't say no to anything -- just try to cooperate -- that's what we're here for. . . .I know some of them* (nursing homes) *are nicer than others, and you're put in with people, undesirables, and so forth, but these are the things in life we've got to put up with.* (2)

These informants had no desire to participate in the consideration of care alternatives or placement and expected others to make the decisions on their behalf. They were content to agree with whatever decisions were made for them and, once these decisions were made, became positive anticipators.

Passive abdication was compliance with the decision of others under protest. Passive abdicators believed that, although they disagreed with others' assessments, they were powerless to change them, and had little choice but to comply. They stated that their compliance met the needs of others. Their own needs were considered secondary in importance.

> *The reason for me being in a nursing home wasn't on account of my old age. Of course not. But it was quite reasonable to realize that the boy and his wife both would be gone, which he had earned the right to be gone. And I shouldn't be selfish. . . .I'm going to be by myself and she didn't want that. She says, "Nothing has ever happened to scare us yet, but I don't want it to And I'd feel much easier if you were in", at that particular time, "a nursing home."* (8)

Movement of the passive abdicator to positive anticipator prior to placement was witnessed, though there was evidence that informants moved in this direction following their admission to the nursing home.

> *. . .all I could do, to make it easier for them to -- if they could get me in a home, they looked all over the doggone country checking here and there and everything else until they finally ran onto this place. And as far as I can see, they couldn't have found a better place than this.* (8)

Imposed Placement. The difference between imposed placement and passive abdication was the degree of informant input into the placement decision. Where placement was imposed, informants disagreed with the decision and believed they had no input into the process. They expressed anger in their belief that other care alternatives were being withheld from them.

> (After bowel surgery). . . .*they came in one day and said that I was going to a nursing home. Placement worker, I think. Well, I was so weak and so sick that I knew that I didn't have much choice, you know. And I thought -- I had no idea what nursing homes were. Not a thing. I'm telling you, you know -- nobody -- this is how dumb I was concerning things, 'cause I never had anything to do with them. So anyway, I was taken to this nursing home, and I was put in a room with four.* (5)

Considered Ineligible. This category included individuals who were considered ineligible for placement by others, although they themselves believed placement was necessary. One informant fitted into this category prior to her involvement in the study. She was eventually accepted for placement, first on compassionate grounds to allow her to move with her husband and later because of an abrupt change in her health status.

> (Son speaking) *The doctor has signed the papers for a nursing home for Dad first and then we've asked for Mother because the nursing home will only take him. So now she has filed for compassionate ground that she could go.* (4)

Delay Response. Delay response is best captured by the statement, "I know that I need placement, but not yet." Informants who delayed their consideration of placement or the actuality of placement were in the process of eliminating other alternatives before agreeing to be placed.

> *Well, she said, "Mother, you know," she says, "I think that you know what you want to do, and -- you make your choice." Well, I certainly didn't want to go to the nursing home. Definitely not.*

> *And so I chose to come back here. Mind you, I'm so dizzy now that, like speaking to you, I just don't know how much longer I'm going to be able to.* (5)
>
> *. . .they* (placement nurses) *decided if we're not ready for a nursing home, we should go into a lodge. Well, we went to a lodge, but nobody's there but old folks like ourselves. And if we get into trouble, there's nobody to help us at all. . . .I can get the neighbour far quicker than somebody out at the lodge. I argue that we are better off here.* (4)
>
> (Granddaughter speaking) *So we set that up and had the assessment done. I was surprised a week later when she phoned me and said, "I don't want to move into anywhere until the spring." She was firmly set, that she was going to be staying in her house. . . .it was just that everything was there and seemed to be ready, and she just suddenly said, "No!"* (3)

If placement occurred before informants had the opportunity to eliminate other alternatives, then they became passive abdicators or experienced imposed placement. If placement occurred after informants eliminated all other alternatives, then they became positive anticipators.

Avoiders. Informants who were assessed by others as needing placement but who disagreed with this assessment and refused placement were categorized as avoiders. These individuals believed that the cost of institutionalization far outweighed the benefits.

Avoiders actively sought other alternatives to meet their needs against the wishes or advice of others. If appropriate alternatives did not exist, then these informants believed that alternatives should be created. They expressed frustration, anger and fear of a system that could not meet their growing needs outside of an institution. One informant implied that the ultimate avoidance was death. To many informants death was preferred over nursing home life.

> *. . .I certainly have known enough seniors who also feel quite strongly when they are well, and before things happen they will make statements such as, "If I ever found myself in that position, I would make certain that things wouldn't happen. Somehow or another I would get rid of my life, because I wouldn't want to take what I see these people now taking in these poorer nursing homes." Therefore the only way that they can see now to avoid it, is to just not live. Which is suicide.* (10)

Avoiding informants interviewed in this study did not experience placement. The possibility of their changing their opinion should placement occur remains unknown.

Placement Not Yet Considered. Two informants had yet to consider placement as a personal experience. They believed that they were able to continue to carry out the tasks of *being able* independently. Consequently, although they were involved in the process of "Taking Care of Self", they had not initiated the process of "Considering Placement".

> *I'm not quite as fast as I -- I'm a little bit slower, but I -- really, as I say, I can do the things that I used to do. Like -- you know, like, my daughter will worry about me going to get my groceries by myself when she can't go with me, but I'm perfectly able to. Like, and I take a cab, so they lift the groceries in for me, and the girls are very good at making sure that I don't have to do any lifting. But, you know, what I mean -- so -- and I can go over town on my own still, and do the things I have to do. My banking and things like that.* (7)

> *. . .I have all my faculties and am able to do things. but when I get dependent to -- and -- well, like a vegetable, I would like to go to the nursing home.* (9)

From the above discussion, it can be seen that responses to the consideration of placement are dependent upon the individual's beliefs and circumstances. The following illustration summarizes the differences in the process of "Considering Placement" according to response (see Figure 8).

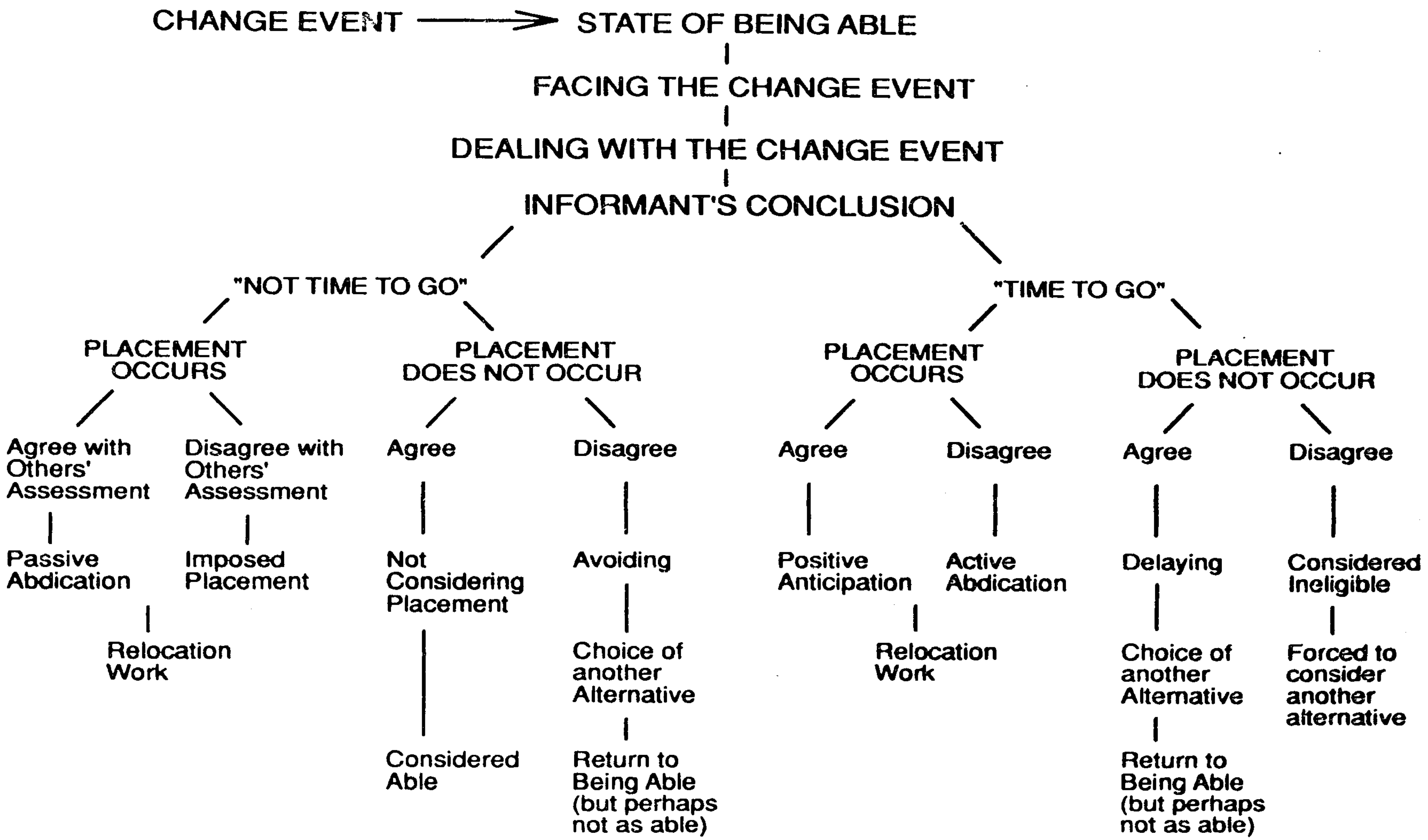

Figure 8. Responses to the Process of "Considering Placement"

Summary

In conclusion, two processes were identified in the course of the research project, the specific process of "Considering Placement" and the generic process of "Taking Care of Self". Informants experienced both processes in response to change events accompanying aging. Eight types of informant responses were identified based on the characteristics of the informants, their agreement with the placement decision, their participation in the consideration and decision-making process, and the actuality of the placement event.

Chapter V: Discussion

The purpose of this study was to describe the elderly person's perspective of consideration of nursing home placement. Informants' comments supported past researchers' conclusions that placement *is* considered a "last resort", and that all other alternatives are investigated and eliminated prior to its consideration (Johnson and Werner, 1982; Smallegan, 1985). Ability to take care of self emerged as the basic social process explaining the phenomenon under study: the consideration of placement. In this chapter, the results of this research will be compared with the findings of past research. Implications for nursing practice, education, and future research will also be discussed.

Transition

Informants moved from a state of *being able*, to a state of *being not as able*, in response to one or more changes in health and/or environment (see Figure 9). During this transition, they may have considered nursing home placement, but they perceived placement as a future possibility rather than an imminent reality. When the intensity, number or timing of change events became an insurmountable barrier to managing the tasks of everyday living, informants considered themselves to be unable to take care of self. Their inability to manage was described as a crisis. They moved from a state of *being not as able*, to a state of *being unable*. Placement was then considered.

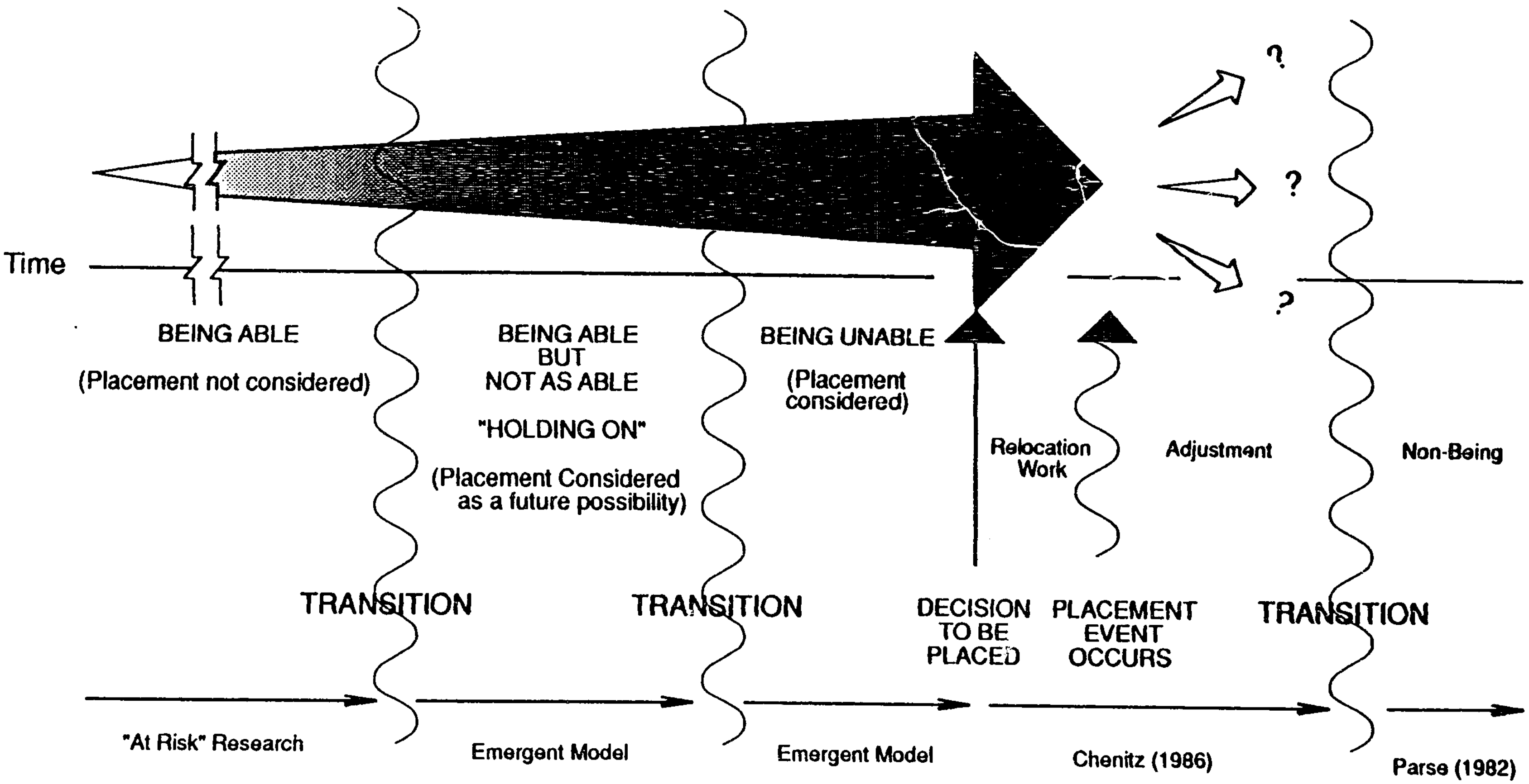

Figure 9. Ability to Take Care of Self Model

Depending upon the outcome of the consideration of placement, some informants were accepted for admission and began the work of relocation. Other outcomes included remaining in a state of *being unable* without any subsequent change in behaviour, or regaining a state of *being not as able*, but continuing to hold on. The vacillation between *being able*, holding on, and *being unable* described in this research has not been specifically documented in the other research reports reviewed by this researcher.

Potentially, individuals could regain a state of *being able* following a crisis although this transition was not witnessed. Selection of individuals expecting a short-term nursing home admission, for the purposes of rehabilitation or recovery, may have provided insight into this type of situation.

The existence of pre-relocation change prompting placement decisions are well documented (Brody, 1977; Chenitz, 1986; Linn and Gurel, 1972; Martin Mathews, 1988; Mirotznik and Ruskin, 1984; Rutman and Freedman, 1988; Smallegan, 1985; Stein, et al., 1985). This researcher found that these pre-relocation changes in fact affected informants' perception of self. Informants' alterations in their definition of self as *being able*, *being not as able*, or *being unable* was the impetus for the consideration of placement. That is, change in self-perception became the pivotal point. This shift in focus to self-perception rather than precipitating "at risk" factors, may provide an explanation for individuals' varied responses to similar change situations.

Nursing home placement was found to be one outcome of change in informants' status. Informants measured their ability to manage through two indicators, that of body function (such as energy levels and freedom in movement) and that of successfully accomplishing daily living activities (as encapsulated in the three sets of tasks involved in *being able*). The results of this study are similar to those found by Daatland (1985). He determined that elderly couples judged their self-sufficiency to be directly related to mobility levels that enabled or hindered their completion of everyday tasks. The present research findings indicate that informants measured management of everyday living tasks both quantitatively and qualitatively, in that, not only did informants state they were *unable* if they couldn't manage, they believed they were *not as able* because they couldn't manage as well.

Informants' movement between self-perceptions of *being able, being not as able*, or *being unable* is captured in the term transition. Glaser and Strauss (1971) incorporate the meaning of transition into their sociologic theory of "status passage". "Status passages entail movement into a different part of the social structure, or a loss or gain of privilege, influence or power and a changed identity and sense of self, as well as changed behavior" (Glaser and Strauss, 1971, p. 2). Two types of status passages exist: (a) reversible and (b) inevitable. Reversible status passages refer to changes that are within the control of the individual and are undertaken in interaction with others.

Glaser and Strauss (1971) consider aging to be an "inevitable status passage" (p. 14). That is, aging is not preventable and the individual has no power to ensure that changes do not occur. The individual's course through an irreversible passage is "socially determined and institutions (educational systems, social welfare and health care) and organizations (schools, homes and hospitals) are in place to manage, direct and control them" (p. 15).

Marshall (1980) has identified two dimensions of status passages: (a) objective definitions including physical and social time and space, and (b) subjective definitions including awareness of the objective dimensions of the passage, whether the passage is considered voluntary and the degree of importance attributed to the passage. Using Marshall's (1980) terms, the objective components of nursing home placement would include the change events initiating the passage, the availability of alternative forms of assistance, and the availability of nursing home beds. Subjective components of nursing home placement would include informant feelings about themselves, the variety of care alternatives and the nursing home, their judgment about the necessity of task management, and the perceptions of involved others and society as a whole.

In the context of these definitions, nursing home placement may be perceived by informants and others as a reversible or an inevitable status passage, depending upon their perceptions of self and situation. The objective and subjective components of nursing home placement constantly interact, and together bring about a response to placement consideration. This may also provide an explanation for incongruencies between informants and their significant others in the consideration of placement. Where incongruencies existed, there was overt or covert informant resistance. Incongruencies (decisions with which the elderly person disagreed) prohibit individuals from legitimizing their relocation (Chenitz, 1986).

The final transition category included in the Ability to Take Care of Self Model incorporates the idea of "non-being", as proposed by Parse, Coyne and Smith (1985). In their ethnographic examination of the aging experience, elderly informants perceived growing old as "a multidimensional complexity of the aging process as one journeys toward the inevitability of non-being" (p. 87-88). This perception of aging was shared by informants in this study. Many informants spoke of expecting to die. Death was looked upon as an expected inevitability and nursing home placement was perceived as a reluctant step toward that inevitability.

Control and Participation

The differences between reversible or irreversible status passages, as noted by Glaser and Strauss (1971) incorporates the element of the control over passage direction. When a change event interfered with informants' ability to take care of themselves, they were obligated to respond by either changing their manner of managing, putting up with the difficulties or giving up the activity. The change events that provided the impetus for nursing home placement were unexpected and beyond informants' control.

In this study, there was evidence of varying degrees of control over the placement process. Informants first decided if a response to change events was required, and then considered and eliminated care alternatives. Informants expressed a desire to remain at home, caring for their own needs as long as possible. In an effort to meet this goal, some informants responded to change events by holding on. While they had lost control over change events that increased their vulnerability, they strove to retain control over their choice of alternatives in order to avoid nursing home placement as long as possible.

With the exception of the active abdicator, informant control over care alternatives became more important as control over changes became more difficult. Even the active abdicator controlled her situation by communicating likes and dislikes to her daughter, knowing that her daughter would act on them.

Most informants stated that their circumstances forced them to consider nursing home placement. They believed that they had no choice. The nursing home was their only option because they felt they had failed to manage their tasks of *being able*. Although the positive aspects of receiving twenty-four hour assistance were acknowledged and, in some instances, stated as the reason for placement consideration, informants did not expect to *be able* within the confines of an institution. Rather, informants stated they expected to get by or to manage out of necessity.

Elderly persons' degree of participation in the decision for placement has been reported in past research. Martin Mathews (1988) examined congruency between participants' perceptions of involvement, rationale for placement and satisfaction with the outcome. She found that family members were considered to be the most involved in placement decisions and that elderly persons played a minor role. Despite their lack of participation, 71% of elderly subjects and family members were satisfied with the admission outcome. Neugroschel and Harwood (1985) reported similar findings. In their study, family members were the most involved in making placement decisions and elderly persons' opinions were infrequently sought.

In contrast, all informants in this study reported experiencing some degree of participation in the placement decision, even though two informants were placed against their wishes. The differences in level of decision-making participation observed in this study as compared with past research may be attributed to the types of selected informants. Both Martin Mathews (1988) and Neugroschel and Harwood (1985) sampled a large variety of subjects including those considered unable to make decisions because of cognitive impairment. It is understandable that families may be more involved in these circumstances. As this researcher purposely selected articulate informants, deeply involved in the consideration of placement, the degree of family involvement may not have been as intense with this sub-group of pre-relocation individuals. The focus of the present research on the elderly person's perspective and not the family member's may also have contributed to the difference in results.

Subjects' sense of control over nursing home placement has been studied by Arling, Harkins and Capitan (1986). They found that institutionalized individuals who were "the least functionally or cognitively impaired, had less sensory impairment, did not anticipate institutionalization, had experienced fewer negative life events, had more education, lived alone or with their spouse and had greater social contacts" (p. 47), expressed higher levels of personal control than more dependent individuals. Levels of perceived control with the same subjects prior to institutionalization was dependent upon "the level of functional impairment, cognitive impairment and sensory deficits, and the amount of social contact" (p. 52). Arling, et al. concluded that personal control is related to the individual's objective capacity to carry out tasks of everyday living, the availability of social support and the level of stress experienced from concurrent negative events. These results are supported by this research.

Arling, et al. (1986) also found that the stress of anticipating relocation did not carry over into institutionalization. Similar results were documented by Brody, Kleban and Moss (1974). In the present study, informants experiencing relocation stated that they had experienced initial difficulties with their new environment, but as time progressed, became more comfortable.

There is concern expressed in the literature regarding the apparent lack of participation by elderly persons in decision-making. Hofland (1988) stated: "Despite general agreement that older adults in long-term care are entitled to maximum possible self-determination and dignity, others tend to make a variety of decisions for them, resulting in an erosion of personal autonomy" (p. 3). He further noted that research has shown that a lack of control affects emotional, physical and behavioral well-being of nursing home residents.

Dubler (1988) states that the elderly person's participation in nursing home admission consideration is particularly important because such decisions are usually irreversible. As there is an apparent society-bound stigma attached to a need for nursing home support, the consideration of placement produces ambivalent feelings. Dubler believes these feelings are of substantial and appropriate concern to patient, family and health professionals and should not be ignored.

In this study, considerations of "if", "where" and "when" were important to informants and determined the differences between observed responses to change events. It must be remembered, however, that the research was purposely limited to investigate only one aspect of the triad involved in placement decision-making. The perspectives of health professionals and family members were not the focus of this research beyond their influence as perceived by informants. The factors that influenced informants' actual or perceived degree of choice involved all of the factors in the consideration and elimination of care alternatives, including the perceptions of others.

Degree of choice also depended upon informants' opportunity and desire to participate in the decision-making process. Opportunity for participation was contingent upon having adequate time and energy to make a choice. Some informants had considered and rejected nursing home placement many times before reaching "Time to Go". Desire for participation was a factor in informants' degree of control through choice. In one instance (active abdicator) opportunity for choice was provided but not taken. Woodward and Wallston (1987) state that such abdication is common in older persons because they fear that they will err in their judgment. This response was not common in this research sample as only one of ten informants chose the active abdication response. The small number of informants actively surrendering their decision-making control to others may have been related to informants' level of cognitive ability or because the researcher actively sought different informants in order to determine a wide range of responses rather than a large number of individuals sharing one response.

In a second instance (avoider), the informant was told that placement was necessary "for her own good". However, the informant chose to ignore the advice of the health care professionals. She made her decision against their wishes. Conflict arose in both the abdicator and the avoider situations because informants' desire for control or lack of desire for control was not recognized or respected.

One disturbing aspect in the consideration of placement was informants' perceptions of the nursing home environment. Nine of the ten informants believed their life in a nursing home would be a negative experience. Most felt they would rather be unaware of their admission and all wished that they could have died before relocation occurred. *Non-being* was preferred over a state of *being unable*. Not choosing to control the timing of their own deaths, informants attempted to control their situation by delaying or avoiding admission, or making premature referrals to "good" nursing homes.

Informants' negative impression of nursing homes, while disturbing, is not surprising. Other researchers have reported similar subject impressions (Barney, 1977; Branch and Jette, 1982; McCauley and Blieszner, 1985). The negative image of the nursing home as society's method of placing the unwanted and unsavoury out of sight emerges from a long history of prisons, poorhouses, asylums and large dormitory-like institutions (Cole, 1987; Forbes, Jackson, and Kraus, 1987).

Stein, et al. (1985) proposed that increased awareness of the individual's anticipated stresses after relocation to a nursing home would assist caregivers in mediating that stress. As in this study, they found that institutionalized elderly were not a homogeneous group, and that the kinds of stresses informants anticipated varied greatly. The number of anticipated stresses prior to relocation was positively related to the presence of negative feelings about relocation. Pain was found to be a major contributing factor to pre-relocation distress. One informant in the present study expressed a similar observation. She attributed her distress not so much to the pain, but to the draining of available energy she may have spent in holding on.

Whether or not the consideration of placement involved the informant's participation, they attempted to maintain control over their situation by deciding what possessions would be taken, planning their coping strategies and stating their preference in institution. Schultz and Brenner (1977) stated that these types of activities increased predictability and therefore the individual's control over a strange environment. However, the realities of nursing home regulations and the availability of beds interfered with where and when informants were admitted, as well as which possessions they could take. Informants experiencing change leading to active treatment hospital admission felt they were compelled to accept the first available nursing home bed in order to free the active treatment bed. The only control informants identified themselves as having was the choice to "make the best of it".

Implications for Nursing Practice

Why should the consideration of nursing home placement be of concern to nurses? Two reasons have been identified. First, nurses are involved with elderly individuals in all stages of placement consideration and relocation. Not only are nurses often the "gate keepers" to the nursing home system, they also provide or coordinate formal care alternatives to nursing home placement and provide institutional care.

Second, the domain of geriatric nursing has been defined as the relationship between management of daily living tasks and functional health status (Carnevali, 1986). Changes in the ability to carry out daily living tasks or in functional health status indicate a need for nursing intervention. As the consideration of placement arises out of a change in function and the ability to take care of self, it may be concluded that nursing home placement consideration *is* within the domain of nursing practice.

Researchers have defined consideration of nursing home placement as a difficult decision, in that it is highly subjective and the outcome may not be satisfactory to all involved parties (Dubler, 1988; Job and Anema, 1988; Hofland, 1988; Moody, 1987). Actions must be weighed in terms of benefits to the elderly person and additional harm the interventions may bring about. A placement decision extends beyond the needs and desires of the elderly individual. The concerns and needs of involved family members must also be addressed (Job and Arnema, 1988). Hofland (1988) concludes that "not only must resolution meet the interests of the elderly person and family, their interests must be ethically balanced against the legitimate interests of nursing homes" (p. 5). An ethical decision-making framework for the consideration of placement implies that nurses must determine all sides of the situation and assist involved parties to make a decision that will be satisfactory or, in the least, the least harmful to all.

The goal of nursing home placement consideration is to "determine the best possible plan for the individual" (Brody, 1977, p. 42). The role of the nurse to meet this objective may include advocate, coordinator, resource person and assessor. Brody also states that the belief that community living is more desirable than institutionalization may be a dangerous misconception. She states that the total picture must extend beyond the individual's desire to stay at home. Therefore, the role of the nurse may also include that of mediator in an emotion-laden situation. As has been discussed, many authors recommend viewing the consideration of placement in the context of an ethical decision thus allowing the nurse to promote positive resolution.

Informants experienced a lifetime of taking care of their everyday needs. Change events in later life were managed in long-established patterns. The difference between later life changes and previous changes was the informants' decreased ability to continue to care for self. Nurses, while supporting the positive problem-solving behaviour of the past, need to assist individuals to modify these problem-solving techniques to meet the demands of the present.

The ability to continue to care for self, with the help of others, required knowledge of, and access to, a variety of alternative support systems. Informants were dismayed at the absence of services they felt would have kept them from the nursing home. Examples included helpers who would come into their homes to provide twenty-four hour personal care and homemaking, and an emergency respite facility for short-term acute illnesses not requiring active treatment (colds, influenza). Although provision of such support services are the responsibility of social policy, nurses have input into their development and utilization. However, the value of nursing input is dependent upon nurses' knowledge of what is available and what is needed.

Placement nurses were often contacted by informants or families considering nursing home relocation after much of the deliberation over alternatives was completed. In order to determine the best solution to the management difficulties, nurses need to be aware of the events leading up to the consideration of placement and the involved individuals' perceptions of those events. The researcher has developed a sample question guide for nurses involved in placement assessment (see Appendix 5). The intent of the question guide is to familiarize nursing staff with the events leading to placement. This guide, in conjunction with the Stress Anticipation Inventory (Stein et al., 1985) may be a useful tool for both placement and institution nurses to capture the individuals' perceptions of placement and initiate discussion about their feelings.

Informants were generally unaware of the placement process outside of the fact that they had been considered eligible and were required to wait for an available bed. The majority of questions directed toward the researcher focussed on what they should expect, what they could take with them and when placement would occur. It is possible that answers to these questions were reviewed with informants at the time of their placement assessment. However, the information may not have been important to them at the time, the questions may not have occurred to them or they may have forgotten. Informants knew they could contact the placement nurse, but in many instances were unaware of who the placement nurse was. The development and circulation of a written handout by the placement agency may assist individuals and their families in preparing for placement.

Some informants stated that they were aware of the existence of services but had never expected that the services might be of use to them. Information about all levels of health care services could be periodically disseminated through the media in order to reach individuals who have not yet contacted the system.

The actuality of placement into a nursing home elicited a variety of informant responses. Informants and their relatives spoke of completing relocation tasks after the actual move, including accepting self as needing institutionalization. Institutional nurses must be aware of how placement came about in order to assist clients in completing their relocation work.

Moody (1988) states that health professionals "should demand evidence that the individual considering admission to a nursing home has an appreciation, not merely of the losses, benefits, or risks of the decision in general, but also of the particular style and form of life available in the nursing home in question" (p. 22). Prior to the relocation event, nursing homes could assist individuals in learning about institutions by offering information sessions and tours. Further, nursing homes should contemplate ways of becoming part of their community, to change their image of being a separate entity.

Implications for Nursing Education

There is a growing number of elderly persons living longer with chronic diseases or debilities of old age. The frail elderly live in the community, are admitted to active treatment hospitals, require long-term care assessment and receive hospice care. In almost every field of nursing, nurses are involved with caring for the elderly. Nursing education must, then, include information on human development in later life, and discussion of concepts such as stress, adaptation and self-care should include geriatric examples.

Nursing student placements could include long-term care institutions beyond the intent of teaching methods of providing basic care. However, before such an educational experience can occur, there needs to be a mutual awareness that long-term care facilities have something to teach.

Finally, in order to educate the public about the variety of care services available, nurses must be aware of these services. In the least, nurses must be aware of where to get information about the variety of services.

Implications for Research

The collection and analysis of data in this study is subject to researcher perspective and bias. Certainly other individuals examining the gathered information may have developed different avenues of questioning, leading to different conclusions. The researcher believes that the results reported in this thesis provide a broad overview of the experience of considering placement from the elderly informant's perspective.

Further research is needed to provide more detail about the characteristics of the eight response types and the predisposing events or personal attributes predisposing individuals toward one response over another. Other individual situations that warrant examination, but not captured in the theoretical sampling of this study include individuals: (a) considered ineligible for placement, (b) living with children while considering placement, and (c) expecting a short-term nursing home admission for the purposes of rehabilitation.

Future research could be built on the hypothesis that response to change in ability to care for self is a basic social process. In addition, the hypothesis that perception of self as *able*, *not as able*, or as *unable* explains how the "at risk" factors, identified by other researchers, affect adjustment to nursing home placement needs to be investigated. Investigation into the relationship of self-perception, satisfaction with the elimination of alternatives and the consideration of and subsequent adjustment to placement would also be a valuable inquiry. Finally, the identification of the three task areas (intimate, supportive and outside) and their importance to self-assessment of *being able* would provide insight into individual behaviour and perception.

Conclusion

In the context of the above discussion, the researcher has drawn the following conclusions about the consideration of placement:

1. The basic social process that explains nursing home placement consideration is the individuals' perception of their ability to take care of self.

2. The transition from perceiving self as *being able* to perceiving self as *unable* constitutes a status passage.

3. The change event causing individuals to believe they can no longer take care of themselves constitutes a crisis.

4. Response to the self-assessment of *being unable* may take one of eight directions including: (a) positive anticipation, (b) passive abdication, (c) active abdication, (d) avoidance, (e) delaying, (f) considered ineligible for placement, (g) considering self as *being able*, and (h) imposed placement.

5. Satisfaction with the resolution of the crisis depends upon congruence of the individual's perception of self with others' perceptions of the individual.

6. Where incongruence exists conflict will occur, regardless of whether or not nursing home placement takes place.

7. Resolution of conflict is not always possible. However, the

difficulty of the decision process and the variety of participants' desired outcomes should be recognized.

The Ability to Take Care of Self Model reflects changes in perception of self in response to internal and external change events. It provides a commentary both on informant perception of nursing home placement consideration and the researcher's interpretation of data. As in all research, one study leads to another. Having completed this research, analyzed the data and written the report to reflect what *was*, the researcher is still left with the question: "Is this what *ought* to be?". Cohen (1988) suggests that:

> American ageism is focused upon the elderly with disabilities, as opposed to the well elderly, and further, that the elderly themselves have concluded that when disability arrives, hope about continued growth, self-realization, and full participation in family and society must be abandoned so that all energy can be directed to avoiding the ultimate defeat, which is not death, but institutionalization, which is regarded as living death (p. 25).

Analysis of data from this study supports Cohen's observations. Informants tried as hard as they could to stay in the community. Once admitting that they could no longer remain there, they resigned themselves to an institution. Their perceptions of self and situation were of failure. Involved health professionals (including the researcher) also focussed on informant failures. Cohen (1988) has coined this misconception as "The Elderly Mystique" (p. 24).

Is it not possible to perceive oneself as *being able* within the confines of the institution? Individuals go to a dentist with caries and retain a sense of having done the "right" thing, that is, they have taken care of self by meeting a health care need. Why is the nursing home not considered on the same plane? Why is admission to a nursing home not seen as a positive move toward health?

The theme of successful aging should be able to transcend residential boundaries. Health professionals' focus on the success of aging is to their credit, but must include the enhancement of what is left, as much as the replacement or regaining of what is lost. It is the opinion of this researcher that recognition and promotion of "abilities within inabilities" -- regardless of living arrangements -- constitutes today's challenge for geriatric nursing care.

Footnotes

[1] A number in brackets refers to the informant's assigned number.

[2] Definitions of the discriminating factors in Table 5 are as follows:

1) Placement Experience: informants experienced or did not experience relocation into a nursing home during the research data collection time period.
2) Informant Agreement: informants agreed or disagreed with the assessment that nursing home admission was the appropriate alternative to manage their state of *being unable.*
3) Informant Participation: level of informants' involvement in assessment of their state of *being able*, the consideration of alternatives and the choice of placement over other alternatives.

[3] Arrows indicate direction of findings: ↑ is positive, ↓ is negative

Bibliography

Arling, G., Harkins, E.B., & Capitman, J.A. (1986). Institutionalizaton and personal control. Research on Aging, 8, 38-56.

Bagshaw, M., & Adams, M. (1986). Nursing home nurses' attitudes, empathy, and ideologic orientation. International Journal on Aging and Human Development, 22, 235-246.

Barney, J.L. (1977). The prerogative of choice in long-term care. The Gerontologist, 17, 309-314.

Baum, D.J. (1977). Warehouses for death. The nursing home industry. Don Mills, ONT: Burnst MacEachran.

Beaver, M. (1979). The decision-making process and its relationship to relocation adjustment in old people. The Gerontologist, 19, 567-574.

Beland, F. (1984). The decision of elderly persons to leave their homes. The Gerontologist, 24, 179-185.

Blenker, M. (1967). Environmental change and the aging individual. Journal of Gerontology, 24, 101-105.

Borup, J.H., Gallego, D.T., & Heffernan, P.G. (1980). Relocation: Its effect on health functioning and mortality. The Gerontologist, 20, 468-479.

Borup, J.H. (1981). Relocation. Attitudes, information network and problems encountered. The Gerontologist, 21, 500-511.

Borup, J.H. (1982). The effects of varying degrees of interinstitutional environmental change on long-term care patients. The Gerontologist, 22, 409-417.

Bourestom, N., & Tars, S. (1974). Alterations in life patterns following nursing home relocation. The Gerontologist, 14, 506-510.

Bowers, B. (1987). Intergenerational caretaking: Adult caretakers and their aging parents. Advances in Nursing Science, 9 (2), 20-31.

Branch, L., & Jette, A.M. (1982). A prospective study of long-term care institutionalization among the aged. American Journal of Public Health, 72, 1373-1379.

Branch, L.G., & Stuart, N. E. (1984). Five-year history of targeting home care services to prevent institutionalization. The Gerontologist, 24, 387-391.

Brand, F.N., & Smith, R.T. (1974). Life adjustment and relocation of the elderly. Journal of Gerontology, 29, 336-340.

Brody, E., Kleban, M.H., & Moss, M. (1974). Measuring the impact of change. The Gerontologist, 14, 299-305.

Brody, E. (1977). The decision-making process, assessment, and relocation. In E. Brody (Ed.), Long-term care of older people (pp. 41-58). New York: Human Sciences Press.

Brody, E. (1985). Parent care as a normative family stress. The Gerontologist, 25, 19-29.

Brody, S., Poulshak, W., & Masciocchi, C.E. (1978). The family caring unit: A major consideration in the long-term care support system. The Gerontologist, 18, 556-561.

Burnette, K. (1986). Relocation and the elderly. Journal of Gerontological Nursing, 12 (10), 6-11.

Canadian Hospital Association (1981). Health care institutions -- Terminology and definitions (2nd ed.). Ottawa: Canadian Hospital Association.

Carnevali, D.L., & Patrick, M. (1986). Nursing management for the elderly (2nd ed.). Philadelphia: Lippincott.

Chandler, J.T., Rachel, J.R., & Kazelski, R. (1986). Attitudes of long-term care nursing personnel toward the elderly. The Gerontologist, 26, 551-555.

Chenitz, W.C. (1986). Entry into a nursing home as a status passage: A theory to guide nursing practice. In W.C. Chenitz, & J.M. Swanson (Eds.), From practice to grounded theory (pp. 215-226). Menlo Park, CA: Addison-Wesley.

Chenitz, W.C., & Swanson, J.M. (1986). From practice to grounded theory. Menlo Park, CA: Addison-Wesley.

Cohen, E.S. (1988) The elderly mystique: Constraints on the autonomy of the elderly with disabilities. The Gerontologist. 28 (Suppl.), 24-31.

Cohen, M.A., Tell, E.J., & Wallack, S.S. (1986). Client-related factors of nursing home entry among elderly adults. Journal of Gerontology, 41, 785-792.

Cole, T.R. (1987). Class, culture, & coercion. A historical perspective on longterm care, Generations, (Summer), 1987, 9-15.

Daatland, S.O. (1985). Managing everyday life: the trivial round made significant. In A. Butler (Ed.), Aging (pp. 67-77). London, England: Croom Helm.

Dechant, R.P. (1975). The Alberta nursing home industry. A descriptive study. Unpublished master's thesis, University of Alberta, Edmonton, ALTA.

Dubler, N.N. (1988). Improving the discharge planning process: Distinguishing between coercion and choice. The Gerontologist, 28 (Suppl.), 76-81.

Ebersole, P., & Hess, P. (1985). Toward healthy aging. Human needs and nursing response (2nd ed.) (pp. 116-139). St. Louis, MO: Mosby.

Ekberg, J.Y., Griffith, N., & Foxall, M.J. (1986). Spouse burnout syndrome. Journal of Advanced Nursing, 11, 161-165.

Engle, V. (1985). Temporary relocation: Is it stressful to your patients? Journal of Gerontological Nursing, 11 (10), 28-31.

Engleman, M. (1987, April). Demography and the needs of an aging population. In N. Keating (Chair), Aging in Alberta. Symposium Conducted by the Center for Gerontology, Edmonton, Alberta.

Field, P.A., & Morse, J.M. (1985). Nursing research. The application of qualitative approaches. Rockville, MD: Aspen.

Fielding, P. (1979). An exploratory investigation of self concept in the institutionalised elderly, a comparison with nurses' conceptions and attitudes. International Journal of Nursing Studies, 16, 345-354.

Forbes, W.F., Jackson, J.A., & Kraus, A.S. (1987). Institutionalization of the elderly in Canada. Toronto: Butterworths.

Gallagher, A.P. (1986). A model for change in long-term care. Journal of Gerontological Nursing, 12 (5), 19-23.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine.

Glaser, B.G., & Strauss, A.L. (1978). Theoretical sensitivity. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A.L. (1971). Status passage. Chicago, IL: Aldine, Atherton.

Goffman, E. (1961). Asylums: Essays on the social situation of mental patients and other inmates, Garden City, NY: Doubleday.

Gottesman, L.E., & Bourestrom, N.C. (1974). Why nursing homes do what they do. The Gerontologist, 14, 501-506.

Government of Canada. (1985). Directory of long-term care centers in Canada. Ottawa: Government of Canada.

Grant, P.R. (1985). Who experiences the move into a nursing home as stressful? Examination of the relocation stress hypothesis using archival, time-series data. Canadian Journal on Aging, 4, 87-99.

Grier, M. (1977). Living arrangements for the elderly. Journal of Gerontological Nursing, 3 (4), 19-23.

Gutman, G.M., & Herbert, C.P. (1976). Mortality rates among relocated extended-care patients. Journal of Gerontology, 31, 352-357.

Gutman, G., & Stark, A.J. (1986). Mortality rates five years after admission to a long term care program. Canadian Journal on Aging, 5, 9-17.

Harel, Z. (1981). Quality of care, congruence and well-being among institutionalized aged. The Gerontologist, 21, 523-531.

Harel, Z., & Noelker, L. (1982). Social integration, health and choice. Research on Aging, 4, 97-111.

Hofland, B. L. (1988). Autonomy in long term care: Background issues and a programmatic response. The Gerontologist, 28 (Suppl.), 3-9.

Hulicka, I.M., Morganti, J.B., & Cataldo, M. (1975). Perceived latitude of choice of institutionalized and noninstitutionalized elderly women. Experimental aging research, 1, 27-39.

Job, S., & Anema, M.G. (1988). Elder care: Ethical dimensions. Journal of Gerontological Nursing, 14 (12), 16-19.

Johnson, M.A., & Werner, C. (1982). "We had no other choice". *Journal of Gerontological Nursing*, *8*, 641-654.

Kahana, E.F., Kahana, B., & Young, R. (1987). Strategies of coping and postinstitutional outcomes. *Research on Aging*, *9*, 182-199.

Kane, R.L., & Kane, R.A. (1980). Alternatives to institutional care of the elderly: Beyond the dichotomy. *The Gerontologist*, *20*, 249-259.

Knight, B., & Walker, D.L. (1985). Toward a definition of alternatives to institutionalization for the frail elderly. *The Gerontologist*, *25*, 358-363.

Koran, M.J., & Rossman, J. (1985). Placement decisions in the elderly. *American Family Practitioner*, *32* (4), 147-152.

Kovar, M.G. (1977). Health of the elderly and use of health services. *Public Health Reports*, *92*, 9-19.

Kraus, A.S., Spasoff, R.A., Beattie, E.J., Holden, E.W., Lawson, J.S., Rodenburg, M., & Woodcock, G.M. (1976a). Elderly applicants to long-term care institutions. I. Their characteristics, health problems and state of mind. *Journal of the American Geriatrics Society*, *24* (3), 117-125.

Kraus, A.S., et al. (1976b). Elderly applicants to long-term care institutions. II. The application process; placement and care needs. *Journal of the American Geriatrics Society*, *24* (4), 165-172.

Kraus, N. (1987). Life stress, social support, and self-esteem in an elderly population. *Psychology and Aging*, *2*, 349-356.

LeCompte, M.D., & Goetz, J.P. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research*, *52* (1), 31-60.

Leiberman, M.A., Prock, V.N., & Tobin, S.S. (1968). Psychological effects of institutionalization. *Journal of Gerontology*, *23*, 343-353.

Leiberman, M. A. (1969). Institutionalization of the aged. *Journal of Gerontology*, *24*, 330-340.

Leiberman, M.A. (1974). Symposium--long-term care: Research, policy, and practice. *The Gerontologist*, *14*, 494-501.

Linn, M.W., & Gurel, L. (1972). Family attitudes in nursing home placement. *The Gerontologist*, *3*, 220-225.

Marshall, V.W. (1980). No exit. An interpretive perspective on aging. In V.W. Marshall (Ed.), Aging in Canada. Social perspectives (pp. 51-62). Don Mills, ONT: Fitzhenry & Whiteside.

Martin Mathews, A. (1988). Movement of the elderly into long-term care: Processes of decision-making. Gerontarion, 5 (2), 2. (abstract)

McAuley, W.J., & Blieszner, R. (1985). Selection of long-term care arrangements by older community residents. The Gerontologist, 25, 188-193.

Melanson, P.M., & Meagher, D. (1986). Living in a long-term care institution: Out of the jungle and into the zoo. Gerontion, 1 (2), 26-30.

Mirotznik, J., & Ruskin, A.P. (1984). Inter-institutional relocation and its effects on health. The Gerontologist, 24, 286-291.

Mitchell, J.B., & Hewes, H.T. (1986). Why won't physicians make nursing home visits? The Gerontologist, 26, 650-654.

Moody, H.R. (1987). Ethical Dilemmas in nursing home placement, Generations, (Summer), 16-23.

Neugroschel, W.J., & Harwood, L. (1985). A model of consumer decision making in the selection of a long-term care facility. The Gerontologist, 25 (Special Issue), 25, (Abstract only).

Parse, R.R., Coyne, A.B., & Smith, M.J. (1985). The experience of aging. An ethnographic study. In R.R. Parse, A.B. Cohen, & M.J. Smith (Eds.) Nursing research. Qualitative methods (pp. 79-89). Bowie, MD: Brady Communications.

Pearlman, R.A., & Ryan-Dykes, M. (1986). The vulnerable elderly. Journal of Gerontological Nursing, 12 (9), 15-18.

Pincus, A. (1968). The definition and measurement of the institutional environment in homes for the aged. The Gerontologist, 8, 207-210.

Pino, C.J., Rosica, L.M., & Carter, T.J. (1978). The differential effects of relocation on nursing home patients. The Gerontologist, 18, 167-172.

Raasok, S.M. (1979). Nursing home bed utilization in Alberta: A patient origin-destination study. Unpublished master's thesis, University of Alberta, Edmonton, Alberta.

Rakowski, W., & Clark, N.M. (1985). Future outlook, caregiving and care-receiving in the family context. The Gerontologist, 25, 618-623.

Rosen, T. (1981). The significance of the family to the resident's adjustment in a home for the aged. In G.H. Weber (Ed.), Assisting the elderly in long-term care (pp. 235-249). Springfield IL: Charles C. Thomas.

Rutman, D.L., & Freedman, J.L. (1988). Anticipating relocation: Coping strategies and the meaning of home for older people. Canadian Journal on Aging, 7, 17-31.

Schultz, R., & Brenner, G. (1977). Relocation of the aged: A review and theoretical analysis. Journal of Gerontology, 32, 323-333.

Schwenger, C. (1983). An overview of our health care system for the elderly. In E. Gallagher, M. Jackson & G. Zilm (Eds.), Proceedings of the First National Conference on Gerontological Nursing (pp. 1-10). Victoria, British Columbia, Canada: University of Victoria, School of Nursing.

Sigman, S.J. (1986). The applicability of the concept of recruitment to the communications study of a nursing home: An ethnographic case study. International Journal on Aging and Human Development, 22, 215-233.

Smallegan, M. (1985). There was nothing else to do: Needs for care before nursing home admission. The Gerontologist, 25, 364-369.

Spooner, C.B. (1980). The provision of long-term care for the Canadian elderly: A selective review of literature and utilization data. Unpublished master's thesis, University of Alberta, Edmonton Alberta.

Stannard, C. (1978). Old folks and dirty work: The social conditions for patient abuse in a nursing home. In R. Dingwell & J. MacIntosh (Eds.), Readings in the sociology of nursing (pp. 164-180). Edinburgh: Churchill.

Stein, S., Linn, M.W., & Stein, E.M. (1985). Patients' anticipation of stress in nursing home care. The Gerontologist, 25, 88-94.

Steinberg, A., Fitten, L.J., & Kachuk, N. (1986). Patient participation in treatment decision-making in the nursing home. The issue of competence. The Gerontologist, 26, 362-366.

Storandt, M., & Wittels, I. (1975). Maintenance of function in relocation of community-dwelling older adults. Journal of Gerontology, 30; 608-612.

Turner, B.F., Tobin, S.S., & Leiberman, M.A. (1972). Personality traits as predictors of institutional adaptation among the aged. Journal of Gerontology, 27, 61-68.

Wolk, S., & Telleen, S. (1976). Psychological and social correlates of life satisfaction as a function of residential constraint. Journal of Gerontology, 31, 89-98.

Woodward, N.J., & Wallston, B.S. (1987). Age and health care beliefs: Self-efficacy as a mediator of low desire for control. Psychology and Aging, 2, 3-8.

Appendix 1

Relocation Effects Literature Review

Table 6

<u>Effects of Relocation:</u>

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes[3]
Beaver (1979)	n=108 ADJUSTERS 56 NON-ADJUSTERS 52	home to high-rise	cross-sectional retrospective	decision model utilized	adjusters were involved in decision; maintained activity levels
Blenker (1967)	n=64(random assignment) E-high intensity service C-normal services community residents	home-institution	longitudinal chart review	admission to institutions	↑ # (E) admitted ↑ mortality of (E)
Borup (1981)	n=326 able to be interviewed	interinstitutional involuntary old to new	longitudinal	attitudes towards move	attitudes changed over time; ↓ adjustment related to age, gender
Borup (1982)	n=556 MOVERS 326 NONMOVERS 249	interinstitutional involuntary old to new	longitudinal	health functioning: mortality	moved group showed an improvement; nonmovers a deterioration

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes
Bourestom & Tars (1974)	n=98 MOVER 1 radical change Mover 2 moderate change NON-MOVER	interinstitutional involuntary old to new bad to good	longitudinal	mortality, health, psychosocial	↑ mortality in MOVER 1 group
Brand & Smith (1974)	n=137 VOLUNTARY 69 INVOLUNTARY 68	home to home old to new	cross-sectional interview	life satisfaction	frail elderly experienced adverse effects
Brody et al. (1974)	n=48 interviewable	interinstitutional involuntary	longitudinal questionnaire	adjustment	adjustment is time bound positive relationship between personality and adjustments or attitude & adjustment
Chenitz (1986)	n=30 interviewable	home to institution	grounded theory interviews	description of relocation process	identified relocation as a crisis
Engle (1985)	n=57 rehabilitative short-term patients	hospital-institution	longitudinal interviews	A.D.L. mental function	immediate reduction of capacities followed by improvement

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes
Gottesman &Bourestom (1974)	n=40 homes n=1144 residents n=200 nurses aides	n/a	cross-sectional observations	behaviours	most patients require assistance; majority of activity was passive; ↑ disability received ↑ care time
Grant (1984)	n=159 mixed health	home to institution	cross-sectional chart audit	psychological stress	psychological stress related to time; ↑ stress related to ↓ control over move
Gutman & Herbert (1976)	n=81 mixed health levels males	interinstitutional involuntary old to new bad to good	longitudinal comparison with past five years	mortality	NO ↑ mortality in relocated group
Gutman & Stark (1986)	n=3516 mixed health	home to institution	longitudinal chart audit	mortality	mortality related to age; gender; 30% deaths occurred at level of initial admission
Harel (1981)	n=125 "elite"	n/a	cross-sectional observation interviews questionnaires	congruence person-environment; wellbeing	person-environment match ↑ wellbeing

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes
Harel & Noelker (1982)	n=125 "elite"	n/a	cross-sectional	social integration; wellbeing	↑ social integration contributed to ↑ wellbeing; ↑ choice contributed to ↑ wellbeing
Hulicka (1975)	n=50 COMMUNITY 25 INSTITUTION 25 females healthy	n/a	cross-sectional questionnaire	choice, self concept, life satisfaction	Institution scored ↓ choice overall Institution scored ↓ self concept & life satisfaction
Kahana et al. (1987)	n=253 ambulatory healthy	home to institution	longitudinal	coping strategy psychosocial indicators	little change in coping patterns; instrumental coping = positive adjustment affective coping = negative
Leiberman et al. (1968)	n=99(matched groups) Community: 40 Waiting List: 25 Institution: 34 healthy	home-institution	cross-sectional structured questionnaire	21 psychosocial indicators	↑ # adverse reactions in waiting list group; institution group experienced adverse effects

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes
Melanson & Meagher (1986)	n=9 (residents)	home-institution	ethnography	perceptions and behaviour	see selves as as tamed, a prisoner, outsider and a survivor
Miller & Leiberman (1965)	n=45 women ambulatory considered in good health	interinstitutional radical change mass transfer	longitudinal interviews qustionnaires	mortality psychological adequacy	23 showed negative changes
Mirotznik & Ruskin (1984)	n=45 random selection mostly non-elderly healthier	interinstitutional poor-good involuntary intensive orientation	longitudianal interviews chart audit	health status mortality psychosocial status	NO effects related to relocation; poor health prior to relocation related to negative relocation effects
Pino (1978)	n=100 25 home to institution 25 institution to Institution (no planning) 25 Institution to Institution (planning) 25 Nonmovers	interinstitutional preparation according to group assignment	longitudinal	health status life satisfaction	planning fostered adjustment

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes
Sigman (1985)	n=2 (facilities)	n/a	ethnographic	patterns of communication	staff and family do not expect facilitate or promote conversation between patients; attitude held that patients are not interested
Stannard (1978)	n=1 home	n/a	ethnography	patterns of abuse	structure of organization facilitated abusive situations
Stein et al. (1985)	n=223 interviewable	home to institution hospital to institution	cross-sectional interviews	patient adjustment expectations; health status satisfaction	moderate anticipation of difficulty concerns were individual; ↑ negative feeling related to ↑ anticipated problems activity levels
Stordant & Wittles (1975)	n=123 MOVERS 89 NONMOVERS 34	home to home old to new voluntary	longitudinal interviews	psychosocial indicators of health & life	NO changes related to relocation

Researcher	Sample Description	Relocation Description	Design/Method	Indicators	Outcomes
Turner et al. (1972)	n=85 ambulatory healthy	home to institution voluntary "good"	longitudinal	adaptation personality traits	negative traits correlated with positive adaptation; ↑ congruence related to ↑ adjustment
Wolk & Telleen (1976)	n=129 SETTING A 51(restricted) SETTING B 78 (controlled) non-random attemt to control bias ambulatory	n/a	cross-sectional comparison of controlled vs open environment	mixed indicators of life satisfaction	controlled setting had negative effect

Appendix 2

Explanatory Letter

TELL ME ABOUT

YOUR EXPERIENCE OF SEEKING PLACEMENT IN A NURSING HOME

Cheryl Knight, a graduate student at the University of Alberta, Faculty of Nursing is anxious to speak with elderly persons who are considering relocation to a nursing home. Cheryl Knight has an interest in understanding the situation that led to the consideration of a nursing home and what steps were taken to seek placement.

The importance of finding out what it is like to seek placement is meaningful and relevant for nurses who care for elderly persons. The sheer numbers of older, dependent persons in today's Canadian population make it essential that support programs, both in the community and within institutions, are developed to meet actual needs.

Cheryl is interested in speaking with both the older person considering placement and others significant in this experience, to find out their point of view about this life change. All information will be kept strictly confidential.

Anyone interested in speaking with Cheryl about their experience, please let the Central Assessment and Placement Nurse know or call 471 - 5856 so that a visit may be arranged.

THANK YOU!

Appendix 3

Telephone Introduction

The researcher will use the following as a guide to introduce herself and to arrange a visit to the elderly person's pre-admission location for the interview:

Thank you for allowing me to contact you about my research project. Let me tell you a little bit about my study. I am trying to find out what, from your point of view, it is like to consider nursing home placement. In order to do that, I would like to visit you either in your home or at a place that you consider to be convenient, to have a private conversation about your experience. I will be tape-recording the interview because I know it will be difficult for me to remember everything that is said, and it is important to me to be accurate. It is also important to me that we have our conversation in private. Placement is sometimes an emotional time for people. I want you to feel as comfortable as possible while sharing with me that which you feel that you can.

I would also like to speak with the person that you feel has been important to you during this experience. I would like to meet with them in private as well so that I can understand what this time has been like for them. The information from one person will not be shared with the other. If we think it will be valuable I may ask to meet with you a third time, together, to help me sort out some of the questions that I have from the previous interviews.

I am asking for your time and assistance because I believe that you, by virtue of your experience, are the expert in the area of placement. I would appreciate your sharing your expertise with me. If you still agree, when could we meet and where would be a good place for us to speak in private?

Appendix 4

Informed Consent Form: Primary Informant

Masters Candidate:	Thesis Advisor:
Mrs. Cheryl L. Knight 3322 - 106 Avenue Edmonton, Alberta T5W 0C2	Dr. M. Allen 3 - 103B Clinical Sciences University of Alberta Edmonton, Alberta T6G 2G3

Project Title: The Experience of Seeking Nursing Home Placement
Investigator: Cheryl L. Knight, Bsc. N. 471 -5856
Institution: University of Alberta, Faculty of Nursing
Supervisor: Dr. M. Allen 432 - 6411

This project is being carried out as partial requirement toward a Masters Degree in the Faculty of Nursing, the University of Alberta.

The purpose of this project is to increase nurses' understanding of the experience of seeking placement. Interviews will be conducted up to three times, in private, at a mutually convenient time and place. Each interview will last approximately one hour.

The first scheduled interview will involve only the person for whom placement is being sought. Questions will be asked regarding your feelings about the experience of seeking nursing home placement.

The researcher will then ask your permission to interview the person you consider to be significant to you in your experience of seeking placement. The information you provide in your interview will not be shared with this person, nor will their information be shared with you, unless you both give the researcher permission to do so.

Should it be necessary, the researcher will request that a third scheduled interview involve both individuals to clarify the sequence of events leading to your consideration of placement.

These interviews will be taped. The tapes will be shared with the researcher's thesis committee so that the progress of the research may be monitored. All names will be erased from the tapes. The final report will include anonymous quotations.

Participation in the study will not affect your placement status, or influence the level of care you will receive.

There may be no direct benefits to the participants of the study, but the information may be helpful to plan future nursing assistance to individuals experiencing placement.

THIS IS TO CERTIFY THAT I, ____________________
HEREBY AGREE TO PARTICIPATE AS A VOLUNTEER IN THE ABOVE NAMED PROJECT.

I understand that there are no health risks to me resulting from my participation.

I hereby give my permission to be interviewed and for the interviews to be tape recorded and transcribed.

I understand that at the completion of the research, the tapes will be erased, and the transcripts destroyed. I understand that the information may be published, including anonymous quotations but that my name will not be associated with the research.

The information I provide will remain confidential unless the researcher believes that my safety is at risk. I will be reminded that the researcher is obligated to report such a situation.

I understand that I am free to refuse to answer any questions that are asked of me. I also understand that I may refuse to allow the researcher to approach another person involved in my placement decision. I understand that I am free to withdrew my consent and terminate my participation at any time, without fear of penalty.

I have been given the opportunity to ask questions and all such questions have been answered to my satisfaction.

DATE ________ PARTICIPANT____________

WITNESS ____________ RESEARCHER ____________

Consent Form: Significant Other

Masters Candidate:	Thesis Advisor:
Cheryl L. Knight 3322 - 106 Avenue Edmonton, Alberta T5W 0C2	Dr. Marion Allen 3 - 103B Clinical Sciences University of Alberta Edmonton, Alberta T6G 2G3

Project Title: The Experience of Seeking Nursing Home Placement
Investigator: Cheryl L. Knight, Bsc. N. 471 - 5856
Institution: University of Alberta, Faculty of Nursing
Supervisor: Dr. Marion Allen 432 - 6411

This project is being carried out as partial requirement toward a Masters Degree in the Faculty of Nursing, the University of Alberta.

The purpose of this project is to increase nurses' understanding of the experience of seeking nursing home placement. Interviews will be conducted up to three times, in private, at a mutually convenient time and place. Each interview will last approximately one hour.

The first scheduled interview will involve only the person for whom placement is being sought. At that time, the researcher will ask their permission to approach a person significant to them in their nursing home placement seeking experience.

The second scheduled interview will involve only you, the designated significant other. Questions will be asked regarding your reflections of how the nursing home placement seeking experience has evolved. You may be able to provide the researcher with information that the elderly person has forgotten, or with insight that the elderly person cannot perceive in their experience. The information that you provide will not be shared with the other person, nor their information with you, unless you give the researcher permission to do so.

The researcher may request that a joint interview take place to confirm the sequence of events involved in the consideration of nursing home placement. Such a joint interview will only take place with your permission.

These interviews will be tape recorded. The tapes will be shared with the researcher's thesis committee so that the progress of the research may be monitored. All names will be erased from the tapes. The final report will include anonymous quotations.

Participation in the study will not affect the elderly person's placement status or influence the level of care they will receive.

There may be no direct benefits to the participants of the study, but the information may be helpful to plan future nursing assistance to individuals experiencing placement.

THIS IS TO CERTIFY THAT I, ______________________
HEREBY AGREE TO PARTICIPATE AS A VOLUNTEER IN THE ABOVE NAMED PROJECT.

I understand that there are no health risks to me resulting from my participation.

I hereby give my permission t be interviewed and for the interviews to be tape-recorded and transcribed.

I understand that at the completion of the research, the tapes will be erased and the transcripts destroyed. I understand that the information may be published, including anonymous quotations but that my name will not be associated with the research.

The information that I provide will remain confidential unless the researcher believes that my safety or the safety of the elderly person seeking placement is in jeopardy.

I understand that I am free to refuse to answer any question. I also understand that I am free to withdraw my consent and terminate my participation at any time, without risk of penalty to myself or to the elderly person seeking placement.

I have been given the opportunity to ask questions and all such questions have been answered to my satisfaction.

DATE ____________ PARTICIPANT ____________

WITNESS ____________ RESEARCHER ____________

Appendix 5

Assessment Questions Emerging from the Process of Considering Placement

1. Who is being considered for placement?
2. What personal characteristics place them at risk for placement?
3. Who initiated the referral for placement?
4. Why has consideration of placement come about?
5. Does the elderly individual perceive himself/herself as being able, holding on, or being unable?
6. What was the change event leading to placement consideration?
7. How has the change event interfered with being able tasks?
8. Have other care alternatives been considered and eliminated?
9. Is the referred elderly person satisfied with the elimination of other alternatives?
10. Who else is involved in this decision?
11. Is there congruency between the elderly person's perceptions of need and the opinions of the other people involved?
12. What are the elderly person's expectations of the nursing home environment in terms of anticipated assistance and anticipated losses?
13. What tasks are involved in this individual's relocation work?
14. Are there areas of relocation work that will require assistance or coordination?